MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

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2018 HOUSE OF DELEGATES RESOLUTIONS

The following resolutions have been submitted for consideration at the MAFP 2018 House of Delegates. They may not be current MAFP policy and will be discussed and voted on by delegates on April 11, 2018. If you have any questions, please contact the MAFP office.

Access to Dental Care for All

Submitted by Lisa S. Prusak, MD

WHEREAS, for traditional dental offices and solo practitioners operating a small business, the return from Medicaid is so low that it doesn't pay for them to offer their services to everyone in their communities, even children;

WHEREAS, in Minnesota, Medicaid reimburses 31.1 percent on every dollar charged, according to figures from the American Dental Association, the lowest in the nation;

WHEREAS, hospital emergency rooms, urgent care centers and medical offices have become the de facto dental offices of the underinsured and uninsured;

WHEREAS, the confluence of few providers to serve what is a growing roster of Medicaid-enrolled children has created what is described within the industry and state health departments as an "access to care" issue;

BE IT RESOLVED that the MAFP will work together with the state legislature and state dental associations to make dental care more universally available to the uninsured and underinsured as for those with insurance and the ability to pay for service;

BE IT FURTHER RESOLVED that the MAFP will assist the legislature and dental organizations with policy reform to improve access to dental providers by identifying barriers and subsequently proposing solutions.

References and Supporting Information

http://www.duluthnewstribune.com/news/4412476-those-medicaid-it-can-be-struggle-find-dental-care-twin-ports

Crisis of Neglect and Abuse in the Assisted Living and Nursing Home Facilities in Minnesota

Submitted by Jamie Peters

WHEREAS, elder abuse is intolerable and an affront to human rights;

WHEREAS, the Office of Health Facility Complaints (OHFC) has reported a 600% increase in maltreatment reports since 2010 and an ability to investigate on 1% of the 24,791 reports from providers and 10% of the 3,491 reports from individuals; further, there has been clear documentation of dysfunction in the processing of complaints at the Minnesota Department of Health as documented in a Minnesota auditors report released in March of 2018;

WHEREAS, assisted Living facilities (including memory care units) in Minnesota are minimally regulated and do not require licensing and there has been clear documentation of ongoing elderly neglect and abuse in many of these facilities as described in the five-part *Star Tribune* article "Left to Suffer" published in November 2017; many of the cases involved poorly trained or inadequate number of staff in the facilities for the level of needs required by these residents (currently 60,000 in assisted living and 28,000 residents in nursing homes in Minnesota);

WHEREAS, the number of new assisted living facilities (most are self pay funded) is increasing rapidly due to accelerating needs; also, the ongoing boom in building these assisted living facilities is fed by investment sector appreciation of these facilities for their high return on investment dollars;

WHEREAS, with inadequate staff training and numbers compounded by a workforce shortage in this segment, the risk to our elderly in these facilities will only worsen until active steps and controls are put in place to improve these issues;

WHEREAS, there is bipartisan support in the Minnesota legislature this session to address this issue;

BE IT RESOLVED that the MAFP board develop a letter addressed to the involved state legislators and appropriate legislative committees to express our extreme concern and the urgent need for action in this session. This letter should also include the need for MAFP selected physician(s) with geriatric care skills to provide input at legislative groups developing solutions;

BE IT FURTHER RESOLVED that the MAFP sponsor forward a resolution to be presented at the annual Minnesota Medical Association (MMA) meeting this fall urging MMA to review and support appropriate remedies to address these issues.

Free Market Pharmacy Reform

Submitted by Robert Koshnick, MD

WHEREAS, in 2015, we spent $3.21 trillion on health care in our country;

WHEREAS, pharmacy costs have become the number one expense in health care as of 2014 according to the America's Health Insurance plans, with 22.1% spent on prescription drugs;

WHEREAS, the IMS Institute for Healthcare Informatics reported that Americans spent $374 billion dollars in 2014 on prescription drugs, up 13.1% from the year before;

WHEREAS, pharmaceutical drugs are the fastest rising health care costs in our country;

WHEREAS, we pay more than twice as much per capita as the rest of the industrialized world for our drugs;

WHEREAS, the primary driver of costs are government-protected monopolies to drug manufacturers combined with government required drug coverage benefits;

WHEREAS, the government precludes meaningful price negotiation by government payers;

WHEREAS, the pharmaceutical companies have spent $3,591,651,507 dollars on lobbying between 1998 and 2017 to keep the monopolistic laws in place and have four lobbyists for every congressman and senator elected to our US Congress;

WHEREAS, we do not have a free market in place for pharmaceutical drugs in our country;

BE IT RESOLVED that, to reduce drug costs, the MAFP and the AAFP support the concept that unscheduled drugs approved by the FDA should be available for people at the age of license to buy over the counter after their patents run out.

