



MINNESOTA
MEDICAL
ASSOCIATION

MMA Policies

2013

(reflects policies adopted through April 30, 2013)

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MMA Policies–2013

10 Abortion

10.01 Disposal of Aborted Fetuses

The MMA opposes legislation requiring the cremation or interment of aborted fetuses on constitutional grounds and because there is the lack of a public health or nuisance problem.
(BT-2/86; Retained 2004)

10.02 Adoption of AMA Position on Abortion

The MMA supports the current AMA position on abortion which states as follows: "The AMA reaffirms that (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his or her state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as withdrawal is consistent with good medical practice."
(BT-1/90 ; Retained 2004)

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)

10.04 Abortion Data Reporting

The MMA will support legislation to repeal the additional abortion data reporting requirements passed by the 1998 Legislature (1998 Minnesota Session Laws Chapter 407, Article 10) because the requirements are too intrusive in the physician-patient relationship and lack sound public health rationale.
(HD-R309-1998; Retained as edited 2008)

10.06 Repeal of 1998 Abortion Reporting Laws

The Minnesota Medical Association will continue to work toward repeal of Minnesota Statute 145.4131 et seq. relating to the reporting of abortion procedures and complications.
(HD-R211-1999)

10.08 Family Planning Gag Clause

The MMA opposes legislation (HF436/SF431, introduced during the 2003 legislative session) that affects the physician/patient relationship by restricting the information that providers give to patients. Specifically, the legislation prohibits the use of state family planning grants for abortions, for any counseling that promotes abortion, or for referral to a health care provider who performs abortions. These grants include the family planning grant funds distributed through the maternal and child health block grant program, the family planning special projects grant program, grants to eliminate health disparities, and "any other state grant program whose funds are or may be used to fund family planning services". This policy is based on opposition to the state interfering in the physician/patient relationship regardless of the issue being discussed.
(BT-3/03)

10.09 Intact Dilatation And Extraction

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

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

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

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

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

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

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

(HD-R403-2003)

10.1 Anesthetics in Abortion

The Minnesota Medical Association (MMA) opposes current legislation that would impose criminal penalties on a physician for failing to first inform a patient receiving an abortion (after 20 weeks) if an anesthetic or analgesic would eliminate or alleviate pain to the fetus.

(BT-03/2005)

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)

10.12 Anesthetics in Abortion

The Minnesota Medical Association (MMA) opposes current legislation that would impose criminal penalties on a physician for failing to first inform a patient receiving an abortion (after 20 weeks) if an anesthetic or analgesic would eliminate or alleviate pain to the fetus.

(BT-03/2005)

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)

20 Access to Health Care

20.01 Access to Psychiatric Treatment in Health Care Plans

The MMA believes that HMOs and other third party payment mechanisms, both public and private, should provide full disclosure of accurate information concerning all benefits and services to their actual or potential enrollees or subscribers which includes but is not limited to the following: the experience and qualification of the providers whom the patient will see, the opportunity for reimbursed referral or consultation, the copayment amount, if any, and the number of visits or days which are covered by the HMO or third party payment program.

(HD-SR11-1984; Retained 2004)

20.02 Medicaid Reimbursement to Assure 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)

20.06 Definition of Terms

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

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

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

(BT-7/94; Retained 2006)

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

The MMA supports the preservation of a woman's ability to directly access preventive health, diagnostic, and treatment services provided by obstetricians and gynecologists.

(HD-R7-1995; Retained 2005)

20.11 Prisoners' Health Care

The Minnesota Medical Association shall study the issues of access to and payment for appropriate medical care for prisoners (including those on work release) as well as adolescents in out-of-home placements.

(HD-R319-2006)

20.12 Providing Health Care to Undocumented Residents

Our Minnesota Medical Association (a) 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; (b) 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 (c) opposes proof of citizenship as a condition of providing health care.

(HD-R300-2008)

20.13 Adequate Access

We as Minnesota physicians affirm our obligation to enhance availability of medical care by our own actions and also by a commitment to influence political leaders who make many of the decisions concerning availability of care.

(HD-R306-2008)

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

The Minnesota Medical Association will explore strategies for how to best improve access to and availability of high-quality geriatric care.

(HD-R305-2012)

20.15 Transgender Health Access

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

(HD-R307-2012)

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

30.01 Physician Education Regarding Prenatal AIDS Transmission and Control

The MMA will promote appropriate AIDS education of family practice, OB/Gyn and other physicians who provide family planning, prenatal and delivery care to women at risk of AIDS.

(HD-R4-1986I; Retained 2004)

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

The MMA adopts the Committee on Ethics and Medical-Legal Affairs recommendations contained in the MMA Committee on Ethics and Medical-Legal Affairs Report Clarifying a Physician's Ethical and Legal Obligations to Treat HIV-Infected Patients.

1. The MMA Committee on Ethics and Medical-Legal Affairs recommends that the MMA Board of Trustees adopt as MMA policy the AMA ethical principles and opinions referenced as follows:

- 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)

2. The MMA Committee on Ethics and Medical-Legal Affairs also recommends:

- a. The MMA recommends to physicians who believe it is necessary to refuse to treat HIV-infected patients to carefully document the facts and underlying reasons for their decisions not to treat, and

- that the MMA strongly recommends that these physicians 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.
- b. The MMA should educate physicians about their ethical and legal obligations to treat patients infected with HIV through publication of this report in [the June 1992 issue of] *Minnesota Medicine*. (BT-3/92; Retained 2004)

30.1 HIV/HBV Joint Task Force Report

I. GOALS OF RECOMMENDATIONS

The task force recommendations are intended to strengthen current infection control procedures for the prevention of transmission of HIV from infected health care workers to patients, and to help allay public fear through a rational approach for the management of HIV infection control in the health care setting. The task force initially intended to more fully address the issue of HBV transmission from health care workers to patients, but decided instead to focus primarily on HIV infection because of the greater need to develop public policy on this important issue.

Specifically, the recommendations attempt to meet the following set of goals:

- A. Enhance trust in the health professions;
- B. continue to provide an infection control system for the prevention of HIV transmission from infected health care workers to patients;
- C. enhance the current system of oversight that is based on scientific expertise and that encourages health care workers to seek treatment and counseling;
- D. continue to provide an efficient, cost-effective, and flexible system capable of change within the rapidly changing environment that surrounds this issue;
- E. enhance the current system of infection control that provides a comprehensive and consistent method of infection control for both licensed and unlicensed health care workers; and
- F. continue to provide a process that protects the due process and privacy rights of health care workers, and that maintains consistency with state and federal anti-discrimination laws.

II. SUMMARY OF TESTING COMMITTEE RECOMMENDATIONS

- A. Based on current data, costly and intrusive routine or mandatory testing of health care workers is not justified and is not recommended, nor should it be a requirement for employment, credentialing and licensure, or used in professional liability insurance underwriting.
- B. All persons who have engaged in behaviors that place them at risk for HIV, or individuals who have received blood products or blood transfusions between 1978 and 1985 should learn their HIV status.
- C. All health care workers are encouraged to undergo personal assessments to determine their need for HIV testing. Testing must be on a voluntary basis. These assessments should include known high-risk behaviors described in the August 14, 1987, "CDC Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS," as well as risks associated with health care related occupational exposure.
- D. HIV antibody test results of health care workers shall be maintained as private information and not disclosed to anyone other than as provided under the data privacy section of this report.
- E. Universal precautions must be used for all procedures. Should an inadvertent exposure occur, follow-up testing should be undertaken as recommended by the August 21, 1987, CDC guidelines.

- F. Currently acceptable guidelines for HBV infection control should be followed and health care workers who are not HBV immune should be vaccinated, when appropriate.
- G. Health care workers should become educated in HIV risk factors, in obtaining adequate medical histories that determine HIV risk factors, and in counseling of patients who test positive for HIV.

III. SUMMARY OF REPORTING, RESTRICTIONS, MONITORING AND DATA PRIVACY RECOMMENDATIONS

The following recommendations address HIV-infected health care workers only and do not address the issue of health care workers infected with HBV. Other published guidelines should be followed for the management of HBV in the health care setting.

- A. Infection Control Responsibilities of the Minnesota Department of Health.
 - 1. The joint task force recommends that the Minnesota Department of Health and an expert review panel within it be responsible for the management of HIV infection control in the health care setting. The Minnesota Department of Health's expert review panel should:
 - a. receive HIV antibody test results from HIV-infected health care workers required to report;
 - b. investigate health care workers required to report to determine their personal health status;
 - c. investigate reported health care workers' practices to determine whether look-backs or restrictions of practice are necessary;
 - d. formulate a plan of action to limit the spread of infection; and
 - e. implement the plan of action and monitor compliance.
 - 2. The Minnesota Department of Health will convene an expert review panel composed of experts who represent a balanced perspective. Expert review panel members will include the following individuals:
 - a. the infected health care worker's personal physician;
 - b. an infectious disease specialist with expertise in the epidemiology of HIV transmission;
 - c. health care professional who has expertise in the procedures performed by the preferably this would be a person from the health care worker's place of employment who routinely has demonstrated an interest in the development of infection control policies;
 - d. state and, if appropriate, local public health officials (state public health officials should include one or two representatives from the state AIDS Epidemiology Unit of the Minnesota Department of Health);
 - e. a member of the infection control committee from the health care worker's place of employment, if such a committee exists; and a representative from the Minnesota Department of Human Rights.
 - 3. The actions of the Minnesota Department of Health and the expert review panel will be undertaken in a manner that protects a health care worker's due process rights. In addition, the Minnesota Department of Health and the expert review panel will institute restrictions that are consistent with requirements of anti-discrimination laws and that provide reasonable accommodation for health care workers.
- B. Method of Oversight.
 - 1. Reporting.
 - a. Licensed and unlicensed HIV-infected health care workers will report their HIV-reactive antibody test results to the Minnesota Department of Health consistent with Minnesota Statutes.

Reporting to the Minnesota Department of Health will be required of only those licensed and unlicensed HIV-infected health care workers whose practices pose a significant risk of transmission of the HIV virus. "Practices posing a significant risk of transmission" will be defined by the CDC or the Minnesota Department of Health using current nationally accepted infection control standards and criteria.

If "practices posing a significant risk of transmission" are not defined by the CDC or by the Minnesota Department of Health, all HIV-infected health care workers will be required to report to the Minnesota Department of Health.

- b. Reporting to health care facilities by HIV-infected health care workers will occur simultaneously with reporting to the Minnesota Department of Health. It is the responsibility of the HIV-infected health care worker to review the HIV policy at his or her health care facility and to comply with the reporting requirements of the facility.

2. Restrictions.

- a. Health care workers who, through standard serologic testing, are known to carry HIV and who engage in practices that pose a significant risk of transmission of the HIV virus to patients will follow restrictions established by the Minnesota Department of Health's expert review panel. The expert review panel will use current nationally accepted infection control standards and criteria to establish restrictions for HIV-infected health care workers.
- b. A health care facility's designated individual will be informed by the Department of Health's expert review panel if the expert review panel determines that restrictions of practice are necessary. Health care facilities will cooperate with the Minnesota Department of Health through development of appropriate policies and procedures for implementation of practice restrictions. The health care facility may institute its own infection control or peer review process prior to state action. Health care facilities' policies and procedures for implementation of practice restrictions must provide a sense of fairness and reasonable accommodation for health care workers. Reasonable accommodation will be made in compliance with anti-discrimination laws and in a manner that will allow infected health care workers to remain in a position of similar professional status in the health care facility.
- c. Licensed health care workers who know their HIV-infected status and fail to report to the Minnesota Department of Health consistent with Minnesota Statutes, will be subject to disciplinary action by their respective licensing boards.
- d. Licensed health care workers who have reported their HIV-infected status to the Minnesota Department of Health and then refuse to comply with restrictions established by the expert review panel will be subject to disciplinary action by their respective licensing boards.

3. Monitoring.

- a. The expert review panel will evaluate the health care worker's practice to recommend whether patients should be notified of the potential for exposure from past practices that posed a significant risk of transmission of HIV to patients, i.e., the expert review panel will recommend whether look-backs are necessary. In determining whether a look-back will be conducted, the expert review panel will consider each health care worker's practice on a case-by-case basis, taking into consideration an assessment of specific risks, confidentiality issues, and available resources. If the expert review panel determines that patient notification is necessary, only those patients who have incurred an identifiable significant risk of transmission of the HIV virus in the health care setting will be notified in writing by the expert review panel. The expert review panel will attempt to avoid disclosing the identity of the infected health care worker.
- b. The Minnesota Department of Health's expert review panel may contract with a health care facility, a professional organization or a qualified independent consultant to monitor the HIV-infected health care worker's practices and ensure that the health care worker is complying with restrictions. The party providing monitoring services will file periodic reports with the expert review panel and will report noncompliance of practice restrictions immediately to the Minnesota Department of Health. The Minnesota Department of Health will report immediately to the appropriate licensing board any incidence of noncompliance of practice restrictions by a licensed health care worker. License restriction, suspension, revocation or other disciplinary actions will be taken as necessary by the licensing boards in response to noncompliance with practice restrictions.

- c. Legislation should be enacted authorizing the Minnesota Department of Health's expert review panel to review confidential patient medical records, health care facility infection control documents, internal health care facility office records, and other information relevant to the health care worker's HIV-infected status.
 - d. Health care facilities will designate a contact person to communicate with the expert review panel and, if needed, the licensing boards.
4. Data Privacy.
- a. Health care facility information relating to the HIV-infected status of health care workers will be maintained as private information and not disclosed to anyone other than to the health care worker, the health care facility's designated individual, individuals monitoring restrictions, and to other people as expressly required by law. Proceedings will be private, and all data and information acquired during any proceeding will be private and will not be disclosed to anyone other than to those individuals as set forth above and as expressly required by law.
 - b. Any legislation enacted should require the Minnesota Department of Health, the expert review panel and the licensing boards to keep the HIV-infected status and any related information on the HIV-infected health care worker private, provided the HIV-infected health care worker is abiding by practice restrictions.
 - c. Legislation enacted should expressly prohibit parties (except those parties criminal prosecutions any information gathered by the health care facility of the HIV-infected health care worker, by the Minnesota Department of Health or its expert review panel, or by the licensing board, including but not limited to investigative information, recommendations, restrictions, periodic compliance reports, and records of proceedings.
 - d. If possible under the Health Care Quality Improvement Act, legislation respecting practice restrictions should be drafted in such a way that it is not necessary to report to the National Practitioner Data Bank restrictions placed on a health care worker's practice, unless the health care worker fails to comply with practice restrictions and, as a result, the licensing board has taken disciplinary action against the health care worker.
- C. Liability.

Legislation should protect the expert review panel and parties contracting with the expert review panel from civil liability for actions that are taken in good faith.

IV. SUMMARY OF EDUCATION/LEGISLATIVE COMMITTEE RECOMMENDATIONS

- A. Public education should be conducted to help the public understand HIV and HBV transmission issues as they pertain to health care workers.
- B. Education of health care workers should be conducted so that they may gain a better understanding of the need for universal precautions and infection-control measures.
- C. Education of public officials should be conducted to help them better understand the public policy issues that need to be addressed for limiting the transmission of HIV and HBV.

V. DEFINITIONS

- A. Health Care Facility.
A health care facility includes a hospital, clinic, institution, office practice, nursing home, home health agency, or any place at which health care services are provided.
- B. HBV.
Hepatitis B virus.
- C. Health Care Workers.

Health care workers are defined as persons, including students and trainees, whose activities involve direct physical contact with patients. Such individuals include, but are not limited to, physicians, nurses, nursing assistants, dentists, dental hygienists, dental assistants, and laboratory and diagnostic technicians. Health care workers may include individuals who are employed by, who have contracts with, or who have staff privileges at a health care facility.

- D. HIV.
Human immunodeficiency virus.
- E. Private Data.
Data that are not public and that are accessible to the individual subject of the data.
(BT-2/92; Retained 2004)

30.13 HIV Testing of Pregnant Women

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

30.14 AIDS Testing

The MMA supports a standard of medical practice that approaches HIV like other infectious agents and AIDS like other infectious diseases.
(HD-R17-1996; Retained 2006)

40 Advertising:

40 Physician/Health Care Advertising

40.01 Advertising of Prescription Drugs

The MMA believes that the AMA should reaffirm its opposition to the advertising of prescription drugs directly to the public and urges the Federal Trade Commission staff to distinguish the unofficial nature of this position in future statements.
(BT-11/85; Retained 2004)

40.03 Tobacco Advertising

The MMA supports banning tobacco advertising.
(BT-1/89) (Retained 2004)

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)

40.06 Monitor Health Care Advertising

The MMA will maintain a vigilant surveillance of the truth of advertising statements made by insurers regarding the breadth of benefits and services they provide.
(HD-R11-1987; 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)

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)

40.09 Board Certification Claims in Advertising

The MMA supports legislation prohibiting inappropriate claims of board certification in physician advertising.
(BT-1/91; Retained 2004)

40.1 Over-the-Counter and Direct-to-Consumer Genetic Testing Kits

The Minnesota Medical Association will provide information to its membership about over-the-counter and direct-to-consumer genetic testing kits including potential issues related to informed consent and general information about genetic counselors.
(HD-R410-2010)

50 Alcohol and Alcoholism/Chemical Dependency

50.02 Commitment Procedures

The MMA recommends that the commitment procedure should be different for inebriated patients than for mentally ill patients. The 72 hour emergency hold for inebriated patients should not include weekends and holidays, whereas the 72 hour emergency hold for mentally ill patients should include weekends and holidays.

(HD-RPT403-1981; Retained 2010)

50.03 Chemical Dependency Education in the Medical Profession

The MMA believes that increased opportunities to obtain information and training about chemical dependency should be encouraged and developed in the medical profession.

(HD-R8-1981)

50.04 Education on the Effects of Alcohol

In the interests of public safety, the MMA will sponsor legislation requiring the posting of charts in all liquor stores which indicate the effect of varying numbers of drinks in relation to body weight. The MMA encourages schools to make similar information available to all students.

(HD-R26-1982)

50.07 Alcohol and Chemical Dependency

The MMA encourages efforts to improve undergraduate medical curriculum content regarding the early identification and treatment of alcoholism and other chemical dependency related diseases.

(HD-R21-1985; Retained 2004)

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)

50.1 Blood Alcohol Standard

The MMA supports reducing the blood alcohol standard for legal intoxication from .10 to .05.

(BT-1/89)

50.11 Alcohol Advertising on Television

The MMA urges state and county auxiliaries, with the approval of and in cooperation with the corresponding state and county medical societies or associations, to encourage removal of alcoholic beverage ads from television.

(HD-SR30-1989)

50.13 Driving While Intoxicated Penalties

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

(HD-R43-1993; Retained 2004)

50.14 Alcohol Screening

The MMA will educate Minnesota physicians about the content and value of the CAGE (cutting down, being annoyed, feeling guilty, and using eye openers) questionnaire as a screening tool for detecting alcohol abuse.

(HD-R50-1996; Retained 2006)

50.15 Alcohol Excise Tax

The MMA reaffirms its existing policy to support an increase in the alcohol excise tax. (HD-R52-1996; Retained 2006)

50.16 Alcohol and Tobacco Promotions

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

50.17 Reporting of Impaired Drivers

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

(HD-LR208-1997)

50.18 Youth Access to Alcohol

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

(HD-LR320-1997)

50.19 Consensus Statement of the Physician Leadership on National Drug Policy (PLNDP)

The MMA endorses the Consensus Statement of the Physician Leadership on National Drug Policy and support the re-allocation of resources toward prevention and treatment of drug addiction to reduce the supply and demand for illegal and addicting drugs.

The MMA supports the Consensus Statement of the Physician Leadership on National Drug Policy, and will advocate for increased support for treatment, including treatment while in prison, and support for drug courts and drug testing of parolees and probationers.

(HD-R411-1999; Retained 2009)

50.2 Methadone Maintenance Treatment

The Minnesota Medical Association shall endorse American Medical Association policies H-95.957 and H-95.964 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 stated in the 1971 guideline on Oral Methadone Maintenance Techniques in the Management of Morphine-Type Dependence 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)

H-95.964 New Guidelines and Regulations for Methadone Maintenance Treatment:

The AMA:

1. Supports the development of new methadone treatment guidelines and regulations with a shift of emphasis from administrative process to performance-based standards of care with greater reliance on the physician's clinical judgment and scientific data in determination of treatment.
2. Encourages the appropriate governmental agencies to provide the needed resources to allow the development of realistic methadone treatment outcome standards with provisions to allow for differences among methadone maintenance treatment program patient populations. (HD-R407-2000)

50.23 Funding For Chemical Dependency Medical Services

The Minnesota Medical Association endorses assigning a portion of the proceeds of the taxes on alcoholic beverages for the following specific purposes: Residential detoxification services; Outpatient chemical dependency assessments and treatment; and Necessary medical care for uninsured individuals enrolled in or detained within these programs.

(HD-R200-2003)

50.24 Methamphetamine Manufacture & Distribution

The Minnesota Medical Association (MMA) will work with appropriate state and local agencies to develop a strong public awareness that people manufacturing and distributing methamphetamine are placing people at risk for severe, debilitating, long-term health problems, and even early death. The MMA will support effective methods, strategies and funding to eradicate use and production of methamphetamines, and support penalties and other intervention strategies shown to be effective to rehabilitate persons convicted of manufacturing and distributing methamphetamines.

(HD-R413-2004)

50.25 Methamphetamines

The Minnesota Medical Association (MMA) supports legislation to classify methamphetamine precursor drugs, defined as any compound, mixture, or preparation containing ephedrine or pseudo-ephedrine as its sole active ingredient or as one of its active ingredients as Schedule V.

(BT-03/2005)

50.26 Alcohol Health Impact Tax

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

(HD-SR201-2006)

50.27 MMA Promotion of Addiction Awareness and Community Collaborations

The Minnesota Medical Association supports evidence-based approaches to the prevention of drug abuse by encouraging physicians to participate in continuing medical education to improve their skills in diagnosis, referral, and treatment of patients with alcohol and drug abuse problems, including illicit and prescribed drugs. The MMA will publicize evidence about drug and alcohol abuse as a preventable and treatable major health problem, and will encourage primary and secondary schools and colleges to provide chemical dependency education programs as part of their curricula.
(HD-R204-2009)

50.28 Economic Interventions for Excessive Alcohol Consumption

The Minnesota Medical Association continues to support efforts to reduce excessive use of alcohol by increasing the alcohol excise tax and indexing it to inflation; supporting a tax on alcoholic beverages based on grams of ethanol per beverage; supporting the imposition of higher fees for retail liquor licensure; and, supporting efforts to prohibit discounts for on-sale alcohol.
(HD-R300-2009)

50.29 Minimum Drinking Age

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

60 Allied Health Professionals/Services

60 Acupuncturists

60.03 Licensure of Naturopaths and Lay Acupuncturists

The MMA opposes the licensure of naturopaths and lay acupuncturists.
(BT-1/88; Retained 2004)

60.031 Naturopathic Licensure

The Minnesota Medical Association (MMA) opposes state licensure of naturopathic physicians as defined in the 2004-2005 Naturopathic Licensing Bill.
(BT-01/2005)

60 Ambulance Personnel/EMT

60.05 Emergency Medical Services Training Standards

The MMA supports existing minimum EMT training standards (110 hours) for ambulance personnel, with additional use of variances to this minimum standard by the Commissioner of Health for areas of the state where this causes extreme hardships. Also, the MMA supports adequate state funding for volunteer training, recruitment, and retention in the recognition that volunteers in many communities provide this necessary emergency service.
(BT-90; Retained 2004)

60 Audiologists/Hearing Aid Dispensers

60 Chiropractors/Chiropractic

60.12 Chiropractic Scope of Practice

The MMA reaffirms its position that performing a comprehensive physical examination, such as a DOT exam, which requires the examiner to diagnose the presence or absence of medical conditions, is outside the scope of chiropractic practice in Minnesota. The MMA will lobby the Legislature to limit the performance of comprehensive physicals to individuals licensed as physicians under Minnesota Statutes, Chapter 147, or their designee. Further, the Minnesota delegation to the AMA will ask the AMA to support similar legislation or to seek administrative action at the federal level.
(HD-R5-1996; Retained 2006)

60.121 Chiropractic Practice Act

The MMA will not oppose the defined changes to the Chiropractic Practice Act if further modifications are made to change authority from "interpreting" high-tech diagnostic imaging to reviewing interpretations for purposes of developing chiropractic treatment plans.
(BT 11-12)

60 Dentists

60.13 Increased Dental Access For MinnesotaCare Patients

Recognizing that dental health is an important part of overall health, the MMA will work with other stakeholders to improve dental care accessibility for all patients.
(HD-R204-2007)

60 Nurses/Nurse Practitioners/Midwives

60.15 Nursing Education

The MMA supports the following recommendations regarding nursing education:

1. That the concept of articulated nursing education be endorsed as a means of meeting nurses' demands for additional education and the market's need for a greater retention of practicing nurses.
2. That the four public post-secondary systems, along with interested private institutions, develop a system of articulated nursing education which would serve nurses in all regions of the state.
3. That additional funding for nursing education programs should be contingent upon submission of the plan developed cooperatively by the four public systems and participating private institutions to be reviewed by each governing board, the Higher Education Coordinating Board and the Board of Nursing.
4. That the Board of Nursing be required to develop the means for reviewing and approving articulated nursing education programs.
5. That the number of graduates prepared for licensure as RNs (i.e., new RNs) should be increased and that this increase should be coordinated with the planning and development of a system of articulated nursing education.
6. That the Governor and the Legislature instruct the University of Minnesota and the State University System to develop a plan in consultation with other graduate programs in the Midwest, which would appropriately increase the number of nurses with master's degrees who would be available for employment in the state in order to ensure an adequate supply of faculty. This plan should be coordinated with the plan for a system of articulated nursing education.
7. That the Governor appoint a statewide task force representing nursing and other health care providers to review means of improving the utilization of current nursing resources, the retention of practicing nurses and the attractiveness of nursing as a career.
(BT-7/81; Retained 2004)

60.16 Midwifery

The MMA supports legislation which would require midwives to: (1) be licensed as registered nurses by the Board of Nursing; (2) be certified by the American College of Nurse Midwifery, and (3) practice midwifery only under the supervision of a physician, with appropriate consideration for legal sanctions against non-compliance with the law.
(BT-7/82; Retained 2004)

60.17 Nurse Midwives

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

(HD-R19-1983; Retained 2004)

60.19 Delegation of Prescribing Authority to Nurse Practitioners

The MMA supports efforts that allow physicians to delegate prescribing authority to certified nurse practitioners in accordance with a written protocol.

(BT-1/90; Retained 2004)

60.2 Regulation of Traditional Midwives

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

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

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

(HD-R36-1993; Retained 2004)

60.21 Nurse Practitioner's Prescribing Authority

The MMA supports the revised Nurse Practitioner Prescribing Memorandum of Understanding: Standards for Written Practice Agreements.

(BT-4/95)

60.23 MMA's Ad Hoc Task Force Report on Advanced Practice Nursing

The MMA approves of the following MMA Ad Hoc Task Force on Advanced Practice Nursing recommendations:

Recommendation 1

The task force recommends that rather than practice independently, APNs work within a collaborative practice framework with physicians.

Recommendation 2

The task force recommends that an APN's autonomy be determined by mutual agreement between a collaborating physician and an APN, and that the APN's scope of practice be determined by relevant state law and by professional standards established by nursing organizations for education, training and certification.

Recommendation 3

The task force recommends that within a collaborative framework the MMA support APNs who practice within their respective nursing specialty.

Recommendation 4

The task force recommends that every collaborative practice arrangement include support systems that allow both the physician and the APN to perform optimally in providing effective and efficient patient care.

Recommendation 5

The task force recommends that within a collaborative practice framework, physicians and APNs prescribing rules and regulations not create barriers to practice and support the efficient and effective provision of patient care.

Recommendation 6

The task force recommends that the MMA support the nursing profession's efforts to standardize APN education, training and the certification process.

Recommendation 7

The task force recommends that, within a collaborative practice framework, the patient care services APNs and physicians provide be appropriately reimbursed.

Recommendation 8

The task force recommends that the MMA support a written collaborative practice agreement, including the continued use of the Nursing Practitioner Prescribing Memorandum of Understanding standards.

Recommendation 9

The task force recommends that the MMA support the nursing profession's efforts to regulate the appropriate use of APN titles.

Recommendation 10

The task force recommends that the MMA support, seek, and encourage regular ongoing dialogue between the MMA and the Minnesota nursing organizations.
(BT-2/97; Retained 2007)

60.233 Minnesota Nurses Association/Minnesota Medical Association Memorandum of Understanding

The MMA supports the revised Memorandum of Understanding between the MNA and the MMA regarding advanced practice nurses' prescribing authority. The MMA will distribute this document to all interested MMA members.
(BT-1/00; Retained 2010)

60.236 Delegation To LPNs

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

60.237 Board of Nursing Action Regarding 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. The MMA will encourage the Minnesota Board of Nursing to change its position that administration of medications for sedation is limited to CRNA practice.
(EC-10/05)

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). To assist physicians, the MMA will provide specific educational materials and resources for physicians who enter into collaborative practice with APRNs.
(BT 07/08)

60.24 Occupational Therapy

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

60.25 Mandatory Referral to Licensed Physicians

The MMA supports legislation requiring a person engaged in optometry to advise a patient to seek an evaluation by a licensed physician when the optometrist is informed by the patient or he or she determines certain signs or symptoms for examination of the patient.

(BT-3/81; Retained 2004)

60.27 Prescribing Authority of Optometrists

The MMA continues to oppose the expansion of the prescribing authority of optometrists.

(BT-11/88)

60.28 Laser Surgery

The MMA supports appropriate legislative or regulatory actions to ensure that the health of Minnesotans is protected by prohibiting the performance of surgery, including laser surgery, by optometrists.

(HD-R51-1996; Retained 2006)

60.281 Optometrists Prescribing

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

(BT-3/03)

60.282 Opposition To Optometric Reimbursement For Invasive Medical Procedures

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

(HD-R217-2003)

60.3 Certified Medical Interpreters

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

(HD-R29-1993)

60.321 Licensing of Complementary and Alternative Health Care Providers

The MMA opposes proposed legislation which would license complementary and alternative health care providers and would grant to such providers broad-based immunity from civil remedies and disciplinary action.

(BT-3/99; Retained 2009)

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)

60 Pharmacists/Pharmacy

60.34 Therapeutic Substitution of Drugs by Pharmacists

The MMA vigorously opposes therapeutic substitution of drugs by pharmacists, and opposes efforts to authorize pharmacists to independently dispense therapeutic substitutes to a physician's prescription.

(HD-R25-1984)

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 or 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, deterrents, and potentially misleading information provided in DTCA.
(BT-3/01)

60.364 Pharmacists Scope Of Practice

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

60.365 Pharmacist Medication Management

The Minnesota Medical Association (MMA) opposes the medication management legislation of 2005 unless it is amended to ensure that the bill would not expand pharmacists' scope of practice.
(BT-03/2005)

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)

60 Physician Assistants

60.37 Physician Assistants Prescribing Authority

The MMA supports efforts that allow physicians to delegate prescribing to appropriately trained physician assistants in accordance with a written protocol.
(BT-1/90; Retained 2004)

60.373 Revision of Physician Review of Physician Assistant Prescribing

The Minnesota Medical Association shall support the revised language of H.F. 1160 Physician Review of Physician Assistant Prescribing, introduced during the 2001 legislative session.
(BT-3/01)

60.374 Physician Assistants

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

60.375 Registration For Physician Assistants

The MMA support the process of registration for physician assistants being separated from the practice setting description.
(BT-01/2004)

60.375 Committee on Legislation

The MMA supports raising the number of physician assistants each physician is allowed by state law to supervise from two to five and changing the regulatory title for physician assistants from registration to licensure.
(BT 01/09)

60 Physical Therapy/Physical Therapist

60.39 Expansion of Physical Therapy Scope of Practice

The MMA opposes efforts to permit physical therapists to diagnose medical conditions for purposes of physical therapy treatment and opposes efforts to allow physical therapists to submit bills when the physical therapist is practicing without the order of a physician.
(HD-R32-1989; Retained 2004)

60.4 Physical Therapy Direct Access

The Minnesota Medical Association (MMA) will continue to oppose the direct access physical therapy legislation in its current form but move into a position of neutral should a compromise be reached (i.e. report back on treatment plan changes, prohibit direct access for physical therapists in their first year of practice, grounds for discipline for failure to make timely referrals).
(BT-3/07)

60.401 Physical Therapists

The Minnesota Medical Association (MMA) opposes legislation to eliminate the requirement that a physical therapist refer patients to a physician after treating for a 30 day period.
(BT-03/2005)

60 Podiatrists

60.41 Hospital Staff Privileges for Podiatrists

The MMA opposes legislation requiring full medical staff hospital privileges for podiatrists.
(BT-1/91; Retained 2004)

60 Psychologists

60.42 Psychiatrists/Psychologists

The MMA will educate physicians and the community regarding the differences in the education, training and expertise of psychiatrists and psychologists. The resolution notes that third party payers, the courts and the public are increasingly consulting psychologists for mental health evaluation and opinion, despite the fact that psychiatrists' medical expertise is the rationale for providing inpatient hospital care and making recommendations for psychotropic therapy and that psychologic testimony is not equivalent to psychiatric testimony, which is medical testimony.

(HD-R19-1990)

60.421 Opposition To Psychologist Prescribing

The Minnesota Medical Association, in order to protect the health and safety of Minnesota patients, using assistance from the American Medical Association, if necessary, strongly oppose any effort to permit prescribing privileges for psychologists in Minnesota, and the Minnesota Medical Association will actively publicize its opposition to legislative efforts by psychologists to gain prescription privileges in Minnesota as a threat to patient safety.

(HD-R208-2002; Retained 2012)

60.422 Psychologist Scope Of Practice

The MMA opposes expansion of psychologist scope of practice with regard to hospital staff privileges for psychologists and with regard to psychologists' authority to sign certification for disability benefits related to mental health.

(EC-2/03)

60 Reimbursement

60.43 Chiropractic Services Allowed Under GAMC

The MMA opposes efforts to allow payment for chiropractic services by the General Assistance Medical Care Program (GAMC). Spinal manipulation should be reimbursed only if it is determined that such services are more critical to the care of the GAMC patient than other optional services like chemical dependency treatment or mental health care. The MMA also opposes efforts to allow chiropractors or consulting psychologists to certify incapacity for the purposes of eligibility for GAMC.

(BT-4/82)

60.46 Reimbursement

The MMA will pursue fair reimbursement for physician-supervised services provided by nurse practitioners, nurse specialists, and physician assistants.

(HD-R22-1994)

60 X-Ray Machine Operators

60.49 X-Ray Machine Operator Requirements for Licensure

Because x-ray operators need to have proper training, the MMA Board of Trustees supports legislation requiring a minimum level of education for all x-ray machine operators in Minnesota.

(BT-4/95)

60.5 Surgical Assistants Licensure

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

(BT-3/03)

60.51 Scope Of Practice

The Minnesota Medical Association work with the appropriate regulatory and legislative agencies to establish, secure, and maintain a high level of standards which must be met and maintained before expanding scope of practice privileges beyond those limited to licensed, practicing medical doctors and, that the MMA lead an effort to promote a strong, unified approach by all state medical organizations to support

its stand on meeting and maintaining high standards on scope of practice issues and, the MMA work with specialty societies to actively fight legislation that would inappropriately expand the scope of practice of non-physicians through all legal means at its disposal.
(HD-SR203-2003)

60.52 Scope of Practice Guidelines

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

1. Review the existing scopes of practice and the effect of requested changes on provision of services and other practitioners providing those services;
2. Review the boundaries of non-physician practice and the advisability of allowing independent practice, or requiring collaboration or physician supervision;
3. Review the formal education and training purported to support scope of practice changes and the existence of formal processes for accreditation;
4. Review the existing or proposed regulatory mechanisms such as licensure, certification and registration;
5. Review the requirements for full and accurate disclosure by all health care practitioners as to their qualifications to perform the proposed health care services;
6. Review the financial incentives related to and affecting the request for scope of practice changes;
7. Review the accountability and liability issues relating to requests for scope of practice changes.
(BT-07/2004)

60.53 Physicians' Roles in Supervision

The MMA shall develop resources for physicians clarifying physicians' roles and responsibilities in supervising and/or collaborating with various health care professionals (e.g., physician assistants, athletic trainers, nurses, etc).
(BT 01/09)

65.01 A Panel To Address The Medical Needs of Minnesota's Military

The MMA shall communicate through its publications to the physicians of Minnesota to increase awareness and assist the medical community of Minnesota so that the men and women of the United States Armed Forces returning from active duty who have served our country are taken care of by those they have served. Furthermore, the Board of Trustees shall create a military liaison to assist in improving the care of military personnel returning from active duty.
(HD-R100-2007)

65.02 Awareness of TRICARE Health Insurance

The MMA shall increase awareness of its membership that military members and their families are often cared for outside the Department of Veterans Affairs (VA) system through insurance known as TRICARE, and the MMA delegation to the American Medical Association shall submit a request to the AMA asking that the AMA work with TRICARE to decrease the complexities associated with the contracting process and to work to increase the level of reimbursement to physicians.
(HD-R106-2007)

70 Bicycle and Motorcycle Safety

70.01 Public Information Program Promoting Use of Helmets by Motorcyclists and Bicyclists

The MMA supports the continuing development of public information programs to inform the public of the risks of motorcycle and bicycle riding without proper head protection.
(HD-R19-1986; Retained 2004)

70.02 Motorcycle Helmets

The MMA supports legislation to require protective head gear for all motorcyclists.
(BT-11/88; Retained 2004)

70.03 Bicycle Helmet Use

The MMA supports the passage of legislation designed to significantly increase bicycle helmet use in children and adults. The MMA will undertake efforts to increase public awareness that all persons riding bicycles should wear tested and approved bicycle helmets, and recommends bicycle helmet use by any person riding a bicycle.
(HD-R1-1991; Retained 2004)

70.04 Bicycle Safety and Helmet Use

The MMA supports legislation that mandates the 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)

70.06 Motor Vehicle and Bicycle Safety

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

70.07 Bicycle Safety Policy Reaffirmation

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)

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

In an effort to improve the public's health, MMA will continue to pursue legislation specifying that the nonuse of helmets for bicycles, motorcycles, snowmobiles, and ATVs is a petty misdemeanor punishable by a \$25 fine.
(HD-R304-1997)

70.1 Protective Headgear

The MMA supports the mandatory use of headgear while minors are 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)

80 Birth Control/Contraception (See also, Pregnancy)

80.01 Funding for Family Planning Activities

The MMA actively supports additional funding for all family planning activities.
(BT-11/89; Retained 2004)

80.02 Insurance Coverage for the Diagnosis and Treatment of Infertility

While the MMA does not oppose insurance coverage for the diagnosis and treatment of infertility, the MMA does oppose mandating such coverage.
(BT-1/90; Retained 2004)

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. The MMA supports educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception.

(BT-1/2002; Retained as edited 2012)

80.04 Emergency Contraception Mandate

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

(BT-3/03)

80.05 Family Planning Gag Clause

The MMA opposes legislation (HF436/SF431, introduced during the 2003 legislative session) that affects the physician/patient relationship by restricting the information that providers give to patients. Specifically, the legislation prohibits the use of state family planning grants for abortions, for any counseling that promotes abortion, or for referral to a health care provider who performs abortions. These grants include the family planning grant funds distributed through the maternal and child health block grant program, the family planning special projects grant program, grants to eliminate health disparities, and "any other state grant program whose funds are or may be used to fund family planning services". This policy is based on opposition to the state interfering in the physician/patient relationship regardless of the issue being discussed.

(BT-3/03)

80.06 Emergency Contraception

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

(HD-R300-2003)

80.07 Emergency Contraceptive Pills

The Minnesota Medical Association reaffirms its policy that promotes access to emergency contraceptive pills.

(HD-R400-2006)

80.08 Pharmacists' Refusal To Fill Prescriptions

The Minnesota Medical Association (MMA) shall introduce and support legislation that requires pharmacies to ensure that protocols exist that provide patients with immediate access to emergency contraception in the event of a pharmacist's refusal to fill the prescription or request. The MMA shall also work with the Minnesota Pharmacists Association regarding this issue.

(HD-R403-2006)

90 Blood (See also, HIV/AIDS)

90.01 Education on Safety of Autologous Blood Transfusions

The MMA will educate physicians about the benefits and availability of autologous blood transfusions.

(HD-R3-1985; Retained 2004)

100 Board of Medical Practice/Physician Discipline (See also, Practice of Medicine)

100.02 Public Accountability

The MMA believes the following actions should be taken to improve public accountability on the Board of Medical Practice:

1. Require that a lay member of the board participate in all disciplinary actions, whether this is as a subcommittee or during the full board discussions.
2. Require that all complaints of sexual misconduct or all complaints be reviewed by the board as a whole.
3. Grant the board authority to hire attorneys and investigators which the board determines are necessary to properly review a complaint.
4. Require the board attorney to review all complaints found to be unsubstantiated by the board members.
5. Require the board to report to the legislature on the cases found not substantiated, but only to the extent it is consistent with the data privacy law.
6. Publicize the disciplinary actions that are taken.
7. Better tracking of complaints within the board office.
(BT-11/84)

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)

100.05 Mandatory Reporting

The MMA adopts the following position on mandatory reporting by peer review organizations:

A review organization or committee shall report to the Board of Medical Practice its findings or conclusions with respect to the conduct of a physician, if such conduct may be grounds for disciplinary action (as required of individual physicians by the Medical Practice Act).