Gun Violence

Submitted by Drs. Christopher Reif, Roli Dwivedi, Karen Jankowski, Andrea Westby

WHEREAS, the gun violence epidemic continues to inflict random mass killings of our citizens and children;

WHEREAS, the American Academy of Family Medicine has called for measures to reduce gun violence, including:

1. Label this violence caused by the use of guns a national public health epidemic.
2. Fund appropriate research at the Centers for Disease Control and Prevention (CDC) as part of the FY 2018 omnibus spending package.
3. Establish constitutionally appropriate restrictions on the manufacturing and sale, for civilian use, of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity;

WHEREAS, the Minnesota Medical Association (MMA) has also identified gun violence as significant risk to public health and issued a call to action:

> MMA Statement on Gun Violence (March 2018)
>
> Gun violence and firearm-related accidents kill more than 30,000 Americans each year. In Minnesota, there were more than 400 firearm-related deaths in 2016. The recent and relentless mass shootings, as well as the daily toll associated with gun violence and accidents, demand a response.
>
> The Minnesota Medical Association (MMA) considers gun violence a public health crisis and calls on policymakers at the state and national levels to step up and protect our health and safety. The MMA supports common-sense changes to gun laws that will promote safe and responsible gun ownership, including criminal background checks on all purchases and transfers/exchanges of firearms; enforcement of laws that will hold sellers accountable when they sell firearms to prohibited purchasers; investment in improved data collection, analysis, and research on firearm injury prevention; and, a renewal and strengthening of the assault weapons ban, including banning high-capacity magazines.
>
> The MMA also renews its call for improved access to and coverage of comprehensive mental health services. Most individuals with mental illness are not violent. It is important, however, to encourage and support the identification of individuals at risk for violence or self harm. Physicians and other health care providers also have a responsibility to talk to patients about responsible firearm ownership and safe storage in the home.
>
> Few threats to our health and safety can be eliminated, but failure to intervene in the face of this significant epidemic is not an option;

BE IT RESOLVED that the MAFP endorse the MMA call to action on gun violence and join other professional and community organizations in educating and advocating to implement the proposed policy changes. The MAFP will continue to speak out and advocate on this important public effort to protect our citizens. Such advocacy and educational efforts will be offered to our members, public leaders, citizen groups, policy makers, and opinion leaders.

References and Supporting Information

https://mafp.org/resource/resmgr/files/Advocacy/MAFPReleaseGunViolence031218.pdf

Health Care Payment Reform

Submitted by Robert Koshnick, MD

WHEREAS, it is important to improve the coordination and efficiency of health care;

WHEREAS, a continuous healing relationship between a primary care provider and patients is the essence of effective health care;

WHEREAS, every patient should have an identified personal primary care provider that they can access as the best health care systems are primary care-based;

WHEREAS, payment systems need to be transparent and understandable and effective health care reform will require payment reform;

WHEREAS, the AAFP in "Health Care for All" outlined services that should have no financial barriers (co-payments);

WHEREAS, prenatal care, well-child care, immunizations, basic mental health care, evidence-based preventive services, chronic care management, and chronic care management are identified as those services;

WHEREAS, direct primary care is defined as care provided by primary care providers that charge a periodic fee but does not bill any third parties on a fee for service basis and eliminates the third-party expenses associated with insurance and government programs;

WHEREAS, direct primary care is a medical expense that should be covered by health savings accounts to incentivize better health care behavior and cost consciousness;

WHEREAS, direct primary care could transform American medicine into a more efficient primary care based personal health care system;

WHEREAS, tax credits for direct primary care could ignite the expansion of the concept;

BE IT RESOLVED that the MAFP and the AAFP ask the government to give a medical tax credit for U.S. citizens buying direct primary care to transform American medical care into a more efficient primary care based personal health care system.

Health Equity

Submitted by Drs. Christopher Reif, Roli Dwivedi, Karen Jankowski, Andrea Westby

WHEREAS, the MDH 2014 report "Advancing Health Equity in Minnesota", identified large inequities in health outcomes based on race, nationality, sexual orientation;

WHEREAS, family physicians are active in all Minnesota communities taking care of our diverse people and families, the MAFP is positioned to lead the primary care effort for health equity across the state;

WHEREAS, nationally, the AAFP has identified health equity as a key component of the "Health is Primary" campaign and the AAFP sponsors a Task Force in Health Equity that focuses on Social Determinants of Health, Vulnerable Populations, Economics and Policy, and Accountability;

BE IT RESOLVED that the MAFP establish a Minnesota Health Equity Task Force to work with our national colleagues and to collaborate with our local professional and community organizations to advance health equity in primary care and in our communities and that the MAFP will engage students, residents, practicing and retired Family Physicians to do the ongoing work of this task force for health equity;

BE IT FURTHER RESOLVED that the MAFP offer Health Equity & Advocacy learning opportunities at our educational forums such as the Spring Refresher.

References and Supporting Information

http://fmahealth.wpengine.com/health-equity-cross-tactic-team/#1505047121139-e28b9f97-4526

Incorporating Information on Physician Wellbeing in the MAFP Website

Submitted by Lauren Williams, MD, Resident member; Abigail Solom, Student member; Emma Erickson, MD, Resident member; Michelle Karsten, MD, Active member

WHEREAS, the MAFP mission includes "support[ing] family physicians as they provide high quality, comprehensive and continuous medical care for patients of all ages" [1];

WHEREAS, burnout "[is] a psychological syndrome in response to chronic interpersonal stressors on the job. The three key dimensions of this response are an overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment" [2];

WHEREAS, family physicians suffer from significantly higher rates of burnout than physicians in most other specialties, with nearly two-thirds of family physicians experiencing at least one element of burnout [3] [4];

WHEREAS, the MAFP website provides a central hub where family medicine physicians in the state can access information and resources relevant to the organization's mission;

WHEREAS, the AAFP has recognized the importance of promoting physician well-being and has developed a Physician Health First portal to disseminate well-being resources [5];

WHEREAS, there are many resources already in place to combat increasing rates of physician suicide, but it may be difficult for physicians already struggling to know where to turn for support [6];

BE IT RESOLVED that the MAFP dedicate a section of its website to information about physician well-being. This should include but would not be limited to links to available state and national resources for promotion of physician wellbeing and prevention of burnout as well as recommendations of where to seek immediate help for physicians already struggling with burnout.

References and Supporting Information

Fiscal Note: limited fiscal impact. Most significant impact is the coding/IT to create this new section of the webpage as well as the staff time to compile appropriate available resources.

[1] https://mafp.org/about

[2] Maslach C, Schaufeli WB, Leiter MP. Job burnout. Annu Rev Psychol. 2001;52:397-422.

[3] Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clin Proc. 2015;90(12):1600-1613.

[4] Medscape Lifestyle Report 2017.

[5] https://www.aafp.org/membership/benefits/physician-health-first.html

[6] https://afsp.org/our-work/education/physician-medical-student-depression-suicide-prevention/

Increase Percentage of Women's Reproductive Health Topics at MAFP Conferences, AAFP FMX and at the National Conference for Residents and Students

Submitted by Nicole Chaisson, MD, MPH

WHEREAS, the AAFP affirms it is essential that family physicians be well trained to provide "comprehensive, continuing care of women throughout their lifecycle" [1];

WHEREAS, the AAFP "supports a woman's access to reproductive health services and opposes non-evidence based restrictions on medical and the provision of such services" [2];

WHEREAS, in order to maintain qualification and a broad scope of practice, family physicians must continue learning throughout their careers so they might provide patients with up-to-date and evidence-based care throughout their lifecycle;

WHEREAS, an estimated 17.9 percent of outpatient visits are by women of reproductive age, with preconception or contraceptive counseling integral aspects of these visits [3];

WHEREAS, in order to recruit new members, the MAFP and the AAFP want to appeal to family medicine residents, 54 percent of whom are female and tend to see majority female patients;