Upon request by the Executive Director of the Board for information regarding a physician, a review organization shall disclose to the Attorney General's office, data and information acquired by the review organization and records of proceedings regarding the physician.
(BT-7/87)

100.06 Patient Referrals

Referring a patient to any health care provider for services or tests not medically indicated at the time of the referral should be grounds for disciplinary action.
(BT-7/87; Retained 2004)

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)

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)

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)

100.15 Investigations of Physicians

The MMA recommends to the Board of Medical Practice that physicians should be given at least thirty (30) working days prior to written notice of an investigative interview and of the nature of the complaint. The MMA also recommends the Board provide reasonable notice of disposition or status of the complaint during the complaint review process; that the Board should also notify physicians in writing at the end of an investigation that the investigation has been completed; and that the Board should also notify physicians and appropriate institutional agencies in writing in the event of an amended order. Finally, the MMA recommends that the consultant's report should continue to be made available to the physician being investigated and that consultants should be used on a regular basis.
(HD-RPT29-1991)

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)

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)

100.21 Non-Discriminatory Treatment of Chemical Dependency

The MMA encourages identification, evaluation and treatment of chemical dependency and endorses the efforts of the State Board of Medical Practice and the Health Professional Services Program (HPSP) to ensure patient safety, as well as proper respect and treatment for chemically dependent physicians.
(HD-R403-2001; Retained as edited 2011)

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

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

100.23 Pain Control

The Minnesota Medical Association will work with the Minnesota Board of Medical Practice and the Minnesota Board of Pharmacy to determine the educational needs of physicians in the areas of pain control and prescribing. The MMA will work to encourage development and implementation of appropriate pain control and pain management educational resources for physicians.

In addition the MMA delegation to the American Medical Association (AMA) will ask the AMA to support more effective educational programs for physicians prescribing pain control, and will ask the AMA for leadership in clarifying state and federal agencies' expectations in regard to physician responsibility in pain management.

(HD-R400-2004)

100.24 Health Plan Regulatory Accountability

The Minnesota Medical Association encourages the Board of Medical Practice to hold makers of health and treatment decisions accountable to the same regulatory plan referral review standards as other providers delivering medical services.

(HD-R404-2005)

100.25 Lyme Disease

The MMA opposes defining what constitutes appropriate or inappropriate medical treatment in statute for the treatment of chronic Lyme disease.

(BT 11/09)

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)

110 Children and Youth (See also, Health Education, Tobacco)

110 Adolescents

110.02 Physicians as Role Models

The MMA supports the Young Physicians Section in its goal to develop in Minnesota a program for junior and senior high school students that would utilize physicians as role models and advocates of the role of science in personal health and careers in health care.

(HD-R13-1989)

110.03 Sleep Deprivation in Adolescents Educational Campaign

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

(HD-R30-1993; Retained 2004)

110.38 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)

110.39 Vaccinating the Underinsured

The Minnesota Medical Association and the Minnesota Chapter of the American Academy of Pediatrics and the Minnesota Academy of Family Physicians will jointly contact the Centers for Disease Control and

Prevention and the Minnesota Department of Health and respectfully request that the Minnesota Vaccines for Children Program permit private practices to provide and receive payment for vaccines.
(HD-R209-2012)

110.40 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)

110.041 Mentoring Programs

The MMA encourages county medical societies to work in conjunction with high schools and junior high schools within their counties to develop mentoring programs that will encourage students of color to consider careers as physicians.
BT-8/97

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)

110.045 Adolescent Health Care Initiative

The MMA supports legislation to improve health care for adolescents by providing increased access to clinic-based health services and prevention resources.
(BT-3/99; Retained as edited 2009)

110.046 Adolescent Self-Administration of Asthma Medication

The Minnesota Medical Association shall support policies that allow for elementary and secondary school students diagnosed with asthma to possess and self-administer their asthma medication.
(BT-3/01; Retained 2011)

110.047 Commercial Tanning of Minors

The MMA will support efforts to raise the age of necessary parental consent for commercial tanning to age 18. In addition the MMA will support efforts to require commercial tanning facilities to include in all promotional materials the requirement that minors under 18 receive parental consent prior to using a commercial tanning facility.
(HD-R205-2001; Retained as edited 2011)

110.049 Parental Consent For Medical Treatment Of Minors

The MMA Board of Trustees opposes HF352/SF570, as introduced during the 2003 legislative session, which would require a minor to obtain parental consent to receive treatment for pregnancy, sexually transmitted diseases, and hepatitis B vaccination and would give parents access to their minor children's health records.
(BT-3/03)

110.05 Child Maltreatment

110.07 Prevention of Child Abuse and Neglect

The MMA will educate physicians regarding the identification and treatment of neglected and abused children. MMA members are encouraged to be active participants in community programs to deal with this problem, including participation in county child protection teams.
(HD-R31-1989; Retained 2004)

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)

110.081 Legislation for Increasing the Severity of Charges for Domestic Violence in the Presence of a Child

The MMA will pursue enactment of legislation that increases the level of criminal offense for domestic violence when perpetrated in the presence of a minor.
(HD-R400-1998)

110.09 General Issues

110.09 Prohibition Against Tuberculosis in Schools

The MMA supports legislation which prohibits 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. Tests for tuberculosis given to correctional and welfare institution employees should include a standard intradermal tuberculin test and a chest X-ray when this test is positive.
(BT-3/80; Retained 2004)

110.1 Physical Exams for Children Attending Summer Camp

The MMA believes the Minnesota Department of Health should adopt the following policy on physical exams for children attending summer camp: A health history is required; an immunization record is required; and if the health history reveals problems, then a physical exam by a physician within one year is required. (BT-8/80; Retained 2004)

110.11 Child Health Screening

The MMA adopts the following policy on child health screening:

Continuity of Care: Every child should have a medical home offering regular health maintenance and illness care. To the extent that screening programs duplicate services and fragment continuity of care, they may be detrimental and can be defended only on the basis of substantial benefits generated that would otherwise not occur.

Needs Assessment: Early and periodic screening clinics can be defended and new EPS clinics justified only where significant underserved population can be identified. Therefore, an ongoing demographic study of the distribution of providers of primary health care to children and adolescents in Minnesota should be undertaken through the Minnesota Center for Health Statistics at the Department of Health, or other appropriate agencies.

Parent Education: Comprehensive child health care should include preventive type guidance as well as screening.

Quality Control and Standards:

1. Screening utilizing minimally trained personnel should be considered:
 - a. only on a pilot basis at startup;
 - b. only when a favorable cost/benefit ratio prevails;
 - c. only when relevant training programs with quality control measures meeting high standards are concurrently introduced.
2. Selective screening programs for height, weight, vision and hearing, and scoliosis, should be supported, if cost-effectiveness quality control and minimum standards are met.

Referral Criteria: Any free-standing screening programs (nonphysician supervised) should operate with referral criteria established in collaboration with appropriate medical societies.

The MMA endorses the concept of state and federally sponsored screening programs which fulfill the above criteria. (BT-10/81; Retained 2004)

110.14 Sudden Unexpected Nocturnal Death Syndrome (SUNDS)

The MMA urges the development of criteria to identify persons at high risk for SUNDS, the creation of guidelines for the clinical evaluation of persons at high risk for SUNDS, and development of an educational program to inform health personnel, including physicians, nurses and paramedics, of the dangers that SUNDS poses to individuals in the Southeast Asian refugee community. The MMA believes the AMA should urge the appropriate federal agency to establish a nationwide surveillance and case registry system and that the appropriate federal agency develop an educational program to inform and encourage physicians to cooperate with efforts to find the cause or causes of SUNDS. (BT-11/84)

110.16 Health Aspects of Child Care

The MMA supports efforts to facilitate the provision of child care at a reasonable cost. Physicians are encouraged to become actively involved in the planning and health aspects of child care facilities. (HD-R34-1989; Retained 2004)

110.17 Sale of Tobacco from Vending Machines/Sale of Tobacco to Minors

The MMA supports a total ban on cigarette sales from vending machines. Also, the MMA supports efforts to ban the sale of tobacco to individuals under 21 years of age.
(BT-1/90; Retained 2004)

110.19 Lead Poisoning

The MMA encourages education of the public and physicians to influence parents to wash children's hands before eating, to bathe them at least twice weekly and to protect children from exposure to paint and soil contaminated with lead. This may also include damp mopping floors at least monthly, covering bare contaminated soil in play areas and removing loose or peeling paint, or encapsulating intact lead-based paint. 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)

110.2 Conflict Resolution Training

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

110.211 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 2007)

110.212 Preparticipation Athletic and Camp Physical Exams

The MMA will encourage the inclusion of prevention, assessment, and screening for high-risk behaviors in preparticipation athletic and camp physical exams.
(HD-R414-1998; Retained 2008)

110.219 Early Childhood Family Education As A Mechanism To Advance Family Health

The Minnesota Medical Association (MMA) continues to support the continuation and expansion of Early Childhood Family Education (ECFE) statewide, and will work to help educate physicians about the educational needs in early childhood.
(HD-R300-2002; Retained as edited 2012)

110.2191 Responsible Sexuality Education

The Minnesota Medical Association (MMA) supports the repeal of the Minnesota Education Now and Babies Later program, and the MMA will develop, introduce, and lobby for legislation to support the use of comprehensive, developmentally appropriate, and medically accurate sexuality education programs that are demonstrated to be effective and that include information about abstinence and contraception.
(HD-R412-2004)

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

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

110.2193 Autism Spectrum Disorder (ASD)

The Minnesota Medical Association shall explore what the physicians of Minnesota who care for children can do to assist in the early identification and intervention of children with autism and other developmental delays.
(HD-R214-2006)

110.22 Immunization of Children Against Disease

The MMA supports legislation requiring all children enrolled in public, private and parochial schools and in day care facilities to be immunized against various diseases. Immunizations against red measles should be made after the child is one year of age. Exceptions, based on age and sex, should be made for immunizations against pertussis, mumps, and rubella. Schools should be required to maintain immunization records and make annual reports. Exceptions should also be made for health reasons and conscientious beliefs.

(BT-3/80)

110.24 Childhood Immunizations

The MMA approves the pursuit of methods to assist physicians in completing immunizations in a timely fashion for at least 90% of all children in Minnesota.

(HD-R26-1992)

110.25 Hepatitis B Vaccinations

The MMA supports universal hepatitis B vaccination for Minnesota's infants.

(BT-7/92; Retained 2004)

110.26 Immunizations

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

The MMA's delegation to the AMA House of Delegates will introduce a resolution asking for federal legislation requiring self-insured companies to cover immunizations as recommended by the National Advisory Vaccine Committee.

(HD-R17-1995; Retained 2005)

110.27 Pediatric Immunization Standards

The MMA will endorse and disseminate the Standards for Pediatric Immunization Practices recommended by the National Vaccine Advisory Committee.

(HD-R51-1995; Retained 2005)

110.272 Varicella Vaccine

The MMA supports immunization against varicella for all persons enrolling in any elementary or secondary school or child care facility in Minnesota.

(HD-R308-1998; Retained as edited 2008)

110.275 Vaccine Safety

The MMA opposes HF887, as introduced during the 2003 legislative session, requiring a Vaccine Safety Checklist.

(BT-3/03)

110.276 Meningitis Vaccine

The MMA opposes legislation mandating meningitis vaccine, but supports the education of parents and students about meningitis and the risk to college students.

(EC-2/03)

110.277 Availability of Vaccines

The Minnesota Medical Association delegation to the American Medical Association (AMA) will submit a resolution to the AMA House of Delegates asking the AMA to support legislation to expand the scope of the National Vaccine Injury Compensation Program (VICP) to apply to adults for all recommended vaccines, including influenza.

(HD-R301-2004)

110.278 Avian Influenza

The Minnesota Medical Association (MMA) will submit a resolution to the American Medical Association (AMA) asking the AMA to strive to increase the number of people vaccinated annually against influenza, particularly high risk patients, by working with appropriate stakeholders to expand understanding among

physicians and patients about who is included in the "high risk" population. In addition, in order to prepare for a potential influenza pandemic, the MMA delegation to the AMA will ask the AMA to lobby Congress and the Administration to ensure that appropriate funding is provided to the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people. (BT-03/2005)

110.2791 Role of Physicians in Developing Diagnosis and Treatment Plans

The Minnesota Medical Association encourages physicians to speak to their patients who are parents regarding the importance of reading to their children and will encourage clinics to develop programs to foster reading to children. In addition, the MMA will seek community partners in this effort in order to make books available to families, increase use of libraries, and encourage others to support reading to children. (HD-R101-2008)

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) which advise the following interventions at blood lead levels less than 10 µg/dL: (a) Providing language-appropriate educational materials to family; (b) Asking questions to identify sources of lead in the child's environment; (c) Discussing primary sources of lead poisoning and measures to keep children safe from lead as well as providing lead poisoning prevention literature; (d) Assessing for lead poisoning risk at every well-child visit; and, (e) Reviewing risk factors in one year. 2. Acknowledge that venous testing is preferable where possible, but support the use of capillary testing where individuals would otherwise go unscreened so long as such tests are done in accordance with Centers for Disease Control and Prevention (CDC) recommendations such that trained clinicians use a lead-free collection device and ensure the collection site is washed thoroughly with soap and water. 3. 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)

110.2793 Minnesota Department of Health Lead Clinical Guidelines Update

The Minnesota Medical Association endorses and supports the childhood blood Lead Case Management and Clinical Treatment Guidelines for Minnesota, developed by the Minnesota Department of Health, and as revised in 2010. (BT 03-11)

110 Infants/Infant Mortality

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

The MMA shall pursue state legislation to increase payment for vaccine administration under the Minnesota Vaccines for Children Program that would at least take full advantage of the federal dollars available to our state. (HD-R315-2007)

110.29 Infant Mortality

The MMA will participate in any statewide commission formed to examine causes and recommend action needed to improve the infant mortality and morbidity rates in Minnesota. (HD-R22-1989; Retained 2004)

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)

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)

110.35 American Academy of Pediatrics (AAP) Guidelines for Circumcision

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

(HD-R302-1999; Retained 2009)

110.36 Continuation of Minnesota Maternal Mortality Studies

The Minnesota Medical Association shall work with the commissioner of health to seek to continue Department of Health authority to access health records regarding maternal mortality studies (Minn. Stat. 145.90).

The MMA, if necessary, shall work with the Department of Health to introduce legislation in this area.

(HD-R400-2000)

110.37 Child Safety

The Minnesota Medical Association on recommendation from the Committee on Legislation unanimously supports the Minnesota Chapter of the American Academy of Pediatrics move to update Minnesota child restraint laws, and the MMA supports state legislation allowing students to possess epinephrine while in school under certain circumstances.

(BT-03/2004)

120 Civil Commitment

120.01 Patient Evaluation Program for Hospitalization and Commitment

The MMA supports legislation directing courts which commit persons to hospitals under the Hospitalization and Commitment Act to establish results oriented evaluation programs designed to assure that persons committed receive the best possible treatment plans and requiring courts to appoint counsel guardians for such persons who are to obtain from heads of hospitals written reports on patients committed and on treatment programs which counsel guardians are to file with the committing court.

(BT-1/80; Retained 2004)

120.02 Commitment Procedures

The MMA recommends that the commitment procedure should be different for inebriated patients than for mentally ill patients. The 72 hour emergency hold for inebriated patients should not include weekends and holidays, whereas the 72 hour emergency hold for mentally ill patients should include weekends and holidays.

(HD-RPT403-1981; Retained 2004)

130 Civil and Human Rights

130.03 Treatment Center for International Victims of Torture

The MMA supports efforts to establish a treatment center for international victims of torture.

(BT-5/85; Retained 2004)

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)

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)

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

The MMA commends and encourages the efforts of the Remembering with Dignity project.

(HD-R404-1999; Retained 2009)

130.07 Education of Physicians regarding Tortured and Traumatized Refugees

The Minnesota Medical Association supports educational programs for physicians who see refugees among their patients to enable the physician to assess the refugee for the possibility of post-traumatic stress, depression, or medical injury due to torture or war trauma.

(HD-R404-2000; Retained as edited 2010)

130.09 Condemnation of Terrorist Actions on September 11, 2001

The MMA condemns the heinous acts against citizens from the United States and many other countries on September 11, 2001 and expresses its sincere and deepest sympathy to the many families who lost loved ones in the events occurring in New York, Washington, D.C. and Pennsylvania. Additionally, the MMA commends the bravery of the victims, their loved ones and the rescue workers and expresses its full support to the President and Congress of the United States of America and the international community in their efforts to bring justice to those responsible for these heinous acts and those who have supported them.

(HD-LR105-2001)

130.1 Human Rights Act

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

(BT-3/03)

130.11 Torture And Human Rights

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

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

AMA Policy E-2.067: Torture refers to the deliberate, systematic, or wanton administration of cruel, inhumane, and degrading treatments or punishments during imprisonment or detainment. Physicians must oppose and must not participate in torture for any reason. Participation in torture includes, but is not limited to, providing or withholding any services, substances, or knowledge to facilitate the practice of torture.

Physicians must not be present when torture is used or threatened. Physicians may treat prisoners or detainees if doing so is in their best interest, but physicians should not treat individuals to verify their health so that torture can begin or continue. Physicians who treat torture victims should not be persecuted.

Physicians should help provide support for victims of torture and, whenever possible, strive to change situations in which torture is practiced or the potential for torture is great. (I, III) Issued December 1999. (HD-R400-2007; Edited BT 1/09)

130.12 Equality in Marriage and its Health Benefits

The MMA (1) recognizes that denying civil 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 civil 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)

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)

140.09 Insurance Companies' Use of Social Security Numbers as Identifiers

The Minnesota Medical Association will adopt AMA policy H-190.963, Identity Fraud, as follows: Our AMA policy is to discourage the use of social security numbers to identify insureds, patients, and physicians except in those situations where the use of the number is required by law and/or regulation. The MMA will work with Minnesota insurance carriers and third party payers to discourage the use of social security numbers as identifiers. (HD-R404-2004)

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)

140.11 Prior Authorization of Medications

The Minnesota Medical Association, in its meetings with the Minnesota health plans, will advocate for developing an online clearinghouse for information pertaining to requirements for medical and mental health prior authorizations from all of Minnesota's health plans. The MMA will further address in its meetings with Minnesota health plans ways to decrease hassles related to prescribing that negatively impact patient care including formulary changes, the use of Pharmacy Benefits Managers (PBMs), and specific qualifications of those making coverage decisions. In addition, the MMA will partner with the Minnesota Pharmacists Association to examine concrete ways to improve information exchanges about medication prior authorizations between pharmacies and physician offices and ways to decrease the administrative burdens related to prior authorizations.

(HD-SR201-2010)

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)

150.03 Information Regarding a Colleague

The MMA believes that it is the ethical duty of a physician to share truthfully 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)

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)

150.05 Public Access to National Practitioner Data Bank

The MMA strongly opposes Congressional action to allow the general public access to information contained in the National Practitioner Data Bank, since such access will lead to unwarranted concern, confusion, and misinterpretation thereby damaging the health care industry and creating a low confidence environment.

(HD-R28-1993; Retained 2004)

150.06 Universal Credentialing Form

The MMA endorses the implementation and use of uniform credentialing forms by all organizations, including hospitals, in Minnesota that require credentialing information from physicians.

(HD-R26-1996; Retained 2006)

150.08 Credentialing Legislation

The MMA opposes legislation authorizing the ability of a health care provider to designate a single credentials verification entity which a health plan or hospital would then be required to utilize. The MMA instead urges the MMA Uniform Credentialing Task Force to continue to discuss the issue of duplicative credentialing forms and to attempt to develop a solution.

(BT-3/99)

150.11 Recertification without Punitive Consequences

The Minnesota Medical Association will work with third-party payers to discuss whether recertification should be the sole measure of competence. The MMA delegation to the American Medical Association (AMA) will take a resolution to the AMA proposing that a task force be formed to study issues surrounding certification and recertification as measures of competency, and their use in economic credentialing.
(HD-201-2004)

150.12 Minnesota Credentialing Collaborative

The MMA shall continue to support the development and implementation of the Minnesota Credentialing Collaborative (MCC). Periodic reports will continue to be made to the MMA Board to monitor MCC progress. The MMA will support this effort with up to \$200,000 from the MMAIA for start-up costs. Actual disbursement of funds will occur over the course of 2007-2009 and will be reviewed regularly by the Executive Committee.
(BT 09/07)

150.13 The Authorization Of Unsecured Email In Communicating About Credentialing And Recredentialing With Hospitals And Health Plans And Possibly Identity Theft

The Minnesota Medical Association will ask the health care organizations that require credentialing and recredentialing to send sensitive information in a secure manner.
(HD-R401-2005)

150.14 Clarity from Joint Commission On Credentialing and Privileging Low-Volume Physicians

The Minnesota Medical Association will submit a resolution directing the American Medical Association to study the challenges in credentialing low-volume providers and work with the Joint Commission and other interested parties in the development of fair and balanced criteria and methods for the credentialing of such providers and procedures. In addition, the Minnesota Medical Association will submit a resolution directing the American Medical Association to work with the Joint Commission to ensure that surveyors utilize specific pre-defined, published, and referenced-based criteria to measure compliance that can account for local hospital variation, hospital and community needs and credentialing decision making.
(HD-R210-2008)

150.15 Patient Choice Physician

The Minnesota Medical Association supports freedom of choice for Minnesota patients to select their own Minnesota-licensed physician and will examine the extent of the problem of physician non-selection and de-selection from health plan networks without having been provided clear rationale, explicit criteria, and a meaningful appeals process. The MMA will pursue appropriate remedies to identified problems of network non-selection and de-selection.
(HD-R300-2010)

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

The Minnesota Medical Association supports legislation that will mandate by law precise and accurate disclosure of specific academic credentials in all patient interactions, advertising/media, and in public/legislative forums; 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)

160 Data & Quality

160.02 Parameters of Quality and Outcomes Essential to Data Collection

The MMA will be involved in the definition and promotion of parameters of quality as essential elements for any data collection projects.
(HD-R5-1986; Retained 2004)

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)

160.14 Data Collection Analysis, Dissemination and Disclosure

The MMA has adopted the document entitled 1994 Policy on Data Collection, Analysis, Dissemination and Disclosure as MMA policy.
(BT-11/94)

160.16 Accountability of Certifying or Accrediting Organizations and Data Collection Services

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

160.22 Reporting Hospital Bed Capacity to the Minnesota Department of Health

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

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)

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 2012)

160.27 "Best Practices Guidelines" are not Clinical Care Guidelines and Evidence Based Medicine

The Minnesota Medical Association (MMA) defines "evidence-based medicine" as individualized patient care based on controlled, clinical care trials; systemic medical care literature reviews; meta-analyses of peer-reviewed research and reference to reputable disease guidelines. The MMA recognizes that implementation of evidence-based medicine guidelines must reflect the need to individualize care that may require modification of the guidelines based on peer and collegial professional consultation, patients' health status, illness severity, response to past treatments, demographic variations

The Minnesota Medical Association will use the health care policy terms "evidence-based medicine" and "clinical care guidelines" when discussing medical care quality improvement, and the MMA will work to remove the vague and inappropriate term "best practices" from current Minnesota health care legislation and regulations and educate policy makers about the practice of evidence-based medicine and the uses and limitations of clinical care guidelines in evidence-based medicine.

(HD-R206-2004)

160.28 Minnesota Community Measurement Project

The Minnesota Medical Association (MMA) will join the MN Community Measurement Project as an active member, and approves the use of up to \$150,000 from the MMA Long Term Investment Account during the period 2005 – 2007 to fund MMA involvement as a member in the MN Community Measurement Project. Furthermore, the MMA Board will receive regular updates on the Community Measurement and review MMA involvement in the MN Community Measurement Project on at least an annual basis.
(BT-01/2005)

160.29 Clinical Care Guidelines

The Minnesota Medical Association will take the lead in educating its members, patients, policy makers, health plan administrators, corporate insurance purchasers, and the public about the benefits, proper uses of, and limitations of clinical care guidelines.
(BT-05/2005)

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 collaborate 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)

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)

160.33 Radiation Dose Index

The Minnesota Medical Association will place a link to the American College of Radiology's National Radiology Data Registry (NRDR) radiation dose database on the MMA website and publish an article in the e-newsletter to increase awareness of the opportunity to participate in the NRDR programs.
(HD-R407-2010)

160.34 Provider Peer Grouping Guiding Principles

- A) Provider Peer Grouping in its current form is no longer achievable. The MMA, however, strongly supports the retention of the all-payer claims database as an extremely powerful tool for measuring and analyzing the delivery of care in Minnesota.
- B) The MMA's most significant concerns are with the current provisions in law that dictate how the PPG results will be used – 1) for hospital and clinic-level public reporting and 2) for payment policy/network design by health plans and the state.
 - The MMA could support the above-noted uses if clinics are able to validate the results attributed to them using patient-level data. Given the complexity of the project, the relative immaturity of the methods, the potential for data errors and the proposed high-risk uses of the

data, physicians must be afforded the opportunity to verify the accuracy of their performance results. There will be no support or buy-in without such validation.

- C) If patient-level data cannot be provided to clinics, the MMA supports changing the Peer Grouping program to focus on analyses of geographic and population-based care patterns (e.g., variation in procedures, utilization, costs, etc.). Such analyses would not identify particular clinics or hospitals. The Dartmouth Atlas, which analyzes variation in utilization and delivery of Medicare services, is a good example of what Minnesota could try to replicate on a local level using the all-payer database.
- D) If there is no support for a shift toward population-based analyses, the MMA will look to support repeal of PPG, which will likely mean the elimination of the all-payer claims database. (EC 02-12)

160.35 MN Community Measurement Evaluation

The MMA adopts the evaluation report and following recommendations:

- 1) The MMA should continue to support and participate in measure development activities;
- 2) The MMA should continue to support Minnesota Community Measurement as the preferred measure development organization in Minnesota;
- 3) The MMA should continue financial support of Minnesota Community Measurement;
- 4) The MMA should work with Minnesota Community Measurement to increase the impact of measurement on patient care and outcomes, as well as work to ensure more balanced and equitable decision-making by advocating for meaningful physician involvement in Minnesota Community Measurement's processes and governance structures. The MMA should consider additional support as Minnesota Community Measurement grows and strengthens. (BT 05-12)

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)

160.37 State Mandated Clinical Reporting: Either Voluntary or Minnesota Must Pay

The Minnesota Medical Association will request that the state determine and publish the costs to clinics for mandatory Statewide Quality Reporting and Measurement System requirements. The MMA will further lobby for full reimbursement to clinics from the state for time, equipment, and other costs associated with gathering and submitting clinical quality data unique to the mandatory Statewide Quality Reporting and Measurement System.

(HD-R204-2012)

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)

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)

170.02 Religious Exemption for Autopsies

The MMA opposes legislation providing for religious exemptions for autopsies.

(BT-3/99: Retained 2009)

170.03 Standard Procedure For Planned/Expected Deaths At Home

The MMA will work to educate physicians about options available for assisting families who are involved with the care of those patients with terminal illness who choose to die at home.

(HD-R409-2002; Retained as edited 2012)

180 Disability

180.01 Disability Certification

The MMA encourages physicians to become more conscious of the need to base disability certification on the physician's objective evaluation of a patient rather than on the patient's request.

(HD-R33-1982; Retained 2004)

180.02 Classification of Learning Disabilities as a Medical Neurodevelopmental Diagnosis

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

(HD-R12-1993; Retained 2004)

180.04 Improving Access to Care for Homebound Minnesotans

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

(HD-R408-2007)

190 Domestic Violence and Abuse

190.01 Domestic Violence and Abuse Campaign

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

(HD-R45-1993; Retained 2004)

190.03 Insurance Coverage for Victims of Domestic Abuse

The MMA opposes denial of insurance coverage to victims of domestic violence and abuse, and supports legislation to prohibit insurance discrimination in Minnesota. (HD-R4-1994)

(HD-R4-1994; Retained as Edited 2006)

190.04 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)

190.05 Legislation for Increasing the Severity of Charges for Domestic Violence in the Presence of a Child

The MMA will pursue enactment of legislation that increases the level of criminal offense for domestic violence when perpetrated in the presence of a minor.
(HD-R400-1998)

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)

200.04 Driving While Intoxicated Penalties

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

200.05 Reporting of Impaired Drivers

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

200.07 Driver Inattention

The Minnesota Medical Association shall educate Minnesota physicians and the public about the dangers of driver inattention due to factors including, but not limited to, sleepiness, cellular phone use, electronic devices (e.g., stereo, global positioning systems, televisions), and the use of certain medications.
(HD-SR311-2000; Reaffirmed: HD-R203-2008)

200.08 Impaired Driving

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

200.09 Cell Phone Use Prohibited/Illegal While Driving a Vehicle

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

200.1 Impaired Drivers

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

210 Elderly Persons

210.01 Health Care for the Elderly--A Minnesota Physician's Perspective

The MMA issues the following recommendations on health care for the elderly:

Preamble: Recommendations for changes should:

- Maximize independence and promote optimal level of function for elderly persons;
- Ensure the provision of necessary and reasonable care; and
- Restructure the care and payment systems to provide a full range of services to meet the unique and diverse needs of elderly persons.

A. Recommendations for Physicians

1. Patients' Rights

Physicians and other health care providers should actively involve elderly patients in discussions regarding their own care including decisions to accept or refuse treatment, consistent with the Patients' Bill of Rights. If the elderly patient is mentally incompetent, physicians should recognize the responsibility of the family or other guardian to participate in the care decisions on behalf of the elderly patient.

Example: The patient may elect not to have chemotherapy or to have a gangrenous leg amputated. If a patient is mentally incompetent, the caring family, speaking in the patients' best interests, could refuse an operation.

2. Physicians' Responsibilities in Care for the Elderly

- the physician is responsible for providing quality health care economically;
- recommending health promotion measures that will foster a productive and active lifestyle;
- making an accurate diagnosis based on special knowledge of the aging process and disease processes;
- providing treatment and ongoing medical evaluation (often for multiple problems);
- ensuring continuity of care and coordination among caregivers;
- facilitating good communications with the patient, the family, and other caregivers to clarify issues relating to treatment goals;
- discussing with the patient and family information regarding the nature and course of the disease and potential treatments;
- supporting the patient in informed decision-making regarding treatment; and
- using life support technology in a medically appropriate manner.

3. Teaching Programs

In response to the large and increasing number of elderly persons in Minnesota, medical schools within the state should formalize undergraduate and post-graduate training programs in geriatric medicine. The curriculum should include such concepts as:

- unique medical needs of the elderly, the effects of the aging process and pharmacological implications;
- special skills for the evaluation, assessment and treatment of elderly persons;
- preventive health measures for elderly persons;
- knowledge of the long-term care system and how to utilize it;
- how to work collaboratively in a multi-disciplinary team;
- the distinction between chronic and acute treatment goals;
- ways to talk with the patient and family regarding such sensitive topics as treatment decisions and ultimately death-related issues; and
- ethical and legal considerations of life support technology.

4. Continuing Medical Education

The MMA and other medical specialty societies should increase their sponsorship of continuing medical education courses for practicing physicians emphasizing the unique body of knowledge and skills required to care for elderly persons.

5. Ethical Issues Regarding Death with Dignity

The MMA should take a leadership role in supporting the general public and the profession in gaining an understanding of the medical and ethical issues regarding the application of life support technology and in increasing the awareness of the patients' rights to accept and/or refuse treatment

Discussion: Inappropriate application of advanced life support technology can prolong the patient's suffering or dying process to the detriment of the patient, the family, and all those involved in the caring process. Physicians and other health care providers and the general public are just beginning to discuss decisions regarding when it is or is not appropriate to apply advanced life support technology.

Example: Guidelines and a process for encouraging the implementation of supportive care plans in Minnesota health care facilities and a standardized process for implementing Do Not Resuscitate (DNR) orders could be developed.

6. Physicians' Responsibilities Regarding Health Care Plans

Physicians should become familiar with the various health care plans available to elderly persons to enable them to advise their elderly patients. Physicians should be advocates in the plans with which they are affiliated for the special needs of elderly persons.

B. Recommendations for Restructuring the Care and Payment Systems:

1. Fewer Restrictions/More Flexibility

Social, housing, health and medical services should be provided in the least restrictive setting consistent with the unique needs of each elderly person. The payment systems should be flexible and allow for use of non-institutionalized care alternatives.

Example: Some options for consideration include:

- remove the fiscal incentive for counties to utilize institutional placements over the provision of community services;
- separate the payments for housing services and medical services;
- provide tax incentives and a favorable regulatory environment to encourage the development of quality non-institutional alternative services;
- provide equivalent payment for physician services regardless of the site of care (e.g., office, hospital, home, nursing home).

2. Care Coordination

The MMA supports systems and models which provide care coordination for elderly persons, with active physician involvement. Care coordination services should be compensated. The collaborative efforts of all involved health care professionals—social workers, public health nurses, and physicians—are necessary. As patient medical needs increase in complexity, physician involvement should also increase.

3. Support for Family Caregivers

Family caregivers play a large role in providing care to elderly persons outside institutional settings. The community, county and state, through both public and private efforts, should preserve and enhance this informal caregiver network by providing support services.

Example: Services which provide relief to family members include: adult day care, home care, respite care, electronic personal emergency response systems, telephone reassurance services, and family patient care conferences.

4. Develop Private Financing Mechanisms

Government should facilitate the development of private financing mechanisms to assist elderly persons and their families to meet financial obligations for their care.

Example: Such proposals as private long-term care insurance, home equity conversion plans, and health individual retirement accounts (HIRAs) seem particularly promising.

5. Regulations Which Promote Quality and Creativity

Regulations for programs which house elderly persons should emphasize quality of care but should not be so restrictive as to interfere with creative and cost-effective methods of delivery of care.

Example: When Medicaid patients are housed in a given setting, the full range of institutional regulation is brought to bear on that facility—potentially making it cost-effective and administratively cumbersome to operate.

6. Use Excess Hospital Capacity

The MMA supports the creative, cost-effective use of excess hospital capacity to meet the service needs of elderly persons.

Example: Excess hospital capacity could be used to provide swing beds, medical evaluation services of respite care, or be converted to provide such services as adult day care, congregate dining, recreational activities, etc.

7. Interdisciplinary Research

The MMA supports the funding of interdisciplinary research in long-term care to provide an informed basis for decision-making and resource allocation.

8. Study Effects of DRGs

The impact of the Medicare Diagnosis Related Group-based payment system on the health of elderly persons should be evaluated.

(HD-RLPT208-1985; Retained 2004)

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)

220 Emergency Medical Care/Services

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

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

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

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

The personal physician should verify orders by signing the EMS form as soon as time permits. The radio control physician should be contacted enroute if indicated according to local operating procedures. The

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

2. An intervening physician not wishing to assume complete responsibility may elect to assist the paramedics and act as a medical consultant to them and to the radio control physician.
3. When no radio control exists and an intervening physician wishes to assume responsibility for the patient, the paramedics should relinquish responsibility for patient management. The intervening physician must accompany the patient to the hospital. Physicians intervening at an emergency scene should avoid involvement in resuscitation measures that exceed their prior training and experience.

The intervening physician should present identification that includes name, address, degrees, and state license number. He or she should sign appropriate forms assuming responsibility and verifying orders. The paramedics should present the physician with a statement regarding area policies and authority of paramedics and the medical control physician. This should include the role of the physician on the scene as developed by local participating physicians and medical societies.

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

4. In the case of multiple intervening physicians at the scene (as at an athletic event), the paramedics should request that the physicians designate one physician to direct the patient care. If the medical director of the paramedics or his or her designee is present at the scene, that physician should direct the patient care.
5. Except as noted in #1 (where the patient's personal physician is present), the radio control physician is ultimately responsible. If an intervening physician wishes to assume responsibility for the patient and radio control exists, the intervening physician must accompany the patient to the hospital. The paramedics shall contact the radio control center as they normally would, and allow communication between the two physicians. The exchange of credentials should proceed as noted in #3 above.

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

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

220.03 Medicaid Patient Co-Pays

The MMA supports the establishment of a minimal co-pay for Medical Assistance emergency room visits in an effort to control utilization. Such co-pays would be paid by the patient at the time of service and returned if hospitalization were to occur within 24 hours.
(HD-SR10-1990)

220.04 Rural Hospital Emergency Department

The MMA supports the establishment and funding of a pool of physicians available to staff emergency departments in rural hospitals to relieve physicians of some on-call responsibilities.
BT-1/90 (Retained 2004)

220.05 Emergency Medical Services Training Standards

The MMA supports existing minimum EMT training standards (110 hours) for ambulance personnel, with additional use of variances to this minimum standard by the Commissioner of Health for areas of the state

where this causes extreme hardships. Also, the MMA supports adequate state funding for volunteer training, recruitment, and retention in the recognition that volunteers in many communities provide this necessary emergency service.
(BT-90; Retained 2004)

220.06 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)

220.07 Standard DNR Form for Use by Emergency Medical Services Personnel

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

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

I. Authorized Definition

Do Not Resuscitate

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

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

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

A. Minnesota Medical Association (MMA) Responsibilities

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

B. Local Medical Society Responsibility

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

C. Physician Responsibilities

The physician is responsible for obtaining DNR forms from the component medical society. The physician is responsible for discussing with the patient and/or family or others acting on behalf of the patient the indications for withholding CPR and explaining the meaning of the DNR order to the individuals involved.

The physician should document this discussion in the medical record and insure that the DNR form is properly completed with the necessary signatures.

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

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

D. Ambulance Service Responsibilities

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

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

EMERGENCY MEDICAL TECHNICIANS STANDARD OPERATING PROCEDURES REGARDING DNR DIRECTIVES:

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

E. Patient Responsibilities and Rights

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

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

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

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

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

1. Nursing Homes/Long Term Care Facilities

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

and ambulance service. A written order in the medical record may be sufficient to transmit the DNR order to emergency medical technicians responding to a long term care facility.

2. Private Homes: Licensed home health care providers.

Procedural Standards for Home DNR Orders

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

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

- a. accountability to proper decision-making principles (including the principle of patient involvement in these decisions);
- b. implementation of these directives as a medical order in the patient's medical record signed by the patient's physicians;
- c. documentation of the rationale for these directives in the medical record by the patient's physician;
- d. procedural requirements for these orders, including regular home surveillance to ensure that these directives are readily accessible to prehospital personnel;
- e. periodic review of these directives. Licensed health care providers should attempt to ensure that patients, families, and others acting on behalf of the patients understand the implementation and decision of DNR orders.

III. Implementation of DNR Orders During Emergency Medical Care

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

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

Prehospital personnel will not honor DNR orders if:

- a. not legibly or properly signed and dated;
- b. using alternative wordings to limit medical care (e.g., living wills, health care durable power of attorney documents, supportive care plans) because the implications of these terms for emergency care have not been defined;
- c. given orally by non-physician staff members;
- d. given over the telephone by family, nursing staff or physicians.

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

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

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

The medical urgency of cardiac arrest precludes prehospital emergency medical personnel from evaluating the propriety of the decision-making processes or administrative procedures used to develop the DNR order.

These personnel will not assume any responsibility for such an evaluation. This responsibility rests with the attending physician, and the licensed health care provider supervising care.

IV. Intent with Regard to DNR Directives

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

220.11 Trauma Care in Minnesota

The MMA adopts the following four policy statements concerning trauma care in Minnesota:

1. The MMA should continue to study state regulations regarding the minimum standards appropriate for trauma systems, and hospital trauma services, and the minimum standards of training for first responders and emergency medical technicians.
2. The MMA should support the authority of the EMS Regulatory Board to regulate interfacility transfers.
3. The MMA should support state data gathering initiatives that will bolster further education, research, outcome measurements and funding initiatives regarding trauma care in Minnesota. Models similar to that developed by MCCAP that provides for comparisons of data in a blinded fashion, feedback to providers, and support-based comparisons of total quality management and improvements should be encouraged. Appropriate educational mechanisms for smaller facilities should also be explored.

The MMA should promote and study initiatives to stimulate physician involvement as medical directors to help encourage the coordination of EMS services in their communities.
(HD-LR53-1996)

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, and supports an appropriation of funds by the Minnesota Legislature for this purpose.
(HD-R411-1998)

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)

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 WEB site to encourage local physicians to be knowledgeable of and participate in emergency preparedness plans in their area.
(HD-LR106-2001; Retained 2011)

220.17 State Trauma System

The MMA encourages hospitals not designated as trauma centers, which provide emergency care for trauma patients, to collect information on such care, which, after review by trauma centers, can be used to improve care.

(HD-R400-2001; Retained 2011)

220.18 Emergency Medical Treatment and Active Labor Act (EMTALA)

The MMA delegation to the AMA will submit a resolution encouraging the AMA's efforts to identify solutions to patient care problems created by EMTALA. Such solutions should include consideration of alternatives to emergency department care for a patient judged not to have emergency problems by an on-call physician will to provide immediate care to the patient.

(HD-R401-2001)

220.19 Upgrading Minnesota's Disaster Preparedness

The Minnesota Medical Association shall promote an increased number of quality disaster preparedness continuing medical education events for physicians and other health care workers in Minnesota and seek external funding to support educational activities. In addition, the Minnesota Medical Association Board of Trustees will study the need for further preparation for Minnesota's physicians and citizens for response to all types of disaster through educational programs, continuing medical education events, media presentations and legislation.

(HD-R105-2008)

220.20 Statewide Systems to Optimize Care for Time Critical Cardiovascular Conditions

By January 1, 2013 the Minnesota Medical Association will write a letter of support for the development and implementation of state-wide systems currently being developed by the Minnesota Department of Health for acute stroke, acute myocardial infarction, and sudden cardiac arrest.

(HD-R200-2012)

230 Environmental Health

230.02 Formaldehyde in Housing Units

The MMA supports the efforts of the Commissioner of Health to establish a maximum permissible ambient level of formaldehyde in air based on the available information.

(BT-10/81; Retained 2004)

230.03 Disposal of Low-Level Radioactive Waste

The MMA adopts the following recommendations regarding disposal of low-level radioactive waste:

1. The principal concerns of medicine should be the assurance that mechanisms be developed for the management of low-level radioactive waste in an economical and reasonable fashion which will provide for the highest degree of public safety and health.
2. The MMA supports and encourages the state to adopt a total management approach for disposing of low-level radioactive waste. MMA further supports the participation of the state in an interstate compact for the disposal of low-level radioactive waste.