WHEREAS, funding for Planned Parenthood and Title X clinics is at risk, shifting care to Federally Qualified Health Clinics, which tend to be family physician-led, requiring a well-prepared work-force to meet the increased demand of reproductive health needs of patients [5];

WHEREAS, for the 2018 Family Medicine Experience FMX, the Curriculum Advisory Panel (CAP) has weighted women's reproductive health topics at four percent;

WHEREAS, at the 2018 MAFP Spring Refresher, there are no presentations focusing on women's health or reproductive health;

WHEREAS, family medicine residents and students have requested more reproductive health care and women's health care at their national conference, passing resolutions and filling out conference evaluations;

BE IT RESOLVED that the MAFP will seek to increase the number of women's reproductive health topics at future MAFP conferences;

BE IT FURTHER RESOLVED that the MAFP will advocate through the American Academy of Family Physicians to the Family Medicine Experience (FMX) Curriculum Advisory Panel (CAP) to increase the weight of women's reproductive health topics at future FMX events and remove the four percent cap;

BE IT FURTHER RESOLVED that the MAFP via its delegation will submit a resolution to the American Academy of Family Physicians (AAFP) calling on the AAFP to increase the representation of women's reproductive health topics among future AAFP CME events.

References and Supporting Information

[1] American Academy of Family Physicians. Reproductive Health Services (COD 2014). http://www.aafp.org/about/policies/all/reproductivehealth-services.html. November 1, 2017.

[2] American Academy of Family Physicians. Women's Healthcare, Family Physician Providing (2015 COD). http://www.aafp.org/about/policies/all/womens-health-care.html. November 1, 2017

[3] Institute of Medicine. Clinical preventive services for women: closing the gaps. Washington, DC: The National Academies Press; 2011.

[4] American Academy of Family Physicians. Table 2: Demographic Characteristics of AAFP Members. https://www.aafp.org/about/the-aafp/family-medicine-facts/table-2.html. December 19, 2017.

[5] Frost, Jennifer. Response to Inquiry Concerning Geographic Service Availability From Planned Parenthood Health Centers. https://www.guttmacher.org/sites/default/files/pdfs/pubs/guttmacher-cbo-memo-2015.pdf. December 13, 2017.

Insuring Access to Long Term Primary Care Physicians and Providers that Are Certified Health Care Homes

Submitted by Deborah Dittberner, MD and the Park Region Chapter

WHEREAS, many health care systems and clinics have undergone the strenuous certification process to become certified Health Care Homes through the Minnesota Department of Health (MDH) to promote the Triple Aim of Health Care and care coordination for the most complex patients;

WHEREAS, Certified Health Care Homes (HCH) put patients first. They have been a proven vehicle for health care savings and improved quality. In February 2016 a University of Minnesota study revealed a $1 billion savings in Medicaid and Medicare in our state AND clinics participating in a HCH model of care outperformed other clinics on quality measures;

WHEREAS, the creation of "narrow networks" by insurance/third party payers has caused interruption of primary care and put patients at risk. Patients have been forced by narrow networks to leave a certified health care home and trusted physician after years of complex care;

BE IT RESOLVED that the MAFP makes it a priority to support legislation that will NOT ALLOW a health plan to deny a primary care provider/clinic the right to contract with the health plan company as an in-network provider (part of the narrow network) if the primary care provider/clinic is certified as a Health Care Home (HCH) by the Minnesota Department of Health (MDH) or in the process of certifying to become an HCH through the MDH.

References and Supporting Information

http://www.health.state.mn.us/news/pressrel/2016/hchomes020916.html

MAFP Bylaws Update

Submitted by Board of Directors

WHEREAS, there have been six strategic discussions over the past three years by the MAFP Board of Directors regarding the makeup of the board, as well as the convening of a Bylaws Work Group that met twice this year to discuss proposed changes;

WHEREAS, the MAFP 2015-2017 Strategic Plan included a goal to streamline and modernize its governance structure;

WHEREAS, the MAFP leadership has discussed similar board re-organization strategies with several other AAFP state chapters and related organizations who have successfully made similar transitions,

WHEREAS, to create a strong and effective board, the AAFP urges state chapters to ensure both demographic and geographic representation of its membership in leadership roles;

WHEREAS, the proposed board representation changes are in alignment with the Principles & Practices for Nonprofit Excellence developed by the Minnesota Council of Nonprofits;

WHEREAS, updates are needed to comply with Minnesota State Statue 317A;

WHEREAS, for the past several years, the MAFP has had unfilled positions on the board, thereby limiting the board's overall effectiveness to advocate on behalf of our members and patients;

BE IT RESOLVED that the MAFP Bylaws be amended as shown by tracked changes in the attached draft.
Executive summary: https://mafp.org/resource/resmgr/files/hod/MAFP_ExecutiveSummary2018.pdf
Bylaws draft: https://mafp.org/resource/resmgr/files/hod/MAFP_Bylaws_EditedJB20180321.pdf

References and Supporting Information

http://www.minnesotanonprofits.org/PrinciplesPractices.pdf

MAFP Support of Opiate Stewardship Program Established, Report Required and Money Appropriated

Submitted by Deborah Dittberner, MD and the Park Region Chapter

WHEREAS, the state of Minnesota is facing an opioid crisis. In 2016, 395 Minnesotans lost their lives to opioid overdoses, an 18 percent increase from 2015. Since 2000, opioid overdoses in Minnesota have skyrocketed by 1000 percent and deaths have grown by 600 percent;

WHEREAS, full spectrum care and healing of the patients suffering in this crisis requires tremendous, care time and team support. This is a substantial cost and time burden to our communities and within our primary care practices. Prevention and public education is equally important and needed urgently;

WHEREAS, legislation has been introduced to the Minnesota House by Representative Dave Baker of Willmar that would support a penny per pill tax on opioids, public education and stewardship programs for our communities;

BE IT RESOLVED that the MAFP makes it a priority to actively advocate to identify funding streams to address the opioid crisis.

References and Supporting Information

https://www.twincities.com/opioidcrisis/

House Version, HF 1440:
https://www.revisor.mn.gov/bills/text.php?number=HF1440&version=latest&session=ls90&session_year=2017&session_number=0

Senate Version, SF 730:
https://www.revisor.mn.gov/bills/text.php?number=SF0730&session=ls90&version=latest&session_number=0&session_year=2017

MAFP Support to Expand the Number of Refills Allowable in the State of Minnesota to Allow Synchronized Prescription Renewal as a Means to Improved Family Physician Efficiency and Resilience in Outpatient Practice

Submitted by Deborah Dittberner, MD, Emma Erickson, MD and the Park Region Chapter

WHEREAS, the second-year survey (2017) of Physicians and Advanced Practice Providers by the Minnesota Hospital Association revealed continued high burnout rates (higher among physicians, and highest among Family Physicians doing outpatient care;

WHEREAS, family physician resiliency and avoidance of burnout has been linked to efficiencies in medical practice and proficient use of the electronic medical record;

WHEREAS, the American Medical Association (AMA) has created a STEPSforward program that advocates Synchronized Prescription Renewal at the point of care to improve physician resiliency and efficiency which can save 30 minutes of physician time per day and 30 minutes of nursing time per day (based on 1000 patients with chronic stable medical problems on a physician panel; approximate cost savings in one year =$26,400);

WHEREAS, this implementation of this easy practice efficiency would require refilling chronic stable prescriptions for greater than 365 days because most third-party payers, including Medicare, will not allow annual wellness visits (AWV), which is the best point of care opportunity to refill chronic, stable prescriptions, to be less than 365 days, or less than one year from the last AWV;

WHEREAS, refills of chronic, non-controlled prescriptions in Minnesota are limited to 365 days. Current Minnesota Administrative Rules Chapter 6800.2510 of the Board of pharmacy states the following: “NO prescription drug order may be filled or refilled more than 12 months after the date on which it was issued. Refills originally authorized in excess of 12 months are void 12 months after the original date of issuance of the prescription drug order. After 12 months from the date of issuance of a prescription drug order, no additional authorizations may be accepted for that prescription drug order. If the prescribe desires continued therapy, a new prescription drug order must be generated, and a new prescription number assigned.”;

WHEREAS, refills of chronic, non-controlled prescriptions in the state of Iowa are allowed for 18 months. The physician author/champion from the AMA of Synchronized Prescription Renewal practices outpatient medicine in Ames, Iowa. She recommends state legislation to allow refill practices similar to the Iowa Board of Pharmacy. Current Iowa Administrative Code - Board of Pharmacy, Rule 155A.29 Prescription Refills states the following: “A prescription for any prescription drug or device which is not a controlled substance shall not be filled more refilled more than eighteen months after the date on which the prescription was issued and prescription which is authorized to be refilled shall not be refilled more than twelve times.”;

BE IT RESOLVED that the MAFP makes it a priority in 2018 to work with the Minnesota Board of Pharmacy to change the Administrative Rule that limits chronic, non-controlled prescriptions to 365 days and expand the Minnesota refill rules to 18 months; similar to the state of Iowa.