(BT-10/81; Retained 2004)

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)

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)

230.08 Infectious Waste Regulation

The MMA adopts the following positions regarding the regulation of infectious waste:

1. the law should not classify all pathological waste as infectious waste unless the waste was exposed to infectious agents;
2. animal blood and blood products should be regulated;
3. "sharps" should be defined as all items having the potential for being invasive;
4. waste should be tracked by "entities" (hospitals or clinics) rather than by "persons" (individual physicians);
5. generators of infectious waste should be regulated by the Health Department, and hauling of waste should be regulated by the Minnesota Pollution Control Agency;
6. generators shouldn't be liable for infractions once waste has left their facility;
7. management plan guidelines should be developed by professional associations but not be required to be filed with the state;
8. small generators should not be exempted from regulation.
(BT-1/89; Retained 2004)

230.09 Lead Poisoning

The MMA encourages education of the public and physicians to influence parents to wash children's hands before eating, to bathe them at least twice weekly and to protect children from exposure to paint and soil contaminated with lead. This may also include damp mopping floors at least monthly, covering bare contaminated soil in play areas and removing loose or peeling paint, or encapsulating intact lead-based paint. 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)

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)

230.12 Environmental Protection

The MMA acknowledges the efforts of those federal and state agencies that are involved in protecting occupational and environmental health by working cooperatively with industry and labor to continue to achieve practical, common-sense solutions for ensuring a safe and healthy environment.

(HD-R41-1996; Retained 2006)

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)

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)

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

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

The MMA's delegation to the American Medical Association (AMA) will bring a resolution to the AMA to request federal phase-out of polybrominated diphenyl ethers.

(HD-R304-2004)

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.

The MMA delegation to the American Medical Association (AMA) will submit a resolution to the AMA to seek to implement these policies on a national level.

(BT-11/2004)

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)

230.21 Contamination Of Drinking Water By Pharmaceuticals And Personal Care Products

The Minnesota Medical Association shall submit a resolution to the American Medical Association House of Delegates asking the AMA to request that the Environmental Protection Agency conduct studies on pharmaceuticals and personal care products in drinking water to determine how harmful the levels of pharmaceuticals and personal care products in our nation's drinking water supplies are to public health. The Minnesota Medical Association shall study the proper disposal of pharmaceutical products in hospitals, clinics, and physician offices, and report back to the 2006 House of Delegates.

(HD-R312-2005)

230.22 Pesticide Safety

The Minnesota Medical Association supports the efforts of the Environmental Resource Council's pesticide safety project, which is intended to educate physicians (and others) about best practices in the handling of pesticides, by helping to promote and distribute the project's educational products through existing MMA communications vehicles.

(BT-5/06)

230.23 Take Back Program for Pharmaceuticals and Personal Care Products

The MMA will explore, in cooperation with the Minnesota Hospital Association, the Minnesota Pharmacists Association, the Minnesota Pollution Control Agency, and other relevant entities, the development of a pharmaceutical “take back” program that would provide for optimal disposal of pharmaceuticals to minimize their presence in Minnesota drinking water.

(BT-7/06)

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 such as hormone disruption and antibiotic resistance. 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. 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)

240 Ethics

240.01 Medical Ethics in a Competitive Environment

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

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

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

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

They are:

- The physician should not allow personal economic motives to compromise his or her decision-making process as it relates to the needs of the patient.
- The individual and the public can and should place the relative value of medicine and health care in comparison with other goods and services.
- A physician's actions should ultimately be guided by his or her primary responsibility to his or her patient.
- Cost-effective medical decision-making should be encouraged when it does not compromise quality health care.

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

- A. If the physician receives more money either directly or indirectly for providing more services per patient, there is an incentive to provide more care than may be necessary.
- B. If the physician stands to gain directly or indirectly from the ordering of services for a patient from others (tests, drugs, referrals) the physician has an incentive to order care consistent with his or her own economic interests rather than the needs of the patient.

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

- Inappropriate mark-ups for lab work subcontracted with an independent provider.
- Failure to pass on volume related discounts to the patient.
- C. Physicians who charge fees which are excessive in relation to prevailing community standards are not acting in the best interests of the public (patients).

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

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

- D. If the physician or health plan receives more money directly or indirectly for providing services per patient, there is an incentive to provide less care than may be necessary.
- E. Health care plans which direct the provider of service to also function as the limiter of services provided by others ("gatekeeper" role) may undermine the physician's primary responsibility to the patient.
- F. Physicians who choose a less costly treatment regimen for their patients without primary consideration for the patient's needs are not acting in the best interests of the patient.

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

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

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

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

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

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

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

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

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

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

All Payment Systems

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

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

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

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

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

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

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

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

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

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

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

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

240.02 Informed Consent

The MMA urges physicians to personally make appropriate and timely notation in the patient's medical record regarding the information provided and the patient's personal consent to treatment. The MMA also urges physicians to participate in educational programs regarding the role of informed consent in providing optimum quality patient care and controlling professional liability claims and losses.
(HD-R1-1984; Retained 2004)

240.03 Institutional Ethics Committee

The MMA encourages physicians to take a leadership role in the formation of Institutional Ethics Committees.
(HD-R6-1985; Retained 2004)

240.04 Information Regarding a Colleague

The MMA believes that it is the ethical duty of a physician to share truthfully quality 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-R17-1988)

240.05 Ethical Principles for Financial Arrangements Among Physicians and Between Physicians and Other Health Care Providers

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)

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)

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

The MMA adopts the Committee on Ethics and Medical-Legal Affairs recommendations contained in the MMA Committee on Ethics and Medical-Legal Affairs Report Clarifying a Physician's Ethical and Legal Obligations to Treat HIV-Infected Patients.

- 1. The MMA Committee on Ethics and Medical-Legal Affairs recommends that the MMA Board of Trustees adopt as MMA policy the AMA ethical principles and opinions referenced as follows:
 - 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)
- 2. The MMA Committee on Ethics and Medical-Legal Affairs also recommends:
 - a. The MMA recommends to physicians who believe it is necessary to refuse to treat HIV-infected patients to carefully document the facts and underlying reasons for their decisions not to treat, and that the MMA strongly recommend that these physicians 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.

- b. The MMA should educate physicians about their ethical and legal obligations to treat patients infected with HIV through publication of this report in [the June 1992 issue of] Minnesota Medicine.
(BT-3/92; Retained 2004)

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

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

1. In the clinical situation, office or hospital, dialogue about legislative matters should occur only when initiated by the patient.
2. The time taken for discussion about legislative matters must be clearly separated from time and charges involving the clinical-professional relationship.
3. Dialogue about legislative matters must be separated from clinical consideration in such a way as to avoid abuse of the physician's authority or power by inappropriate persuasion or coercion. Communications that might interfere with the patient's voluntariness by threat of abandonment, through erroneous communication, or other forms of manipulation are unethical.
(HD-R21-1993; Retained 2007)

240.09 AMA Council on Ethical and Judicial Affairs

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

240.1 Self-Treatment or Treatment of Family Members

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

240.37 Anencephalic Neonates as Organ Donors

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

240.122 Improving Health Literacy

The Minnesota Medical Association (MMA) shall work with interested parties including the Minnesota Hospital Association and Minnesota Alliance for Patient Safety, to develop a model of informed consent document (written at an approximate 6th grade reading level) that may be used by Minnesota health care institutions. The MMA shall also work with the interested parties to implement more readable and understandable informed consent forms throughout Minnesota health care facilities so as to improve patient safety and understandability of decisions. The MMA shall direct its American Medical Association (AMA) delegation to submit a similar resolution to the AMA House of Delegates to develop nationwide awareness and efforts through national patient safety organizations, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and other interested parties to improve informed consent forms for patients with low and marginal health literacy.
(HD-R406-2006)

240.124 Transparency in Recruiting and Marketing Techniques for Young Physicians

The MMA supports submission of a resolution to the AMA as follows: that our American Medical Association explore strategies to increase transparency in marketing techniques used to recruit physicians who are finishing their residency or fellowship to ensure that hospitals, clinics, or health plans are not using deceptive or anti-competitive recruiting techniques without fully disclosing all components of any contract with the

physician being recruited; and further that our AMA work through its councils and sections to develop resources to assist physicians in training in career decision-making that provides them the full range of information concerning various practice models, including private practice.
(BT 05-12)

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)

240 End of Life Issues

240.13 DNR Guidelines for Hospitals

The MMA approves the following "Do Not Resuscitate" (DNR) guidelines for hospitals: Definition: DNR (do not resuscitate) - In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitative measures will be initiated. Considerations: 1. An appropriate knowledge of the patient's medical condition is necessary before consideration of a DNR order. 2. The attending physician should determine the appropriateness of the DNR order for any given medical condition. 3. DNR orders are compatible with maximal therapeutic care. The patient may be receiving vigorous support in all other therapeutic modalities and yet justifiably be considered a proper subject for the DNR order. 4. When the patient has decision-making capacity (as defined in Minnesota Statute, 145C.01, Subd. 1b), he/she may execute a DNR order. When the patient is judged to lack decision-making capacity, this order may be executed by the patient's appointed health care agent, proxy or court-appointed guardian. Under all circumstances, the attending physician must act in good faith and in accordance with applicable standards of care under Minnesota Chapters 145B (Living Wills) and 145C (Health Care Directives).
(BT-1/81; Retained as edited BT 03/08)

240.14 Guidelines for the Determination of Death

In establishing guidelines for the determination of death, the MMA adopts the Summary of Conclusions and Recommended Statute issued by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research:

The enabling legislation for the President's Commission directs it to study "the ethical and legal implications of the matter of defining death, including the advisability of developing a uniform definition of death." In performing its mandate, the Commission has reached conclusions on a series of questions which are the subject of this Report. In summary, the central conclusions are:

1. That recent developments in medical treatment necessitate a restatement of the standards traditionally recognized for determining that death has occurred.
2. That such a restatement ought preferably to be a matter of statutory law.
3. That such a statute ought to remain a matter for state law, with federal action at this time being limited to areas under current federal jurisdiction.
4. That the statutory law ought to be uniform among the several states.

5. That the "definition" contained in the statute ought to address general physiological standards rather than medical criteria and tests, which will change with advances in biomedical knowledge and refinements in technique.
6. That death is a unitary phenomenon which can be accurately demonstrated either on the traditional grounds of irreversible cessation of heart and lung functions or on the basis of irreversible loss of all functions of the entire brain.
7. That any statutory "definition" should be kept separate and distinct from provisions governing the donation of cadaver organs and from any legal rules on decisions to terminate life-sustaining treatment.

To embody these conclusions in statutory form the Commission worked with the three organizations which had proposed model legislation on the subject. The American Bar Association, the American Medical Association, and the National Conference of Commissioners on Uniform State Laws. These groups have now endorsed the following statute, in place of their previous proposals:

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 Commission 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 [For a more thorough review of the Criteria for Determination of Death see the article published in the November 13, 1981 Journal of the American Medical Association, entitled Special Communication: Guidelines for the Determination of Death, (Volume 246, No. 19, page 2184)] (BT-2/82; Retained 2004)

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. The MMA recognized these factors when they adopted Do Not Resuscitate Guidelines in 1981.

In the implementation of DNR orders, one of the concerns that has emerged relates to how emergency personnel called to a nursing home can know that DNR orders, or other orders limiting treatment, have been issued. Further, there should be a recognized means to transfer such orders from the nursing home to the hospital setting, via emergency service personnel. Verbal orders communicated by nursing home personnel are clearly insufficient, since failure to initiate cardiopulmonary resuscitation has life-threatening consequences. Transfer of written orders can be problematic, too, since the resident's chart must remain in the nursing home, and it may not be possible to reproduce the limited treatment order at the time of an emergency.

The purpose of this policy is to provide a framework for the implementation of limited treatment orders in the long-term care facility and to provide guidelines for how those orders can be transferred via emergency personnel to the hospital setting. The policy builds on the MMA's Do Not Resuscitate guidelines adopted in 1981, and provides a definition for "Do Not Intubate."

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.)

Other terms have been used to indicate limitations to treatment (e.g., supportive care, terminal care, conservative care). However, these terms are subject to varied interpretations and have no generally accepted definition in Minnesota at this time. Because these alternative terms are not clear, they cannot be honored by paramedics or other emergency service personnel. If the patient and/or family members (or other designated proxy) and the physician agree that treatment should be limited in some specific way other than what is represented by the terms DNR and DNI, the physician should note clearly in the patient's medical record the specific treatment or plan (e.g., no antibiotics, "do not call 911").

III. IMPLEMENTATION OF LIMITED-TREATMENT ORDERS

A. The writing of the Order

1. The writing of a limited treatment order (DNR and DNI) 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. Both DNR and DNI orders are compatible with maximal therapeutic care. Persons may appropriately receive evaluation, assistance, treatment and hospital transport by the Emergency Care System. 911 may still be used to summon emergency assistance for such patients.
3. When the patient is competent, the limited treatment decision will be reached consensually between the patient and physician. When the patient is judged to be incompetent, this

decision will be reached consensually by the appropriate family members (and/or designated proxy) and the physician. Limited treatment orders will not be written if a competent patient disagrees, or, in the case of incompetency, a member of the family (and/or designated proxy) disagrees. The nursing staff may also be asked to participate in this type of discussion.

4. If all relevant parties are in agreement with a DNR 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. The physician may wish to use a form which has been adopted by the hospital or nursing home for recording this information.
 5. 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
6. Long-term care facilities are encouraged to adopt institutional guidelines to facilitate the appropriate implementation of DNR and 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 DNR and/or DNI orders signed and dated by the attending physician.
- C. Implementation by Emergency Medical Providers
7. Ambulance providers are encouraged to develop standard operating procedures that enable paramedics and emergency medical technicians to honor properly signed and dated DNR and DNI orders in the medical record.
 8. Emergency department and hospital staff are encouraged to honor a valid written DNR and DNI order. The order should accompany the patient during medical transport, and one of the following forms of documentation is recommended:
 - An original 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
 - A photocopy or carbon copy of such an order; or
 - If none of the previous means is available for transferring the limited-treatment order, the paramedic may document on the Minnesota State Ambulance Form that he or she witnessed a properly signed and dated DNR or DNI order. The entry on the Ambulance Form should state: the specific order, the name of the physician, and the date of the signature. (For example, the run record might state: "A written DNR or DNI order was observed in the medical record signed on December, 1, 1985, by John Doe, M.D.")
 9. 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)

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 relevant 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.
 - 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. The MMA will initiate an educational effort for physicians regarding the writing of limited treatment plans and promote the development and implementation of policies and guidelines consistent with reasonable standards of medical practice.
(BT-3/86; Retained 2004)

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)

240.18 Limited Treatment Orders

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

1. Orders to limit (withhold or withdraw) treatment should not be undertaken without full discussion with the patient and appropriate family members of the diagnosis, prognosis, benefits, risks and consequences of various treatment alternatives.
2. With the concurrence of the patient and/or appropriate family members, the physician should seek to involve the nursing staff or other caregivers in the discussion.
3. If the patient is competent, the decision to limit treatment will be reached consensually between the patient and the physician.

4. For patients who are not competent, the decision to limit treatment will be reached consensually by the appropriate family members and/or the patient's designated proxy or legal guardian and the physician.
5. If the relevant parties agree that treatment should be limited, the physician shall record and note the patient's medical condition, other facts and considerations pertinent to the decision, and the nature of the discussion in the progress notes.
6. The limited treatment plan may be rescinded at any time by those originally involved in the decision and the plan shall be subject to review at least annually.
7. The MMA will initiate an educational effort for physicians regarding the writing of and guidelines consistent with reasonable standards of medical practice.
(HD-R13-1986; Retained 2004)

240.19 Futility

The MMA approves the following:

1. Cardiopulmonary resuscitation should not be instituted for patients or nursing home residents in the event that it can be shown to be of no benefit.
2. The determination of no benefit of cardiopulmonary resuscitation to the patient or nursing home resident must be made on the basis of published, valid, scientific evidence that demonstrates negligible chance of survival after cardiopulmonary resuscitation of similar classes of patients.
3. A No CPR or DNR order should be written to withhold cardiopulmonary resuscitation in the event of a cardiac arrest for individuals where cardiopulmonary resuscitation can be predicted to be of no benefit.
4. A decision to withhold cardiopulmonary resuscitation should be fully disclosed to the patient or nursing home resident in the event that cardiopulmonary resuscitation can be predicted to be of no benefit.

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

240.2 Decisions Near End of Life -- Patient Autonomy

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

240.21 Decisions Near End of Life

The MMA endorses the AMA Council on Ethical and Judicial Affairs recommendations adopted at the 1991 AMA Annual Meeting as follows:

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.

4. Physicians must not perform euthanasia or participate in assisted suicide. The societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide.
(HD-SR30-1992)

240.22 Decisions to Forego Life-Sustaining Treatment for Patients Lacking Decision-Making Capacity

The MMA endorses the AMA Council on Ethical and Judicial Affairs recommendations adopted at the 1991 AMA Annual Meeting as follows:

1. Advance directives, (living wills and durable powers of attorney for health care) are the best insurance for individuals that their interests will be promoted in the event that they become incompetent. Generally, it is most effective if the individual designates a proxy decision-maker and discusses with the proxy his or her values regarding decisions about life support.
2. Without an advance directive that designates a proxy, the patient's family should become the surrogate decision-maker. Family includes persons with whom the patient is closely associated. In the case when there is no one closely associated with the patient, but there are persons who both care about the patient and have some relevant knowledge of the patient, such relations should be involved in the decision-making process, and may be appropriate surrogates.
3. It is the responsibility of physicians to provide all relevant medical information and to explain to surrogate decision-makers that decisions should be based on substituted judgment (what the patient would have decided) when there is evidence of patients' preferences and values. If there is not adequate evidence of preferences and values the decision should be based on the best interests of the patient (what outcome would most likely promote the patient's well-being.)
4. Institutional ethics committees should be established for the purpose of facilitating sound decision-making. These ethics committees should be structured so that a diversity of perspectives, including those from outside medicine, are represented.
5. The surrogate's decision should almost always be accepted by the physician. However, there are four situations that may require either institutional or judicial review and/or intervention in the decision-making process. These situations are when (a) there is no available family to be the patient's surrogate decision-maker; (b) there is a dispute among family members and there is no decision-maker designated in an advance directive; (c) a health care provider believes that the family's decision is clearly not what the patient would have decided if competent; and (d) a health care provider believes that the decision is not a decision that could reasonably be judged to be in the patient's best interests. Decisions based on a conflict of interest generally would not be in a patient's best interest. In these four cases, the guidelines outlined in the report should be followed. In particular, when there are disputes among family members or between family and health care providers, the use of ethics committees specifically designed to facilitate sound decision-making is recommended before resorting to the courts.
6. Judicial review for decisions about life-sustaining treatment should be a last resort. It is strongly encouraged that when judicial review is necessary, in nonemergency situations, the courts should determine who is to make treatment decisions, including appointing a guardian, rather than making treatment decisions.
7. When a permanently unconscious patient was never competent or had not left any evidence of previous preference or values, since there is no objective way to ascertain what would be in the best interests of the patient, the surrogate's decision should not be challenged as long as the decision is based on the decision-maker's true concern for what would be best for the patient.
8. In the case of seriously ill or handicapped newborns, present and future interests of the infant must be considered. Due to the complexities involved in deciding about life support for seriously ill newborns, physicians should specifically discuss with parents the risks and uncertainties involved. When possible, parents should be given time to adjust to the shock of the situation and absorb the medical information presented to them before making decisions about life-sustaining treatment. In addition, counseling services and an opportunity to talk with couples who have had to make similar decisions should be available to the parents.

9. Due to the complexity of decisions for permanently unconscious patients and newborns, an ethics committee should be available, whenever possible, to facilitate the surrogate's decision-making.
10. Hospitals and other health care facilities should establish protocols regarding assessment of decision-making capacity, informing patients about advance directives, identifying surrogate decision-makers, the use of advance directives, substituted judgment and best interests in decision-making, and the procedures for challenging the decision of a surrogate. These protocols should be in accordance with the Council's preceding guidelines.

The MMA will seek improvement of the state's ability to expedite final decisions about life-sustaining treatment for wards of the state who are lacking decision-making capacity.
(HD-R31-1992)

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)

240.24 No CPR Orders

The MMA endorses the terminology "No CPR" to effectively communicate the intended meaning, "In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitative measures will be instituted or continued."
(HD-R39-1992; Retained 2004)

240.25 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)

240.26 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)

240.27 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 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.

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)

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

I. Authorized Definition

Do-Not-Resuscitate

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

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

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

A. Minnesota Medical Association (MMA) Responsibilities

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

B. Local Medical Society Responsibility

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

C. Physician Responsibilities

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

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

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

D. Ambulance Service Responsibilities

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

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

EMERGENCY MEDICAL TECHNICIANS STANDARD OPERATING PROCEDURES REGARDING DNR DIRECTIVES:

Do-Not-Resuscitate (DNR) orders are orders issued by a patient's physician to refrain from initiating cardiopulmonary resuscitative measures in the event of an acute cardiopulmonary arrest. DNR

orders are compatible with maximal therapeutic care and the patient may receive vigorous support (IV, drugs, anti-shock trousers) up until the point of cardiac or respiratory arrest. DNR orders are valid in long-term care facilities, in the home and any other setting when the DNR form is properly completed and validated. DNR orders must be signed by the patient/proxy/agent/court appointed guardian or conservator/next of kin or loved one, the witness and the physician. [DNR orders written in the order section of the medical record may be signed by only the physician to be valid.] The DNR order should be reviewed periodically. In the event of uncertainty, resuscitative measures should be initiated.

E. Patient Responsibilities and Rights

A patient has the right to refuse cardiopulmonary resuscitation. The patient should be involved to the greatest degree possible in the decision making process. Patients are encouraged to discuss these decisions with family members, if appropriate. When the decision for a DNR order is reached, a DNR form should be completed, signed and dated by the patient/proxy/agent/court appointed guardian or conservator/next of kin or loved one, physician and witness, or the order should be written in the order section of the medical chart (if one is available), signed by the physician.

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

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

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

1. Nursing Homes/Long Term Care Facilities

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

2. Private Homes: Licensed home health care providers.

Procedural Standards for Home DNR Orders

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

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

- a. accountability to proper decision-making principles (including the principle of patient involvement in these decisions);
- b. implementation of these directives as a medical order in the patient's medical record signed by the patient's physicians;
- c. documentation of the rationale for these directives in the medical record by the patient's physician;
- d. procedural requirements for these orders, including regular home surveillance to ensure that these directives are readily accessible to prehospital personnel;

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

III. Implementation of DNR Orders During Emergency Medical Care

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

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

Prehospital personnel will not honor DNR orders if:

- a. not legibly or properly signed and dated;
- b. using alternative wordings to limit medical care (e.g., living wills, health care durable power of attorney documents, supportive care plans) because the implications of these terms for emergency care have not been defined;
- c. given orally by non-physician staff members;
- d. given over the telephone by family, nursing staff or physicians.

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

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

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

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

IV. Intent with Regard to DNR Directives

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

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)

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)

240.36 Education Regarding New Advance Directives Mechanisms

The MMA will work with state and local professional associations and health agencies to disseminate information to MMA members and the public regarding the purpose and use of advance health care directives. (HD-R404-1998; Retained 2008)

240.38 Decisions at the End of Life Policy Paper

The MMA adopts the paper prepared by the Committee on Ethics and Medical Legal Affairs, entitled "Decisions at the End of Life: The Distinctions from a Policy and Ethical Perspective" as an official publication of the Minnesota Medical Association, and to support its use and dissemination as appropriate in educating the public and health care professionals concerning the significant and complex issues surrounding end of life care. (BT-3/99)

240.39 Policy Statements Concerning Health Care Directives

The MMA adopts the document entitled "Policy Statements Concerning Health Care Directives" and the policy statements contained in that document as MMA policy. (BT-5/99)

240.4 Minnesota Health Care Directive

The MMA approves the use of the Minnesota Health Care Directive which was developed by a state workgroup and facilitated by the University of Minnesota Extension Service and reviewed by MMA Committee on Ethics and Medical-Legal Affairs, as a resource document for Minnesota physicians and their patients. The MMA logo will be used on reproductions of these materials. (BT-7/99; Retained 2009)

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)

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)

250.04 Defining "Illegal Fee-Splitting"

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)

250.05 Determination of Usual and Customary Fees by Third Party Payers

The MMA supports legislation to define usual and customary fees based only on comparisons of like trained professionals and requests procedural codes which denote the professional activity of such professionals.
(HD-R31-1988; Retained 2004)

250.08 Telephone Fees

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

250.09 Fee Review Companies

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

250.13 Self-Referrals To Independent Radiation Therapy Facilities

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

250.14 Transparency in Risk Sharing Contracts

The Minnesota Medical Association will inform its membership about the legal requirements (M.S. § 62J.72) to disclose reimbursement methodologies that create a financial incentive to limit or restrict health care.
(HD-R312-2008)

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

260.01 Mandatory Reporting Requirements for Wounds Caused by Dangerous Weapons

The MMA opposes mandatory physician reporting of victims wounded by dangerous weapons.
(BT-3/91; Retained 2004)

260.02 Firearm Related Deaths and Injuries

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

260.04 Firearms

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

260.05 Drive-by Shootings

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

260.06 Minimum Sentencing

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

260.07 Firearms and Dangerous Weapons

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

260.08 Public Education About Firearm Injuries and Death

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

260.09 MMA Policy on Handguns and Automatic Repeating Weapons

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

1. The destruction of any weapons obtain in local buy-back programs after checking to determine whether the gun is evidence from a crime or stole property.
2. Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
3. Support stricter enforcement of present federal and state gun control legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.
4. Reaffirm AMA policy and create MMA policy supporting waiting periods and background checks for purchasers of handguns and automatic repeating weapons.
(HD-R39-1994; Retained 2006)

260.1 Firearms and Dangerous Weapons

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

Further, the MMA supports efforts to expand the scope of the original mortality study conducted by the Firearm Injury Prevention Task Force to include new data (beyond 1988).

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

The MMA recommends similar efforts nationally through the AMA.
(HD-SR31-1994)

260.11 Firearm Locks

The MMA will introduce legislation mandating the use of a locking device on all firearms stored in homes where children 18 years-of-age and younger are present or reside.
(HD-R57-1995)

260.12 Gun Control

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

260.13 Permit to Carry a Concealed Weapon

The MMA supports the recommendation of the Minnesota Chiefs of Police that issuing permits to carry concealed weapons remain at the discretion of local law enforcement.
(HD-R38-1996; Retained 2006)

260.14 Student Pledge Against Gun Violence

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

(HD-SR301-1998; Retained 2008)

260.16 Firearms

The MMA supports efforts to change current Minnesota law that pre-empts local ordinances regulating the sale and use of firearms.

(BT-7/2001; Retained as edited 2011)

260.17 Firearm Mortality Surveillance System

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

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

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

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

(BT-07/2004)

270 Gambling

270.01 Compulsive Gambling

The MMA requests that all gambling institutions post signs indicating that gambling may be addictive and lead to serious health and family problems and that the signs list a contact number for help/assistance.

(BT-5/94; Retained 2006)

280 Health Care Costs/Cost of Health Care

280.04 Physician Awareness of Hospital Costs

The MMA encourages hospitals to provide physicians with copies of their patients' bills, at the physician's request, and encourages physicians to become knowledgeable about the cost of hospital services by randomly reviewing their patients' hospital bills.

(HD-R17-1987)

280.06 Hospitalized Patient Billing Information

The MMA reaffirms Resolution 17, adopted at the 1987 MMA Annual Meeting, which states that the Minnesota Medical Association requests that hospitals make available to physicians copies of their patients' bills, at the physician's request, and the MMA encourages physicians to avail themselves of the opportunity to become knowledgeable about the cost of hospital services which they order by reviewing their patient's hospital bills.

(HD-R20-1992; Retained 2004)

280.07 Data Collection to Reduce Health Care Spending

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

(BT-2/93)

280.09 Reporting Health Care Expenditures

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

(HD-R28-1994; Retained as Edited 2006)

280.12 Employer Disclosure of Health Care Benefit Costs

The MMA encourages Minnesota employers to disclose and itemize the costs of health care premiums, including employer contributions, on all payroll checks for their employees.

(HD-R201-1998; Amended by HD-SR207-2006; Retained 2008)

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 2012)

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. The MMA will submit a resolution to the American Medical Association requesting that the AMA advocate for patient-specific payment disclosure to patients and their treating physicians prior to receiving services.

(HD-R204-2005)

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)

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)

280.2 Radiation Therapy Facilities

The MMA opposes legislation to make permanent the current moratorium on construction of new radiation therapy facilities that are not owned or built in partnership with a hospital. The MMA supports the existing sunset of this moratorium that is scheduled for August 1, 2008.

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)

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)

280.23 Third Party Payer Tiering System

The MMA shall submit a resolution asking the American Medical Association to develop a tiering system of third party payers, to be used by state medical associations, ranking value and performance, and that this information be distributed to individual and corporate consumers of health care to promote informed decision making in the purchase of health insurance.
(HD-R207-2007)

280.24 Health Plan Cost-Shifting

The MMA shall acquire information from members about increased physician practice expenses resulting from unilateral health plan decisions and the consequential cost-shifting to providers.
(HD-R411-2007)

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)

280.25 Peer Grouping Implementation

The MMA will work aggressively to modify the current path and timeline for peer grouping activities to allow for: data set exploration; focused data analysis/methodology testing; meaningful data review by physicians/hospitals; interpretation & education of results; measurement refinement; quality improvement; and, ongoing research.
(BT 09/09)

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

290.02 Local Area Health Planning

The MMA, consistent with past support for locally-directed planning and recognizing a continued need to address cost and accessibility of care, recommends a strong program for physician involvement in planning for the health system. Such a program will encourage participation by physicians, other providers, consumers and local public officials, and reflect and advocate local needs.
(HD-R10/18-1981; Retained 2004)

290.05 Reforms to Repeal Medicaid Waiver Authority

The MMA reaffirms its policy that the payment and marketing methodologies of the public sector should neither encourage one health care delivery system over another nor discourage the development of a pluralistic delivery system. The MMA supports publicly funded health care programs requiring prepayment of providers so long as health maintenance organizations, health insurance companies, health service corporation plans and preferred provider organizations are allowed to contract with such programs so as to ensure maximum patient access to the provider of their choice.
(HD-R23-1985; Retained 2004)

290.06 Recommendations of the MMA Ad Hoc Committee on Competition

The MMA supports the following recommendations of the Ad Hoc Committee on Competition:

1. The MMA opposes direct financial inducements that would reduce needed and appropriate medical services.
2. The MMA supports the concept that physicians may be at financial risk for services that only those physicians or their employees provide--services that are ethical, professional, and appropriate.
3. The MMA supports incentives to physicians and to patients that result in appropriate and effective medical care; and that the MMA oppose all financial incentives to physicians and to patients that may result in overutilization or underutilization of medical care.
4. The MMA should develop and support legislation to consolidate and coordinate the regulation of health care plans by the government, with clearly defined and publicized objectives and guidelines.
5. The MMA should facilitate activities necessary for the development of standards of care and for the preservation of the quality of medical care in the state of Minnesota.
6. The MMA should work with the legislature, attorneys, and ethicists to seek concurrence of medical ethics and current law. It is important that reforms clarify current practices such as risk sharing and capitation to be sure they do not violate professional and ethical standards of the medical

profession. The MMA will monitor the activities of the recently formed task force of the University of Minnesota Center for Biomedical Ethics, which has representatives from the various groups listed in this recommendation.

7. The MMA Board of Trustees should study the need for medical education curriculum revisions, given the continuing rapid change of the medical environment. The medical schools of Minnesota should then revise their curricula to address inadequacies that are discovered. In addition, the MMA should develop an educational program for practicing physicians regarding ethical and contractual issues.
8. The MMA supports a public education effort to inform patients of all details of their health insurance contracts.
(BT-11/88; Retained 2004)

290.11 ERISA Waiver

The MMA supports a limited ERISA waiver. Section 2 amends Section 514(b) of the Employee Retirement Income Security Act of 1974 (ERISA), allowing states to apply to the Secretary of Labor for a limited ERISA waiver to allow them to more equitably finance state risk pools for the uninsurable, or to finance state universal health care access programs.
(BT-9/92; Retained 2007)

290.14 Mid-Level Practitioners

The MMA supports the intent of the 1993 MinnesotaCare legislation that seeks to encourage and facilitate the use of mid-level practitioners (nurse practitioners and physician assistants). The implementation of such policies must include appropriate patient safeguards, such as adequate physician supervision. In addition, these legislative initiatives should recognize education and training differentials of independent practitioners in unsupervised settings.
(BT-11/93)

290.18 Definition of Terms

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

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

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

290.22 MMA Principles for Medicare Reform

The MMA approves the following general reform principles as its four major talking points on Medicare reform, and agrees that these principles will be further developed and disseminated to the membership, the Minnesota congressional delegation, and other policy makers:

- The security of Medicare recipients must be ensured.
- Market based reforms must be utilized to introduce greater competition into 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)

290.2481 Promoting a Primary Care Physician Based Healthcare System for Minnesota

The Minnesota Medical Association, in conjunction with the primary care-based specialties will explore the development of a primary care physician-based health care system for Minnesota.
(HD-R306-2004)

290.2482 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.
- (2) 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)

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)

290.24831 Mandatory Health Insurance

The Minnesota Medical Association reaffirms policy from the Physicians' Plan for a Healthy Minnesota that would require, by law, that all residents of Minnesota have health care coverage for an essential set of benefits.

(HD-SR300-2006)

290.2484 Medical Home

The MMA, in an effort to expand the views and voices involved in the development of the medical home concept, will support and promote a multidisciplinary summit to explore the implementation of a medical home in Minnesota.

(BT-11/05)

290.2485 Financial Model for a Medical Home

The Minnesota Medical Association shall support the concept of a medical home and the exploration of payment restructuring options that would better support the development of medical homes in Minnesota, and continue to explore ways to implement the concept of a medical home.

(HD-R315-2006)

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)

290.2487 Constitutional Amendment

The MMA supports current efforts and commitments to advance meaningful and timely health care reform, including efforts to achieve universal coverage. Adoption of a constitutional amendment of any type, at this time, will only serve to derail current cooperation and to distract and polarize policy makers and other relevant stakeholders from implementing and advancing reform during the 2008 legislative session. The MMA, therefore, will continue to provide leadership to advance health care reform and will actively oppose efforts that serve to distract attention from that important work, including passage of any constitutional amendment, such as the amendment proposed in 2007/2008 (HF683/SF2097).
(BT 11/07)

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)

290 Financing

290.25 Health Care Reform-Payment Reform Proposals

The MMA strongly opposes payment reform proposals, whether mandatory or voluntary, for physician accountability for the "total cost of care" that requires physicians to take on insurance risk. The MMA supports payment reform proposals that provide for the voluntary use of bundled or package pricing, including such pricing for chronic conditions. The MMA supports further study and investigation of alternative payment reform proposals that support quality care and quality improvement, address the various factors contributing to the rising cost of care, and encourage innovation in care delivery.
(EC-04/08)

290.26 Two Percent Tax

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

290.27 Health Services Tax

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

290.28 Health Care Access Funding

The MMA will develop and pursue legislation which will ensure that revenues that are received specifically to fund the MinnesotaCare program cannot be transferred or used for any other purpose than to fund the MinnesotaCare program.
(HD-R54-1994)

290.29 Provider Tax Reporting

The MMA will continue to work through existing coalitions to develop a consistent format for reporting the

2% provider tax that will be used uniformly by all third party payers when making payments to physicians and other health care providers until the 2% provider tax is repealed.
(HD-R32-1994)

290.31 Two Percent Provider Tax

The MMA will continue its efforts to seek repeal of the 2 percent provider tax.
(BT-12/94)

290.32 Financing Universal Coverage

The MMA supports funding mechanisms to achieve universal coverage. Suggested funding mechanisms in order of priority include: 1) tobacco tax; 2) alcohol tax; 3) sales tax; and 4) tax on clothing. Specific suggested mechanisms include:

- a. Increase the cigarette excise tax by \$.40 per year over five years.
- b. Increase the alcohol excise according to the proposed schedule.
- c. Extend 6.5% sales tax to articles of clothing.
- d. Request that a portion of the state sales tax rate be designated to fund uninsured health care.
(BT-12/94; Retained as Edited 2006)

290.35 Substitution of Tax for 2% Provider Tax

The MMA will introduce appropriate legislation that would lead to the repeal of the 2% provider tax and replace the revenue with alternative funding sources such as increased tobacco, alcohol, or income taxes, as needed.
(HD-R30-1996)

290.36 Provider Tax Itemization and Appeal Process

The MMA shall make information available to physicians explaining how to file complaints with the appropriate state commissioner when third-party payers fail to pay the provider tax as required by the pass-through language of the law.

The MMA encourage physicians to inform MMA of circumstances where they feel the provider tax is not being paid by third-party payers.
(HD-R200-1997; Retained as edited 2007)

290.39 Provider Tax: Shift to Health Plans

The MMA opposes legislation that would shift the obligation to collect, administer and pay the provider tax to health plan companies and other insurers.
(BT-1/00; Retained as edited 2010)

290.41 Use Of The Sick Tax For Health Care

The Minnesota Medical Association reaffirms its strong opposition to the 2 percent provider tax and will continue its position that this tax be repealed and that more appropriate sources of funding for state health care programs be sought. The MMA denounces all diversions of provider tax revenue from the Health Care Access Fund. The MMA will inform patients, the public, the governor, legislators, and the media as to the unfair, regressive, and inappropriate nature of this tax and the misappropriation of these funds.
(HD-SR201-2005)

290.411 Health Care Access Fund Oversight Committee

The Minnesota Medical Association shall promote the creation by the Legislature of a Health Care Access Fund (HCAF) Oversight Committee, that includes physicians, consumers, others who pay the provider tax, and other stakeholders. The committee would review and advise the Legislature on HCAF expenditures, with the goal that the HCAF is used only for health care purposes.
(HD-R218-2006)

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)

290.413 Health Care Access Fund

The MMA does not oppose the use of surplus revenue in the Health Care Access Fund from being used in fiscal years 2009-2011 to improve primary prevention through the public health improvement program described in HF3391.

(EC- 04/08)

290.42 Removal Of Congressional Restrictions On Qualified Indemnity Health Insurance Products

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

(HD-R215-2003)

290.44 Consolidation Of Oversight Of Health Plan Contracts

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

(HD-R409-2003)

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

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

1. Epidemiological studies of psychiatric disorders;
2. Coordination of mental health identification and treatment data;
3. Dissemination by the Health Department of a newsletter outlining the best practices for treatment of these disorders to primary care physicians (as is now done for infectious diseases);
4. Promotion of mental health screening activities by primary care professionals and public health nurses;
5. Promotion of the public health mental health model;
6. Working with professional societies, medical schools, primary care residency programs, and continuing education programs to promote mental health education to primary care physicians;
7. Encouragement through state grants, policy changes, etc., of improved coordination and shared care arrangements between psychiatrists and primary care physicians;
8. Working with professional societies and advocacy groups to clarify best practices for medical necessity treatment criteria;
9. Aiding in oversight of health plan contractual agreements for accessible mental health services; and
10. Providing outcome analysis of clinical and cost-offset outcomes of these activities.

(HD-R410-2003)

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

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

1. Monitor access to inpatient and outpatient psychiatric services in Minnesota;
2. Monitor health plan network coverage of psychiatric services to ensure that geographic and timely access are provided in accordance with Minnesota Statute 62D.124 (geographic accessibility) and Minnesota Rule 4685.1010;
3. Require health plans to publish their mental health medical necessity criteria for access to inpatient and outpatient services. The agencies will review the criteria to ensure that they are in compliance with standards of care as defined by provider groups including the Minnesota Medical Association and the Minnesota Psychiatric Society (Minnesota Rules re: Health care programs, 9505.0175 subp. 25);
4. Collect data regarding geographic and timely access to inpatient and outpatient psychiatric services, including frequency of patients diverted to another city or state beyond 30 miles or 30 minutes from their primary place of residence due to capacity constraints;
5. Following a six-month period of data collection, if there is significant evidence that psychiatric access is not meeting state guidelines, the state departments of Health, Human Services, and Commerce will take steps to vigorously enforce the contracts in order to ensure that health plans and insurance entities aggressively enlarge their networks and facilitate mental health care and reimbursement for care that is delivered by psychiatrists, psychiatric clinical nurse specialists, and primary care clinicians. This would include ending the administrative roadblocks that have delayed and disrupted the delivery of timely mental health care to Minnesotans up to this point. The legislature should require health plans to show how they are successfully improving access to psychiatric and primary care clinicians, according to their respective levels of expertise. If these steps are not followed within a reasonable timeline, the state departments will address these contract violations with all available methods, including financial penalties and consideration of contract probation or cancellation;
6. Produce an annual report to the legislature and to the citizens of Minnesota with aggregate data collected; and
7. Provide the legislature with recommendations as appropriate regarding the need for increased access to psychiatric treatment in Minnesota.

(HD-R411-2003)

290.47 Any Willing Provider (AWP) Legislation

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

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

(BT-11/2003)

290.48 Personal Health Care Team as Medical Home

The Minnesota Medical Association will work to ensure that the certification process for medical homes is designed in such a way that those who are currently providing many of the services of a medical home can reasonably be certified as a medical home, and that the basis for creating a medical home is the physician-directed personal health care team and not an insurance company. In addition, the Minnesota Medical Association will submit a resolution asking the American Medical Association to work to ensure that physician-directed personal health care teams, who currently provide many of the services of a medical home for most patients, be designated as the basis for creating a medical home.

(HD-R205-2008)

290.49 Health Care Reform and Payment Methods

The Minnesota Medical Association will provide ongoing information to Minnesota physicians regarding the implementation of the 2008 health care reform legislation, including information about and experiences with payment methodologies such as capitation.

(HD-R308-2008)

290.5 System Reforms

The Minnesota Medical Association will provide information in MMA publications about local, national and international health care reform initiatives.

(HD-R309-2008)

290.51 Essential Benefit Set

The MMA adopts the following policies and principles to guide development of an essential benefit set:

Purpose of an Essential Benefit Set:

- To determine what "insured" means for purposes of Minnesota health care coverage.
- To encourage access to care, including early diagnosis and routine care, as opposed to merely asset protection (i.e., financial protection for severe illness or catastrophic event)

Essential Benefit Set Definition:

- A set of services that is sufficiently comprehensive to sustain the health of an individual.
- Principles:
 - The essential benefit set is the minimum level of coverage that would be guaranteed for every Minnesotan.
 - The essential benefit set will be comprehensive and adequate to maximize the health of every Minnesotan through all phases of life and health.
 - Behavioral health services will be covered in the same way as care for other illnesses.
 - The essential benefit set will be standardized across insurers and buyers (public, private and self-insured).
 - The essential benefit set should facilitate the development of health care homes.
 - The essential benefit set should have standardized copays and deductibles.
 - The essential benefit set should be affordable.