References and Supporting Information

https://www.sciencedirect.com/science/article/pii/S2213058617300463

https://www.stepsforward.org/modules/synchronized-prescription-renewal

MAFP to Join in Support of an Organization Working on Establishing Minnesota's First Breast Milk Bank

Submitted by Angela Smithson, MD

WHEREAS, more than 5,000 babies are born in Minnesota annually either prematurely or ill and may require human donor milk. WHEREAS, Minnesota currently receives an inadequate supply from the closest breast milk banks in Iowa or Colorado;

WHEREAS, the biggest predictor in stopping breastfeeding before three months in Minnesota is hospital formula supplementation;

WHEREAS, pasteurized donor milk for premature and high-risk infants has been shown to reduce the incidence of necrotizing enterocolitis, sepsis, and infection, resulting in shorter hospital stays;

WHEREAS, Minnesota WIC breastfeeding initiation is approaching the Healthy People (HP) 2020 objective of 81.9%;

WHEREAS, since national directives encourage hospitals to provide donor milk and research shows the benefits of breast milk for all babies, it becomes even more important that Minnesota establishes a milk bank;

WHEREAS, national directives encourage hospitals to provide donor milk and research shows the benefits of breast milk for all babies, it becomes even more important that Minnesota establishes a milk bank;

BE IT RESOLVED that the MAFP provide a letter of support to the organization working on establishing a human breast milk bank in Minnesota.

References and Supporting Information

http://www.breastmilkforbabies.org/letter-of-support/

Office-based Treatment of Opioid Use Disorder

Submitted by West Metro Chapter

WHEREAS, more than 15,000 people die each year from opioid abuse, including 376 Minnesotans in 2016 [1];

WHEREAS, there is substantial, strong, and reproducible evidence in randomized clinical trials and well-designed observational studies that medications for treatment of opioid use disorder improve mortality, reduce opioid use, reduce infectious risks, reduce incarcerations, and improve birth outcomes [2];

WHEREAS, under the Drug Addiction Treatment Act of 2000 (DATA 2000), qualified U.S. physicians can offer buprenorphine for opioid dependency in various settings, including in an office, community hospital, health department, or correctional facility [3];

WHEREAS, just over 4 percent of physicians in the U.S. have gone through the training process that enables them to prescribe buprenorphine [4];

BE IT RESOLVED that the MAFP provide a clinical education session at the 2018 "Destination CME" that address office-based treatment of opioid use disorder

BE IT FURTHER RESOLVED that the MAFP provide a clinical education session at the 2019 "Spring Refresher" that address office-based treatment of opioid use disorder

BE IT FURTHER RESOLVED that the MAFP provide members information about the eight-hour buprenorphine waiver training courses that are required for physicians to prescribe buprenorphine.

References and Supporting Information

[1] Minnesota is taking opioid abuse seriously. *Minneapolis Star Tribune*. Editorial Board. December 18, 2017. http://www.startribune.com/minnesota-is-taking-opioid-abuse-seriously/465051483/ accessed 03/08/2018.

[2] Volkow ND, Frieden TR, Hyde PS, Chu SS. Medication-assisted therapies - tackling the opioid-overdose epidemic. N Engl J Med. 2014;370(22):2063-6.

[3] Buprenorphine. SAMHSA Website. https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine accessed 03/08/2018.

[4] Hostetter M and Klein S. In focus: Expanding Access to Addiction Treatment Through Primary Care. Transforming Care. September 28, 2017. http://www.commonwealthfund.org/publications/newsletters/transforming-care/2017/september accessed 03/08/2018.

Petitioning

Submitted by Robert Koshnick, MD

WHEREAS, petitioning is an activity;

BE IT RESOLVED that the MAFP no longer uses passive “opt out” memberships lists on petitions.