Note - in 2008, the Legislature defined "affordable" if the sum of premiums, deductibles, and other out-of-pocket costs paid by an individual or family for health coverage does not exceed the applicable percentage of the individual's or family's gross monthly income set forth as follows:

Federal Poverty Guideline Range; Percent of Average Gross Monthly Income

0-45%; minimum

46-54%; 1.1%

55-81%; 1.6%

82-109%; 2.2%

110-136%; 2.9%

137-164%; 3.6%

165-191%; 4.6%

192-219%; 5.6%

220-248%; 6.5%

249-274%; 7.2%

275-300%; 8.0%

- The essential benefit set should facilitate achievement of the "Triple Aim" for health reform in Minnesota by:
 - Improving the experience of individuals with the health care system eliminating confusion about coverage and benefits
 - Improving the health of individuals and the population by improving access to care and assuring coverage for essential services
 - Reducing the cost of health care by reducing dependence on emergency department care and reducing preventable hospitalizations

Other Recommendations

- There should be no co-pays for primary care visits, immunizations and covered preventive services.
- There should be no need to have mandated covered services when the essential benefit set is established
- There should be coverage for clinical trials for patients for whom there are no available therapeutic options.
- There should be no coverage for services that have a class III recommendation (contraindicated) in clinical guidelines.
(BT-05/09)

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)

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)

290.54 Work Group to Study MMA Policy Relative to Rapid Changes in the Medical Care System

The Minnesota Medical Association shall establish a work group to study and make recommendations regarding existing MMA policy relevance to 1) the rapid changes in private and public sector medical insurance markets; 2) the economics of political reform proposals; 3) new threats to patient protection laws that prohibit fee splitting; and 4) the patient need for high quality professional care at a reasonable price.
(HD-R311-2009)

290.55 Federal Reform: America's Affordable Health Choices Act of 2009

The work on health care reform in Congress is very fluid, changing by the day. The first proposal in bill form is HR 3200, which includes provisions supported by MMA policy and provisions opposed by MMA policy. Because of this and our expectation that many aspects of this first draft of reform legislation will change over the next few weeks and months, the MMA does not take a formal position in support or in opposition of HR 3200. The MMA supports the direction of many aspects of health care reform that is being discussed in Congress, especially: the elimination of the SGR; the focus on prevention, primary care, and Medical Home; the expansion of coverage and the move toward universal coverage; and, the insurance reforms and the establishment of an Insurance Exchange. The MMA believes that any reform bill must include Medicare payment reform designed to reward high-value states. The MMA strongly opposes any reform that is based on the flawed Medicare payment system. Reimbursements for any new reform that are based on Medicare, plus a percentage, will be devastating for Minnesota. The MMA expresses our continued support of the AMA and their continued work to implement the directives of the 2009 House of Delegates to support reforms "that are consistent with the principles of pluralism, freedom of choice, freedom of practice and universal access for patients."
(EC 07/09)

290.56 A Marketing Plan to Abolish the Provider Tax

The MMA will form a task force to discuss the development and implementation of a marketing campaign to educate providers and the general public about the provider tax.
(HD-R205-2010)

290.57 Work to Advance Health Care Reform

To further advance health care reform in Minnesota, the MMA should pursue action on the following items: 1) Develop messaging/resources for legislators (especially new members) on the need for ongoing attention to health system reform (late 2010/early 2011); 2) Develop messaging/resources for legislators on the need to leverage federal health care reform (not dismiss it), particularly on those topics that allow for state operation/shaping (e.g., insurance exchange, payment reform demonstration opportunities [shared savings, etc.]) (early 2011); 3) Develop messaging/resources for legislators on the potential for real harm to the state's health care infrastructure/capacity, to patient access to care, and to the actual health status of Minnesotans associated with significant cuts in public health care programs (includes both eligibility and payment rates); highlight the Coordinated Care Delivery System (CCDS) as an example of "reform" that was unsuccessful and should not be replicated (early 2011); 4) Provide information to legislators on the trade offs associated with various payment models; on the value and necessity of multiple payment models to support the various types and locations of care delivery; on the importance of ongoing innovation in payment model design; and on the limitations associated with a "one-size-fits-all" approach to payment reform (utilizing grid/table developed by work group); 5) Develop messaging/resources for legislators on the need for

attention to health care professional (especially physician) workforce capacity, with particular emphasis on such capacity as additional individuals obtain insurance coverage (i.e., 2014 effective date of individual mandate and expanded Medicaid coverage) (early 2011); 6) As new models for payment and delivery evolve and the need for a regulatory framework for accountable care organizations (ACOs) is determined, attention to the following key issues is critical: a) Ensuring opportunities for broad physician/clinic participation (i.e., not limited to only integrated systems of care) – this may require attention to antitrust barriers, need for technical assistance, and/or access to capital; b) Examining protections needed for independent practices to participate in new models; c) Understanding levels of risk assumption and whether financial solvency/reserve requirements are needed; c) Defining the role of physicians in new models, including specific roles in leadership and governance; d) Exploring the value of ACO licensure or certification; e) Determining the mechanisms for patient participation (i.e., voluntary selection vs. attribution); f) Developing ACO data needs/access; g) h) Pursuing multi-payer involvement and support; i) Defining and standardizing quality and cost metrics used. 7) Develop guiding principles/policy to guide implementation of a Minnesota-run health insurance exchange (early to mid 2011); Key issues to address include: a) Governance structure; b) Health plan participation requirements (e.g., qualified plans, profit/nonprofit status, administrative simplification requirements, etc.); c) Premiums and risk adjustment; d) Benefit options (e.g., state mandates, benchmark plan); e) Subsidy management and interface with current Minnesota health care programs (especially Medical Assistance and MNCare). 8) Explore opportunities to improve Minnesota's quality measurement efforts through the use of patient-reported outcomes that could capture more meaningful and relevant indicators of patient health, including physical, mental, and social aspects of health. Patient-reported outcomes may be more meaningful to patients and may be less burdensome to practices in terms of data collection (time TBD).

In addition, as the items in this report move forward to the MMA Committees on Health Care Access, Financing & Delivery and Quality, the MMA will work to address additional issues including patient engagement/involvement, cost shifting, tort reform, the importance of focusing on the needs of physicians and focus of being proactive in the MMA approaches rather than reactive.

(BT 01-11)

290.58 Affordable Care Act

The MMA opposes repeal of the Patient Protection and Affordable Care Act (ACA) of 2010.

(EC 01-11)

290.59 Health Insurance Exchange Study

The Minnesota Medical Association will work with the Minnesota Department of Commerce to ensure that physicians are involved in the development of Minnesota's health insurance exchange. The Minnesota Medical Association will study the ramifications of all the options relevant to physician practices and patient care that might be brought forward as part of the implementation of Minnesota's health insurance exchange. (HD-R300-2011)

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., MNMCM, 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)

290.62 Health Care Home Certification

The Minnesota Medical Association will work with the Minnesota Department of Health to evaluate the complexity and administrative burden of the health care home certification and recertification criteria, and will further work to extend the time period between health care home certification and recertification.
(HD-R307-2011)

290.63 NCQA Recognition as Alternative Health Care Home Certification in Minnesota

The MMA supports legislation that would add 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)

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)

300 Health Education

300.01 Education on the Effects of Alcohol

In the interests of public safety, the MMA will sponsor legislation requiring the posting of charts in all liquor stores which indicate the effect of varying numbers of drinks in relation to body weight. The MMA encourages schools to make similar information available to all students.
(HD-R26-1982)

300.04 Alcohol and Chemical Dependency

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

300.06 Public Information Program Promoting Use of Helmets by Motorcyclists and Bicyclists

The MMA supports the continuing development of public information programs to inform the public of the risks of motorcycle and bicycle riding without proper head protection.
(HD-R19-1986; Retained 2004)

300.08 Lead Poisoning

The MMA encourages education of the public and physicians to influence parents to wash children's hands before eating, to bathe them at least twice weekly and to protect children from exposure to paint and soil contaminated with lead. This may also include damp mopping floors at least monthly, covering bare contaminated soil in play areas and removing loose or peeling paint, or encapsulating intact lead-based paint. 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)

300.09 Reimbursement for Qualified Patient Educator Services

The MMA encourages the AMA to support the addition of a CPT code assignment providing the opportunity for physicians who employ qualified patient educators to bill for their services and to support the addition of a CPT code assignment providing education on an individual basis.
(HD-R15-1991)

300.1 Domestic Violence and Abuse Campaign

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

300.12 Public Education About Firearm Injuries and Death

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

300.14 Conflict Resolution Training

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

300.18 Parent Education Classes

Members of the MMA shall encourage all new parents to participate in parent education classes and health systems will be encouraged to provide parent education for their clients so that we may raise healthier children and produce a healthier, less violent society.
(HD-R22-1996; Retained 2006)

300.22 Cigars and Smokeless Tobacco

The MMA, as part of its anti-tobacco campaign, will incorporate and identify cigars, pipe tobacco, and smokeless tobacco as dangerous products in order to protect the public health.
(HD-LR319-1997; Retained 2007)

300.23 Passive Smoking

The MMA, in partnership with other organizations, will study the feasibility of developing and/or distributing materials for physicians to give to parents and prospective parents about the effects of passive smoke exposure on children.

The MMA encourages all parents to protect the health of their children by declaring their home a smoke free home.

The MMA will seek a requirement that all licensed day care homes and centers be smoke free 24 hours a day.

(HD-LR321-1997)

300.25 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)

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. The MMA will also educate physicians about the importance of GAPS.

(HD-R304-1998)

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)

300.3 Driver Inattention

The Minnesota Medical Association shall educate Minnesota physicians and the public about the dangers of driver inattention due to factors including, but not limited to, sleepiness, cellular phone use, electronic devices (e.g., stereo, global positioning systems, televisions), and the use of certain medications.

(HD-SR311-2000)

300.31 Antibiotic Resistance Public Education Campaign

The Minnesota Medical Association supports a statewide public education campaign regarding the appropriate use of antibiotics and the potential dangers of antibiotic resistance

(HD-R314-2000; Retained as edited 2010)

300.33 Ethnic and Cultural Speaker's Bureau

The MMA supports the establishment of an MMA Ethnic and Cultural Speaker's Bureau. These physicians would be the experts in their field and would not have to be a member of the MMA to be a part of the speaker's bureau.

(BT-11/2001)

300.37 Public Education Program That Emphasizes The Benefits Of Having A Personal Physician

The Minnesota Medical Association will work collaboratively with primary care specialty societies and other appropriate organizations to study the possibility of developing a public education program that emphasizes all of the benefits to the patient, other specialists, and the entire health care system of having a personal physician who can provide high quality health care and can assist patients in obtaining other appropriate health services in a more efficient and effective manner.

(HD-R104-2003)

300.38 Responsible Sexuality Education

The Minnesota Medical Association (MMA) supports the repeal of the Minnesota Education Now and Babies Later program, and the MMA will develop, introduce, and lobby for legislation to support the use of comprehensive, developmentally appropriate, and medically accurate sexuality education programs that are demonstrated to be effective and that include information about abstinence and contraception.

(HD-R412-2004)

310 Health Fraud and Quackery

310.01 Mineral Analysis

The MMA strongly opposes the expenditure of Minnesota public funds for hair mineral analysis.

(HD-R24-1982)

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)

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)

310.05 Evidence-Based Health Care

The MMA will endorse the use of evidence-based standards, such as those used by the U. S. Preventive Services Task Force in making health care decisions when considering proposed legislative initiatives that would mandate standards of care.
(HD-R24-1996)

320 Home Health Care

320.01 Home Health Agencies

The MMA recommends statewide registration of all home health agencies with limited regulation, carefully applied. The MMA sees a clear need for close involvement of physicians in directing the care given in a home health case to assure that services are both necessary and appropriate to the needs of the patient.
(BT-9/84; Retained 2004)

330 Hospitals (See also, Credentialing)

330.01 Full Service Community Hospital Concept

The MMA supports the concept of the full service community hospital providing core medical services of internal medicine, surgery, pediatrics, obstetrics and appropriate levels of emergency and intensive care. Maintenance of these services should be predicated upon such factors as quality and local needs as perceived by the hospital's board of directors and medical staff.
(HD-R13-1981)

330.05 Data Reporting Requirements

The MMA supports legislation to repeal existing data reporting requirements for both hospitals and freestanding surgical centers.
(BT-2/85)

330.06 Risk Management Activities

The MMA (1) actively supports the development of formal risk management activities within the hospital; (2) encourages the involvement of medical staffs in the development and ongoing operation of those risk management activities; and (3) encourages educational activities for physicians in risk management activities and programs.
(HD-R31-1986; Retained 2004)

330.07 Support of Community Hospitals

The MMA supports health care outreach models which provide specialty care in the local community.
(HD-SR6-1992; Retained 2004)

330.23 Hospital Overhead Paging Standards

The MMA supports and endorses MHA's overhead paging standards and recommendations.
(BT 01-12)

330.08 Mandatory Implementation of Reduced Hospital Stays

The MMA supports 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 2004)

330.082 Workplace Violence and Abuse Prevention

The MMA encourages all hospitals and clinics to adopt policies to reduce and prevent workplace violence and abuse and develop policies to manage reported occurrences.

The MMA encourages local medical societies and other professional associations to adopt a policy to reduce and prevent workplace violence and abuse.
(HD-R103-1998 ; Retained 2008)

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)

330.084 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)

330.089 Minnesota Hospital Association Legislation Re; Unequal Certificate Of Need, Licensing Of Imaging Centers And Disclosure

The Minnesota Medical Association actively opposes all aspects of HF 2127/SF 2080 legislation introduced during the 2004 legislative session, with the exception of those that pertain to quality and safety.
(BT-03/2004)

330.0891 Nurse Staffing and Quality of Care

The Minnesota Medical Association will work with the Minnesota Nurses Association, the Minnesota Hospital Association, and other interested stakeholders to develop standards for appropriate staffing in Minnesota hospitals regarding patient care.
(HD-200-2004)

330.0892 Moratorium from Additional Prohibited Medical Abbreviations from Joint Commission on Accreditation of Healthcare Organizations

The Minnesota Medical Association delegation to the American Medical Association (AMA) will carry a resolution to the AMA calling on the AMA to request (through the AMA representatives on the Joint Commission on Accreditation of Healthcare Organizations Board) that the JCAHO Board slow the pace of implementation through a moratorium of additional "do not use" abbreviations until there is evidence of overall compliance with the currently recommended list; work with the American Hospital Association to develop an acceptable interim mechanism to correct abbreviations that are legible but on the "do not use" list; and support the continued exemption of "do not use" abbreviations, acronyms, and symbols on dictated, transcribed, or computerized forms of clinical documentation from the JCAHO standard.
(HD-R209-2004)

330.0893 Improvements in Joint Commission Standard and Interpretations of Medication Reconciliation

The MMA shall submit a resolution to the AMA House of Delegates that requests that the AMA advocate for medication reconciliation standards and interpretations that will improve patient safety and will be consistently interpreted by hospitals, health care systems, physicians and the Joint Commission survey team members. The MMA will also request that the AMA work with other interested parties including the American Hospital Association, National Patient Safety Foundation and the Joint Commission, among others, to standardize the interpretation of health-care system-wide medication reconciliation policies based on pre-established, uniform, specific, and consistently interpreted criteria as a mechanism to improve health care systems implementation of medication reconciliation to enhance patient safety.
(HD-R213-2007)

330.0894 Prairie St. Johns Hospital

The Minnesota Medical Association supports the need for more inpatient psychiatric beds in Minnesota, but opposes the Prairie St. John's Psychiatric Hospital Proposal unless the following conditions are met: Prairie St. John's must accept all patients regardless of insurance status or type; Prairie St. John's must provide 24-hour access for psychiatric evaluation and admission; and, Prairie St. John's must provide medical and psychiatric services to all patients. In addition, the MMA supports including these conditions as part of any legislatively-approved moratorium exception.
(BT 03/08)

330 Hospital Costs

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)

330.11 Physician Awareness of Hospital Costs

The MMA encourages hospitals to provide physicians with copies of their patients' bills, at the physician's request, and encourages physicians to become knowledgeable about the cost of hospital services by randomly reviewing their patients' hospital bills.
(HD-R17-1987)

330.13 Hospitalized Patient Billing Information

The MMA reaffirms Resolution 17, adopted at the 1987 MMA Annual Meeting, which states that the Minnesota Medical Association request that hospitals make available to physicians copies of their patients' bills, at the physician's request, and that the MMA encourages physicians to avail themselves of the opportunity to become knowledgeable about the cost of hospital services which they order by reviewing their patient's hospital bills.
(HD-R20-1992; Retained 2004)

330 Medical Staff

330.14 JCAH Accreditation Standards

The MMA supports the following five principles, developed and approved by the AMA Board of Trustees, for use in reviewing future revisions of the Joint Commission on Accreditation of Hospitals' Accreditation Manual for Hospitals:

1. continue the use of the term "medical staff";
2. delete references to dentists, podiatrists, oral surgeons and other limited licensed practitioners in the medical staff chapter;
3. provide for consideration of qualified limited licensed practitioners when authorized by state law and approved by the executive committee of the medical staff;

4. require greater than a majority of fully licensed physician membership on the executive committee of the medical staff in acute care general hospitals; and ensure that all hospitalized patients receive the same standard of care through appropriate language relating to admission and the responsibility for the medical care of patients.
(HD-R12-1983)

330.15 Hospital Staff Privileges for Podiatrists

The MMA opposes legislation requiring full medical staff hospital privileges for podiatrists.
(BT-1/91; Retained 2004)

330.16 Hospital Medical Staff Section

The MMA approves the Hospital Medical Staff Governing Principles.
(BT-11/92)

330.17 Study and Issue Guidelines for the Immunization of Physician Members of Hospital Medical Staffs

The MMA will study the legal and regulatory aspects of requiring physician members of hospital medical staffs to be immunized in order to prevent the infection of patients and employees for the purpose of adopting guidelines to be disseminated throughout the state, and will request the Minnesota Delegation to the AMA Hospital Medical Staff Section Assembly to sponsor a similar resolution in the 1993 Interim HMSS Assembly.

(HD-R46-1993)

330.18 Organized Medical Staffs & MMA-HMSS

The MMA supports the concept of representatives from other organized, non-hospital medical staffs serving as representatives to the MMA-HMSS. The MMA-HMSS is authorized to propose and recommend the policy defining the eligibility criteria and role for the organized non-hospital medical staffs.

(HD-R3-1994)

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 supports the inclusion of physician membership on hospital governing boards.

(HD-R404-2002; Retained as edited 2012)

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)

330.22 Support of Lactation Services in Minnesota Hospitals

The Minnesota Medical Association supports and will communicate a position that all Minnesota hospitals providing maternity care should also provide 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. The MMA will further initiate a dialogue with relevant organizations such as the Minnesota Department of Health, the Minnesota Council of Health Plans, the Minnesota Hospital Association, the Minnesota Nurses Association and the American Academy of Pediatrics-Minnesota Chapter to discuss the importance (medically and financially) of improved lactation services.
(HD-SR203-2005)

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

340.01 Universal Precautions

The MMA supports additional education for health care workers with regard to Universal Precautions. Also, the MMA will consider developing educational programs respecting universal precautions for physicians.
(BT-3/91)

340.03 MMA Opposes Current HEPA Mask Requirement

The MMA will work with the Minnesota Hospital Association to protest the current regulation on HEPA masks as an expensive and unproven safety measure, until their efficacy can be proven with appropriate epidemiologic studies.
(HD-R36-1994)

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 encourages the appropriate state agencies to investigate the role that antibiotic use plays in antibiotic resistance.
(BT-5/01; Retained as edited 2011)

340.05 Health Screening of Minnesota offenders

The MMA supports routine HIV testing of all Minnesota inmates in the care of the Department of Corrections as a standard of care and further encourages the Minnesota Department of Corrections to implement said screening immediately. The MMA will continue to monitor the need for routine testing of inmates for Hepatitis B and C. In addition, the MMA will submit a letter to the Department of Corrections supporting routine HIV testing of all Minnesota inmates. The MMA shall archive out-of-date policy that conflicts with this updates position (i.e., 530.53-Health Screening of Minnesota Offenders; and, 2005 Resolution 407, not yet codified in the MMA policy compendium).
(BT 07/07)

340.06 Advocate for Strategies to Address Antimicrobial Resistance (STAAR) Act

The Minnesota Medical Association shall lend its voice and resources to advocate aggressively for enactment of the Strategies to Address Antimicrobial Resistance (STAAR) Act, in order to protect the people of Minnesota from the growing scourge of antimicrobial resistant infections, and shall contact each member of the Minnesota congressional delegation and encourage MMA members to contact their respective members of Congress to urge them to cosponsor the Strategies to Address Antimicrobial Resistance (STAAR) Act, to fully support the STAAR Act's enactment in 2008, and to provide sufficient appropriations beginning in Fiscal Year 2009 to implement the STAAR Act's strategies upon the bill's enactment. (HD-R402-2008)

350 Laboratories

350.01 Reference Laboratory Contracts

The MMA approves the encouragement of Minnesota health care plans to enlist the input and advice of plan physicians, consider the effects of reference lab contracts on good patient care, provide an adequate period of time from announcement to introduction of such arrangements, and communicate the announcement to physicians in an appropriate manner. (HD-R23-1993; Retained 2004)

350.04 Laboratory Billing

It is the position of the Minnesota Medical Association that it is an ethically permissible billing practice whereby an ordering and billing physician adds to the charge of the professional services rendered by a pathologist for anatomic and cytologic services if those added charges reflect the reasonable costs incurred by the ordering and billing physician during the billing process (such added charges would not include costs otherwise incorporated in the ordering physician's professional services associated with the patient visit, specimen collection and handling (i.e., inconsistent with CPT coding standards)). Therefore, the MMA will oppose any legislative or regulatory efforts to prohibit such billing practices. The MMA will educate Minnesota physicians about the complex issues involved in the billing of anatomic and cytologic pathology services. (BT-11/06)

350.05 UnitedHealthcare Laboratory Protocol

The MMA expresses strong concern about the recent decision by UnitedHealthcare to fine physicians (effective March 1, 2007) on an ad hoc basis when patients obtain laboratory services from an out-of-network provider. High quality, reasonably accessible laboratory services are a critical component of patient care. The potential for the UnitedHealthcare decision, or policies like it, to impede patient access to laboratory services is of foremost concern to the MMA.

The MMA notes that physicians work with their patients on a daily basis to help them obtain laboratory and other medical services from providers that are included in patients' insurance plan network. However, for reasons that may be beyond the control of the physician, patients may obtain laboratory services from non-network providers. In this instance, it should be the responsibility of the patient to incur any penalties, financial or otherwise, that UnitedHealthcare, or any other health plan, may wish to impose consistent with the terms and conditions of the patient's certificate of coverage.

The MMA recognizes that physicians who negotiate contracts with UnitedHealthcare, or other health plans, may elect to accept contract terms that require them to direct patients to preferred providers and that impose financial or other penalties for non-compliance. The MMA, as a result of this position statement, is in no way limiting or seeking to influence the ability of physicians to accept such contract terms.

(BT 07/07)

350.06 Medical Laboratory Science Personnel Licensure

The MMA shall work closely with the Minnesota Society of Pathologists to share the concerns identified by the MSP with the sponsors of the bill to license medical laboratory personnel. In addition, the MMA will work to try to address those concerns prior to the bill passing.

(BT 11/07)

360 Litigation

360.01 Expert Witnesses

The MMA restates its historic policy that participation by physicians in the professional liability judicial process, whether on behalf of plaintiffs or defendants is ethical and of benefit to society, and encourages physicians to so participate.

(HD-SR21-1982; Retained as edited 2007)

360.03 Expansion of Antitrust Law Regarding Personal Injuries

The MMA opposes legislation expanding the remedy under Minnesota antitrust law to allow anyone injured directly or indirectly to sue for trebled damages.

(BT-3/84; Reaffirmed: BT-03/08)

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)

360.05 Litigation Support Program

The MMA endorses the concept of malpractice insurance coverage or other proof of indemnification for all practicing health professionals. Further, we believe that this should be part of a comprehensive reform proposal based on MICRA-type reforms, including limits on non-economic damages, limits on attorney contingency fees based on a sliding scale proposal, apportionment of damages based upon percentage of fault, and equal access to health care providers for both the plaintiff and defense.

(BT-2/94; Retained 2006)

370 Media (See also, Advertising, Public Relations)

370.04 Media Violence Campaign

The membership of the MMA strongly supports the MMA's "Stop the Violence" campaign. The MMA also encourages all physicians to instruct the parents of their pediatric patients on the "10 Tips on Media Violence" as prepared and distributed by the MMA.

(HD-R19-1995; Retained 2005)

370.05 Children's Impact Statement on Video

The MMA commends the work of the National Institute on Media and the Family, and supports the placement of a children's impact statement on video cassettes such as the statement developed by the National Institute on Media and the Family.

(HD-R60-1996; Retained 2006)

370.09 MMA Spokesperson Guidelines

The MMA Spokesperson Guidelines are for MMA officers, Board Members, the delegation to the AMA, committee chairs, CEO, and spokespersons who are asked to give a media interview on behalf of the MMA. They do not apply to interviews or expressed opinions about clinical topics or topics on which the MMA has not established policy. When speaking publicly on behalf of the Minnesota Medical Association or being interviewed by the media in the role of MMA representative, your public statements should coincide with MMA policy. If you are asked to comment on a topic on which your own personal opinion differs from MMA policy, you should notify staff and ask that someone else give the interview. Expressed views or statements that differ from established MMA policy, whether inadvertent or purposeful, may be viewed as showing dissension or lack of cohesion within the physician community and may detract from the MMA's ability to achieve its policy goals. If you are asked to give an interview or write an article for another health care publication on a topic related to health care policy, you are asked to contact the MMA Communications Department before agreeing to do so.

The MMA's goal is to increase visibility of MMA officers and promote MMA policies. Other considerations would be timing, and consistency with MMA policy. It would be appreciated if you would submit articles that you write for other publications to MMA communications staff to review for accuracy before they are published.
(EC-2/06)

380 Medical Education

380.01 Alcohol and Chemical Dependency

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

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)

380.03 Medical Schools

The MMA encourages the University of Minnesota Medical Schools at Minneapolis and Duluth and the Mayo Medical School to develop recruiting plans directed at recruiting applicants likely to practice in rural settings.
(BT-1/90)

380.07 Report of the MMA Ad Hoc Task Force on Medical Education

The MMA adopts the Minnesota Medical Association: Report of the Ad Hoc Task Force on Medical Education (Appendix C) and the principles therein as MMA policy on medical education.
(BT- 9/95; Retained 2005)

380.08 Nutrition Education

The MMA will encourage Minnesota's medical schools to ensure that instruction on nutrition is adequately covered in their curricula. The MMA delegation to the AMA will also ask the AMA to encourage the National Board of Medical Examiners to ensure that all areas of nutrition and nutritionally-related diseases be covered adequately on the United States medical license examination.
(HD-R48-1996)

380.081 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 2007)

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)

380.086 Use of Anatomical Gifts in Medical Research and Education

The Minnesota Medical Association delegation to the American Medical Association shall request that the AMA modify ethical policy E-2.08 sub. (1) to include use of organs or tissues for educational purposes, and that the AMA study current legal safeguards for proper ethical use of human tissue for research and education, to determine if they are appropriate and sufficient.
(HD-R405-2000)

380.087 Clinical Skills Assessment Exam

The Minnesota Medical Association shall encourage the Minnesota Board of Medical Practice to exclude the Clinical Skills Assessment Exam from state medical licensure requirements until the following conditions are met: (1) the examination has been demonstrated to be statistically valid, reliable, practical, and evidence based; (2) scientific studies have been published in peer review journals validating the examination for U.S. medical students and graduates and demonstrating that the fiscal and societal benefits of the examination

justify the costs; and (3) testing sites are available in more reasonable geographic locations than currently proposed by the National Board of Medical Examiners.
(HD-LR411-2002)

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

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

380.089 Opposing the Requirement of the United States Medical Licensing Exam Step 2 Clinical Skills Exam as a Requirement for Medical School Graduation

The Minnesota Medical Association (MMA) will immediately contact Minnesota medical schools and strongly urge them not to require the passage of the United States Medical Licensing Exam (USMLE) Step 2 Clinical Skills Exam. The MMA reiterates support for MMA policies 380.087 and 380.088.
(HD-R408-2004)

380.0891 Healthcare Workforce

The Minnesota Medical Association will work in conjunction with the Minnesota Department of Health, the Minnesota Legislature, and the University of Minnesota Academic Health Center to identify the health care workforce needs of the diverse population of the state of Minnesota and support efforts to ensure that we train an adequate supply of physicians to meet those needs.
(HD-R209-2010)

380.0892 Access to Procedural Training for Residents and Fellows

The MMA supports submission of a resolution to the AMA as follows: that our American Medical Association study the trends in numbers of residency training sites that also employ mid-level providers and/or concurrently train students of these midlevel programs; and further that our AMA more clearly define a physician-in-training's role in the hospital and specifically make it a high educational priority for trainees to receive the needed exposure to procedures required for them to master competency in their specialty and that these exposures are not delegated to midlevel providers and mid-level provider trainees; and further that our AMA study the financial impact for institutional training sites of hiring more mid-level providers versus investing in a physician training program.
(BT 05-12)

380 Continuing Medical Education

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)

380.15 Physician Education Regarding Prenatal AIDS Transmission and Control

The MMA will promote appropriate AIDS education of family practice, OB/GYN and other physicians who provide family planning, prenatal and delivery care to women at risk of AIDS.
(HD-R4-1986; Retained 2004)

380.16 Prevention of Child Abuse and Neglect

The MMA will educate physicians regarding the identification and treatment of neglected and abused children. MMA members are encouraged to be active participants in community programs to deal with this problem, including participation in county child protection teams.
(HD-R31-1989; Retained 2004)

380.17 Universal Precautions

The MMA supports additional education for health care workers with regard to Universal Precautions. Also, the MMA will consider developing educational programs respecting universal precautions for physicians. (BT-3/91)

380.2 Public Sector Medical Reimbursement Education Program

The MMA approves working in conjunction with its component medical societies and appropriate state and federal agencies to develop an education plan for physicians and/or their clinic managers to enhance understanding and to facilitate patient utilization of local, state, and federal health care programs such as TEFRA, SSI, MCHA, MinnesotaCare, EPSDT, Medicaid, Medicare, GAMC, etc. (HD-R9-1993; Retained 2004)

380.22 Regulation of CME Subject Matter

The Minnesota Medical Association reiterates its current policy opposing any legislation or government regulation that defines the subject matter or content of continuing medical education required for physician relicensure in Minnesota. (HD-R10-1994; Retained 2006)

380.23 Firearms and Dangerous Weapons

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

380.24 Recommended CME Requirement

That the MMA supports the Minnesota Board of Medical Practice's proposal to change the CME requirements for a three-year licensure period to 75 hours of AMA PRA Category 1 credits or its equivalent. (BT-7/94)

380.25 Mission Statement

The MMA reapproves the current MMA CME Mission Statement. (BT-7/94)

380.26 Continuing Medical Education Mission Statement

The MMA adopts the following CME mission statement as revised by the Committee on Accreditation and Continuing Medical Education and approved by the Board of Trustees: "To accredit, promote, and assist intrastate CME programs, and to provide continuing medical education activities which assist physicians in attaining and maintaining high standards of patient care and professional performance." (HD-R4-1996)

380.27 Elimination of Special State Requirements for Licensure to Practice Medicine

The MMA shall work with the AMA and the Federation of State Medical Boards to standardize licensure requirements specifically pertaining to continuing medical education requirements. The MMA will also consider the elimination of other special physician licensure requirements that create barriers for physicians seeking licensure in multiple states. (HD-R35-1996)

380.273 American Academy of Pediatrics (AAP) Guidelines for Circumcision

The MMA shall encourage physicians to become knowledgeable on the American Academy of Pediatrics policy regarding circumcision and to follow its recommendations. (HD-R302-1999; Retained 2009)

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).

The MMA shall provide information to physicians, from published sources, detailing policies for reimbursement and deductibility of CME within Minnesota and throughout the United States.

The MMA shall develop a report that describes current methods to fully deduct the cost of required continuing medical education and assess the need for changing current tax laws to ensure full deductibility of required CME.

(HD-R101-2000; Retained 2010)

380.276 Resolution Regarding Discontinuing the Secure Examination as Part of The ABMS MOC Program

The Minnesota Medical Association delegation to the American Medical Association will request that the AMA work with the American Board of Medical Specialties to discontinue the requirement for a secure examination as part of their Maintenance of Certification program.

(HD-R205-2011)

380 Student Loans/Funding Medical Education

380.29 Study Funding for Medical Education and Research

The MMA urges private and public medical insurance programs, health care plans and industry to assume fair responsibility in support of research, development, and education costs which are an intrinsic component of the "product" that they market to the "medical care consumer". The MMA will strive toward a better balance between immediate medical cost containment, and a long range concern for medical excellence and progress in future decades. This emphasis can take the form of public statements, exchanges with legislative groups, public conferences, information brochures to patients, and the active voices of MMA members on advisory bodies and medical care plan management groups.

(HD-R2-1984; Retained 2004)

380.31 Program Funding

The MMA supports the existing summer intern program for high school students to expose them to medical careers, and supports the Rural Physician Associate.

(BT-1/90; Retained as edited 2007)

380.32 Financial Incentives

The MMA supports efforts to establish a state funded loan forgiveness programs for physicians who practice in rural Minnesota, and that local matching dollars be encouraged to provide additional funding.

(BT-1/90; Retained 2004)

380.33 Student Status Deferment of Resident Physicians

The MMA will use its resources to work toward reinstatement of the student status deferment of resident physicians.

(HD-R12-1990; Retained 2004)

380.34 Primary Care Funding

The MMA supports increased funding for training physicians in the provision of general primary care.

(BT-1/91; Retained 2004)

380.35 Medical School Training for Rural Physicians

It is the MMA's position that a grave shortage of physicians exists in Minnesota and that the state funding of the Minnesota medical school programs should be directed to support those efforts to train physician specialties needed in the state, and to encourage the placement of those physicians to the areas most in need. These efforts should enhance the University of Minnesota's and Mayo Medical School's mission by:

1. Continuing current efforts and developing new efforts to attract students who exhibit a strong potential for primary care.

2. Studying the establishment of a significant active admitting family practice program with ongoing care and teaching responsibilities at the University of Minnesota Hospitals.
3. Urging and assisting, as needed in the continued development of rural primary care resident variances based on existing and developing educational models.
(BT-1/91)

380.38 Student Loan Deferment

The MMA will bring to the AMA a resolution supporting the creation of a deferment program 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)

380.41 Financing Medical Education

The MMA, on behalf of Minnesota physicians and citizens will take a leadership role in identifying and implementing new strategies designed to assure a long-term stable financing base for medical education in this state.

The MMA will develop strategies to facilitate communication with the members of the Medical Education and Research Cost Advisory Committee (MERCAC) and request that MERCAC annually report to the MMA House of Delegates.
(HD-R201-1997)

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)

380.44 Discourage University Of Minnesota Medical School Tuition Increases

The Minnesota Medical Association will work to support adequate funding for medical schools to avoid inordinate tuition increases, and to remind 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 2012)

380.45 Student Loan Forgiveness Programs for Rural Physicians

The Minnesota Medical Association shall advocate for an increase in the funding in the number of positions available to primary care physicians and residents for state-run student loan forgiveness programs including the Minnesota State Loan Repayment Program and Rural Physician Loan Repayment Program, and will advocate for a secure annual funding source for state loan forgiveness programs, so as to prevent limitations in the number of positions due to deficits in the state or federal budget. The MMA will further inform the Minnesota congressional delegation of the importance of fully funding the 20-220 pathway for economic hardship deferral to allay a resulting shortage of primary care physicians which is exacerbated by debt burden placed on medical students and will bring forward a resolution re-affirming AMA support of the 20-220 pathway for economic hardship deferment, and further make maintenance of the 20-220 pathway or reasonable equivalent, a top legislative priority.
(HD-R100-2008)

390 Medical Records

390.02 Health Workers Notification Statement

The MMA adopts the following statement on worker notification: If the patient insists on not having his or her diagnosis stated in the medical record, his or her wishes should generally be respected. In this event, appropriate precautions for isolation should be clearly documented in the medical record and is a physician responsibility.

(BT-8/86)

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 will seek to introduce legislation which repeals 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)

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)

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 Ownership

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 2012)

390.13 Patient Consent To Release Medical Records

The Minnesota Medical Association will notify and educate its members regarding the provisions of Minnesota Statutes Sec. 144.335, subdivision 3(a) requiring patient consent to release medical records to an insurer, health plan, HMO or third party administrator. The MMA supports as policy and will advocate for inclusion in health plan contracts the following language in the AMA/MMA Model Contract Section 6.1:

Confidential Medical Records. All medical records of Enrollees shall be maintained as confidential in accordance with applicable state and federal laws. All medical records shall belong to Medical Services Entity's Qualified Physicians consistent with the dictates of medical ethics. The release, disclosure, removal, or transfer of such records shall be governed by state and federal law and by the Medical Services Entity's established policies and procedures. Prior to the release of copies of any medical records to Company or other third parties, Company shall obtain from the subject Enrollee (or the Enrollee's legal representative) and present to Medical Services Entity an effective written consent or release that satisfies ethical constraints and applicable laws and is narrowly tailored to accomplish the sole purpose of such release, which the parties agree is to determine whether care was properly and efficiently rendered.

(BT-5/03)

390.14 Enforce Minnesota Law Requiring Patient Consents For Medical Records Releases

The Minnesota Medical Association affirms existing MMA policy 390.13, Patient Consent to Release Medical Records, which states:

390.13 Patient Consent to Release Medical Records

The Minnesota Medical Association will notify and educate its members regarding the provisions of Minnesota Statutes Sec. 144.335, subdivision 3(a), requiring patient consent to release medical records to an insurer, health plan, HMO, or third party administrator. The MMA supports as policy and will advocate for inclusion in health plan contracts the following language in the AMA/MMA Model Contract Section 6.1: Confidential Medical Records. All medical records of Enrollees shall be maintained as confidential in accordance with applicable state and federal laws. All medical records shall belong to Medical Services Entity's Qualified Physicians consistent with the dictates of medical ethics. The release, disclosure, removal, or transfer of such records shall be governed by state and federal law and by the Medical Services Entity's established policies and procedures. Prior to the release of copies of any medical records to Company or other third parties, Company shall obtain from the subject Enrollee (or the Enrollee's legal representative) and present to Medical Services Entity an effective written consent or release that satisfies ethical constraints and applicable laws and is narrowly tailored to accomplish the sole purpose of such release, which the parties agree is to determine whether care was properly and efficiently rendered. (BT-5/03), and, that the MMA call on the Attorney General to enforce Minnesota Statutes Section 144.335. (HD-SR405-2003)

390.15 Reporting All Immunizations to the Minnesota Immunization Information Connection (MIIC)

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)

400 Mental Health/Mental Illness

400.01 Patient Evaluation Program for Hospitalization and Commitment

The MMA supports legislation directing courts which commit persons to hospitals under the Hospitalization and Commitment Act to establish results oriented evaluation programs designed to assure that persons committed receive the best possible treatment plans, and requiring courts to appoint counsel guardians for such persons who are to obtain from heads of hospitals written reports on patients committed and on treatment programs which counsel guardians are to file with the committing court. (BT-1/80; Retained 2004)

400.05 Community-Based Programs

The MMA endorses development of effective community-based treatment of acutely and chronically mentally ill persons. The MMA also endorses public and private financial support for such community-based programs only if treatment of mentally ill persons is adequately supervised by a psychiatrist or other physician if no psychiatrist is available. (BT-10/82; Retained 2004)

400.06 Discrimination Against Mental Health Benefits in Insurance Programs

The MMA endorses voluntary disclosure by insurance companies and HMOs of information regarding payment for mental health services. (BT-2/84; Retained 2007)

400.07 Access to Psychiatric Treatment in Health Care Plans

The MMA believes that HMOs and other third party payment mechanisms, both public and private, should provide full disclosure of accurate information concerning all benefit and services to their actual or potential enrollees or subscribers which includes but is not limited to the following: the experience and qualification of the providers whom the patient will see, the opportunity for reimbursed referral or consultation, the copayment amount, if any, and the number of visits or days which are covered by the HMO or third party payment program.

(HD-SR11-1984; Retained 2004)

400.09 Receiving and Reimbursing Outpatient Psychiatric Treatment Based on Procedure

The MMA recommends increases in reimbursement for psychiatric services performed on an outpatient basis as denoted by procedure. The MMA also supports and endorses utilization and quality reviews performed by medical review agents for psychiatric outpatient treatment programming supervised by a psychiatrist, and encourages development of outpatient psychiatric treatment standards (including those for psychotherapy) to be used by medical review agents including the Department of Human Services in Minnesota.

(HD-R11-1985; Retained 2004)

400.13 Reimbursement for Treatment of Mental Illness

The MMA:

1. Supports the concept of nondiscrimination of payments for chronic or prolonged major mental illnesses for the purposes of copayments and deductibles;
2. supports reimbursement for treatment of mental illness in inpatient settings under MA and GAMC programs on a negotiated per diem rather than DRG3. Supports modifications of the Adult Commitment Act to allow patients and families to seek treatment prior to demonstrating a dangerousness standard and the requirement that treatment be provided in the least restrictive and most appropriate setting.

(BT-9/86; Retained 2004)

400.14 Utilization Review of Psychiatric and Chemical Dependency Cases

The MMA endorses the principle of prospective and concurrent review, encourages physicians to make appropriate review information available in a timely fashion, and discourages denial of payment based on retrospective utilization review in both the public and private sector. The MMA will educate its membership concerning contract problems with third party payers which hold the third party harmless from suit in the case of adverse patient outcome. The MMA recommends establishing community based standards for inpatient and outpatient psychiatric and chemical dependency treatment.

(HD-R5-1987; Retained 2004)

400.17 Psychiatrists/Psychologists

The MMA will continue to educate physicians and the community regarding the differences in the education, training and expertise of psychiatrists and psychologists.

(HD-R19-1990; Retain as edited 2007)

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)

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)

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. The MMA, through its AMA Delegation, supports federal legislation and/or rulemaking to end the discriminatory Medicare 50% copayment for treatment of mental disorders.

(HD-R29-1991; Retained 2004)

400.22 Classification of Learning Disabilities as a Medical Neurodevelopmental Diagnosis

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

(HD-R12-1993; Retained 2004)

400.23 MMA Opposes Health Plan Restrictions

The MMA supports efforts to end discriminatory restrictions on the treatment of mental illness and addictive disorders; supports removal of health plan restrictions to appropriate mental illness and addictive disorder treatment by primary care physicians; and seeks similar support from the AMA on those items which are not already AMA policy.

(HD-R23&25-1994; Retained 2006)

400.25 Mental Illness Awareness Week

The MMA supports the annual activities of Mental Illness Awareness Week, promoting awareness and educational efforts concerning mental disorders among the membership and their patients.

(HD-R105-1998; Retained 2008)

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.

The Minnesota delegation to the American Medical Association will carry a resolution to the American Medical Association House of Delegates seeking American Medical Association support for national and state parity bills to ensure standard health care coverage for mental health and chemical dependency.

(HD-R212-1998)

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)

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

The MMA commends and encourages the efforts of the Remembering with Dignity project.

(HD-R404-1999; Retained 2009)

400.3 Commitment of Mentally Ill Persons who pose a likelihood of harm

The Minnesota Medical Association actively supports legislation, introduced during the 2001 legislative session by Representative Mindy Greiling, to facilitate the commitment of mentally ill persons whose conduct poses a substantial likelihood of harm to self or others.

(BT-1/01)

400.35 Consolidation Of Oversight Of Health Plan Contracts

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

(HD-R409-2003)

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

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

1. Epidemiological studies of psychiatric disorders;
2. Coordination of mental health identification and treatment data;
3. Dissemination by the Health Department of a newsletter outlining the best practices for treatment of these disorders to primary care physicians (as is now done for infectious diseases);
4. Promotion of mental health screening activities by primary care professionals and public health nurses;
5. Promotion of the public health mental health model;
6. Working with professional societies, medical schools, primary care residency programs, and continuing education programs to promote mental health education to primary care physicians;
7. Encouragement through state grants, policy changes, etc., of improved coordination and shared care arrangements between psychiatrists and primary care physicians;
8. Working with professional societies and advocacy groups to clarify best practices for medical necessity treatment criteria;
9. Aiding in oversight of health plan contractual agreements for accessible mental health services; and
10. Providing outcome analysis of clinical and cost-offset outcomes of these activities.

(HD-R410-2003)

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

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

1. Monitor access to inpatient and outpatient psychiatric services in Minnesota;
2. Monitor health plan network coverage of psychiatric services to ensure that geographic and timely access are provided in accordance with Minnesota Statute 62D.124 (geographic accessibility) and Minnesota Rule 4685.1010;
3. Require health plans to publish their mental health medical necessity criteria for access to inpatient and outpatient services. The agencies will review the criteria to ensure that they are in compliance with standards of care as defined by provider groups including the Minnesota Medical Association and the Minnesota Psychiatric Society (Minnesota Rules re: Health care programs, 9505.0175 subp. 25);
4. Collect data regarding geographic and timely access to inpatient and outpatient psychiatric services, including frequency of patients diverted to another city or state beyond 30 miles or 30 minutes from their primary place of residence due to capacity constraints;
5. Following a six-month period of data collection, if there is significant evidence that psychiatric access is not meeting state guidelines, the state departments of Health, Human Services, and Commerce will take steps to vigorously enforce the contracts in order to ensure that health plans and insurance entities aggressively enlarge their networks and facilitate mental health care and reimbursement for care that is delivered by psychiatrists, psychiatric clinical nurse specialists, and primary care clinicians. This would

include ending the administrative roadblocks that have delayed and disrupted the delivery of timely mental health care to Minnesotans up to this point. The legislature should require health plans to show how they are successfully improving access to psychiatric and primary care clinicians, according to their respective levels of expertise. If these steps are not followed within a reasonable timeline, the state departments will address these contract violations with all available methods, including financial penalties and consideration of contract probation or cancellation;

6. Produce an annual report to the legislature and to the citizens of Minnesota with aggregate data collected; and
7. Provide the legislature with recommendations as appropriate regarding the need for increased access to psychiatric treatment in Minnesota.
(HD-R411-2003)

400.38 Comprehensive Medical and Psychiatric Care

The Minnesota Medical Association (MMA) supports and endorses the Minnesota Medical Association/Minnesota Psychiatric Society report "Principles for Access to Mental Health Care," and will work to educate physicians, third party payers, and other stakeholders about the principles contained in the report.
(HD-R401-2004)

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)

400.4 Study of Psychiatric Bed Problem

The Minnesota Medical Association (MMA) shall submit a resolution to the American Medical Association (AMA) supporting a study to determine the national scope of the problem of psychiatric bed availability and its impact on the nation's community emergency and general medicine resources, and encourage the AMA to join with the American College of Emergency Physicians to study, in conjunction with the American Psychiatric Association, the National Association of EMS Physicians and the American Ambulance Association, the EMS impact of psychiatric bed shortages and to look for solutions to this significant problem. The MMA shall also reconvene its task force on access to mental health services in order to identify statewide solutions to the problem of access to psychiatric services.
(HD-R411-2006)

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. Furthermore, the MMA will work with the Minnesota Psychiatric Society to monitor health plans and insurance entities for compliance with existing regulatory law regarding mental health benefits and access, and consider needs for new rules, penalties, and criteria in law if access and reimbursement problems persist.
(HD-R402-2007)

400.42 Promoting Psychiatric Care

The MMA reaffirms the MMA and Minnesota Psychiatric Society Access to Psychiatric Services Workgroup Principles adopted in 2004, encourages the training of more psychiatrists and the appropriate training in psychiatry of primary care physicians, will advocate for physicians to receive appropriate reimbursement for psychiatric services, and opposes the discrimination and the societal stigma associated with psychiatric care.
(HD-R405-2007)

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)

400.44 Educating Physicians and Patients about the Mental Health Parity Act of 2007

Pending the enactment of the Mental Health Parity Act of 2007, the Minnesota Medical Association will work to educate Minnesota physicians about the implications of this act, and will submit a resolution asking the American Medical Association and interested state and specialty societies to consider developing a nationwide campaign geared at educating the public about the benefits now afforded to them by this act.

(HD-R207-2008)

400.45 Major Depression, Evaluation and Treatment

The Minnesota Medical Association will work with the Institute for Clinical Systems Improvement (ICSI) to critically evaluate the effectiveness of the Depression Improvement Across Minnesota Offering a New Direction (DIAMOND) project, specifically related to the necessary parameter of sufficient psychiatric evaluation and appropriate consultation that leads to the correct treatment, of major depression and the role of the care manager within the implementation and monitoring of a properly executed evaluation/treatment plan.

(HD-R211-2008)

400.46 Major Depression, Evaluation and Treatment

With respect to implementation of HOD-08 Resolution 211, the MMA will: 1. Monitor the implementation of DIAMOND: the MMA will meet with ICSI staff to understand the data, DIAMOND's implementation, and learn about the initiative's successes and lessons learned; 2. Engage Minnesota's psychiatric community in a dialogue and advocate on their behalf, as appropriate: Identify concerns and successes with DIAMOND and when appropriate identify opportunities to collaborate with ICSI, MPS, and others to address these concerns and share successes; 3. Communicate with MMA members about DIAMOND: Identify opportunities to share DIAMOND's successes and barriers via existing MMA publications.

(BT 03/10)

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)

400.48 Treatment of Mental and Substance-Related Disorders in Minnesota

The MMA will develop and appoint a task force of primary care physicians and psychiatrists to recommend and to oversee the development of good/best direct care and consultation practices consistent with the aims and architecture of the medical home, that meet a reasonable standard of individualized comprehensive evaluation and direct treatment of mental and substance-related disorders.

(HD-R204-2011)

400.49 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)

410 Minorities

410.02 Racial and Ethnic Disparities in Health Care

The MMA commends the AMA's efforts to alleviate the disparities in health care to minority populations. The MMA also opposes racially and culturally based disparities in health care in Minnesota and support initiatives to alleviate these disparities in Minnesota.
(HD-R39-1996; Retained 2006)

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)

410.04 National Standards for Culturally and Linguistically Appropriate Services

The MMA shall promote awareness of 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)

420 MMA Administration/Membership

420 On-Line Access to Physician Regulations

The Minnesota Medical Association will develop a resource on the MMA's web site that provides links to the most commonly used federal and state regulations relevant to the practice of medicine.
(HD-R402-2004)

420.03 Committee Appointment Process

The MMA approves the revision of the committee appointment process to change the terms of member appointments to two years (with the exception of the Committee on Accreditation and CME); that the terms be staggered to maintain continuity; and that a maximum of three terms (six years total) be established. This maximum number of years does not include appointments to fill an unexpired term.
(BT-3/93; Retained 2004)

420.04 Committee Year

The MMA approves the committee year to be the calendar year.
(BT-3/93; Retained 2004)

420.05 Gender Neutrality Policy

The MMA adopts the following policy on gender neutrality:

1. The MMA adopts a policy of gender-neutral language, to be incorporated into its bylaws, policies, procedures, and publications, during the normal process of printing and updating/reprinting documents;
2. The term "chairman" no longer will be used to designate the head of a committee and that the term "chair" or "chairperson" be used instead; and

The MMA encourages component medical societies and state chapters of national specialty societies to review their bylaws and policies and eliminate gender-based language where it exists.
(BT-5/93; Retained 2004)

420.06 Categories of Membership

The MMA supports working closely with the component medical societies to establish common categories of membership throughout the state, and supports the consideration of AMA membership categories when developing common categories of membership.

(HD-R14-1994)

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.

The MMA will encourage the Minnesota Council of Health Plans to adopt a policy recommending its members not invest in tobacco company stocks.

(HD-R109-1997)

420.13 Definition of Minority

The MMA approves the definition of minority, for MMA purposes to include following groups:

African Americans/Africans
Native Americans
Asian/Pacific Islanders
Hispanics/Latinos
(BT-2/98; Retained 2008)

420.14 Committee on Workers Compensation

The Committee on Workers Compensation will be disbanded. However, the MMA will continue to serve as a resource/liaison to the Medical Services Review Board of the Department of Labor and Industry. An Ad Hoc Committee on Workers Compensation may be assembled to address pertinent issues as they arise.

420.17 Training/Orientation of Leadership

The MMA will develop a training/orientation program targeted to MMA leadership, MMA committee chairpersons and committee members that includes at least the following elements: small group processes, meeting management and media relations. The Internet should be used as a resource for training materials and as a way to provide training.

(BT-4/98)

420.18 Invited Guests

MMA Committee Chairs shall have the authority to designate regularly invited guests to attend MMA Committee Meetings. It is expected that these regularly invited guests would represent organizations, agencies, or institutions whose input and dialogue adds value to the deliberations of the specific committee. Regularly invited guests shall be encouraged to participate in Committee discussion, but shall have no vote or be able to hold office within the Committee, such as Committee Secretary, Chair, or Vice Chair. A roster of regularly invited guests for each committee shall be provided by MMA staff to the MMA Board Chair.

(BT-11/98)

420.19 Physician Assistants-Committee Participation

The Minnesota Academy of Physician Assistants will be invited to submit to the MMA Board Chair the names of three individuals to serve as regularly invited guests to the Minnesota Medical Association Committee on Legislation, Committee on Ethics and Medical-Legal Affairs, and the Committee on Medical Practice and Planning. One such individual shall serve on each Committee. As regularly invited guests, they will be invited to participate in Committee discussion, but shall have no right of vote on the Committee or shall serve as Committee Officer, including Chair, Vice Chair, or Secretary. These shall be reviewed and resubmitted annually.

(BT-11/98)

420.2 Membership by Choice

The MMA will continue to study the issue of options for membership in Minnesota and will report recommendations to the 1999 House of Delegates.
(HD-R113-1998)

420.27 Implement a Practice Hassle Factor Project

The MMA, as part of its physician advocacy program shall continue to maintain a practice hassle factor project to track and address administrative obstacles physicians encounter to providing patient care.
(HD-R400-1999; Retained as edited 2009)

420.34 Addition to the Definition of Minority

The Minnesota Medical Association shall modify the definition of "minority," for all MMA purposes, to include the following, "other racial and ethnic minority groups," within the current definition.
(BT-5/01)

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)

420.37 Minnesota Antibiotic Resistance Collaborative (MARC)

The MMA approves the commitment to contribute \$10,000 to the Minnesota Antibiotic Resistance Collaborative (MARC) to support their activities during 2001.
(EC-10/2001)

420.4 Minnesota Coroners and Medical Examiners Association

In accordance with procedures outlined in MMA Bylaws, the MMA establishes the Minnesota Coroners and Medical Examiners Association as a section of the Minnesota House of Delegates with subsequent authority to appoint a delegate.
(BT-11/2001; Retained 2011)

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 2012)

420.43 Secondhand Smoke

The Minnesota Medical Association and its constituent societies will choose facilities for their meetings, conferences, and conventions based on the facility's smoking policy (including its restaurant and bar policies) as an equal criterion to the facility's size, service, location, cost, and other similar factors, and that the MMA delegation to the American Medical Association (AMA) submit a resolution to the AMA asking that a similar policy be adopted by the AMA to encourage national medical specialty societies, other state and county medical societies, and other health care organizations to adopt such a policy.
(HD-R105-2003)

420.44 Ten-Year Sunset Evaluation Of Policy

The Minnesota Medical Association will establish a mechanism to evaluate all policies ten years after their adoption for current relevance and contradiction or superseding by later House action, at no time changing the will of the organization without full deliberation of the House through its usual procedures, and, the MMA establish a task force to evaluate all policies adopted prior to 1994 for current relevance and later contradiction or supervening, and that this task force report to the 2004 House of Delegates any recommended action with the recommendation that this report procedure be done through a special reference committee of the 2004 House established for this purpose.
(HD-R106-2003)

420.45 Bylaws Committee And Committee Membership Selection

The Minnesota Medical Association responding to recommendation of the Executive Committee will

1. Dissolve the Committee on Committees By-Laws and Membership and transfer the by-laws responsibilities to the MMA Executive Committee, and
2. The "Committee Appointment Process" memorandum be adopted and used starting with appointments that are effect 2005.
(EC-12/2003)

420.46 Adhoc Committee On Quality

The Minnesota Medical Association will develop an ad hoc committee on quality.
(BT-03/2004)

420.47 Secondhand Smoke

The Minnesota Medical Association will schedule its annual meeting only in jurisdictions (cities or counties) in which there is an ordinance that eliminates tobacco smoke in restaurants, bars, and other commercial establishments serving food.
(HD-R103-2004)

420.48 Governance Task Force

The Minnesota Medical Association (MMA) Board of Trustees will create a governance task force to provide recommendations regarding changes in bylaws, governance, and standing committee appointment process for the MMA and report recommendations to the 2005 House of Delegates.
(HD-R105-2004)

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)

420.5 On-Line Access to Physician Regulations

The Minnesota Medical Association will develop a resource on the MMA's web site that provides links to the most commonly used federal and state regulations relevant to the practice of medicine.
(HD-R402-2004)

420.51 Trustee Representation

The trustee composition representing the geographic trustee districts of the Minnesota Medical Association (MMA) Board of Trustees, effective at the end of the 2006 MMA Annual Meeting, shall be as follows: West Metro Trustee District-6, Southeast Trustee District-4, East Metro Trustee District-3, North Central Trustee District-2, Northeast Trustee District-2, Southwest Trustee District-2, Northwest Trustee District-1.
(HD-R100-2005)

420.52 Education About High Deductible Health Plans

The Minnesota Medical Association shall organize, promote, or publicize educational opportunities for members and clinic staff about high deductible health plans (e.g. major medical insurance combined with a Health Savings Account, Health Reimbursement Accounts, or flexible savings accounts) and their impact of these plans on the operation of clinics.
(HD-SR103-2005)

420.53 Committee Meetings Through Use Of Teleconferencing Technology And Outstate Meeting Locations

The Minnesota Medical Association will evaluate video and audio communications technology to facilitate more effective participation by committee members who would not otherwise be able to attend MMA committee meetings, and report back to the 2006 House of Delegates. The MMA will evaluate options for conducting some committee meetings in greater Minnesota and will report back to the 2006 House of Delegates.
(HD-R104-2005)

420.54 Physician Finder Link To The Public

The Minnesota Medical Association (MMA) shall encourage its members to provide their practice Web site addresses for use in the Physician Finder and explore the option to advertise the Physician Finder service to the general public and patient support and advocacy organizations.

(HD-R102-2006; Reaffirmed: HD-R101-2010)

420.55 MMA Investment Policy

The Minnesota Medical Association (MMA) shall continue its prohibition on direct investment in tobacco company stocks and explicitly expand that prohibition to also include direct investment in the debt of companies that produce tobacco products, and that index or exchange-traded funds or similar investments be allowed as long as they exclude companies that produce tobacco products.

(HD-R108-2006)

420.56 Health Care Coverage and Early Retirement

The MMA will provide information on its Web site and in its publications regarding early retirement options for physicians.

(BT-7/06)

420.57 Audio/Video Conferencing and Outstate Meetings

The MMA will pilot test a potential A/V solution (i.e., WebEx Meeting Center and one-way camera) during the 3rd and 4th quarters of 2006 and expand use/availability to all MMA committees and RMS and HMS committees in 2007.

The MMA, during the second half of 2008, will evaluate the effectiveness of the committee A/V effort by assessing how participation has changed and the satisfaction of members participating in these meetings. That the MMA not require any MMA committee meetings to be held in Greater Minnesota pending the outcome of the evaluation of the A/V effort during the second half of 2008.

(BT-7/06)

420.58 Membership Task Force

The MMA shall form a Membership Task Force/Committee which shall pro-rate dues for new members; expand the Alternative Dues Program to all members with discounts varying by recruitment/retention and groups/individuals; assign the MMA staff the task of determining appropriate methods of recognition and representation for clinics that make a 100%, multi-year commitment.

(BT 07/07)

420.59 Specialty Societies & American Medical Association (AMA) Dues

The MMA delegation to the American Medical Association shall submit a resolution to the AMA House of Delegates asking that the AMA request that all national specialty societies include a succinct list of the American Medical Association's advocacy goals and the benefits of being an AMA member with the societies' annual dues statement, and that the societies' annual dues statements include the AMA dues amount and a chance to join the AMA.

(HD-R103-2007)

420.6 Changing The Name of Hennepin Medical Society

The name "Hennepin Medical Society" shall be changed to "West Metro Medical Society."

(HD-R104-2007)

420.61 Changing The Name of Hennepin Medical Society

The name "Ramsey Medical Society" shall be changed to "East Metro Medical Society."

(HD-R105-2007)

420.62 Fair Discounting of Dues

The MMA shall promote dues discount policies that are fair to all members.

(HD-R107-2007)

420.63 Sunset Policy Review

The seven “questionable” policies identified during the 2007 sunset policy review process shall be subject to further review by MMA staff and leadership and recommended action on them be brought to a future meeting of the MMA House of Delegates, and the MMA compendium of archived MMA policies, which contains MMA polices that are no longer relevant but can be consulted for historical or informational reasons, include the 66 attached recommended “archive” policies, and the MMA shall reaffirm support for the 13 attached recommended “retain” polices, and he MMA approve and reaffirm support for the 19 attached recommended “retain as edited” policies.
(HD-R108-2007)

420.64 Budget and Dues Bylaws Changes

The MMA shall approve a change in its Bylaws clarifying roles and responsibilities of the House of Delegates and the MMA Board of Trustees in the budget development and dues process, and the Board of Trustees shall be responsible for developing the MMA budget and dues process within the fiscal polices approved by the House of Delegates, and will 1) determine and approve annual operating and capital budgets; 2) determine investment policy; and 3) determine and approve dues and assessment changes, and the House of Delegates shall provide regular oversight and recommendation to the MMA Board of Trustees regarding 1) annual review of dues rates and status; and 2) annual review of financial status including MMA investment policy and operating and capital budgets.
(HD-R109-2007)

420.65 Protecting the Medical Home

The MMA shall develop a mechanism to give members an opportunity to alert the organization to threats to the medical home concept as envisioned by the MMA.
(HD-R410-2007)

420.66 MMA BOT Chair Election

The MMA Board of Trustees shall change the timing of its process for identifying a new Board Chair. The nominations for MMA Board Chair should be opened at the May meeting each year and remain open until the July meeting at which time an election for the Board Chair-elect shall occur. When appropriate, a transition plan shall be developed and implemented to provide the new Board Chair-elect time between the election in July and time of installation in September to become familiar with the duties and responsibilities of the position.
(BT 03/08)

420.67 Minnesota Medical Association Advocacy Outreach

The Minnesota Medical Association will address the methods and processes by which broad MMA physician input is obtained on advocacy issues, and a report on the progress of this effort will be provided back to the Minnesota Medical Association House of Delegates at its 2009 Annual Meeting.
(HD-R102-2008)

420.68 MMA Appointments

The MMA Board of Trustees should develop a policy and procedures for the appointment of MMA representatives to external groups assuring transparency in the appointment/nomination process.
(HD-R104-2008)

420.69 Sunset Policy Review

The nine “questionable” policies identified during the 2008 sunset policy review process will be subject to further review by the MMA staff and leadership and recommended action on them will be brought to a future meeting of the MMA House of Delegates. The MMA compendium of archived MMA policies, which contains MMA polices that are no longer relevant but can be consulted for historical or informational reasons, will include the recommended “archive” policies (28), the recommended “retain” polices (16), and the recommended “retain as edited” policies (6).
(HD-R106-2008)

420.7 MMA External Appointments

Process for the appointment of MMA representatives to external groups
In response to the resolution, and in order to codify current practice and assure transparency in MMA decision-making, the following process for determining MMA member participation on external groups is

recommended (note: this process is intended to be limited to those situations in which an MMA member and/or the MMA perspective is explicitly needed):

Position Analysis

MMA staff will analyze the request for MMA participation in order to determine the specific responsibilities of the position. Factors that may be assessed include: desired skill set and attributes, relevant specialty, time commitment, turnaround time, geographic limitations/expectations, required knowledge of MMA policy/positions, etc.

Candidate Solicitation

Based on the needs of the position, MMA staff will determine the most appropriate means by which to identify interested candidates; options include member-wide announcements (email and/or printed publications), targeted communications (e.g., Board members, committee members, specific specialties, limited geographic areas, etc.), and individual member outreach (e.g., personal invitations to relevant candidates).

Participant Selection

MMA staff will review all candidates and evaluate candidates' qualifications and interest relative to the responsibilities of the specific position. With the exception of recommendations for the Minnesota Board of Medical Practice, which are reviewed by the MMA Executive Committee, and unless otherwise required (e.g. MEDPAC bylaws call for the MMA Board to approve MEDPAC Board members), MMA Staff will identify preferred candidates and, in consultation with the MMA Board Chair, will identify the MMA representative(s).

Notification

The identified MMA representative(s), including selection criteria and rationale, will be communicated to voting members of the Board of Trustees for purposes of communication and to address any major concerns that Board members may have prior to notification of the selected individual(s). Should major concerns arise prior to appointment, staff will consult with the Board chair regarding next steps.

MMA Participation Tracker

MMA staff will develop and update a comprehensive listing of MMA member participation on external groups. This document will be available on the MMA Web site.
(BT 11/08)

420.71 Non-Staffed Component Medical Societies

A workgroup shall be appointed by the Speaker of the House to study the effectiveness and organization of the non-staffed component medical societies and a report, with input from the Board of Trustees, shall be provided to the House of Delegates at its 2010 Annual Meeting.
(HD-R101-2009)

420.72 Sunset Policy Review

The five "questionable" policies identified during the 2009 sunset policy review process shall be subject to further review by Minnesota Medical Association staff and leadership and recommended action on them shall be brought to a future meeting of the Minnesota Medical Association House of Delegates; the Minnesota Medical Association compendium of archived Minnesota Medical Association policies, which contains Minnesota Medical Association policies that are no longer relevant but can be consulted for historical or informational reasons, shall include the recommended "archive" policies (31); the Minnesota Medical Association reaffirms support for the recommended "retain" policies (12); the Minnesota Medical Association approves and reaffirms support for the recommended "retain as edited" policies (9).
(HD-R102-2009)

420.73 Consolidation of EMMS and WMMS

The Minnesota Medical Association House of Delegates approves the consolidation of the EMMS and the WMMS into a single component medical society and authorizes the Minnesota Medical Association to issue a charter, subject to the approval of the proposed combined metro societies' Plan of Merger, to become the new Twin Cities Medical Society as the successor organization of the East Metro Medical Society and the West Metro Medical Society. The Minnesota Medical Association Board of Trustees shall study the following issues, develop Bylaws amendments as appropriate, and report back to the House of Delegates on the following questions: (1) Can one component medical society be subdivided in to more than one trustee district? (2) Should there be an upper percentage limit on the number of delegates that a component medical society be allocated in the House of Delegates? and (3) Should there be an upper percentage limit

on the number of Trustees that can be allocated from one trustee district to the Minnesota Medical Association Board of Trustees.
(HD-R103-2009)

420.74 Change to the MMA Bylaws Section 4.3 on Disciplinary Actions

The amendments to section 4.3 of the MMA Bylaws shall be adopted as described in Exhibit A of this resolution, effective immediately. The MMA Board of Trustees shall study the issue of membership disciplinary policy and develop bylaws amendments as appropriate to establish a fair and thorough mechanism for hearing and deciding disciplinary complaints.
(HD-R105-2009)

420.75 Changing the Name of Stearns-Benton County Medical Society

The name “Stearns-Benton County Medical Society” is approved for change to “Stearns Benton Medical Society.”
(HD-R106-2009)

420.76 Board Effectiveness

MMA staff will develop a plan for the electronic distribution of board and committee meeting materials taking into consideration technological requirements at the meeting site and board/committee members' access to meeting site display technology (e.g., laptops); If at all possible, MMA board meetings should be face-to-face board meetings. Audio conferencing will be limited to conditions when short-term weather forecasts or actual weather conditions jeopardize the quorum at the board meeting; Audio conferencing will not be available to those members who are absent from the meeting due to scheduled conflicts (e.g., other business travel). The MMA staff will develop a contingency plan to manage the board meeting using only audio conferencing technology. It is recognized that for this to occur the physical site of the meeting may need to be changed to accommodate changed audio capabilities; the MMA staff will investigate meeting sites where audio/video conferencing can be best accomplished; the MMA staff will continue to explore this issue balancing the need for availability of audio/video conferencing, choices of location and cost to the Association.
(BT 05/10)

420.77 Sunset Policy Review

The five “questionable” policies identified during the 2010 sunset policy review process shall be subject to further review by Minnesota Medical Association staff and leadership and recommended action on them shall be brought to a future meeting of the Minnesota Medical Association House of Delegates; the Minnesota Medical Association compendium of archived Minnesota Medical Association policies, which contains Minnesota Medical Association policies that are no longer relevant but can be consulted for historical or informational reasons, shall include the recommended “archive” policies (21); the Minnesota Medical Association reaffirms support for the recommended “retain” policies (14); the Minnesota Medical Association approves and reaffirms support for the recommended “retain as edited” policies (5).
(HD-R105-2010)

420.78 MMA Annual Meeting

A committee will be appointed by the MMA Speaker of the House, in collaboration with the component medical society presidents, to review all resolutions to recommend to the MMA House of Delegates which resolutions will be forwarded to the MMA House of Delegates for consideration or reaffirmation and which will be forwarded to the MMA Board of Trustees for action, assuring the following: 1) careful consideration of all resolutions, 2) discussion with resolution authors, 3) review of members' comments from the online posting of resolutions, 4) identification of policy themes for reference committee assignments, and 5) a procedure for retaining a democratic process while streamlining consideration of resolutions. The MMA committee and section reports will be compiled for an MMA Annual Report to the membership instead of being submitted as individual reports to the House of Delegates.

The MMA Executive Committee, acting as the Bylaws Committee, will bring to the 2011 Minnesota Medical Association House of Delegates bylaws amendments: 1. To allow component medical societies to delegate to the Minnesota Medical Association the authority to seat delegates or alternate delegates; 2. To allow sufficient time prior to the commencement of the House of Delegates for resolutions that are submitted as regular business to be considered by the committee appointed by the Minnesota Medical Association Speaker of the House to review all submitted resolutions; and 3. To determine the size and composition of the committee appointed by the Minnesota Medical Association Speaker of the House to review all submitted resolutions.

(HD-R106-2010)

420.79 MMA Membership for Students, Residents and Fellows

It is the policy of the MMA to offer all medical students, residents and fellows free MMA membership throughout the duration of their program.

(BT 05-11)

420.81 Sunset Policy Review

The three "questionable" policies identified during the 2011 sunset policy review process will be subject to further review by Minnesota Medical Association staff and leadership and recommended action on them will be brought to a future meeting of the MMA House of Delegates. The MMA compendium of archived MMA policies, which contains MMA policies that are no longer relevant but can be consulted for historical or informational reasons, will include the recommended "archive" policies (39). The MMA reaffirms support for the recommended "retain" policies (8), and approves and reaffirms support for the recommended "retain as edited" policies (9).

(HD-R101-2011)

420.82 Resolution Review Committee Process

The Minnesota Medical Association will continue to refine the resolution review process and report back to the 2013 House of Delegates meeting with an evaluation and recommendations for modifications with proposed bylaws changes, if appropriate, consistent with MMA Policy 420.78. The MMA will also continue to explore, through the Governance Task Force, the governance responsibilities of the House of Delegates and the Board of Trustees.

(HD-R102-2011)

420.83 Valuing, Tracking and Communicating Resolutions Passed by the MMA House of Delegates

The Minnesota Medical Association will attach the names of all individual authors and appropriate component medical society authors to all resolutions submitted to the House of Delegates. Resolution authors, or their designee, will be asked to testify, if necessary, on their proposals at meetings of the MMA Board of Trustees and MMA committees. The MMA will continue to improve communications to members and delegates on resolutions passed by the House of Delegates.

(HD-R106-2011)

420.84 McLeod-Sibley Medical Society Merger

The McLeod County Medical Society and the Sibley County Medical Society will merge to become the McLeod-Sibley Medical Society.

(HD-R108-2011)

420.85 Ad Hoc Committee/Task Force Structure and Regular MMA Committee Rule

When the MMA Board appoints its ad hoc committees or task force members, it should include a broad representation of all MMA members. The authors of resolutions should be invited as guests to the early deliberations of the committee or task force.

(HD-R104-2012)

420.86 Sunset Policy Review

The one "questionable" policy identified during the 2012 sunset policy review process will be subject to further review by MMA staff and leadership and recommended action on it be brought to a future meeting of the MMA House of Delegates. The MMA compendium of archived MMA policies, which contains MMA

policies that are no longer relevant but can be consulted for historical or informational reasons, will include the recommended "archive" policies (15), and the MMA reaffirms support for the recommended "retain" policies (8), and approves and reaffirms support for the recommended "retain as edited" policies (8). (HD-R105-2012)

420.87 MMA Recommendations for Board of Medical Practice Members

The MMA will clarify and disclose to members its criteria and processes for reviewing and recommending physicians to serve on the Minnesota Board of Medical Practice. (HD-R302-2012)

420.88 Minnesota Medical Association Governance Changes

The Minnesota Medical Association will continue its discussion of the recommended model for a new governance structure, as developed by the Governance Task Force and approved by the Board of Trustees and Executive Committee, in order to gather more member input on the proposed model and further define the details needed for full implementation. Prior to the next House of Delegates meeting the MMA will begin piloting the listening sessions and policy discussions as proposed in the policy council model and report back to the House of Delegates whether these pilots increase member involvement and engagement. The bylaws amendments recommended by the Governance Task Force, the Board of Trustees, and Executive Committee related to the changing of the size and composition of the Board of Trustees are adopted and will be phased-in over the next three years. There will be no action taken on further governance amendments to the bylaws of the MMA until the next meeting of the House of Delegates. (HD-LR400-2012)

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)

430.05 Motor Vehicle and Bicycle Safety

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

430.06 Speed Limit

The MMA recognizes the relationship between driving speed and severity of injury in accidents, and urges policy makers to consider this impact prior to the adoption of any changes in state speed limits. (HD-R56-1995; Retained 2005)

430.07 Motorcycle Safety Devices

The MMA will work with the Department of Transportation and the Minnesota Department of Public Safety to identify options for improving motorcycle safety.

The Minnesota delegation to the American Medical Association will ask the American Medical Association to work with national organizations to identify options for improving motorcycle safety. (HD-R301-1997)

430.08 Seatbelt Safety

The MMA reaffirms existing MMA policy to develop and pursue legislation that would make nonuse of seatbelts a primary offense. (HD-R303-1997; Retained as edited 2007)

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

In an effort to improve the public's health, MMA will continue to pursue legislation specifying that the nonuse of helmets for bicycles, motorcycles, snowmobiles, and ATVs is a petty misdemeanor punishable by a \$25 fine.

(HD-R304-1997)

430.1 Protective Headgear

The MMA supports the mandatory use of headgear while minors are 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)

430.11 Telephone Use While Driving Policy

The MMA adopted as public health policy that telephones not be used by a motor vehicle driver while the motor vehicle is in motion except in the case of emergency.

(HD-SR203-2001)

430.12 Proper Vehicle Lighting

The Minnesota Medical Association will initiate legislation requiring all motorists to use headlights or daytime running lights when driving motor vehicles in Minnesota, and, the Minnesota Medical Association delegation to the American Medical Association submit a resolution to the AMA urging the AMA to support federal legislation requiring all motorists to use headlights or daytime running lights when driving motor vehicles and require all new vehicles to have as original equipment automatic headlights while operating.

(HD-R303-2002; Reaffirmed: HD-R408-2008)

430.13 Road Rage

The Minnesota Medical Association encourages the State of Minnesota to collect data on driver behaviors and highway infrastructure issues that most often lead to angry or violent responses, and use 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 2012)

430.14 Cell Phone Use Prohibited/Illegal While Driving a Vehicle

The Minnesota Medical Association will request that the Minnesota State Legislature pass a law forbidding the use of cell phones, handheld or otherwise, while driving a vehicle, but allowing use while parked and out of traffic.

(BT-11/2004)

430.15 Children in Cars

The Minnesota Medical Association supports legislative and educational efforts to protect young children from being injured or killed when left alone in a motor vehicle.

(BT-07/2004)

430.16 Graduated Driver Licensing

In recognition of the prevalence of death and injuries among teen drivers, and given the strong evidence in support of methods to reduce teen drivers' exposure to traffic crashes, the Minnesota Medical Association supports the establishment of a Graduated Driver Licensing program in Minnesota that would restrict the number of teenage passengers allowed in vehicles and establish unsupervised nighttime driving restrictions.

(BT-1/07)

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)

440.02 Food Requirements in Nursing Homes

The MMA believes that food requirements in nursing homes conform with currently recognized nutrition standards for weight, sex and activity. (HD-R15-1983; Retained 2004)

440.04 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. The MMA recognized these factors when they adopted Do Not Resuscitate Guidelines in 1981.

In the implementation of DNR orders, one of the concerns that has emerged relates to how emergency personnel called to a nursing home can know that DNR orders, or other orders limiting treatment, have been issued. Further, there should be a recognized means to transfer such orders from the nursing home to the hospital setting, via emergency service personnel. Verbal orders communicated by nursing home personnel are clearly insufficient, since failure to initiate cardiopulmonary resuscitation has life-threatening consequences. Transfer of written orders can be problematic, too, since the resident's chart must remain in the nursing home, and it may not be possible to reproduce the limited treatment order at the time of an emergency.

The purpose of this policy is to provide a framework for the implementation of limited treatment orders in the long-term care facility and to provide guidelines for how those orders can be transferred via emergency personnel to the hospital setting. The policy builds on the MMA's Do Not Resuscitate guidelines adopted in 1981, and provides a definition for "Do Not Intubate."

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.)

Other terms have been used to indicate limitations to treatment (e.g., supportive care, terminal care, conservative care). However, these terms are subject to varied interpretations and have no generally accepted definition in Minnesota at this time. Because these alternative terms are not clear, they cannot be honored by paramedics or other emergency service personnel. If the patient and/or family members (or other designated proxy) and the physician agree that treatment should be limited in some specific way other than what is represented by the terms "DNR" and "DNI", the physician should note clearly in the patient's medical record the specific treatment or plan (e.g., no antibiotics, "do not call 911").

III. IMPLEMENTATION OF LIMITED-TREATMENT ORDERS

A. The writing of the Order

1. The writing of a limited treatment order (DNR and DNI) 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. Both DNR and DNI orders are compatible with maximal therapeutic care. Persons may appropriately receive evaluation, assistance, treatment and hospital transport by the Emergency Care System. 911 may still be used to summon emergency assistance for such patients.
3. When the patient is competent, the limited treatment decision will be reached consensually between the patient and physician. When the patient is judged to be incompetent, this decision will be reached consensually by the appropriate family members (and/or designated proxy) and the physician. Limited treatment orders will not be written if a competent patient disagrees, or, in the case of incompetency, a member of the family (and/or designated proxy) disagrees. The nursing staff may also be asked to participate in this type of discussion.
4. If all relevant parties are in agreement with a DNR 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. The physician may wish to use a form which has been adopted by the hospital or nursing home for recording this information.
5. 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

1. Long-term care facilities are encouraged to adopt institutional guidelines to facilitate the appropriate implementation of DNR and 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 DNR and/or DNI orders signed and dated by the attending physician.

C. Implementation by Emergency Medical Providers

1. Ambulance providers are encouraged to develop standard operating procedures that enable paramedics and emergency medical technicians to honor properly signed and dated DNR and DNI orders in the medical record.
2. Emergency department and hospital staff are encouraged to honor a valid written DNR and DNI order. The order should accompany the patient during medical transport, and one of the following forms of documentation is recommended:

An original 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

A photocopy or carbon copy of such an order; or

If none of the previous means is available for transferring the limited-treatment order, the paramedic may document on the Minnesota State Ambulance Form that he or she witnessed a properly signed and dated DNR or DNI order. The entry on the Ambulance Form should state: the specific order, the name of the physician, and the date of the signature. (For example, the run record might state: "A written DNR or DNI order was observed in the medical record signed on December, 1, 1985, by John Doe, M.D.")

3. 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)

440.05 Supervision of Psychoactive Medication, Recordkeeping and Accountability for Patients Residing in Nursing Homes, Board and Care Homes, and Rule 36 Facilities

The MMA supports educational efforts to improve the quality of medical records in nursing, board and care homes, especially concerning neuroleptic and other psychoactive medications. The MMA supports careful documentation of diagnoses and patient treatment in non-hospital and non-office situations such as nursing homes and board and care homes.

(HD-R38-1989; Retained 2004)

440.06 Nursing Home Moratorium

The MMA urges the institution of selected exceptions to the moratorium on nursing home bed construction based upon regional review of medical needs in the area.

(HD-R57-1990; Retained 2004)

440.07 Nursing Home Policies Regarding Cardiopulmonary Resuscitation

The MMA adopts the following:

1. Advocates the development of nursing home policies and procedures that promote the proper use of cardiopulmonary resuscitation.
2. Supports nursing home cardiopulmonary resuscitation policies that are drafted in accordance with the Federal Patient Self Determination Act, the Minnesota Nursing Home Residents' Bill of Rights, and the Minnesota Living Will Law (formerly the Adult Health Care Decisions Act.)
3. Advocates nursing home cardiopulmonary resuscitation policies that specifically state that cardiopulmonary resuscitation not be provided by nursing staff or other personnel in the presence of a written physician order to withhold cardiopulmonary resuscitation.
4. Advocates nursing home cardiopulmonary resuscitation policies that require informed consent from the resident to withhold cardiopulmonary resuscitation; or, in the event that CPR can be predicted to be of no benefit, that the policy will require fully informed disclosure to withhold CPR.
5. Advocates that some criteria for the definition of "no benefit" of cardiopulmonary resuscitation be delineated in nursing home cardiopulmonary resuscitation policies.
6. Advocates that nursing home cardiopulmonary resuscitation policies include provisions to communicate "No CPR" or "DNR" orders to nursing home personnel and emergency providers.
7. Discourages the use of nursing home cardiopulmonary resuscitation blanket policies mandatorily providing or withholding cardiopulmonary resuscitation to all residents.
8. Advocates nursing home cardiopulmonary resuscitation policies drafted with state law, that require the presence of an individual trained in cardiopulmonary resuscitation 24 hours a day in the facility.

9. Advocates nursing home cardiopulmonary resuscitation policies that require periodic review of cardiopulmonary resuscitation orders and the clinical policies that govern their use. (HD-R35-1992; Retained 2004)

440.08 Nursing Home Individualized Treatment Planning Regarding CPR

The MMA approves the following:

1. Nursing home residents or their surrogates be made aware of the probability of successful cardiopulmonary resuscitation and that this prediction be based on scientific, valid, published studies of patients with similar conditions.
2. If CPR is to be withheld, informed consent should be obtained from nursing home residents, or, if CPR is predicted to be of no benefit, the decision to withhold CPR should be fully disclosed to the patient.
3. Regardless of what a resident's decision will be regarding cardiopulmonary resuscitation, the resident will continue to get medical and nursing care appropriate to his or her individual needs.
4. Physicians initiate discussions about cardiopulmonary resuscitation with all residents within a reasonable period of time of admission to nursing home facilities and clearly document these discussions and their indications for instituting or not instituting cardiopulmonary resuscitation in the event of cardiac arrest. (HD-R36-1992; Retained 2004)

440.09 The Role of the Nursing Home Medical Director

The MMA adopts the following:

1. Nursing home medical directors be involved in developing institutional policies regarding the provision of cardiopulmonary resuscitation to residents in their facilities.
2. Nursing home medical directors be responsible for providing information and valid studies to their facilities regarding the probability of successful resuscitation following cardiopulmonary resuscitation in various populations.
3. Nursing home medical directors review deaths in their facilities to insure that the appropriate medical care is provided to the dying patient.
4. Nursing home medical director should be available if necessary to interpret clinical policies as they apply to an individual resident.
5. The nursing home medical director should serve as an integral member of the ethics committee if such a committee exists at his or her nursing home facility. (HD-R34-1992; Retained 2004)

440.1 Determination of Death in the Nursing Home

The MMA approves the following:

1. The determination of death can be made in certain situations without a trial of cardiopulmonary resuscitation.
2. Cardiopulmonary resuscitation should not be instituted on nursing home residents with "No CPR" or "DNR" orders written by the physician in the medical record.
3. When the determination of death is made using reliable criteria by the nursing personnel, cardiopulmonary resuscitation need not be instituted.
4. The criteria for the determination of death in the nursing home require that no signs of life be present, including no pulse, no respiration, no pupillary response, no neurologic activity, and the resident was not seen to collapse, have a sudden cardiac arrest, or other immediately reversible cause such as choking or airway obstruction.