Preventing Gun Violence in Minnesota

Submitted by Nancy Baker MD & East Metro Chapter

WHEREAS, in the United States, firearm-related injuries, including suicides, homicides and accidental shootings, killed 38,700 people in 2016, according to the Center for Disease Control and Prevention (CDC), up from 33,600 in 2014 [1];

WHEREAS, the AAFP's policy on firearms safety states, "The AAFP recognizes firearm-related deaths, injury and violence as a significant public health problem [2];

WHEREAS, AAFP policy is on record as supporting increased research into all areas of how gun violence affects public health, including but not limited to, research into the epidemiology, prevention, safety and risks related to gun violence in the United States [2];

WHEREAS, research on gun violence has demonstrated that access to firearms results in a direct increase in conflict-related deaths and injuries, and increases the risk of serious unintentional injury and death;

WHEREAS, the federal assault weapons ban which prohibited the sale and manufacture expired in 2004 has not been renewed and research at the CDC on the impact of gun violence was prohibited by the federal Dickey Amendment in 1996;

WHEREAS, there have been several high-profile mass shootings in the United States, including those at Columbine High School (Colorado), Virginia Tech, Tucson, Aurora (Colorado), Oak Creek (Wisconsin), Newtown (Connecticut), Las Vegas and now Parkland (Florida), in which high capacity magazines and use of an automatic weapon resulted in significant loss of life;

WHEREAS, from 2010-2014 there were an average of 922 deaths and injuries per year from firearms in Minnesota and the direct cost of fatal and nonfatal firearm injuries in Minnesota to employers is estimated to be $4.5 million/year [3];

WHEREAS, support for the US Constitution's 2nd amendment right of law-abiding citizens to bear arms goes hand in hand with keeping guns away from dangerous people;

BE IT RESOLVED that the MAFP support proposed legislation in Minnesota that requires the following: 1. Universal background checks and licensing restrictions for all gun sales, not just those purchased from a federally licensed gun dealer but including those sold at gun shows, at flea markets or purchased on-line; 2. Enforces an age limit of 21 years on the ability of any individual to purchase a firearm; 3. Allows law enforcement and family members to keep guns out of the hands of individuals with protective orders and who are considered a danger to others, or themselves; 4. Prohibits the sale of military-style assault weapons such as semiautomatic rifles and pistols, along with high-capacity magazines, typically defined as cartridges which hold more than 10 rounds of ammunition at a time; 5. Prohibits the manufacture and sale of bump stocks, or other mechanisms that can turn a semi-automatic weapon into an automatic firearm;

BE IT FURTHER RESOLVED that the MAFP delegation to the AAFP House of Delegates work with the AAFP leadership to champion the federal re-authorization of research on the causes and impact of gun violence on the health and well-being of children and adults in this country.

References and Supporting Information

[1] "How Strictly are guns regulated where you live?" by Shapiro, et. al. Washington Post, updated Feb 20, 2018. State-by-state firearm law data comes from the Boston University School of Public Health State Firearm Law database. https://www.washingtonpost.com/graphics/2017/national/assault-weapons-laws/?utm_term=.e791155d396d

[2] 2014 AAFP COD actions

[3] "Report: Gun violence costs Minnesota $764 million annually" by Zamora, Star Tribune, Dec 1, 2016. From a report by the Minnesota Coalition for Common Sense. http://www.startribune.com/report-gun-violence-costs-minnesota-764-million-annually/404057036/

Prior Authorization Alternative Medication Ranking

Submitted by Glenn Nemec, MD

WHEREAS, it is well established that prior authorizations delay medical care for patients and cost medical practices large amounts of time and money;

WHEREAS, the goal of both the physician and the insurance company/pharmacy benefit manager (PBM) is to have the patient use the medication that will cost the least to the patient and also be effective;

WHEREAS, insurance companies and PBMs have the cost information for each patient and physician offices do not;

WHEREAS, in most cases of non-covered medications, there are no significant differences in clinical effectiveness between the available medicines and sound medical decisions can be made on the basis of patient cost;

BE IT RESOLVED that the MAFP join with other interested parties to create legislation requiring insurance companies and pharmacy benefit managers (PBMs) to provide the following information that must accompany the notice that a requested medication is not covered by the patient's insurance: 1. the exact reason that the medication is not covered or requires a prior authorization; 2. a list of medications of the same class or type that are covered or do not require a prior authorization, preferably ranked from least out of pocket expense to most out of pocket expense.