5. A policy to withhold cardiopulmonary resuscitation at the time of death is in no way intended to encourage nursing personnel to abandon dying patients, or to avoid witnessing their cardiac arrest.
6. Nursing personnel be trained to recognize nursing home residents in distress and seek help in their management.
7. Nursing personnel be trained to recognize and treat choking and airway problems and the initiation and performance of cardiopulmonary resuscitation.
8. A nursing home policy that allows nurses the opportunity to determine death at the bedside without initiating cardiopulmonary resuscitation in no way releases the physician of his/her obligation for advanced treatment planning, including a discussion of cardiopulmonary resuscitation with nursing home residents or their surrogates.
(HD-R38-1992; Retained 2004)

440.11 Timely Nursing Home Transfers

The MMA will identify barriers to timely transfer of patients from hospitals to nursing homes and will work with physicians, nursing homes, and others, as appropriate, to decrease barriers to nursing home transfers.
(HD-R17-1994; Retained 2006)

440.12 Nursing Home Reimbursements

The MMA's delegation to the AMA will encourage the AMA to aggressively seek a continued dialogue with HCFA regarding revising the rules governing Medicare reimbursement for skilled nursing facility care which require payments not be contingent on a patient being hospitalized three consecutive days (not counting the day of discharge).

The MMA will also work with the AMA to educate Congress on the financial implications to the health care system as a result of this rule when a lesser number of days' hospitalization could be more fiscally appropriate.

(HD-R40-1995; Retained 2005)

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)

440.14 Hospice Care

The MMA endorses the Minnesota Hospice Organization's document Hospice Care: A Physician's Guide with one final review of the document by the Chair of the Committee on Ethics and Medical-Legal Affairs focusing on the effect the document may have on pending MMA legislative positions.

(BT 2/96)

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 2012)

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)

450.03 Organ Transplantation

The MMA adopts the following policy on organ transplantation:

1. The MMA will become involved with other organizations in an endeavor to develop a statewide central organization of groups interested in or affected by issues relating to implementations of costly and innovative therapies with the purpose of resolving the significant existing data issues.
2. The MMA will carefully monitor developments which result from research, recommendations and policy pronouncements by the National Organ Transplant Task Force and its bearing on statewide activities.
3. These actions will be forwarded to the AMA for review and implementation on a nationwide basis.
4. The MMA should also encourage the involvement of the University of Minnesota, the Mayo Clinic, and others working in the field of organ transplants.
(BT-11/85; Retained 2004)

450.04 Standard Procedures for Identification of Organ/Tissue Donors

The MMA encourages the adoption by hospitals and physicians of standard procedures for identification and referral of potential organ/tissue donors.
(HD-R9-1986; Retained 2004)

450.06 Anencephalic Neonates as Organ Donors

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

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)

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)

460.02 Protection of Peer Review Records in Litigation

The MMA believes the AMA should work for Congressional clarification so that state peer review confidentiality laws are binding on actions for damages or other relief in both state and federal courts. The AMA should also seek Congressional action affirming that participants in peer review activity are exempt from antitrust scrutiny.
(BT-11/85; Retained 2004)

460.03 PRO Physician Reviewers

The MMA recommends to the Foundation for Health Care Evaluation (FHCE), or any successor PRO, that it instructs its physician reviewers to be available for voice communication with the physician being reviewed, and be willing to identify themselves as to specialty certification and experience and criteria upon which the renewal or denial is being based. FHCE, or any successor PRO, should develop more specific and detailed training programs for their physician reviewers, and be instructed to disseminate their utilization and review criteria on a per-occurrence basis so that physicians will have a broader understanding of the criteria. Component medical societies should recruit physicians who are willing to assist FHCE or any successor PRO, in conducting its reviews and activities. These physicians should agree in advance to identify themselves at the time of these reviews. Finally, the evaluation criteria used by the PRO should be forwarded to each hospital within the state of Minnesota.
(HD-R17-1986; Retained 2004)

460.04 Mandatory Reporting

The MMA adopts the following position on mandatory reporting by peer review organizations:

A review organization or committee shall report to the Board of Medical Practice its findings of conclusions with respect to the conduct of a physician if such conduct may be grounds for disciplinary action (as required of individual physicians by the Medical Practice Act).
(BT-7/87; Retained as edited 2007)

460.08 Peer Review Indemnity

The MMA urges hospitals to fully indemnify their physicians for good-faith peer review activities. The MMA will work with appropriate groups to develop plans to provide indemnification for good-faith peer review.
(HD-SR26-1990; Retained 2004)

460.15 Quality Improvement Organizations (QIOs) in peer case review

The MMA will draft a letter of support for retaining local case review and the need for clearly defined boundaries between organizations that review and provide QI assistance and those organizations that disclose and regulate. The letter will be sent to State and Federal health care policymakers and appropriate leaders at CMS.
(BT-7/06)

470 Practice of Medicine

470 "Best Practices Guidelines" are not Clinical Care Guidelines and Evidence Based Medicine

The Minnesota Medical Association (MMA) defines "evidence-based medicine" as individualized patient care based on controlled, clinical care trials; systemic medical care literature reviews; meta-analyses of peer-reviewed research and reference to reputable disease guidelines. The MMA recognizes that implementation of evidence-based medicine guidelines must reflect the need to individualize care that may require modification of the guidelines based on peer and collegial professional consultation, patients' health status, illness severity, response to past treatments, demographic variations
The Minnesota Medical Association will use the health care policy terms "evidence-based medicine" and "clinical care guidelines" when discussing medical care quality improvement, and the MMA will work to remove the vague and inappropriate term "best practices" from current Minnesota health care legislation and regulations and educate policy makers about the practice of evidence-based medicine and the uses and limitations of clinical care guidelines in evidence-based medicine.
(HD-R206-2004)

470.01 HCFA Definition of Physician Under Medicaid

The MMA believes the Health Care Financing Administration should define "physician" as a "doctor of medicine or osteopathy."
(BT-1/86; Retained 2004)

470.02 Definition of "Physician"

The MMA seeks to clarify existing law regulating the use of the word "physicians", to assure that other allied health care professionals licensed by health boards (chiropractors, nurses, psychologists, social workers, etc.), cannot use that term when referring to their services.
(BT-11/87; Retained 2004)

470.03 Definition of "Physician" and "Provider"

The MMA supports legislation requiring health care entities, when using the term "provider" in contracts, advertising and other communications, to specify the type of provider being referred to by using the provider's recognized title which reflects education, training, license status, and other recognized qualifications.

The MMA will submit a resolution to the AMA, asking that legislation continue to be pursued which would call for the replacement of the current definition of physician in federal law with the AMA's definition.
(HD-R30-1994; Retained 2006)

470.04 Minnesota Professional Firms Act

The MMA opposes any amendments to the Minnesota Professional Firms Act that would further erode the corporate practice of medicine doctrine, or reduce physician autonomy.
(BT-2/95; Reaffirmed: BT-03/08; Edited HD-R105-2011)

470.08 Elimination of Special State Requirements for Licensure to Practice Medicine

The MMA shall work with the AMA and the Federation of State Medical Boards to standardize licensure requirements specifically pertaining to continuing medical education requirements. The MMA will also consider the elimination of other special physician licensure requirements that create barriers for physicians seeking licensure in multiple states.
(HD-R35-1996)

470.09 The Erosion of Medical Decision Making by Physicians

The MMA will establish, in conjunction with component medical societies, a "hotline" system for member physicians to report inappropriate influence on their clinical decision-making by third-party payers or health plans when they advocate for their patients by recommending options that they believe are in the best interest of the patients.

The MMA will also study the feasibility of developing a dispute resolution mechanism to be used with third-party payers utilizing for cases of denial of requested medical care an independent third party, and that the decision of treatment be based on acceptable professional standards for the medical care that is requested.
(HD-R310-1997)

470.13 Preparticipation Athletic Examinations

The MMA will develop and support legislation defining preparticipation 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)

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)

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)

470.23 Improving Interest In Primary Care Among Graduating Medical Students

The Minnesota Medical Association will work to identify and implement effective methods to arrest and reverse the trend of U.S. medical students away from the primary care professions.
(HD-R102-2002; Retained as edited 2012)

470.28 Patient Safety Task Force

The MMA adopts the following recommendations of the MMA Patient Safety Task Force:

Recommendation 1: Sunset The Task Force In Its Present Form

As of May 1, 2003, sunset the MMA Patient Safety Task Force in its current form (an ad hoc task force that meets every other month). Retain the option of reconvening the Task Force to discuss specific issues that may arise from time to time.

Recommendation 2: MMA Continue to Monitor Patient Safety Issues Addressed in Various Forums Within Minnesota

MMA staff will continue to monitor and represent MMA physician membership on the health care groups that currently address patient safety issues, such as MAPS, MHA, BMP, JCAHO, Minnesota legislature, and other forums. Staff will use information and pending actions as a guide to alert the leadership and membership of potential opportunities and directions for improving patient safety.

Recommendation 3: Develop an MMA List Serve

The MMA will create an electronic list serve hosted by MMA to facilitate discussions and information sharing about patient safety issues. The list serve would be comprised of MMA Patient Safety Task Force members as well as other MMA physicians who state an interest in participating in discussions and sharing learning about patient safety.

Recommendation 4: Develop a Dedicated Patient Safety Page on The MMA Website

Update the patient safety/medical error area on the MMA website to facilitate a dedicated page that is titled "Patient Safety". This page will direct members to up-to-date information on patient safety issues, articles specific to patient safety, and links to other information patient safety web sites. Also develop a list serve that accommodates discussions on patient safety issues.

Recommendation 5: Highlight Patient Safety Issues in MMA Publications

The MMA should publish a series of articles spotlighting individual physicians or groups of physicians who have made changes in their practice to improve patient safety as well as disseminate evidence-based patient safety initiatives to physicians. The focus of the articles would be: 1.) Real-life, practical examples of areas in which physicians are making changes in their practice that have a positive impact on safety. 2.) Detail initiatives for patient safety that are developed and approved by other forums/entities/organizations. 3.) Facilitate debates regarding patient safety initiatives and proposals to allow for a wider discussion of their impact to physicians and patients. The articles could be a series featured in Minnesota Medicine or a website-based series. Consider regularly publishing a column on patient safety in every Minnesota Medicine with member physicians as guest columnists.

Recommendation 6: Continue to Monitor and Encourage Education of Patient Safety Responsibilities At The Graduate Medical Education Level Within The State

MMA should continue to develop a relationship with the University of Minnesota and Mayo medical schools to advocate for inclusion of patient safety education for medical students. MMA should monitor the impact of the resident work hour restrictions (effective July 1, 2003) in association with the teaching institutions, residency sponsors and hospitals, and assist where necessary to educate physicians about the impact of extended work hours on patient safety.

Recommendation 7: The Task Force Recommends that Resolution 210 (referred to the Board of Trustees in 2002) Not Be Adopted.

This recommendation is being made because the resolution emphasized standardizing computerized and other systems in hospitals including the abbreviations that would be found acceptable for use in acute care settings. Although standardized abbreviations are an important issue, this issue is being moved forward by the Safest in America group as well as the issue of safe surgery site identification. Therefore, the MMA does not need to address an issue that is already being addressed by another patient safety group.
(BT-5/03)

470.29 Model Employment Agreements

The Minnesota Medical Association will develop a Minnesota-specific model employment agreement based upon the AMA's model employment agreement, the MMA will disseminate the model employment agreement to all MMA members and encourage all Minnesota organizations that employ physicians to use the model agreement.
(HD-SR404-2003)

470.3 "Best Practices Guidelines" are not Clinical Care Guidelines and Evidence Based Medicine

The Minnesota Medical Association (MMA) defines "evidence-based medicine" as individualized patient care based on controlled, clinical care trials; systemic medical care literature reviews; meta-analyses of peer-reviewed research and reference to reputable disease guidelines. The MMA recognizes that implementation of evidence-based medicine guidelines must reflect the need to individualize care that may require modification of the guidelines based on peer and collegial professional consultation, patients' health status, illness severity, response to past treatments, demographic variations

The Minnesota Medical Association will use the health care policy terms "evidence-based medicine" and "clinical care guidelines" when discussing medical care quality improvement, and the MMA will work to remove the vague and inappropriate term "best practices" from current Minnesota health care legislation and regulations and educate policy makers about the practice of evidence-based medicine and the uses and limitations of clinical care guidelines in evidence-based medicine.
(HD-R206-2004)

470.31 Disease Management by Insurers

The Minnesota Medical Association will develop and lobby for legislation that prescribes: 1) health plans and insurers shall honor appropriate CPT codes so that physicians and/or their clinics are reimbursed for providing disease-management services, including telephone calls, educational counseling to patients and families, interdisciplinary case conferences, and other administrative and networking activities; 2) the decision to participate or not to participate in a disease management program should always be the prerogative of the patient, who should be fully informed of any plan coverage conditions attendant on such decisions; 3) the total costs of health plan disease-management programs administered by the health plan or by another entity will be reported as public information to the Minnesota Department of Health and other appropriate regulatory agencies to include detail on aggregate total costs of disease-management programs and the number of patients impacted.
(HD-R208-2004)

470.32 Reimbursement for Management and Coordination of Complex Hospital Care

The Minnesota Medical Association will develop a work group, including representatives from the physician community and payers that would examine the issue of reimbursement and make recommendations to allow for appropriate reimbursement of physicians providing overall management of care and coordination of complex hospital care.

(HD-R300-2004)

470.33 Promoting a Primary Care Physician Based Healthcare System for Minnesota

The Minnesota Medical Association, in conjunction with the primary care-based specialties will explore the development of a primary care physician-based health care system for Minnesota.

470.34 Pain Control

The Minnesota Medical Association will work with the Minnesota Board of Medical Practice and the Minnesota Board of Pharmacy to determine the educational needs of physicians in the areas of pain control and prescribing. The MMA will work to encourage development and implementation of appropriate pain control and pain management educational resources for physicians.

In addition the MMA delegation to the American Medical Association (AMA) will ask the AMA to support more effective educational programs for physicians prescribing pain control, and will ask the AMA for leadership in clarifying state and federal agencies' expectations in regard to physician responsibility in pain management.

(HD-R400-2004)

470.35 Health Plan Legal Liability

The Minnesota Medical Association adopts the following AMA policy regarding health plan liability: H-285-945 Establishment of Liability of Managed Care Organizations. Our AMA 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)

470.36 "Never" Event Payment

The Minnesota Medical Association adopts as policy opposition to HealthPartners' decision to withhold hospital payments for "never" events.

(BT-11/2004)

470.37 Chronic Care

The Minnesota Medical Association (MMA) approves the following recommendations as presented by the Chronic Care Task Force:

Practice

- The MMA should explore the feasibility of creating a consortium of medical practices willing to provide disease management (paid for by health plans or employers) to patients with chronic, complex illnesses.
- The MMA should conduct a campaign to generate physician and payer enthusiasm for better chronic care delivery.
- The MMA should work to ensure that every patient with a chronic or complex illness has a medical home where much of that patient's care is provided and from which other care is arranged and coordinated. For patients with chronic conditions, the medical home generally will be a primary care practice, although there are certain conditions where a specialty practice may be better suited to provide the medical home.
- The MMA should endorse evidence-based guidelines (those developed by ICSI and others) that pertain to chronic illness.

Public & Private Sector Advocacy

- The MMA should submit a request to the AMA CPT Editorial Panel for the development of CPT codes for group visit, inter-visit (including consultant codes), and other adaptive codes to support chronic care delivery models.
- The MMA should work with Minnesota public and private payers to obtain payment for non-visit care, such as telephone consultation and online E&M services (CPT code, 0074T).

- The MMA should encourage the AMA to lobby Congress and the Centers for Medicare and Medicaid Services (CMS) to allow payment for the broader array of services that are critical to ideal chronic care delivery. Advocacy is vital to expand Medicare coverage from payment for individual face-to-face services, to payment for effective chronic care delivery such as group, internet, and inter-visit services.
- The MMA should encourage Minnesota public and private payers to increase payment for clinical systems that utilize the Chronic Care Model.
- The MMA should work with Minnesota health plans/payers and employers/purchasers to encourage changes in the way in which disease management is conducted by exploring opportunities to pay physician practices directly for disease management services.
- The MMA should work with Minnesota public and private payers to obtain payment for specialized services delivered to patients with qualifying conditions that are provided by non-physician professionals (e.g., pharmacists, social workers) who are actively linked with physicians in co-managing patients' care.
- The MMA should explore opportunities to support the expansion of the electronic transfer of information across sites of care, including the use of public and private capital investments to stimulate the adoption of electronic medical record systems.
- The MMA should explore ways to improve communication between the providers of community-based services and the primary medical care team. (Note – this item is most immediately applicable to Medicaid and Elderly Waiver beneficiaries participating in the new statewide Minnesota Senior Health Options program and the new Minnesota Senior Care program [integrating PMAP and Elderly Waiver] in which health plans and care systems have extensive covered benefits and special flexibility in clinical delivery.)
- The MMA should seek opportunities to work with the Department of Human Services to conduct pilot projects of case and disease management consistent with these recommendations for public program enrollees with complex, chronic illnesses.

Education

- The MMA should develop or sponsor opportunities for Minnesota physicians to learn how to improve knowledge of and skills in team management of chronic conditions and the working relationships among team members.
- The MMA should provide information to Minnesota physicians about local and state community resources that are available to assist patients with chronic conditions. This information should be community-specific.
- The MMA should develop or sponsor opportunities for Minnesota physicians to learn how to improve physician practices' ability to teach patients self-management skills.
- The MMA should develop or sponsor opportunities for Minnesota physicians and patients to learn how patients and physicians can set priorities and focus resources for patients with chronic conditions.
- The MMA should encourage Minnesota medical schools and teaching programs to improve curricula on and give students and trainees increased opportunities for delivery of care to patients with chronic, complex illnesses.
- The MMA should help physicians increase their awareness of opportunities for grants or demonstration projects in treating patients with chronic conditions.

Research

- To help overcome the lack of evidence regarding treatment for the "old-old" and for patients with multiple chronic conditions, the MMA should encourage research that will identify a stronger evidence base for the treatment of chronic conditions among those over 75 and those with several chronic conditions.
- The MMA should encourage public and private payers to coordinate data collection and pursue research that improves the quality of data available to those wishing to use clinical care data to determine best practices in patients with chronic and complex illnesses.

(1) Note that this is a Category III CPT Code: 0074T- Online evaluation & management service, per encounter, provided by a physician, using the Internet or similar electronic communications network, in response to a patient's request, established patient.

Online Medical Evaluation

An online medical evaluation is a type of Evaluation and Management (E/M) service provided by a physician or qualified health care professional, to a patient using Internet resources, in response to the patient's online inquiry. Reportable services involve the physician's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hard copy) of the encounter. This service should not be reported for patient contacts (egg, telephone calls) considered to be pre-service or post-service work for other E&M or non E&M services. A reportable service would encompass the sum of communication (e.g.,

related telephone calls, prescription provision, laboratory orders) pertaining to the online patient encounter or problem(s).
(BT-01/2005)

470.38 Multiple Chronic Diseases

The Minnesota Medical Association (MMA) shall promote education regarding patient safety concerns that may occur when following multiple guidelines while treating patients with multiple chronic medical diseases, and support the development of quality indicators and best practice guidelines when caring for patients with multiple chronic diseases when guidelines are in conflict. The MMA shall also lobby for improved payment to physicians who care for patients with multiple chronic medical diseases.
(HD-R215-2006)

470.39 Improving Communication

The Minnesota Medical Association (MMA) shall endorse a position in support of 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. The MMA shall also work to educate its members on the obligations of communicating clinical information between health care professionals, including mental health clinicians, related to a hospitalization, and further analyze the Minnesota Academy of Family Physicians' position statement, "Communication Between Inpatient Care Physicians and Primary Care Physicians." The MMA Board of Trustees shall report back to the 2007 House of Delegates regarding the Board's recommendations on the MAFP position statement, "Communication Between Inpatient Care Physicians and Primary Care Physicians," and dialogue with the Minnesota Academy of Family Physicians regarding any recommendations or concerns that occur before the 2007 House of Delegates.
(HD-R216-2006)

470.391 Improving Communication among Health Care Professionals

The Minnesota Medical Association (MMA), upon review of the Minnesota Academy of Family Physicians' position statement, "Communication Between Inpatient Care Physicians and Primary Care Physicians," concludes that the statement is generally consistent with MMA policy; however, the MMA supports further review of the document by MAFP in order to simplify it, to remove items that do not appear related to inpatient/primary care communication, and to consider language that would support development and use of the term "medical home."
(BT-3/07)

470.4 Promotion of Primary and Medical Care Continuity

The Minnesota Medical Association (MMA) will: 1) reaffirm 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 shall also support the statement that care should be: 1) given by the providers who know the patient's condition directly; 2) coordinated with the primary physician or referral specialist; 3) integrated at the point-of-care, including diagnosis and medication, rather than through inference by "benefit managers" or PBM vendors; and 4) accessible, patient-centered, diagnosis-specific and cost-efficient.
(HD-R301-2006)

470.41 Health Plan Regulatory Accountability

The Minnesota Medical Association shall develop and lobby for legislation that 1) clarifies the ability of the Board of Medical Practice to hold makers of health plan referral and treatment decisions accountable to the same regulatory review standards as other providers delivering medical services, and 2) defines referral and treatment decisions by health plans as medical practice.
(HD-R408-2006)

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 will educate and communicate to the physicians of Minnesota about shared decision-making tools in its publications and assist the medical community of Minnesota in moving towards patient-centered care. In addition, the Minnesota Medical Association shall submit a resolution directing the American Medical Association to educate and communicate to physicians about shared decision-making tools, in order to move towards patient-centered care.
(HD-R203-2008)

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)

470.45 Support for the Independent Practice of Medicine

The Minnesota Medical Association will establish a task force to develop strategies to address the issues and challenges facing independent medical practice.
(HD-R302-2010)

470.46 Minnesota Alliance for Patient Safety (MAPS)

The MMA approves up to \$60,000 in funding over the next 3 years consistent with the recommended proposal. The Executive Committee also recommends that the financial commitment be reviewed by the Committee on Administration and Finance to determine whether this is part of the ongoing operations budget, investment account or other financial source.
(EC 06-11)

480 Pregnancy (See also, Abortion, Birth Control/Contraception)

480.01 Sick Leave Following an Uncomplicated Obstetrical Delivery

The MMA adopts the following position on sick leave following an uncomplicated obstetrical delivery: The MMA Resource Group on Maternal Health, after extensive review of the problem besetting the pregnant patient who must remain in the work force during her pregnancy, respectfully suggests that the MMA avoid any pre-determined arbitrary policy on this matter.

We acknowledge that in uncomplicated cases with non-stressful employment in a pregnancy where the health of the mother is unimpeded, a useful rule of thumb might be to grant disability status from six to eight weeks following the onset of labor. However, each pregnancy must be individually evaluated in this regard. The final decision must take into account the health of the employee before pregnancy commenced, her age and nutritional status, the type of work and job-related stress incident to her employment, the presence or absence of risk factors in her pregnancy, the pregnancy leave policy of her employer if they have a formal Department of Industrial Medicine with a Medical Director, and what her other collateral responsibilities are at home. Only her personal physician is in possession of all of these facts, and he or she must apply judgment on an individual basis.
(BT-1/81; Retained 2004)

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)

480.04 HIV Testing of Pregnant Women

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

480.05 Post-Partum Length of Stay

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.

The MMA opposes mandatory reduced hospital stays of one (1) day for vaginal delivery, and three (3) days for Cesarean sections (the day of delivery being defined as day 0).
(HD-SR31-1995; Retained 2005)

480.06 High Risk Pregnancy Assessment

The MMA endorses the implementation and use of a uniform Minnesota pregnancy assessment form pending the evaluation and approval by the MMA Board of Trustees of the pilot test results.
(HD-R25-1996)

480.07 Maternity Carve Outs

The Minnesota Medical Association supports existing state law that prevents health insurance plan discrimination against maternity coverage
(HD-R404-2006)

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)

480.09 The Financial and Health Benefits of Paid Parental Leave

The Minnesota Medical Association shall study the potential fiscal and societal impacts of paid parental leave for the birth or adoption of children with report back to the Minnesota Medical Association House of Delegates in 2010
(HD-R104-2009)

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)

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))

490.05 Prescribing by First-Year Residents

The matter of prescribing by first-year residents be referred to the Board of Medical Practice with the recommendation that the board request that the deans of the medical schools and the administrators of teaching hospitals with first-year residents advise their first-year residents that they cannot write prescriptions for dispensing outside the institution without having them countersigned by a licensed physician.
(BT-7/81 (Retained 2004))

490.08 Therapeutic Substitution of Drugs by Pharmacists

The MMA vigorously opposes therapeutic substitution of drugs by pharmacists, and opposes efforts to authorize pharmacists to independently dispense therapeutic substitutes to a physician's prescription.
(HD-R25-1984; Retained 2007)

490.09 Multiple Prescriptions

The MMA opposes efforts to ban the writing of multiple prescriptions on a single prescription form.
(BT-2/85; Retained 2004)

490.1 Advertising of Prescription Drugs

The MMA believes that the AMA should reaffirm its opposition to the advertising of prescription drugs directly to the public and that it urge the Federal Trade Commission staff to distinguish the unofficial nature of this position in future statements.
(BT-11/85)

490.11 Disciplinary Action

Prescribing a drug or device for other than medically accepted therapeutic or experimental or investigative purposes authorized by a state or federal agency should be grounds for disciplinary action.
(BT-7/87; Retained 2004)

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)

490.16 MMA Drug Utilization and Review Policy

The MMA adopts the following policy on drug utilization and review (DUR):

1. The MMA will establish a pro-active position and vigorous interaction in the development of a state DUR program;
2. The MMA will appoint an ad hoc committee to research the DUR issue and recommend to the MMA Board of Trustees plans for active participation in the DUR program;
3. Provide current Formulary Committee members with information on the DUR programs available on the market listing the pros and cons of each program;
4. Actively solicit the input, cooperation and involvement of MMA physicians who are interested in and have the ability to become actively involved in a state DUR program for Medicaid patients.
(BT-7/91; Retained 2004)

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)

490.19 Volume Purchasing/Statewide Formulary

The MMA supports the increased use of volume purchasing, where appropriate, as a means to achieve the lowest cost possible for the consumer. The MMA does not support the establishment of a statewide drug formulary because of concern that it may adversely impact access to specific necessary drugs. The MMA supports the educational efforts for its physician membership in better use of less expensive alternatives.
(BT-3/93; Retained 2004)

490.22 Pharmaceutical Manufacturers

The MMA will seek to 1) work with appropriate groups in attempting to ensure that the most cost-effective and efficacious compounds are included for those organizations which choose to use formularies, and 2) will develop a public education program to balance public expectations with the efficacy of the formulary compounds.
(HD-R56-1996)

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)

490.25 Medicinal Use of Marijuana

The MMA takes no position on a legislative proposal to exempt from criminal and civil penalties the use of marijuana for qualifying persons to mitigate symptoms or effects of a medical condition and to protect physicians providing documentation needed for such use from arrest, prosecution or disciplinary action.
(BT-3/99; Retained 2009)

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)

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 or 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, deterrents, and potentially misleading information provided in DTCA.
(BT-3/01)

490.4 Reimbursement for Processing Formulary Changes

The MMA will work toward the goal of achieving physician reimbursement for time spent processing formulary changes.

(HD-R211-2001; Retained as edited 2011)

490.45 Prescription Medication Refills

The Minnesota Medical Association advocates that pharmacy benefit management (PBM) companies allow refill intervals of at least 100 days.

(HD-R206-2002; Retained 2012)

490.46 Optometrists Prescribing

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

(BT-3/03)

490.47 Physician-Specific Prescribing Data

The MMA supports current language in Minnesota House File 437, Omnibus Health and Human Services Bill, Article 2, page 119, line 21 (2003 legislative session) that would prohibit pharmaceutical manufacturers and wholesale drug distributors from purchasing physician-specific prescribing data. Should the above language in House File 437 not pass this session, the MMA will work with the Minnesota Pharmacists Association to reintroduce this language in the 2003-2004 legislative session.
(EC-4/03)

490.48 National Uniform Pharmacy Refill Form

The Minnesota Medical Association delegation to the American Medical Association will submit a resolution to the AMA encouraging the AMA to collaborate with appropriate national organizations to develop a uniform refill format and process for prescription refills to be used throughout the United States.
(EC-4/03)

490.49 Propose Printing Chemical Name And Strength On Each Pill

The Minnesota Medical Association adopt a policy that would support the creation of a code for legend and over-the-counter medications that would indicate compound and strength and be printed on each tablet and capsule, and that the MMA investigate the development of a system of copyrights on this coding system and, that the MMA delegation to the American Medical Association (AMA) submit a resolution to the AMA endorsing Federal legislation to enact this policy.
(HD-R204-2003)

490.5 Pharmaceutical Benefits Manager

The Minnesota Medical Association will

1. Opposes mandating the use of "fail first" and step therapies for pharmaceuticals based on acquisition costs rather than therapeutic efficacy;
2. Support Minnesota state government initiatives to join coalitions with other state governments to negotiate favorable pharmaceutical prices for products on the Minnesota Medical Assistance formulary;
3. Recommend that all Minnesota health plans and pharmaceutical benefits managers that utilize pharmacy and therapeutics committees, and state drug utilization boards, have a membership that consists of a majority of physicians who are primarily involved in the provision of patient care; and
4. Support compensation for physician time/work spent on pharmaceutical prior authorization procedures.

(HD-SR208-2003)

490.51 Drug Importation Policy

The MMA endorses efforts that help to increase patient access to more affordable prescription drugs with attention to product integrity and safety.
(BT-11/2003)

490.52 Drug Reimportation

The Minnesota Medical Association (MMA) will educate its members regarding the risks and benefits associated with drug importation and reimportation efforts, and the MMA will support 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. Furthermore, the MMA delegation to the American Medical Association (AMA) will introduce a resolution asking the AMA to request that the Food and Drug Administration (FDA) allow the safe reimportation of FDA-approved prescription drugs as a possible interim step.
(HD-SR205-2004)

490.53 NASPER

Prescription Services

The MMA will support legislation to establish a controlled substances electronic monitoring system in Minnesota (based on NASPER criteria and federal start-up funds) in order to aid physicians in providing care to their patients, and in recognition of the increasing rates of drug abuse, drug-seeking behavior, and the non-medical use of controlled substances.

(BT-3/06)

490.531 NASPER

The Minnesota Medical Association (MMA) supports controlled substance monitoring programs designed to aid physicians in providing care for their patients and in eliminating barriers, real or perceived, to the provision of that care. Controlled substance monitoring programs should be designed to be a tool for those who prescribe and those who dispense narcotics, to ensure that patients are not diverting prescription drugs for illicit use. Therefore, the MMA supports controlled substance monitoring programs as long as there is no identifying information related to the prescriber included in the information collected. If identifying information is included, such as what is required by the federal National All Schedules Prescription Electronic Registration act (NASPER), the MMA will oppose those programs.

(BT-1/07)

490.54 Best Buy Drugs Program

The MMA will collaborate with the Minnesota Senior Federation to develop a physician/patient-focused dissemination and implementation plan for the Best Buy Drug reports in Minnesota and sit on a Minnesota Senior Federation Advisory Group.

(BT-5/06)

490.55 Direct-To-Consumer Advertising of Sleep Medications

The Minnesota Medical Association delegation to the American Medical Association (AMA) shall submit a resolution on the issue of direct-to-consumer advertising of sleep medication asking the AMA to 1) explore possible restrictions on direct-to-consumer advertising for this specific potentially dangerous category of medications, and 2) establish a dialogue with the drug manufacturers and other stakeholders in order to encourage a modification of the current aggressive marketing tactics for the use of these drugs.

(HD-R409-2006)

490.56 Generic Medication Price Information

The Minnesota Medical Association (MMA) will partner with the Minnesota Department of Human Services (DHS) to co-promote greater awareness of prescription drug price differences by making such information available to physicians.

(BT-1/07)

490.57 Use of Prescription Information for Marketing Purposes

The MMA supports legislation to restrict the sale of prescribing data for the purpose of marketing pharmaceutical products.

(BT 03/09)

490.58 Pharmacy Benefit Managers

The MMA will work with the Minnesota Department of Commerce and, if necessary, the Minnesota Legislature to ensure that Pharmaceutical Benefit Managers (PBMs) that are engaged in prior authorization are appropriately licensed and regulated 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)

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. The MMA will work with the Minnesota Academy of Family

Physicians to meet with the Minnesota Council of Health Plans to institute this prohibition as soon as possible. If the health plans refuse to comply with this request, the MMA will ask the Minnesota Department of Health to take action as a means to help control health care costs.
(HD-R207-2011)

490.61 Affordable Asthma Medications

The MMA will work with public and private payers to ensure lowest co-pays for at least one inhaled steroid and one short acting beta adrenergic inhaler in their formularies, and will further work with public and private payers to ensure coverage for at least one nebulizer and one asthma inhaler spacer, and that any co-pays be at their lowest tier level.
(HD-SR305-2011)

490.62 Eliminate Duplication of Prescription Refills in the Automated Refill and Electronic Prescribing Systems

The Minnesota Medical Association will work closely with the Minnesota Department of Health E-Health Advisory Committee and its members to develop a policy that prescription refills are carefully monitored in the pharmacy database so that duplication errors can be caught at the pharmacy level to avoid overprescribing of medications. If the issue cannot be resolved with the Minnesota E-Health Advisory Committee, the Minnesota Medical Association will explore legislation to mandate pharmacies to monitor prescriptions for duplicates.
(HD-R202-2012)

490.63 Prescription Monitoring Program

The MMA supports changes to the Prescription Monitoring Program that would repeal current reporting exceptions (i.e., skilled nursing facilities, assisted living, intravenous medications, hospice and palliative care, home care); clarify that licensing boards may not access the PMP data to initiate or substantiate action related to unusual or excessive controlled substance prescribing; and, expand access to the data by coroners/medical examiners and HPSP. The MMA further supports legislation that would eliminate the current requirement for prescribers to provide written consent prior to the release of their name on the Minnesota Prescription Monitoring Program (PMP).
(BT 03-13 and EC 03-13; electronically)

500 Preventive Medicine

500.01 Timing of Pap Smears

The MMA advocates a yearly examination for women by a physician. This examination ordinarily should include a breast and pelvic examination, and a pap smear at the discretion of the physician.
(BT-3/81; Retained 2004)

500.03 Medicare PAP Smear Payment

The MMA believes that appropriate preventive medical services such as pap smears should be reimbursed under Medicare.
(HD-SR14-1985; Retained 2004)

500.04 Primary Care Providers

The MMA approves lobbying appropriate regulatory and legislative agencies to assure that a patient's access to primary care services provided by a physician are not limited by the specialty or sub-specialty designation of the physician, but should be determined by the training and competence of the physician.
(HD-R3-1993; Retained 2004)

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

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

500.06 Preventive Services Guidelines

The MMA will support the continued development of the Preventive Services Guidelines and will assist in the promotion, distribution, and implementation of the guidelines to physicians and the public.

The Preventive Services Guidelines should be considered a floor on such services and not a limit on new, cost-effective preventative health care practices that might be developed in the future. The Preventive Service Guidelines are not to be used as a guide for reimbursement.
(HD-R41-1995)

500.07 Preventive Services Principles

The MMA endorses the following statement based on the United States Preventive Services Task Force principles adopted by the Minnesota Council of HMOs:

- Interventions that address patient, personal health practices are vitally important.
- Physicians and patients should share decision-making.
- Physicians should be selective in ordering tests and providing preventive services of unproven effectiveness.
- Physicians should take every opportunity to deliver appropriate, effective preventive services, especially for persons with limited access to care.
- For some health problems, community-level interventions may be more effective than clinical preventive services.

(HD-23-1996; Retained 2006)

500.08 Dental Care Required During Child Primary Care Visits

While the MMA recognizes the importance of dental care as part of achieving overall optimal health for children and adults, the MMA opposes mandating the inclusion of primary caries prevention as part of primary care medical visits for children.
(BT 03/09)

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, and the MMA will enter into discussions with the Minnesota Dental Association to address pediatric dental access issues.
(HD-R201-2009)

510 Professional Liability/Professional Liability Insurance (See also, Litigation, Tort Reform)

510.01 Professional Liability Coverage for Retired Medical Doctor Volunteers

The MMA will explore mechanisms that would relieve retired medical doctor volunteers of the cost of liability with insurers.
(HD-LR65-1990; Retained 2004)

510.03 Enterprise Liability

The MMA actively opposes enterprise liability as an option in Minnesota for controlling professional liability costs. The MMA supports AMA efforts to work with the federal government to accomplish the same end at the national level, and will continue to call for meaningful tort reform as exemplified by current MMA and

AMA policy in the area of professional liability. The MMA supports tort reform similar to the MICRA reforms enacted in California.
(HD-R17-1993; Retained as edited 2007)

510.04 Malpractice Insurance Coverage

The MMA endorses the concept of malpractice insurance coverage or other proof of indemnification for all practicing health professionals. Further, we believe that this should be part of a comprehensive reform proposal based on MICRA-type reforms, including limits on non-economic damages, limits on attorney contingency fees based on a sliding scale proposal, apportionment of damages based upon percentage of fault and equal access to health care providers for both the plaintiff and defense.
(BT-2/94; Retained 2006)

510.05 Liability for the Substitution of Physician Orders for Inpatients

The MMA will study the problem of changes in physician orders for inpatients and develop recommendations for requiring a timely notice to the treating physician prior to initiating alterations in medications, nursing orders, dressings, implantable surgical devices, or other physician directives and for establishing the liability for changing physician orders.
(HD-R407-1999)

510.06 Risk Management and Malpractice Cases

The Minnesota Medical Association (MMA) shall develop an educational program on risk management or retain an appropriate consultant to help with this for the State of Minnesota. In addition the MMA delegation to the American Medical Association (AMA) will bring a resolution to the AMA calling upon the AMA to develop a risk management educational program on billing practices to help prevent malpractice cases.
(HD-R100-2004)

510.07 Apology Laws

The Minnesota Medical Association will collaborate with MMIC and other partners to develop and promote materials that educate and train physicians on how to effectively apologize and disclose adverse events to patients.
(BT 07-10)

520 Provider Contracting (See also, Ethics)

520.05 Exclusive Contracts

The MMA supports the following concepts regarding exclusive contracts: Subdivision 1. No provider or third party payor shall restrict any person's right to provide services or procedures to another provider or third party payor unless the person is an employee.

Subdivision 2. No provider or person providing goods or services to a provider shall enter into any contract or subcontract with any third party payor on terms that require the provider or person not to contract with any other third party payor.

Subdivision 3. Enforcement. The commissioner shall periodically review contracts among health care providing entities to determine compliance with this section. Any provider may submit a contract to the commissioner for review, if the provider believes this section has been violated. Any provision of a contract found to violate this section is null and void, and the commissioner may seek civil penalties in an amount not to exceed \$25,000 for each such contract.

(BT-2/94; Retained as Edited 2006)

520.09 Prohibiting of Global Risk Sharing Contracts between Providers and Health Plans

The Minnesota Medical Association shall lobby the Minnesota State Legislature to amend laws governing health plans to remove all provisions of law that permit physicians to enter into global risk sharing contracts with health plans for services other than their own (such as from a hospital, laboratory, consultant, or pharmacy).

The MMA delegation to the American Medical Association delegation shall carry a resolution to the AMA House of Delegates that the AMA will lobby Congress to amend laws governing health plans to remove all provisions of laws that permit physicians to enter into global risk-sharing contracts with health plans for services other than their own such as from a hospital, laboratory, consultant, or pharmacy.
(HD-R306-2000; Reaffirmed: HD-R304-2010)

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 2011)

530 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.

The MMA delegation to the American Medical Association (AMA) will submit a resolution to the AMA to seek to implement these policies on a national level.
(BT-1/2005)

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

530.01 Milk and Human Health

The AMA should urge Congress to adopt legislation requiring that unpasteurized milk products sold in the United States be labeled, "Not pasteurized and may cause disease in human." The AMA should also develop model legislation for states to require the labeling of unpasteurized milk and encourage the state medical societies to seek adoption of the model act.
(BT-11/85)

530.02 Pasteurized Milk

The MMA supports the concept of requiring the pasteurization of all milk sold for human consumption.
(BT-2/86; Retained 2004)

530.03 Bovine Somatotropin (BST) Use in Dairy Cows

Literature from the AMA, the FDA, and the National Institutes of Health indicates the use of BST in the production of milk poses no additional health threat to the public.
(BT-1/91; Retained 2004)

530.04 Five-a-Day Program

The MMA supports the National Cancer Institute's and the Produce for Better Health Foundation's Five-a-Day Program, that encourages Americans to eat five servings of fruits and vegetables a day. The MMA will also assist in educating Minnesota physicians and patients about the benefits and goals of the Five-a-Day Program.
(HD-R43-1996)

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)

530.042 FDA Regulation of Dietary Supplements and Herbal Therapies

The MMA shall continue to identify resources for Minnesota physicians about the use, safety, risks, and liabilities associated with the use of dietary supplements and herbal remedies.
(HD-SR209-1999; Retained as edited 2009)

530.05 Criminal Sanctions for Sale or Possession of Drug-Related Pipes

The MMA supports legislation making it a misdemeanor to possess a drug-related device with intent to violate controlled substance laws or to sell, offer to sell, transfer, or display for sale any drug-related device. The MMA believes drug-related devices that are used for illegal substances should be illegal. The current legality of such devices gives children the idea that the use of drugs is acceptable.
(BT-3/80; Retained 2004)

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. The MMA will initiate a program to educate physicians and the public about the catastrophic medical consequences of nuclear war.
(HD-SR5-1982; Retained 2004)

530.09 Measles Epidemic

The MMA will continue to inform its members through existing MMA communications programs about all issues surrounding vaccine preventable, communicable diseases.
(HD-R33-1986; Retained 2004)

530.1 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)

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)

530.17 Center for Cross-Cultural Health

The MMA supports the concept of the development, implementation, continued operation and promotion of the Center for Cross-Cultural Health which will serve as a clearinghouse, resource and research center for health care providers.

The MMA Board of Trustees shall determine the level and type of support for the Center for Cross-Cultural Health.
(HD-R14-1995; Retained 2005)

530.21 Investigation of Birth Defects and Anomalies in Frog Population

The MMA shall support and encourage scientific efforts to investigate the cause of abnormalities in the Minnesota frog population and their possible relationship to human birth defects, and work to reduce the biological impact of identifiable etiologic agents.
(HD-R1-1996; Retained 2006)

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)

530.27 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.

The MMA encourages local medical societies and other professional associations to adopt a policy to reduce and prevent workplace violence and abuse.
(HD-R103-1998; Retained 2008)

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)

530.29 Educating Physicians about Sexual Abuse

The MMA shall promote physician education regarding sexual abuse and its consequences.
(HD-R100-1999; Retained as edited 2009)

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)

530.36 Consensus Statement of the Physician Leadership on National Drug Policy (PLNDP)

The MMA endorses the Consensus Statement of the Physician Leadership on National Drug Policy and support the re-allocation of resources toward prevention and treatment of drug addiction to reduce the supply and demand for illegal and addicting drugs.

The MMA supports the Consensus Statement of the Physician Leadership on National Drug Policy, and will advocate for increased support for treatment, including treatment while in prison, and support for drug courts and drug testing of parolees and probationers.
(HD-R411-1999; Retained 2009)

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)

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 Program

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)

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. (Res. 423, A-98)

Additionally, the MMA shall develop a statewide education campaign, in conjunction with interested parties, to create awareness of the modifiable causes of obesity, obesity complications, and effective, sustained obesity treatment.
(HD-R307-2000)

530.41 Tuberculosis Testing and Treatment

The Minnesota Medical Association shall work with the appropriate parties to research and develop options to secure full public and private 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)

530.44 Driver Inattention

The Minnesota Medical Association shall educate Minnesota physicians and the public about the dangers of driver inattention due to factors including, but not limited to, sleepiness, cellular phone use, electronic devices (e.g., stereo, global positioning systems, televisions), and the use of certain medications.
(HD-SR311-2000)

530.49 Telephone Use While Driving Policy

The MMA adopted as public health policy that telephones not be used by a motor vehicle driver while the motor vehicle is in motion except in the case of emergency.
(HD-SR203-2001)

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 2011)

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 2011)

530.58 Pouring Contract Recommendation For Public Schools

The Minnesota Medical Association recommends to the Minnesota Department of Education that all beverage vending machines in the state's public schools contain only healthy choices.
(HD-R310-2002; Retained as edited 2012)

530.59 Guidelines And Regulations For Tattoos And Body Piercing

The Minnesota Medical Association urges the Minnesota Department of Health to protect the public health by publishing and disseminating standards for appropriate blood borne pathogen precautions and sterile practices to be used in tattoo and body piercing establishments. The MMA encourages physicians to report all adverse reactions associated with tattooing to the Food and Drug Administration MedWatch program.
(BT-7/03)

530.61 Epidemic Of Obesity

The Minnesota Medical Association supports the Diabetes Care Program of the Minnesota Department of Health (MDH) in its efforts to prevent diabetes and obesity, including disparities in diabetes that affect minority groups, the MMA endorse the goals of the Minority Affairs Consortium of the American Medical Association to address discrepancies in obesity, dysmetabolic syndrome, and diabetes in minority populations.
(HD-SR311-2003)

530.62 Health Plan Coverage For The Treatment Of Obesity

The Minnesota Medical Association will continue its ongoing dialogue with the Minnesota Council of Health Plans to strongly encourage full coverage for evidence-based obesity care in the State of Minnesota, including ancillary services (such as dietitians, exercise physiologists, and psychologists) and medication coverage under appropriate physician supervision.
(HD-R313-2003)

530.63 Child Safety

The Minnesota Medical Association on recommendation from the Committee on Legislation unanimously supports the Minnesota Chapter of the American Academy of Pediatrics move to update Minnesota child restraint laws, and the MMA supports state legislation allowing students to possess epinephrine while in school under certain circumstances.
(BT-03/2004)

530.64 Excise Tax On Sugared Beverages

The Minnesota Medical Association supports the Committee on Public Health and Preventive Medicine's recommendation to not adopt Resolution 213: that the MMA approach the state Legislature to institute an excise tax on sugared beverages similar to that on malt beverages and wine.
(BT-05/2004)

530.65 State Authority For Isolation And Quarantine

The MMA supports the concept of state authority for isolation and quarantine.
(BT-11/2003)

530.66 Physical Education In Schools

MMA supports legislation introduced during the 2004 legislative session that mandates health and physical education as educational standards.
(BT-01/2004)

530.67 Obesity Carve-Outs from State Plan Formularies

The Minnesota Medical Association will lobby for the removal of language in Minnesota Statutes 2003, Chapter 256B, Subd. 13d, Drug Formulary, which currently specifically excludes medications to treat obesity. The MMA will take the strong position that obesity is a treatable disease and carry this position to the Minnesota Legislature and the Minnesota Department of Human Services.
(HD-R210-2004)

530.68 Availability of Vaccines

The Minnesota Medical Association delegation to the American Medical Association (AMA) will submit a resolution to the AMA House of Delegates asking the AMA to support legislation to expand the scope of the National Vaccine Injury Compensation Program (VICP) to apply to adults for all recommended vaccines, including influenza.
(HD-R301-2004)

530.69 Methamphetamine Manufacture & Distribution

The Minnesota Medical Association (MMA) will work with appropriate state and local agencies to develop a strong public awareness that people manufacturing and distributing methamphetamine are placing people at risk for severe, debilitating, long-term health problems, and even early death. The MMA will support effective methods, strategies and funding to eradicate use and production of methamphetamines, and support penalties and other intervention strategies shown to be effective to rehabilitate persons convicted of manufacturing and distributing methamphetamines.
(HD-R413-2004)

530.7 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. The MMA delegation to the American Medical Association (AMA) will submit a resolution to the AMA to seek to implement these policies on a national level. (BT-1/2005)

530.71 Methamphetamines

The Minnesota Medical Association (MMA) supports legislation to classify methamphetamine precursor drugs, defined as any compound, mixture, or preparation containing ephedrine or pseudo-ephedrine as its sole active ingredient or as one of its active ingredients as Schedule V. (BT-03/2005)

530.72 Avian Influenza

The Minnesota Medical Association (MMA) will submit a resolution to the American Medical Association (AMA) asking the AMA to strive to increase the number of people vaccinated annually against influenza, particularly high risk patients, by working with appropriate stakeholders to expand understanding among physicians and patients about who is included in the "high risk" population. In addition, in order to prepare for a potential influenza pandemic, the MMA delegation to the AMA will ask the AMA to lobby Congress and the Administration to ensure that appropriate funding is provided to the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people. (BT-03/2005)

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 and will encourage Minnesota physicians to register with the program. (BT-07/2005)

530.74 Health Care Facility Food And Obesity

The Minnesota Medical Association will promote healthy diets in health care facilities throughout Minnesota. The MMA advocates that health care facilities that sell and/or serve food have healthy food choices available, and limit unhealthy choices for patients, visitors, and staff. The Minnesota Medical Association encourages health care facilities to include nutritional information about food sold in these facilities. (HD-R205-2005)

530.75 Obesity Task Force Recommendations

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. (EC-12/05; amended BT 05/11)

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)

530.77 Impact of High-Speed Locomotives

The Minnesota Medical Association (MMA) will communicate its opposition to the proposed expansion of the Dakota, Minnesota & Eastern Railroad (DM&E) railway system through Minnesota, to the Under Secretary of Transportation for Policy and the Minnesota congressional delegation. (HD-R101-2006)

530.78 Dysmetabolic Syndrome

The Minnesota Medical Association (MMA) Obesity Task Force shall collect and disseminate information about the problem of insulin resistant Type 2 Diabetes Mellitus in children to the physicians who treat children. The MMA delegation to the American Medical Association shall submit a resolution asking the American Medical Association to promote the study of the circumstances associated with this new onset of insulin-resistant Type 2 diabetes mellitus in children and recommend methods of prevention and treatment of this new public health threat.

(HD-R204-2006)

530.79 Public Safety, Public Health, And Public Transportation

The MMA publicly acknowledges the well-established safety and personal health benefits of improved public mass transit, pedestrian and bicycle use where feasible and appropriate, while ensuring that persons with disabilities are not disadvantaged by a public transportation emphasis.

(HD-R102-2007)

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)

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," support health care employers in educating employees about the dangers of drowsy driving and support employers' consideration of these dangers when determining shift schedules, and educate physicians and clinics on resources available to them and their staff to combat drowsy driving through inclusion of resources in Minnesota Medicine and the weekly MMA email newsletter.

(HD-R313-2007)

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)

530.84 Minnesota Colorectal Cancer Prevention and Early Detection Act

The MMA supports the Colorectal Cancer Prevention and Early Detection Act, a bill to establish access to colorectal screening services for uninsured and underinsured Minnesotans who are at risk.

(BT 05/08)

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)

530.86 Public Health Committee - Expedited Partner Therapy

The MMA endorses and supports implementation of the recently passed Expedited Partner Therapy as a means to reduce the incidence of chlamydia and gonorrhea in Minnesota.
(BT 11/08)

530.87 Standardized Policy and Practice on Vaccinations for Hospital Medical Staffs

The Minnesota Medical Association shall work promptly with the Minnesota Hospital Association, the Minnesota Department of Health, and other interested parties to develop a standard policy and process for Minnesota hospitals regarding medical staff influenza vaccinations, which shall include a mechanism for an active immunization declination process at Minnesota hospitals.
(HD-LR314-2009)

530.88 Health Care Worker Vaccination Task Force

The MMA Health Care Worker Vaccination Task Force recommends that the MMA Board of Trustees approve the following actions: 1) The MMA will endorse and promote physician leadership to achieve the following elements as components of a model policy on influenza vaccinations for hospital medical staff across Minnesota: Establish an annual influenza vaccination program that includes, at a minimum, staff and licensed independent practitioners*; provide access to influenza vaccinations on site,* free of cost, and during all work shifts; educate staff and licensed independent practitioners about influenza vaccination, non-vaccine control measures (such as hand hygiene, sneeze and cough etiquette), and the diagnosis, transmission, and potential impact of influenza*; As part of the vaccination program, implement a "required learning" module that includes information about vaccine benefits, risks to patients and other staff associated with non-vaccination, and a mechanism for managing contraindications or declinations; actively monitor vaccination rates and reasons for nonparticipation in the organization's immunization program* by using the Minnesota Immunization Information Connection database; develop positive reinforcement strategies that acknowledge staff internally for high influenza vaccination rates; promote influenza vaccination among health care workers as not just a personal protective measure, but a patient safety issue; 2) The MMA will work with the Minnesota Department of Health (MDH), the Minnesota Hospital Association, and other relevant organizations to promote awareness, adoption, and implementation of the model policy on influenza vaccinations for hospital medical staff and to further identify additional strategies to increase health care worker vaccination rates in all health care facilities across Minnesota. 3) In connection with MDH efforts to survey health care worker influenza vaccination rates (and, if possible, those of physicians), the MMA Committee on Public Health and Preventive Medicine will report updated rate data to the 2012 MMA House of Delegates. 4) The MMA will refer the above recommendations to the Minnesota Alliance for Patient Safety to consider broadening them to all health care workers in all health care facilities and to help monitor and implement these recommendations to improve patient safety. 5) The MMA will work with MDH to develop positive reinforcement strategies and public awareness of facility influenza vaccination rates (e.g., establish awards or designations for units or facilities meeting a threshold vaccination rate). Note: * Practices currently required by Joint Commission standard IC.02.04.01 at all critical access hospitals, hospitals, and long term care facilities.
(BT 01/10)

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)

530.9 Understanding Colon Cancer DVD

The Minnesota Medical Association shall disseminate through its various information sources the availability of the multilingual 20-minute DVD presentation entitled "Understanding Colon Cancer" to all of its members to encourage appropriate screening and eliminate misunderstandings relative to the procedures involved. The MMA Board of Trustees will establish a process for identifying and disseminating information about educational resources to members, with a priority on resources that are multimedia, multilingual, and culturally sensitive.
(HD-R301-2009)

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)

530.92 Healthy Menus Minneapolis

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, education on sodium consumption, improved calorie balance, and the associated work of the Healthy Menus Minneapolis coalition.
(BT 07/09)

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)

530.94 Supporting the Use of Health Impact Assessments (HIAs) to Guide Policymaking

The Minnesota Medical Association supports legislation that would provide grant funding and technical assistance for the use of health impact assessments (HIAs) to guide community development and policy decisions at all levels of Minnesota government.
(HD-R409-2010)

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)

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)

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)

530.98 Partners in Prevention

The MMA endorses and supports (non-financial) the Partners in Prevention Program.
(BT 05-12)

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)

530.101 Vaccinations Given in Healthcare Settings and in For Profit Pharmacies

The Minnesota Medical Association will work with the Minnesota Department of Health and the Minnesota Legislature to pass legislation requiring that any entity providing vaccines to patients enter the data into the Minnesota Immunization Information Connection registry.
(HD-R206-2011)

530.102 Indoor Tanning

The Minnesota Medical Association (MMA) actively supports legislation developed by the Minnesota Dermatological Society with support from the American Academy of Dermatology, the American Society of Dermatological Surgeons, the Minnesota Academy of Family Physicians, and the American Cancer Society, that would prohibit those under 18 years of age from using tanning beds. The MMA encourages the Minnesota Department of Health and the Minnesota Legislature to establish stronger requirements for the education, training, testing, and re-certification of tanning bed employees and for the posting of warning requirements for customers on the risks of usage.
(HD-R209-2011)

530.103 Healthy Eating Active Living Resolution for Communities

The Minnesota delegation to the American Medical Association (AMA) will encourage the AMA to advocate for US Farm Bill budget allocations to be directed through a newly created advisory board that includes, among other stakeholders, physicians and public health officials.
(HD-R201-2012)

530.104 Reform the U.S. Farm Bill to Improve U.S. Public Health & Food Sustainability

The Minnesota Medical Association will write a letter of support for the work of the Twin Cities Obesity Prevention Coalition, a project of the Twin Cities Medical Society, and whose mission is to provide leadership in mobilizing a community-based coalition of organizations, physicians and individuals who are committed to improving public health by advocating for healthy eating active living strategies in Twin Cities metro area communities. The MMA will also write a letter to the Minnesota League of Cities and the Minnesota Local Public Health Association encouraging Minnesota communities, large and small, to develop and implement healthy eating active living resolutions.
(HD-R203-2012)

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 efforts to encourage and publicize 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)

540 Public Programs

540 Medicaid

540.02 MMA Policy on Medical Assistance

The MMA adopts the following policy on the state Medical Assistance Program:

1. The Medical Assistance Program is designed to assure persons with insufficient financial resources access to the health care delivery system.
2. Effective and appropriate cost containment strategies of the private sector should be utilized in the public sector.
3. The physician has the professional, moral and legal responsibility to provide necessary medical care to his or her patient. As such, the physician should act as the gatekeeper to the remainder of

the health care delivery system. The physician should control the access of the MA recipient to all the services covered by medical assistance, with no exclusions. The MA recipients should have the opportunity to select their gatekeeper and should remain with that provider for a specified period of time. This gatekeeper's responsibility must be adequately compensated to insure provider participation and continued quality care. Cost-effective results should be rewarded.

4. Payment methodology for hospitalization and nursing homes must be modified from a cost-based system.

Community-based services for maintaining the elderly outside of nursing homes should be utilized when, combined with all support services utilized, it is less expensive than institutionalized care. (BT-1/83; Retained 2004)

540.06 Department of Human Services Eligibility Verification System

The MMA will continue to work to ensure that the eligibility verification system selected by the Department of Human Services meets the verification needs of the providers, and will work to assure that the department does not pass the cost of the system to the providers. (HD-R19-1985; Retained 2004)

540.07 Reforms to Repeal Medicaid Waiver Authority

The MMA reaffirms its policy that the payment and marketing methodologies of the public sector should neither encourage one health care delivery system over another, nor discourage the development of a pluralistic delivery system. The MMA supports publicly funded health care programs requiring prepayment of providers so long as health maintenance organizations, health insurance companies, health service corporation plans and preferred provider organizations are allowed to contract with such programs so as to ensure maximum patient access to the provider of their choice. (HD-R23-1985; Retained 2004)

540.08 HCFA Definition of Physician Under Medicaid

The MMA believes the Health Care Financing Administration should define "physician" as a "Doctor of Medicine or Osteopathy." (BT-1/86; Retained 2004)

540.1 Reimbursement for Treatment of Mental Illness

The MMA:

1. Supports the concept of nondiscrimination of payments for chronic or prolonged major mental illnesses for the purposes of copayments and deductibles,
2. Supports reimbursement for treatment of mental illness in inpatient setting under MA and GAMC programs on a negotiated per diem rather than DRG,
3. Supports modifications of the Adult Commitment Act to allow patients and families to seek treatment prior to demonstrating a dangerousness standard and the requirement that treatment be provided in the least restrictive and most appropriate setting. (BT-9/86; Retained 2004)

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)

540.16 Medicaid Patient Co-Pays

The MMA supports the establishment of a minimal co-pay for Medical Assistance emergency room visits in an effort to control utilization. Such co-pays would be paid by the patient at the time of service and returned if hospitalization were to occur within 24 hours.

(HD-SR10-1990)

540.17 Revision of the Base Year for Medical Assistance Reimbursement

The MMA supports revising the base year for medical reimbursement to the 50th percentile of the most recent year for which data is available as well as indexing the base year for advancement every two years.

(BT-1/91; Retained 2004)

540.18 Medicaid Reimbursement to Assure 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)

540.21 Geographic Equality in Medicaid Reimbursement

The MMA will support and work aggressively for geographic equality in General Assistance Medical Care and Medicaid capitation rates ensuring continued appropriate access to all levels of care for all Minnesotans.

(HD-R48-1994; Retained 2006; Reaffirmed HD-R205-2009)

540.26 Ad Hoc Task Force on Medical Assistance

The MMA adopts the document Policy Principles for Minnesota's Public Sector, Government-Subsidized Health Care Programs, drafted by the MMA's Ad Hoc Task Force on Medical Assistance.

(BT-2/96)

540.264 Financing Public Healthcare Programs (Oregon Model)

If sufficient revenues are not available to meet all the needs of all the beneficiaries of public programs, the MMA supports meeting the higher level needs of all beneficiaries than to meet all the needs of some beneficiaries.

(EC-4/03)

540.265 Obesity Carve-Outs from State Plan Formularies

The Minnesota Medical Association will lobby for the removal of language in Minnesota Statutes 2003, Chapter 256B, Subd. 13d, Drug Formulary, which currently specifically excludes medications to treat obesity. The MMA will take the strong position that obesity is a treatable disease and carry this position to the Minnesota Legislature and the Minnesota Department of Human Services.

(HD-R210-2004; Reaffirmed HD-R316--2006)

540.266 Minnesota Health Care Programs Coverage

The Minnesota Medical Association supports legislative changes that would reinstate Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare coverage for circumcisions. The MMA also supports legislative changes that would eliminate the prior authorization requirement for MA, GAMC, and MinnesotaCare coverage for non-emergency cesarean sections. The MMA, in light of the Emergency Medical Treatment and Active Labor Act (EMTALA) requirements, shall review the appropriateness of changes made by the 2005 Minnesota Legislature that, effective October 1, 2005, eliminate MA and MinnesotaCare coverage for emergency department visits and services that are determined retrospectively to be non-emergent or non-urgent.

(HD-SLR313-2005)

540.267 Emergency Department Services

The MMA will support efforts to repeal the state public health care program payment policy adopted during the 2005 legislative session that reduces payment to hospital emergency departments for non-emergency visits.

(BT-5/06; SLR 313-2005)

540.268 Health and Human Services Budget

The MMA opposes, as a high priority, payment cuts for balancing the budget, including permanent 3% cuts to fee-for-service payments for medical services under MinnesotaCare, GAMC and MA, as well as a PMAP withhold of 3%.

(EC- 04/08)

540.269 Minnesota Medicaid Physician Payment Rates

The MMA will develop a 1-3 year advocacy campaign to: a) educate and communicate issue to members; b) educate and communicate issue to policy makers; c) avoid cuts to physician payments; d) implement an RVU-based system immediately; e) ensure inclusion of annual inflationary factor in biennial budget; f) secure pass-through to providers of increases in health plan capitation rates; g) pursue rate increase.

(BT 11/08)

540.2691 General Assistance Medical Care

The MMA supports the development of an appropriate long-term solution to General Assistance Medical Care and supports increasing broad-based revenue sources to accomplish this. The health and human services category has already borne more than its fair share of cuts and reductions. The MMA will not support any proposal to resolve GAMC that includes cuts to physician reimbursement as existing payments already do not cover the cost of providing care.

(BT 01/10)

540.2692 ACA Medicaid Expansion

The MMA supports Medicaid expansion in Minnesota up to 138% of poverty, consistent with the Affordable Care Act.

(BT 07-12)

540.2693 Repeal the MN DHS Rule 101 “All or Nothing Rule”

The MMA will work to explore alternative mechanisms to ensure access to care for Medicaid enrollees in lieu of Rule 101.

(HD-R300-2012)

540.2694 Basic Health Plan

The MMA supports development of a Basic Health Plan to cover individuals from 138 to 200% of the federal poverty level but strongly opposes the use of the Health Care Access Fund (provider tax) as its funding source.

(EC 02-13)

540.27 Medicare

540.27 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

540.33 Medicare PAP Smear Payment

The MMA believes that appropriate preventive medical services such as pap smears should be reimbursable under Medicare.

(HD-SR14-1985; Retained 2004)

540.39 Medicare Payment

The MMA will formulate and promote federal legislation to correct disparities in medical reimbursement so that all Medicare patients in the United States are reimbursed equal amounts by Medicare for the same CPT

code. This policy applies to the CPT codes for all medical services and procedures. The MMA will formulate a pamphlet that will explain this disparity and which may be used by MMA members to be given to our patients and our state legislators.
(HD-R35-1988; Retained 2004)

540.44 Reimbursement to Rural Hospitals for Patients Returning from Tertiary Care Centers

The MMA supports a revision in Medicare regulations allowing reimbursement for patients returning to rural hospitals from tertiary care centers.
(HD-LR67-1990)

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)

540.47 Number of Medicare Carriers and Their Interpretation of HCFA Rules

The MMA urges the Health Care Financing Administration (HCFA) to reduce the discrepancies that exist among the interpretations that Medicare carriers make of HCFA rules and regulations using a mechanism that will ensure physician input.
(BT-5/91; Retained 2004)

540.48 Continuation of Medicare Toll-Free Phone Service

The MMA supports the continued existence of Medicare carriers' toll-free phone service.
(BT-5/91; Retained 2004)

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)

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 as its four major talking points on Medicare reform and that the document be further developed and disseminated to the membership, the Minnesota congressional delegation, and other policy makers.

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)

540.59 Medicare User Fees

The MMA opposes the imposition of Medicare user fees on physicians and will lobby against Medicare user fees to the Minnesota Congressional delegation.
(HD-R316-1998; Retained 2008)

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)

540.62 Support Centers For Medicare And Medicaid Services (CMS) Demonstration Project

The Minnesota Medical Association delegation to the American Medical Association (AMA) will carry a resolution to the AMA that directs the AMA to lobby for and support demonstration projects funded by the federal government through the Centers for Medicare and Medicaid Services (CMS) to reduce the cost of Medicare by improving the appropriateness and quality of care provided.

(HD-R305-2003)

540.63 Medicare Payment Neutrality

The Minnesota Medical Association will submit a resolution to the American Medical Association House of Delegates requesting that the American Medical Association adopt policy, consistent with the position of the Medicare Payment Advisory Commission, to support a financially neutral Medicare payment policy that would let beneficiaries choose the delivery system (fee-for-service or Medicare Advantage) that provides them with the highest value.

(HD-R308-2005)

540.64 Reduction of Burdensome CMS Signature Compliance Requirements

The Minnesota Medical Association will submit a resolution asking the American Medical Association to actively engage the Centers for Medicare and Medicaid Services (CMS) to re-evaluate the burdensome Medicare requirement that physicians sign all notes and orders, such as reoccurring physical therapy and lab orders, to reduce the overwhelming and time-consuming compliance burdens placed on physicians.

(HD-R202-2010)

540.65 Greater PMAP Transparency to Achieve the Triple Aim

The Minnesota Medical Association continues to support transparency of quality of care, cost of care, and physician payment data in the Prepaid Medical Assistance Program and other state-supported medical plans to ensure efficient use of state dollars, quality care delivery, and access to care by patients.

(HD-SR301-2011)

550 Public Relations

560 Research

560.01 Pound Seizure

The MMA supports limited use of pound dogs for research purposes, since extermination is the only other alternative for such dogs.

(BT-11/85; Retained 2004)

560.02 Humane Treatment of Animals

The MMA reaffirms its commitment to the humane treatment of research animals.

(HD-R19-1988; Retained 2004)

560.03 Appropriate Use of Animal Research

The MMA will develop and disseminate a position statement regarding the appropriateness and the necessity of animal research to better understand human disease or injury. The MMA will also develop a public education program for animal research and request that the AMA expand its public education program for animal research.

(HD-R14-1996)

560.07 Continuation of Minnesota Maternal Mortality Studies

The Minnesota Medical Association shall work with the commissioner of health to seek to continue Department of Health authority to access health records regarding maternal mortality studies (Minn. Stat. 145.90).

The MMA, if necessary, shall work with the Department of Health to introduce legislation in this area. (HD-R400-2000)

560.08 Use of Anatomical Gifts in Medical Research and Education

The Minnesota Medical Association delegation to the American Medical Association shall request that the AMA modify ethical policy E-2.08 sub. (1) to include use of organs or tissues for educational purposes, and that the AMA study current legal safeguards for proper ethical use of human tissue for research and education, to determine if they are appropriate and sufficient.

(HD-R405-2000)

560.12 U of MN Facilities Authority Request

The MMA will support, legislatively, the University's Biomedical Research Facilities authority using general tax dollars or other funding mechanisms. The MMA would oppose this effort if it were to be funded by provider tax or health care access fund dollars.

(EC-4/06)

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)

560.14 Comparative Effectiveness Research (CER) Principles

The Minnesota Medical Association supports the concept that Comparative Effectiveness Research (CER) should recognize that both clinical care and health behaviors are valid determinants that improve health care quality and control costs. The Minnesota Medical Association's Principles for Comparative Effectiveness Research recognize this concept and are as follows: 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; CER should encourage such improvements as well. While the likelihood is minimal that CER can simultaneously impact all three components of the Triple Aim™, a priority should be given to research on conditions with important public health consequences, on improving patient adherence to clinical and behavioral treatment plans, on improving healthcare 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)

570 Reportable Diseases

580 Rural Health and Underserved Areas

580.01 Rural Physicians' Associate Program

The MMA urges the continued support of the Rural Physicians' Associate Program.
(HD-SR17-1982; Retained 2004)

580.02 Adoption of the Recommendations of the Ad Hoc Committee on Rural Health

The MMA adopts the following recommendations in hopes of drawing those people together in an effort to avert a crisis in rural health care:

1. The MMA should work to alert federal, state and county government, other third-party payers, health care providers, and rural residents to the potential crisis in rural health care and cooperate with all parties involved to prevent such a crisis.
2. A statewide coordinating office (and phone number) should be set up by state government to assist in making mental health referrals and identifying areas that do not have adequate mental health services, especially in crisis intervention. A system should include home health care services and could be modeled after the metropolitan area's "First Call for Help."
3. The MMA, in cooperation with primary care medical specialty societies, should develop crisis intervention continuing medical education courses in mental health for primary care physicians.
4. The MMA should work with the state government to establish a list of psychiatrists who are willing to offer phone consultation regarding mental health patients.
5. The MMA's Emergency Medical Services Committee, in cooperation with other relevant parties such as the Emergency Medical Services System, should develop guidelines for local and regional emergency services systems. This could be done in cooperation with a broader state-initiated study to determine where specific access problems exist in rural communities.
6. Minnesota must maintain support for ambulance services so that most state residents are within a reasonable distance of a Basic Life Support vehicle. This must be done after a statewide emergency services plan has been redeveloped, based on the current economic environment. The MMA should cooperate in this effort through its Emergency Medical Services Committee.
7. The Minnesota Hospital Association, the MMA, and the Minnesota Department of Health should jointly conduct a study of small, rural hospitals of 50 beds or less to define specific problems and the basic viability of these institutions.
8. The MMA should ask the legislature to explore the possibility of creating a one-time federal/state buy-out of selected small hospitals for debt resolution and, if an agreement can be reached to convert the facilities to other needed services such as nursing home beds, emergency medical services, or outpatient services. The MMA also should join the Minnesota Hospital Association in a study of the negative effects of duplication of services and ways to increase cooperation among smaller hospitals.
9. The state legislature should investigate a higher level of mental health coverage from third-party payers. The MMA should work to inform legislators that, in some cases the minimum level of required mental health coverage may be inadequate. However, additional regulation may be a further drag on the economy and should be approached cautiously.
10. The Minnesota Department of Health, in cooperation with the MMA and other interested parties, should create a commission to study the sometimes conflicting roles of public health and private sector medical services. Duplication and competition should be eliminated or at least minimized. The commission should make recommendations on cooperative efforts and set guidelines that specifically address the needs of a rural rather than urban community.

11. The MMA should pursue legal, administrative, and political strategies like the following to end Medicare reimbursement inequities:
 - MMA members should pay a voluntary special assessment to be used to attack this problem.
 - State and federal office holders and policy-makers should be alerted to the extreme frustration rural physicians feel over their patients' Medicare reimbursement disparities.
 - The MMA should consider a public information campaign to further publicize this problem.
 - The MMA should further develop its ties to the active senior organizations (Minnesota Senior Federation and American Association of Retired Persons) and ask for their assistance in this effort.
12. The MMA should monitor the current national debate on medical reimbursement, particularly that concerned with a relative value scale for physicians (i.e., cognitive vs. procedural).
13. The MMA's Medical Practice and Planning Council should be asked to participate in the development of guidelines for identifying persons unable to pay for basic health care who don't qualify for government assistance; rural physicians can then continue to voluntarily provide free care on a case-by-case basis. The MMA should also support a concept similar to the AMA's proposal for providing care to the uninsured.
14. The MMA should support and provide input into legislative efforts to require standards for home health care providers and assist the state in establishing a statewide referral system for the growing number of public and private home care services.
15. The MMA should encourage the legislature to establish a more simplified system for qualifying for government support programs and to reduce paper work. A toll-free number should be established for first-time applicants and to allow applicants to quickly check on the eligibility in a "non-threatening" way.
16. The state should begin studying ways to relieve the economic difficulties facing physicians who practice in areas lacking adequate health care services, especially obstetrics. This could take the form of further tort reform, establishment of a risk pool for obstetrical malpractice judgments over a certain amount, or even a direct incentive to physicians who practice in these areas and provide obstetrical care.
17. The state legislature should investigate the possibility of developing something like a sliding scale fee reimbursement model based on numbers of Medical Assistance patients treated by a physician. This would encourage some practitioners, who treat as many as 30% Medical Assistance patients, to remain in practice in their area.
18. The MMA should work with its members to assure that physicians insist that they serve a primary role in efforts to measure quality of care through data collection and analysis of patient outcomes.
19. The role of the Minnesota Medical Services Corporation of the MMA should be publicized as a valuable resource for assisting in practice management. Because of the many challenges now confronting both rural and urban physicians, they must learn to run efficient practices and learn how to cope with changes in the medical profession. Seminars should be developed on rural medical practice arrangements, networking, satelliting, capitalization of practice, mergers, buy-outs, contracts, and training. Practice seminars should also be developed to educate physicians about practicing medicine with very little (or no) hospital practice.
20. The MMA and the Minnesota Hospital Association should develop a consultative service for small hospitals to educate them about networking, sharing services, and other cooperative efforts.
21. Continuing medical education courses should be offered to rural physicians on emergency recognition, stabilization and transfer, and long-term care.

22. The MMA should support the extension of peer review and quality enhancement efforts to the outpatient setting.
23. The MMA should focus a major part of its public education efforts on helping patients understand:
 - the positive and negative aspects of competition and the intricately related health care delivery structure
 - insurance purchasing and how to be smart buyers of health care policies
 - that local health care institutions need local support and patronage
 - how to identify good quality medical care and understand that it can be found in a smaller or rural setting
24. The MMA should work with other organizations to encourage the state legislature and local communities to continue working for new industry in farming areas and encourage physician members to assist in this effort at the local level.
25. The MMA should ask the governor to find ways to improve data collection and regional economic analysis to determine areas of the state suffering the greatest distress. Collective efforts should then be focused on those areas.

Other initiatives described in these recommendations are aimed at all of rural Minnesota or, when appropriate, the entire state.
(HD-RPT209-1987)

580.05 Financial Incentives

The MMA supports efforts to establish a state funded loan forgiveness program for physicians who practice in rural Minnesota and that local matching dollars be encouraged to provide additional funding.
(BT-1/90 (Retained 2004))

580.06 Medical Schools

The MMA encourages the University of Minnesota Medical Schools at Minneapolis and Duluth and the Mayo Medical School to develop recruiting plans directed at recruiting applicants likely to practice in rural settings.
(BT-1/90)

580.07 Program Funding

The MMA supports legislation to establish and fund a summer intern program for high school students to expose them to medical careers and increase funding for Rural Physician Association Programs to provide for an increase in the number of available positions.
(BT-1/90)

580.08 Rural Hospital Emergency Department

The MMA supports the establishment and funding of a pool of physicians available to staff emergency departments in rural hospitals to relieve physicians of some on-call responsibilities.
(BT-1/90; Retained 2004)

580.1 Reimbursement to Rural Hospitals for Patients Returning from Tertiary Care Centers

The MMA supports a revision in Medicare regulations allowing reimbursement for patients returning to rural hospitals from tertiary care centers.
(HD-LR67-1990)

580.11 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)

580.12 Creation of State Office of Rural Health

The MMA strongly endorses an Office of Rural Health for the State of Minnesota, and the MMA will remain an active participant in the Minnesota Rural Health Coalition (HD-R13-1990; Retained 2004)

580.14 Medical School Training for Rural Physicians

It is the MMA's position that a grave shortage of physicians exists in Minnesota and that the state funding of the Minnesota medical school programs should be directed to support those efforts to train physician specialties needed in the state, and to encourage the placement of those physicians to the areas most in need. These efforts should enhance the University of Minnesota's and Mayo Medical School's mission by:

1. Continuing current efforts and developing new efforts to attract students who exhibit a strong potential for primary care.
2. Studying the establishment of a significant active admitting family practice program with ongoing care and teaching responsibilities at the University of Minnesota Hospitals.

Urging and assisting, as needed in the continued development of rural primary care resident variances based on existing and developing educational models. (BT-1/91)

580.15 Medicare On-Call Reimbursement 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)

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)

590.04 Helmets for Hockey Referees

The MMA endorses the mandatory use of hockey helmets for all referees in amateur, high school and college hockey programs in the United States. (HD-R34-1981; Retained 2004)

590.07 Eye Protection for Racquet Sports

The MMA endorses the use of industrial safety lenses (plain or prescription) meeting or exceeding standard Z87.1-1968 established by the American National Standards Institute and mounted in a sturdy industrial or athletic frame for racquetball, squash and handball. (HD-R9-1983; Retained 2004)

590.08 Protective Headgear for Horse Events Within the State of Minnesota

The MMA recommends that educational programs be given to parents, riding instructors, show organizers and managers outlining the risks in horseback riding and methods to minimize them. Satisfactory, protective headgear should be selected for each type of riding activity and worn when riding or preparing to ride. Riding schools, horse shows and other events in which persons participate with horses should encourage that protective headgear be worn during the activities. (HD-SR21-1984; Retained 2004)

590.09 Boxing

It is the consensus of the MMA that the sport of boxing should be banned; however, considering the reality of the times, in the interim the MMA will institute an ongoing educational effort for the public, which includes the athletes, physicians, parents, and members of the Minnesota Boxing Commission, to alert those groups involved in boxing to the potential lifelong hazards of the sport. The Boxing Commission of 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)

590.1 Protective Sports Equipment

The MMA supports the following guidelines for the manufacture of equipment used in sports: (1) the physician community is encouraged to establish an active role in understanding ongoing and future research of materials and designs used in manufacturing equipment for all sports, so as to effectively reduce the potential of serious injury to all future participants; (2) physicians are encouraged to take an active role in writing and/or establishing guidelines which manufacturers should follow in producing equipment used for all contact sports; (3) physicians should continue to play an active role in promoting safety in all contact sports; (4) research of all products used in all sports which will promote increased safety and prevention of potentially serious injuries to all parts of the body should be continued; (5) the importance of strict enforcement of rules by coaches and referees to further minimize injuries is strongly reinforced; (6) the MMA will develop programs to create public awareness regarding the need for safe equipment in contact sports.

(HD-R16/SR18-1986; Retained 2004)

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)

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 while minors are 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)

590.15 "No Check" Hockey

The MMA will develop educational materials to inform 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)

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.

(HD-R307-2002; Retained as edited 2012)

590.17 Requirement of Minnesota School Districts to Provide Physical Education for Grades K-8

The Minnesota Medical Association supports legislation that would increase the level of physical activity for students in grades K – 8.

(HD-R401-2008)

600 Support Services for Physicians

600.01 Advocacy for Physician Members

The MMA will study the provision of information and services to members who are facing regulatory and contractual problems, or have other issues or concerns with the Board of Medical Practice, the health plans, employers, the Minnesota Department of Human Services and Health and other state and federal agencies. The MMA will also recommend to the Minnesota Physicians Foundation the need to provide support services to physicians facing these issues.
(HD-R33-1996)

600.02 Support Services for Minnesota Physicians

The MMA's Board of Trustees recommends to the Minnesota Physicians Foundation that a program be developed to include appropriate support services for Minnesota physicians who are experiencing stress due to significant changes taking place in the nature of their practices or illness.
(HD-R44-1996)

600.04 Physician Wellbeing

The MMA supports the development of a business and implementation plan to create an ongoing initiative that will promote the wellbeing of physicians by: 1) advocating to change the culture of the profession by further identifying breakdowns in collegiality between medical students, residents and physicians and working to reduce or eliminate those breakdowns; 2) providing informational resources (regular articles in Minnesota Medicine, web-based resources and other) to advance awareness of the prevalence of physician burnout and offer methods to remedy it; 3) educating 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)

610 Surgery

610.02 Ambulatory Procedures

The MMA endorses the concept of outpatient surgery as a potentially effective means of containing health care costs and encourages physicians to select this option whenever possible without jeopardizing quality of care. The following points serve to amplify physicians' concerns and expectations regarding ambulatory procedures:

1. The competitive marketplace has been, and will continue to be, the biggest force for increasing the scope of ambulatory care practice in this country.
2. A hard and fixed list of ambulatory procedures is inconsistent with a physician's need to judge a patient's condition before determining where a procedure can be safely performed.
3. Utilization review and quality assurance mechanisms are necessary to assure quality of care in ambulatory settings at a reasonable cost.
4. Evolutionary changes in practice such as outpatient surgery may be temporarily impeded by the unavailability of appropriate facilities.
5. Reimbursement incentives should be used to encourage physicians and patients to select outpatient surgery. This will greatly reduce overall health care costs and to a degree will recognize the increased efforts and costs of physicians in providing health care in an ambulatory setting.
6. The Interspecialty Council should encourage individual specialty societies to begin ongoing internal dialogue and education concerning guidelines for ambulatory care within their respective specialties.
7. The MMA will act as a resource to third party payors in the development of their ambulatory procedure lists.
(BT-3/85; Retained 2004)

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)

610.05 Post-Operative Care

The MMA adopts the policy that it is the responsibility of a physician to provide post-operative care through the convalescent period. (HD-R36-1991; Retained 2004)

610.06 Establishment Of Ethical Guidelines For Co-Management Of Surgical Patients

The Minnesota Medical Association adopts a policy that a surgeon should only engage in co-management of post-operative care when he/she feels it is in the best interest of the patient, and be it further and the MMA adopt a policy that when post-operative care is planned to be transferred to a co-managing practitioner, a pre-procedural informed consent shall be obtained which includes:

1. The reason for the transfer;
 2. The licensure or certification and qualifications of the provider who will be managing the patient's care post-operatively;
 3. The post-operative availability of the surgeon needs to be disclosed;
 4. That there is no pre-determined time when the patient shall be sent back to the referring provider; and
 5. Any special risks that may result from the surgical co-management.
- (HD-R202-2003)

610.07 Delegation Of Lasers And Intense Pulsed Light Source Procedures

The Minnesota Medical Association will work to create public awareness about the risks of scarring and blindness associated with the use of treatments from lasers, intense pulse light sources, radio frequency devices and related technologies and the importance of having such treatments performed or supervised by a knowledgeable physician. The Minnesota Medical Association also will modify existing MMA Policy to include supporting legislative or regulatory efforts to: 1) define the laser, intense pulsed light procedures, radio frequency devices and related technologies that require physician supervision; 2) require that every patient receive a physician evaluation before he/she receives treatment with any of these defined technologies; 3) establish minimum physician supervision requirements for these technologies; and 4) require that the use of these technologies on or in the eye and on ocular adnexa only be performed by licensed doctors of medicine or osteopathy. (HD-R200-2005)

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)

620.03 Medical Information System

The MMA encourages and supports physicians to record appropriate clinical information electronically, so that duplication of effort is minimized, and so that information can be electronically shared with various entities as appropriate. The MMA Board of Trustees should also study the feasibility of a single medical information system for the state of Minnesota. (HD-SR39-1995; Retained 2005)

620.08 Pathology Consultations Under Telemedicine Regulations

The MMA encourages the Board of Medical Practice to narrow the telemedicine consultation interpretation so that it does not exempt pathology altogether.
(EC-2/03)

620.09 Reimbursement for Electronic Medical Care

The Minnesota Medical Association supports development of more efficient patient care through the development of appropriate reimbursement for electronic communications that are part of an ongoing physician patient relationship.
(BT-11/2004)

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)

620.11 ICSI High-Tech Imaging Initiative

The MMA will further clarify the operational issues related to ICSI's alternative to the high-tech diagnostic imaging initiative and return with additional information prior to formally endorsing and collaborating with this effort.
(EC 12/08)

630 Third Party Payers (See also, Ethics)

630.01 Physician Involvement in Health Care Plans

The MMA believes that physicians should be integrally involved in the planning, organization, and management of plans involving the delivery of health care services in order to ensure that adequate protection of the interests of patients is included. Physicians should carefully consider, with respect to any health care plan or proposal for which they are considering support, whether proposed business or financial arrangements will or could impinge upon the independent exercise of their professional judgment, thereby risking the quality of medical care to patients.
(HD-R14-1982; Retained 2004; Reaffirmed HD-R310-2009)

630.04 Access to Psychiatric Treatment in Health Care Plans

The MMA believes that HMOs and other third party payment mechanisms, both public and private, should provide full disclosure of accurate information concerning all benefit and services to their actual or potential enrollees or subscribers which includes but is not limited to the following: the experience and qualification of the providers whom the patient will see, the opportunity for reimbursed referral or consultation, the copayment amount, if any, and the number of visits or days which are covered by the HMO or third party payment program.
(HD-SR11-1984; Retained 2004)

630.06 Monitor Health Care Advertising

The MMA will maintain a vigilant surveillance of the truth of advertising statements made by insurers regarding the breadth of benefits and services they provide.
(HD-R11-1987; Retained 2004)

630.07 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)

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)

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)

630.105 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)

630.106 Reimbursement for Processing Formulary Changes

The Minnesota Medical Association will work with health plans to reduce the administrative burdens associated with prescription changes as the result of health plan formulary changes, as well as the burdens associated with appeals for coverage of non-formulary drugs.

(HD-R302-2000; Retained 2010)

630.107 Prohibiting of Global Risk Sharing Contracts between Providers and Health Plans

The Minnesota Medical Association shall lobby the Minnesota State Legislature to amend laws governing health plans to remove all provisions of law that permit physicians to enter into global risk sharing contracts with health plans for services other than their own (such as from a hospital, laboratory, consultant, or pharmacy).

The MMA delegation to the American Medical Association delegation shall carry a resolution to the AMA House of Delegates that the AMA will lobby Congress to amend laws governing health plans to remove all provisions of laws that permit physicians to enter into global risk-sharing contracts with health plans for services other than their own such as from a hospital, laboratory, consultant, or pharmacy.

(HD-R306-2000; Reaffirmed, HD-R205-2009)

630.1091 Insurance Companies' Use of Social Security Numbers as Identifiers

The Minnesota Medical Association will adopt AMA policy H-190.963, Identity Fraud, as follows: Our AMA policy is to discourage the use of social security numbers to identify insureds, patients, and physicians except in those situations where the use of the number is required by law and/or regulation. The MMA will work with Minnesota insurance carriers and third party payers to discourage the use of social security numbers as identifiers

(HD-R404-2004)

630.1092 Health Plan Legal Liability

The Minnesota Medical Association adopts the following AMA policy regarding health plan liability: H-285-945 Establishment of Liability of Managed Care Organizations. Our AMA 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)

630.1093 Fair Pay

The Minnesota Medical Association shall advocate that third-party payers reimburse health care providers for costs related to pay-for-performance data collection and reporting.

HD-R212-2006

630.1094 Principles for Pay for Performance

1. Pay-for-performance programs must be designed to drive improvements to health care quality and the systems in which quality care is delivered.
 - Pay-for-performance programs should measure quality across the full continuum of care. Quality should be measured comprehensively considering the six aims as defined by the Institute of Medicine (i.e., safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity).
 - Pay-for-performance programs must demonstrate improvements to health care quality.
 - Pay-for-performance programs must offer increased value to health care consumers.
 - Pay-for-performance 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. Pay-for-performance 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).
3. Pay-for-performance programs should support and facilitate broad participation and minimize barriers to participation.
- Pay-for-performance programs must work to include physician groups across the continuum of health care as soon as possible.
 - 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. Pay-for-performance 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 and implementation of accountability and performance-improvement measures.
 - Clinical performance measures must be objective, transparent, reliable, evidence-based, current, statistically valid, clinically relevant, and cost-effective; the methodology should be prospectively defined.
 - 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.
 - Pay-for-performance programs should collect, report upon, and link payment to both process and outcome measures.
 - 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.
 - 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.
 - The American Medical Association's Physician Consortium for Performance Improvement incorporates these characteristics (What characteristics) into clinical measure sets that can be used across specialties. Developers of P4P programs should consider using AMA measure sets.
 - 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.
 - Pay-for-performance 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. Pay-for-performance 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 target then rewarding physicians who meet or exceed it (absolute value) and in rewarding physicians who make significant improvements to the quality of care they provide, regardless of whether they make relative improvements or reach the desired threshold.
 - 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 efforts 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)

630 Benefits/Reimbursement

630.110 Discrimination Against Mental Health Benefits in Insurance Programs

The MMA supports legislation requiring, upon request, disclosure from insurance companies and HMOs the following:

1. The total monies on all health care during a previous reporting period, the number of patients served, the amount of dollars spent by patient diagnosis, and the dollars allocated per provider to the patients with various diagnoses.

2. Total dollars spent on psychiatric and mental health care as well as chemical dependency treatment; the amount for inpatient psychiatric treatment and that for outpatient; the amount for inpatient chemical dependency treatment and the amount for outpatient.
(HD-R4-1981)

630.111 Fair Contracting Legislation

The MMA supports the Fair Contracting Legislation, HF606, as amended introduced during the 2003 legislative session.
(BT-3/03)

630.13 Reimbursement of Cognitive Services

The MMA supports the concept that third party payors should provide more equitable reimbursement for physicians' cognitive service in comparison with their procedural services.
(HD-R7-1984; Retained 2004)

630.15 Access to Psychiatric Treatment in Health Care Plans

The MMA believes that HMOs and other third party payment mechanisms, both public and private, should provide full disclosure of accurate information concerning all benefit and services to their actual or potential enrollees or subscribers which includes but is not limited to the following: the experience and qualification of the providers whom the patient will see, the opportunity for reimbursed referral or consultation, the copayment amount, if any, and the number of visits or days which are covered by the HMO or third party payment program.
(HD-SR11-1984; Retained 2004)

630.16 Insurance Coverage Disclosure

The MMA encourages the development of truth in health insurance legislation for the benefit of patients. The MMA will analyze the contracts of various health care plans and provide information to physicians regarding the benefits and risks associated with each. The MMA will also analyze whether transfer of risk by payers to physicians undermines the quality and availability of care to patients and determine whether legislative reform in this regard is necessary.
(HD-SR23-1984; Retained 2004)

630.17 Physician Payment Policy

The MMA adopts the following policy on physician payment:

- A. A payment mechanism for physician services is one which establishes a certain price or value, usually by a third party payer, which may vary from the actual fee established by the physician for services rendered.

Current payment mechanisms include:

Fee-for-Service

Usual, customary and reasonable

Indemnity

Prospective Pricing

One means of pricing may be the relative value index approach.

Pricing systems which allow open access to providers should not prohibit balance billing by those providers who choose not to participate.

- B. The health care marketplace, both public and private, should reflect a diversity of system approaches to health care payment.

Within the health care marketplace, physicians should be free to contract with the entity(ies) of their choice.

Fee-for-service coverage must be included as one option in the pluralistic marketplace as the system which offers the greatest freedom of choice of provider and minimizes barriers to care.

All health care payment systems should be treated equally under the law.

- C. Payment mechanisms and pricing policies of all health care plans should include specifically identifiable components which are uniform among plans:

Determination of price should not consider location of a physician's practice as a criterion.

Cognitive as well as procedural services should be appropriately weighted in price determination.

Costs of medical research, development and education should be assessed in the price determinations of each health care plan.

Health care plans should develop payment levels which fairly reflect the actual cost of the service being delivered. Discounts must reflect economies of scale or other quantifiable cost reductions resulting from plan design.

Prices established for certain services should not vary based on the place in which the service is rendered.

- D. All health plans must clearly define and disclose the actual process by which actual or potential subscribers or enrollees may obtain access to care or treatment, as well as clearly identifying the experience and qualification of the providers whom the patient will see, the assurance that referral or consultation will be provided when necessary, the co-payment amount, if any, and the extent of coverage for particular benefits or services.

Health care plans should provide for adequate supervision of care provided by non-physician providers.

Health care plans should guarantee patient access to appropriate services.

- E. All health care plans should have quality assurance programs which can measure aspects of quality against clearly defined standards and criteria.

The MMA supports peer review conducted by organizations directed by physician-dominated boards.

Review entities must use physician-determined criteria and use physicians as the final arbiters of quality of care issues.

Physician reviewers should not be subject to discipline by the review entity because of any consequences of their review decisions.

The relationship with any review entity, physician-dominated or otherwise, should be at arms-length.

- F. Cost containment efforts must not preclude the maintenance of appropriate quality of care. Placement of incentives within the health care plan structure, designed to encourage cost control, must allow for delivery of care within the bounds established as appropriate for quality assurance.

Data collection efforts, for purposes other than those used for identifying physicians on a preferred provider basis, which result in the identification of physician practice patterns which fall outside the established community and plan norm may result in physicians being subjected to plan sanctions. Practice patterns should not be interpreted to mean purely financial statistics, but should include such variables as patient age, severity of cases, etc.

Utilization review, concurrent review and pre-admission certification programs are all appropriate cost containment measures when administered in conjunction with a quality assurance program.

- G. Administration of health care plans must allow for an ethical and honest relationship to be established among the plan, the physician and the patient/subscriber/enrollee.

Any health plan which promises certain services or certain levels of benefits or coverage to actual or potential enrollees or subscribers must be able to verify that delivery of those services is possible under its established funding mechanism.

The MMA will continue to monitor the Minnesota Medicaid Demonstration Project in order to affirm its position that transfer of risk from the health care plan to the health care provider does not in itself undermine quality and availability of care.

Health care plans should communicate with subscribers or enrollees regarding limits to, or levels of payment in a way which does not undermine the prerogative of physicians to set their fees at the level they deem appropriate for the service rendered.

(BT-1/85)

630.19 Receiving and Reimbursing Outpatient Psychiatric Treatment Based on Procedure

The MMA recommends increases in reimbursement for psychiatric services performed on an outpatient basis as denoted by procedure. The MMA also supports and endorses utilization and quality reviews performed by medical review agents for psychiatric outpatient treatment programming supervised by a psychiatrist, and encourages development of outpatient psychiatric treatment standards (including those for psychotherapy) to be used by medical review agents including the Department of Human Services in Minnesota.

(HD-R11-1985; Retained 2004)

630.2 Reimbursement for Treatment of Mental Illness

The MMA:

1. Supports the concept of nondiscrimination of payments for chronic or prolonged major mental illnesses for the purposes of copayments and deductibles;
2. Supports reimbursement for treatment of mental illness in inpatient setting under MA and GAMC programs on a negotiated per diem rather than DRG;
3. Supports modifications of the Adult Commitment Act to allow patients and families to seek treatment prior to demonstrating a dangerousness standard and the requirement that treatment be provided in the least restrictive and most appropriate setting.

(BT-9/86; Retained 2004)

630.22 Determination of Usual and Customary Fees by Third Party Payers

The MMA supports legislation to define 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)

630.24 Mandated Benefits

The MMA supports the need for consistency in how minimum and mandated benefits are determined. Also, the MMA will take a leadership role in gaining community consensus in making these determinations in order to not be minimized in the process.

(BT-1/90; Retained 2004)

630.25 Insurance Coverage for the Diagnosis and Treatment of Infertility

While the MMA does not oppose insurance coverage for the diagnosis and treatment of infertility, the MMA does oppose mandating such coverage.

(BT-1/90; Retained 2004)

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)

630.29 Reimbursement for Qualified Patient Educator Services

The MMA encourages the AMA to support the addition of a CPT code assignment providing the opportunity for physicians who employ qualified patient educators to bill for their services and to support the addition of a CPT code assignment providing education on an individual basis.
(HD-R15-1991)

630.31 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. The MMA, through its AMA Delegation, supports federal legislation and/or rulemaking to end the discriminatory Medicare 50% copayment for treatment of mental disorders.
(HD-R29-1991; Retained 2004)

630.32 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)

630.33 Classification of Learning Disabilities as a Medical Neurodevelopmental Diagnosis

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

630.35 Reimbursement

The MMA will pursue fair reimbursement for physician-supervised services provided by nurse practitioners, nurse specialists, and physician assistants.
(HD-R22-1994)

630.36 MMA Opposes Health Plan Restrictions

The MMA supports efforts to end discriminatory restrictions on the treatment of mental illness and addictive disorders; supports removal of health plan restrictions to appropriate mental illness and addictive disorder treatment by primary care physicians; and seeks similar support from the AMA on those items which are not already AMA policy.
(HD-R23&25-1994; Retained 2006)

630.37 Immunizations

The MMA will support the coverage of childhood immunizations and specifically encourage self-insured companies to also provide coverage for childhood immunizations. The MMA's delegation to the AMA House of Delegates will introduce a resolution asking for federal legislation requiring self-insured companies to cover immunizations as recommended by the National Advisory Vaccine Committee.
(HD-R17-1995; Retained 2005)

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)

630.39102 MMA to Cosponsor a Community Conference to Discuss the Next Generation of Health Care Delivery and Financing Systems

The MMA in cooperation with other interested parties, will produce a conference in 2002 devoted to examining the next generation of health care delivery and financing systems.
(HD-302-2001)

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 continue to 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 as edited 2011)

630.39107 Reimbursement for Pathologists

The MMA recognizes the role the pathologists play in the delivery of high quality clinic laboratory services and support payment and policies that compensate pathologists for their contributions.
(BT-7/2001; Retained 2011)

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 contraceptive medications and devices, which require prescriptions, as they would for other prescription medications.
(HD-R300-1998; Retained 2008)

630.396 Agreement on Payment for Services

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)

630.398 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)

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)

630.3992 Prompt Pay Legislation

The MMA supports HF606 as amended (introduced during the 2003 legislative session) and continues to support HF458/SF455, introduced during the 2003 legislative session.
(BT-3/03)

630.3993 Terminology Of Medical Necessity

The Minnesota Medical Association supports usage of the term "medical necessity" that is consistent between the medical profession and the insurance industry, and urge health plan denials for non-covered services be stated explicitly and not confounded with determinations of lack of "medical necessity."
(HD-R308-2003)

630.3994 Health Plan Coverage For The Treatment Of Obesity

The Minnesota Medical Association will continue its ongoing dialogue with the Minnesota Council of Health Plans to strongly encourage full coverage for evidence-based obesity care in the State of Minnesota, including ancillary services (such as dietitians, exercise physiologists, and psychologists) and medication coverage under appropriate physician supervision.
(HD-R313-2003)

630.3995 Paying For Interpretive Services

The Minnesota Medical Association endorses and supports currently pending federal legislation that provides that physicians are not financially responsible for funding foreign language interpreter services as currently required by the U.S. Department of Health and Human Services.
(HD-R408-2003)

630.3996 Disease Management by Insurers

The Minnesota Medical Association will develop and lobby for legislation that prescribes: 1) health plans and insurers shall honor appropriate CPT codes so that physicians and/or their clinics are reimbursed for providing disease-management services, including telephone calls, educational counseling to patients and families, interdisciplinary case conferences, and other administrative and networking activities; 2) the decision to participate or not to participate in a disease management program should always be the prerogative of the patient, who should be fully informed of any plan coverage conditions attendant on such decisions; 3) the total costs of health plan disease-management programs administered by the health plan or by another entity will be reported as public information to the Minnesota Department of Health and other appropriate regulatory agencies to include detail on aggregate total costs of disease-management programs and the number of patients impacted.
(HD-R208-2004)

630.3997 Reimbursement for Management and Coordination of Complex Hospital Care

The Minnesota Medical Association will develop a work group, including representatives from the physician community and payers that would examine the issue of reimbursement and make recommendations to allow for appropriate reimbursement of physicians providing overall management of care and coordination of complex hospital care.
(HD-R300-2004)

630.3998 Reimbursement for Electronic Medical Care

The Minnesota Medical Association supports development of more efficient patient care through the development of appropriate reimbursement for electronic communications that are part of an ongoing physician patient relationship.

(BT-11/2004)

630.3999 Insurance Billing Practices

The Minnesota Medical Association supports efforts to ensure that patients are informed of what was billed to the insurer and what was actually paid.

(HD-R302-2006)

630.39991 Physician Telephonic Visit

The Minnesota Medical Association shall establish a strategy to encourage health plans to recognize the appropriateness, safety, and compensatory value of telephonic visits provided by their subscriber's health care team, and likewise examine the use of the Internet as a valuable, reimbursable patient encounter opportunity.

(HD-R312-2006)

630 Health Maintenance Organizations

630.4 MMA Recommendations to PHP

The following MMA recommendations will be forwarded to the Physicians Health Plan Board of Directors for its consideration:

That the executive officer of PHP be a paid employee of PHP and that he/she not have any direct personal or financial involvement with United Healthcare Corporation.

That a medical director/advisor be retained by PHP whose primary role would be to interface with the physician community. Further that this person be paid by PHP and not have any direct personal or financial involvement with United Healthcare Corporation.

That the PHP Board of Directors look into creating a physician advisory council to the PHP board to deal with the issue of quality of care as it may be affected by utilization review and other related policies adopted by the board. And further, that PHP seek ways to improve the functioning of its formal appeal mechanisms for PHP participating physicians who have grievances with PHP.

(BT-1/84; Retained 2004)

630.41 HMO Equalization

The MMA adopts the following positions on HMO equalization:

1. The MMA believes HMOs should be denied the option of using a co-payment based solely on health status or length of time in a plan, so long as an option allowing the HMO to use a co-payment based on health status or length of time in the plan when more than one health plan or insurance company is offered to employees.
2. The frequency which the HMO must notify enrollees of changes in participating providers should be every 90 days.
3. HMOs should not be required to offer second opinions for cases of psychiatry and chemical dependency treatment.
4. The MMA reaffirms its policy to restrict Department of Health access to data in individual offices, particularly medical records.
5. The MMA opposes granting the Department of Health the power to review and retroactively deny contracts between HMOs and providers.

(BT-3/84)

630.42 Conflicts of Interest in HMO Management

The MMA adopts the position that Minnesota HMOs should maintain strong, independent management and counsel, free of any cross-membership, joint employment, significant ownership or other conflicts of interest with any company that contracts to provide management or financial services to the HMO, and that the principal officers of the HMO should be employees of the HMO alone, and not employees of any HMO management company, financial consulting firm, law firm, or any other vendor with a significant stake or financial interest in the managed HMO. The MMA will strongly support and instruct its staff to seek the introduction and passage of legislation to amend the state's HMO statutes to eliminate conflicts of interest between HMOs and HMO management companies; insuring that non-profit HMOs in Minnesota will maintain independent management and counsel, free of any conflicts of interest.
(HD-LR24-1987; Retained 2004)

630.434 Carveouts of Mental Health and Chemical Dependency Benefits

The Minnesota Medical Association opposes the carving out of psychiatric and chemical dependency treatments from general medical care in health insurance and managed care programs.

The MMA supports educational program aimed at patients, employers, and other interested parties to promote the advantages of health care insurance policies that integrate medical, surgical, psychiatric, and chemical dependency services in any clinical setting.
(HD-R300-2000; Retained as edited 2010)

630 Preferred Provider Organizations (PPOs)

630.44 Guiding Principles for the Development and Operation of a Preferred Provider Organization (PPO)

1. The PPO plan, as with any other plan, should address overall health care costs to the community, not just cost-cutting mechanisms within its own selected population.
2. The PPO plan should incorporate the concept that physicians must be integrally involved in the planning, organization and management of all plans involving the delivery of health care services.
3. The PPO plan should provide incentives for consumers to make cost-effective choices in their own health care. First dollar coverage and total coverage are disincentives.
4. The PPO plan should provide incentives to hospitals to reduce the expenses of providing their services.
5. The PPO plan should provide financial incentives which reward patients for cost-effective behavior.
6. The PPO plan should support continuity of care, the development of a continuing relationship between physician and patient.
7. PPO planning must recognize the role of the physician as the purchasing agent of health care for his or her patient. The plan should measure this function, and award good performance. This role is probably more important than fee levels in determining who is a high cost and who is a low cost provider.
8. Similarly, the PPO plan must provide for assessment and maintenance of quality of care, by some mechanism of peer (that is physician-controlled) review.
9. The PPO plan must assure the physician's role as advocate for the needs of each patient. The physician must never be placed in a position of becoming the patient's adversary as an agent for a health plan.
10. The PPO plan, as with any other plan, should in some way recognize the need for education in the health sciences, and the costs involved.
11. Data systems relating to physician performance have several requirements.
 - a. The often complex medical information must be interpreted by physicians.

- b. Methodology should be developed to identify the severity/acuity of individual cases so that fair comparisons can be made.
- c. Physicians should have access to detailed information concerning their own "practice profile"; the data system should also facilitate the comparison of physicians with similar practices.
- d. Aggregate data should be used to establish community norms. Data about any individual should be made available to that individual for personal comparison and education.

Advertising for PPOs, like any physician advertising, must be fair, objective, and truthful. It should clearly state any limitation in the manner in which services are to be provided.

PPOs should not limit physicians to participation in a single PPO.
(BT-1/83; Retained 2004)

630.45 Prospective Online Enrollee Insurance Benefit and Medication Formulary Details

The Minnesota Medical Association shall advocate 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, and that the Minnesota Medical Association delegation to the American Medical Association submit a similar resolution to the AMA House of Delegates.
(BT 07/08)

630.46 Co-Pay Equality

Payment reform should recognize and reward the development of a continuous, healing relationship between a patient and physician. This relationship is critically important in achieving better clinical outcomes, patient outcomes and reducing cost of care over a period of time. Current health plan payment policies that impose co-pays for visits to primary care physicians or medical home physicians are counter-productive to the goals of improving health in Minnesota. The Minnesota Medical Association will educate patients, policy makers and health plans about the problems caused by co-pays for primary care and advocate that payers eliminate co-pays for primary care physicians and medical home providers.
(BT 05/09)

640 Tobacco

640.01 Tobacco Advertising

The MMA supports banning tobacco advertising.
(BT-1/89; Retained 2004)

640.02 Limits on Advertising and Advertising at Government Sponsored Events

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

640 Children and Youth

640.05 Sale of Tobacco from Vending Machines/Sale of Tobacco to Minors

The MMA supports a total ban on cigarette sales from vending machines. Also, the MMA supports efforts to ban the sale of tobacco to individuals under 21 years of age.
(BT-1/90; Retained 2004)

640.071 Legal Age for Use of Tobacco Products

The MMA reaffirms its policy to ban the sale of tobacco to individuals under 21 years of age.

The MMA will make the passage of a ban on the sale of tobacco products to individuals under 21 years of age a high legislative priority.

(HD-R205-1997; Retained 2007)

640.08 Cigarette Tax

The MMA supports a sufficient increase in the tax on cigarettes, in order that smokers be assigned some of the costs incurred by the entire nation as a result of their smoking.

(HD-R19-1982; Retained 2004)

640.11 Fire Safety Standards

The MMA supports fire safety standards for cigarettes and little cigars.

(BT-1/89; Retained 2004)

640.14 Tobacco Tax

The MMA supports the use of cigarette tax revenue for tobacco use prevention initiatives and health care.

(HD-R43-1995; Retained as edited 2007)

640.15 Anti-Smoking Legislation

The MMA, in its continued efforts to achieve a smoke-free society, will publish, at the MMA Board of Trustees' discretion, the votes of legislators who have voted against relevant initiatives supported by the Smoke-Free 2000 Coalition. The MMA will also provide information on tobacco-related votes to the MMA's Political Action Committee (MEDPAC) and ask that MEDPAC use this information when making its candidate endorsement decisions.

(HD-R10-1996; Retained 2006)

640.152 Cigars and Smokeless Tobacco

The MMA, as part of its anti-tobacco campaign, will incorporate and identify cigars, pipe tobacco, and smokeless tobacco as dangerous products in order to protect the public health.

(HD-LR319-1997)

640.153 Passive Smoking

The MMA, in partnership with other organizations, will study the feasibility of developing and/or distributing materials for physicians to give to parents and prospective parents about the effects of passive smoke exposure on children.

The MMA encourages all parents to protect the health of their children by declaring their home a smoke free home.

The MMA will seek a requirement that all licensed day care homes and centers be smoke free 24 hours a day.

(HD-LR321-1997)

640.154 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.

The MMA will encourage the Minnesota Council of Health Plans to adopt a policy recommending its members not invest in tobacco company stocks.

(HD-R109-1997)

640.155 Coalition To Save Lives, Not Tobacco

The MMA will send a letter of support for the work of the coalition.
(BT-2/98)

640.157 MMA Position on Use of Tobacco Settlement Revenue

The MMA supports the use of tobacco settlement funds only for health care related programs.
(HD-SR206-1998; Retained as edited 2008)

640.1591 Tobacco Tax Increase

The MMA supports an increase in of Minnesota's tobacco tax in an effort to reduce its use and harmful health effects.
(HD-R201-2001; Retained as edited 2011)

640.1594 Smoke Free Housing

The Minnesota Medical Association supports efforts to increase the availability of housing units, both publicly and privately owned, in which smoking is prohibited in all common areas and individual apartments
(HD-R305-2004)

640.1595 Implementation of Provider Tobacco Cessation Guidelines

The MMA shall actively encourage all Minnesota physicians to 1) follow cessation intervention guidelines such as those included on the ClearWay MinnesotaSM Provider Tobacco Intervention Card, 2) encourage other health care providers to provide tobacco cessation intervention, and 3) support systems changes in their health care organizations to enhance tobacco cessation initiatives.
(HD-R211-2007)

640.16 Smoking by MMA Employees and Representatives

The MMA adopts the following recommendations:

1. Prohibits smoking by participants in MMA meetings;
2. Request that physicians representing the MMA in the community not smoke;
3. Consider a smoking cessation program for MMA employees who smoke;

Consider incentives in the salary schedule for MMA employees who do not smoke;
Encourage MMA employees to not smoke while they are within the MMA office or when they are representing the MMA.
(BT-7/83; Retained 2004)

640.19 Passive or Second Hand Smoke

The MMA will (1) continue its efforts toward a smoke-free society and assume a leadership role in working for the elimination of passive smoke from the Minnesota indoors; (2) work with the Minnesota Coalition for a Smoke-Free Society 2000 in efforts targeted at educating and actively encouraging employers, parents and public officials to eliminate smoking in any indoor area where children live or play or where another person's health could be adversely affected through passive smoke.
(HD-SR16-1985; Retained 2004)

640.24 Smoking at Building Entrances

The MMA will initiate legislation to prohibit smoking within 75 feet of any entrance to a facility which is designated smoke-free.
(HD-R20-1995; Retained 2005)

640.26 Smoke-Free Health Care Facilities/Grounds

The MMA will promote state legislation that would make health care facilities and grounds smoke-free by the year 2000.
(HD-R402-1998)

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

The Minnesota Medical Association opposes attempts to adopt state law that pre-empts local ordinances that restrict the sale and use of tobacco.
(HD-R201-2000; Retained 2010)

640.3 Smoke Free Restaurants and Bars

The Minnesota Medical Association endorses the elimination of secondhand smoke in all restaurants and bars in Minnesota by supporting the passage of local, county, and state ordinances that prohibit smoking in restaurants and bars, thus expanding the coverage of the Minnesota Clean Indoor Air Act.
(HD-R210-2000; Retained 2010)

640.32 Secondhand Smoke

The Minnesota Medical Association and its constituent societies will choose facilities for their meetings, conferences, and conventions based on the facility's smoking policy (including its restaurant and bar policies) as an equal criterion to the facility's size, service, location, cost, and other similar factors, and that the MMA delegation to the American Medical Association (AMA) submit a resolution to the AMA asking that a similar policy be adopted by the AMA to encourage national medical specialty societies, other state and county medical societies, and other health care organizations to adopt such a policy.
(HD-R105-2003)

640.33 Smoking Ban By Minnesota Counties

The Minnesota Medical Association strongly recommends that Minnesota counties eliminate secondhand smoke on or in all county property, including buildings, jails, vehicles and land, and the MMA urges the Association of Minnesota Counties (AMC) to provide support for members in drafting and introducing ordinances to eliminate secondhand smoke on county property and that the counties with smoking restrictions or bans be commended by the AMC. The MMA also urges that county employees who use tobacco receive smoking cessation information and, for those who desire, referral to smoking cessation services in conjunction with their insurance providers and other organizations and the MMA urges counties to purchase health insurance that covers smoking cessation programs, and the MMA convey these policies to all elected county commissioners in Minnesota.
(HD-R309-2003)

640.34 Secondhand Smoke

The Minnesota Medical Association will schedule its annual meeting only in jurisdictions (cities or counties) in which there is an ordinance that eliminates tobacco smoke in restaurants, bars, and other commercial establishments serving food.
(HD-R103-2004)

640.35 Smoking Ban in Bars, Restaurants, and other Public Buildings

The Minnesota Medical Association will take a leadership role and support the drafting and passage of legislation for a statewide ban on smoking in bars, restaurants, public buildings, and workplaces, and will provide its support to other groups working toward the passage of legislation for a statewide smoking ban.
(HD-R212-2004)

640.36 Eliminating the Sale of Tobacco Products on Minnesota University Campuses

The Minnesota Medical Association strongly urges the University of Minnesota Board of Regents and the Vice President for Student Affairs to require the student union to end the sale of tobacco products on the University of Minnesota – Twin Cities campus. The MMA strongly supports local, county, and state efforts to prevent the sale of tobacco products on all University of Minnesota and Minnesota State Colleges and Universities (MnSCU) campuses.
(HD-R308-2004)

640.37 Restricting the Sale of Tobacco Products

The Minnesota Medical Association (MMA) will support the development of and lobby for local, county, and state legislation that would limit the sale of tobacco products to tobacco specialty stores; such activity, however, should be pursued as a strategy only after the more proven tobacco reduction strategies of a state-wide smoke free workplace (including bars and restaurants) and a tobacco tax increase have been implemented.

(BT-07/2005)

640.38 Adoption of Comprehensive Tobacco Cessation Benefits

The Minnesota Medical Association recommends that all payers provide comprehensive tobacco cessation benefits, including counseling and pharmaceutical therapies. The MMA shall disseminate this recommendation to its membership and advocate through its collaborative partnerships for its adoption by all Minnesota payers. The MMA commends the efforts of the Minnesota Cancer Alliance and will continue to collaborate with the Alliance in support of the above goals.

(HD-R303-2009)

640.39 Consequences of Smoking in Cars With Minors

The Minnesota Medical Association will continue to advocate to decrease secondhand smoke exposure among children, and will support educational efforts, and legislative efforts upon assessment by the MMA Board of Trustees, to reduce children's exposure to secondhand smoke in vehicles.

(HD-R312-2009)

640.4 Safe Schools Coalition and Support for Anti-Bullying Legislation

The Minnesota Medical Association will join the Safe Schools for All Coalition and supports legislation that would require school boards in Minnesota to adopt anti-bullying policies and provide staff training on preventing and responding to bullying.

(HD-R408-2010)

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)

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)

650.04 Tort Reform Legislation

The MMA supports Medical Alley's amendment to expand MICRA-type tort reform to apply to product liability cases involving medical devices and pharmaceuticals. (BT-4/95)

650.06 Medical Malpractice Legislation

The MMA will develop and, if necessary, bring forward a tort reform bill that would cap non-economic damages at \$250,000, include a sliding scale cap on attorney contingent fees, use periodic payments for large awards, include changes to joint and several liability provisions consistent with MMA policy, and provide equal access by the defense and the plaintiff to the physician experts. (HD-R406-1998)

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)

660 Uninsured/Underinsured

660.01 Economically Disadvantaged Patients

The MMA reaffirms the importance of physicians continuing to render care to all persons without primary regard to the individual's ability to pay. (HD-R9-1982; Retained 2004)

660.03 Health Care Needs for the Medically Indigent

The MMA recognizes the health care needs of the medically indigent and continues to support efforts to provide access to health care for this sector of our society. (HD-R15-1985; Retained 2004)

660.05 Health Insurance for the Uninsured

The MMA supports the concept of requiring employers to maintain adequate health insurance for their employees and dependents. Appropriate safeguards should be provided to protect against excessive hardship for marginal employers which might cause business failures and employee layoffs. The MMA believes there should be no interference with the physician's ability to make sound medical judgments regarding individual patients and that the doctor/patient relationship be preserved, and that the quality of health care shall not be compromised.

(HD-R16-1988; Retained 2004)

660.18 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 or 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 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, deterrents, and potentially misleading information provided in DTCA.
(BT-3/01)

660.19 Physicians Serving Uninsured/Underinsured

The Minnesota Medical Association will provide resources and information to physicians regarding the legal issues and options associated with reducing fees or waiving co-payments for uninsured and underinsured patients.

(HD-R302-2008)

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)

670.02 Receiving and Reimbursing Outpatient Psychiatric Treatment Based on Procedure

The MMA recommends increases in reimbursement for psychiatric services performed on an outpatient basis as denoted by procedure. The MMA also supports and endorses utilization and quality reviews performed by medical review agents for psychiatric outpatient treatment programming supervised by a psychiatrist, and encourages development of outpatient psychiatric treatment standards (including those for psychotherapy) to be used by medical review agents including the Department of Human Services in Minnesota.

(HD-R11-1985; Retained 2004)

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)

670.05 Utilization Review

The MMA believes insurance carriers should report medical providers who are outliers to the Department of Labor and Industry for peer review. The Medical Services Review Board may conduct reviews and/or conduct hearings regarding utilization and report findings to the Department of Labor and Industry for action.

(BT-1/91)

670.06 MMA Drug Utilization and Review Policy

The MMA adopts the following policy on drug utilization and review (DUR):

1. The MMA will establish a pro-active position and vigorous interaction in the development of a state DUR program;
2. The MMA will appoint an ad hoc committee to research the DUR issue and recommend to the MMA Board of Trustees plans for active participation in the DUR program;
3. Provide current Formulary Committee members with information on the DUR programs available on the market listing the pros and cons of each program;

Actively solicit the input, cooperation and involvement of MMA physicians who are interested in and have the ability to become actively involved in a state DUR program for Medicaid patients.

(BT-7/91; Retained 2004)

670.1 Patient Protection in Utilization Review of Psychotherapy Cases

The Minnesota Medical Association shall develop and advocate Minnesota state legislation prohibiting 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)

670.11 Utilization Review Reform Bill

The Minnesota Medical Association shall continue to support utilization review reform that would place:

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 2011)

670.12 High-Tech Imaging

The Minnesota Medical Association (MMA) will request that Minnesota health plans and DHS withdraw or suspend their high-tech imaging consultation/notification programs immediately; will urge all health plans and DHS to work collaboratively with the MMA and others to develop a community-wide, time-limited, minimally intrusive data collection effort; will urge Minnesota physicians to incorporate and use decision-support tools in their practices; and will communicate these approaches to MMA members.
(BT-1/07)

670.13 High-Tech Imaging

The Minnesota Medical Association (MMA) shall proceed with a 2007 legislative solution to address high-tech imaging prior authorization programs.
(BT-3/07)

670.14 Health Plan Accountability to Pay For Rx for Patients Awaiting Prior Authorization

The MMA shall work to hold health plans responsible for the timely implementation of medical therapies while the health plan processes prior authorization requests.
(HD-R209-2007)

670.15 Financial Burden of Pharmaceutical Prior Authorizations

The Minnesota Medical Association continues to support awareness among medical students, residents, and practicing physicians of those medications that provide the most value among available therapeutic options, and affirms that clinical decisions regarding medications are most appropriately made by the prescribing physician. The MMA opposes burdensome prior authorization requirements that negatively impact patient care or access to needed medications.
(HD-R207-2009)

680 Veterans

680.01 Veterans' Benefits

The MMA believes that the federal government should allow veterans to receive medical and surgical services in the local community as long as the total cost for the illness or surgical service is less than the cost would be to provide the same service at the Veterans Hospital.
(HD-R20-1981; Retained 2004)

680.02 Chiropractic Services to Minnesota Veterans Home Residents

The MMA opposes legislation that requires the state to provide spinal care services of a licensed chiropractor to residents of the Minnesota Veterans Home.
(BT-4/82)

690 Violence

690.01 Violence Free Society

The MMA will support and work toward achieving a Violence Free Society by the year 2010.
(HD-R28-1992; Retained 2004)

690.02 Domestic Violence and Abuse Campaign

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

690.05 Media Violence Campaign

The membership of the MMA strongly supports the MMA's "Stop the Violence" campaign. The MMA also encourages all physicians to instruct the parents of their pediatric patients on the "10 Tips on Media Violence" as prepared and distributed by the MMA.

(HD-R19-1995; Retained 2005)

690.1 Condemnation of Terrorist Actions on September 11, 2001

The MMA condemns the heinous acts against citizens from the United States and many other countries on September 11, 2001 and expresses its sincere and deepest sympathy to the many families who lost loved ones in the events occurring in New York, Washington, D.C. and Pennsylvania. Additionally, the MMA commends the bravery of the victims, their loved ones and the rescue workers and expresses its full support to the President and Congress of the United States of America and the international community in their efforts to bring justice to those responsible for these heinous acts and those who have supported them.

(HD-LR105-2001; Retained 2011)

690.11 Workplace Violence

The Minnesota Medical Association will continue to support raising awareness and reduce workplace violence.

(BT 07/09)

700 Vital Statistics

700.01 Vital Statistics Information

The MMA will work with Department of Health representatives to communicate the MMA's concern that the automated Vital Statistics system retain the physician signature on the original birth and death certificates and copies of birth and death certificates, if retention of the signature on copies is economically feasible.

(HD-R24-1994)

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)

710 Vulnerable Adult Maltreatment

710.01 Prevention of Abuse of Adults in Institutions and Facilities

The MMA conceptually supports legislation requiring reports of physical or sexual abuse or willful neglect of persons who are vulnerable to abuse and neglect in institutions and licensed facilities (hospitals, nursing homes, day care or residential facilities and adult halfway houses). The legislation also requires hearing arts, social services, hospital services, hospital administration, psychological or psychiatric treatment, education, law enforcement professionals, and their employees to report abuse or neglect of adults to local law enforcement agencies who are to notify local welfare agencies.

(BT-3/80; Retained 2004)

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)

730 Reimbursement for Workers' Compensation Cases

The Minnesota Medical Association will actively oppose any further reductions in the workers' compensation fee schedule for physicians, and will oppose proposals by certified managed care organizations to lower physician compensation for treating patients covered under workers' compensation. The MMA will work to better understand and communicate to its membership the implications of managed care negotiating the workers' compensation fee schedule, and the MMA will actively work to prevent the commissioner of the Department of Labor and Industry from implementing new rules through regulation instead of legislation. (HD-R213-2004)

730 Workers' Compensation

730.01 Timely Return to Work After Disability or Illness

Minnesota physicians should pursue efforts to communicate with insurance companies, personnel managers and appropriate supervisors, to ensure that recovered employees have a timely return to suitable work. The MMA will promote and support continuing medical education programs to assure physician understanding of the workers' compensation system.

(HD-R1-1983; Retained 2004)

730.02 Injuries Not Included in the Disability Rating Schedule

The MMA believes that any case involving an injury not included in the disability rating schedule be referred to the Medical Services Review Board for a rating.

(BT-1/91)

730.03 Physician Enrollment

The MMA encourages the Minnesota Department of Labor and Industry to enroll all licensed practitioners in order to carry out education and monitoring of programs of licensed practitioners within the workers' compensation system and to establish a provider ID number for each practitioner, with the provision that the provider shall be able to opt out of the program.

(BT-1/91)

730.04 Fee Schedules

The MMA supports the following policies regarding fee schedules in workers' compensation:

1. MMA supports the implementation of a RVS Fee Schedule with the understanding that no study demonstrates that RVS controls utilization;
2. In the interim of RVS there should be no reduction of fees and if the interim goes beyond one year, there will be an appropriate increase of fees until RVS is in place;
3. Any conversion factor used in the implementation of a fee schedule should be based on the Medicare Economic Index (MEI);
4. The Minnesota Commissioner of Labor and Industry should make the decision on the implementation of a state-wide conversion factor in consultation with the Medical Services Review Board;
5. The Minnesota Department of Labor and Industry should establish a fee schedule for providing depositions and medical records required by the workers' compensation system of medical providers; and
6. Diagnostic and therapeutic procedures, not established as medically effective, should be excluded from the fee schedule until such time as the Medical Services Review Board (MSRB) reviews and approves the procedure.

(BT-1/91; Retained 2004)

730.05 Use of Qualified Rehabilitation Counselor

The medical provider should be allowed to request, in addition to the employee, employer, and the Commissioner, a Qualified Rehabilitation Counselor at any time after treatment commences in order to facilitate the earlier return of the patient to gainful employment.

(BT-1/91)

730.07 Employer/Employee Choice of Physician

The MMA believes that the employee should be allowed to have the first choice to select a treating practitioner in the workers' compensation program.

(BT-1/91; Retained 2004)

730.08 Penalty for Deviation from Workers' Compensation Rule

The MMA strongly opposes provisions in the workers' compensation rules and legislation that provide for criminal penalties on physicians who deviate from the compensation and treatment guidelines included in the rules.

(BT-7/93; Retained 2004)

730.1 Reimbursement for Workers' Compensation Cases

The Minnesota Medical Association will actively oppose any further reductions in the workers' compensation fee schedule for physicians, and will oppose proposals by certified managed care organizations to lower physician compensation for treating patients covered under workers' compensation. The MMA will work to better understand and communicate to its membership the implications of managed care negotiating the workers' compensation fee schedule, and the MMA will actively work to prevent the commissioner of the Department of Labor and Industry from implementing new rules through regulation instead of legislation.

(HD-R213-2004)