References and Supporting Information

If insurance companies are serious about wanting patients on the medication that is least expensive for the patient, then physicians and insurance companies share a common goal. Since the insurance companies have the information and providers do not, it is in both of our best interests to have that information provided as soon as possible after a determination of non-coverage has been made. There are no legitimate arguments that industry can make against such legislation and the legislation has the benefit of having a very narrow focus and thus low likelihood of unintended negative effects.

PROTECT MINNESOTA: 2018 Model Resolution

Submitted by Pat Fontaine

WHEREAS, gun violence is an increasing public health crisis in our state and nation;

WHEREAS, gun violence takes the lives of over 37,000 Americans every year [1];

WHEREAS, gun violence is the third leading cause of death of children and youth in America, the second leading cause of death of all male youth and the first leading cause of death of African American male youth [2];

WHEREAS, 2-3 times as many toddlers as police officers die of gun violence every year in America [3] and toddlers with guns kill more Americans every year than foreign terrorists do [4];

WHEREAS, women in the U.S. are 16 times more likely to be killed with a gun than women in other high-income countries, making America the most dangerous country in the developed world when it comes to gun violence against women [5];

WHEREAS, gun violence claims the lives of more than 425 people every year in Minnesota, devastates the lives of over 500 others who are wounded but not killed [6], costs the state over $764 million in measurable expenses [7] and 77% of gun deaths in Minnesota are suicides [8];

WHEREAS, in 2016, there were 376 opioid deaths [9] in Minnesota and 392 traffic fatalities [10], compared to 432 gun deaths [11];

WHEREAS, many of these lives could be saved by passing common sense laws that would prevent gun violence without taking away the Second Amendment rights of responsible gun owners [12];

WHEREAS, public health studies have repeatedly shown that states with the strongest gun laws have the lowest rates of gun death in all forms, and states with the weakest gun laws have the highest rates of gun death in all forms [13];

WHEREAS, Minnesotans, including hunters and other gun owners, overwhelmingly support keeping guns out of the hands of those who represent a danger to themselves or others [14];

BE IT RESOLVED that the MAFP commits to saving lives by supporting common sense gun violence prevention measures, including but not limited to: passing Universal Criminal Background Check and Gun Violence Protection Order bills; making state funds available for trauma-informed gun violence prevention programs; removing prohibitions in current state law against the collection of gun-related data for the purpose of public health research;

BE IT FURTHER RESOLVED that the MAFP commits to blocking any and all attempts to weaken Minnesota's gun laws and stand opposed to dangerous gun bills, including but not limited to Stand Your Ground, Permitless Carry, Lifetime Permit to Carry, Campus Carry, and the repeal of gun-free school zones.

References and Supporting Information

[1] Gun Violence Archive, http://www.gunviolencearchive.org/past-tolls. *TIME*, "Gun-Related Deaths in America Keep Going Up," by Maya Rhodan, November 6, 2017.

[2] Minião, 2010; Webster, Whitehill, Vernick, & Curriero, 2012. As reported in "Gun Violence: Prediction, Prevention and Policy," American Psychiatric Association, by Eric Mankowski

[3] Mindy Fischer, Writer. Posted October 24, 2015. Using 2013 data from the FBI and CDC.

[4] 11/29/2015 08:46 am ET Updated Nov 25, 2016 "Toddlers Involved in More Shootings Than Terrorists in 2015" by Benjamin Powers.

[5] Grinshteyn, E., & Hemenway, D. (2016). Violent death rates: the US compared with other high-income OECD countries, 2010. *The American journal of medicine*, 129(3), 266-273.

[6] Minnesota Department of Health

[7] "The Economic Cost of Gun Violence in Minnesota," Americans for Responsible Solutions, December 1, 2017.

[8] Minnesota Department of Health

[9] MPR report on opioid deaths, by Jon Collins, September 7, 2017.

[10] Minnesota traffic deaths in 2017 were the lowest since 1943, by Pat Pheifer. *Star Tribune*, January 3, 2018.

[11] Minnesota Department of Health report on gun deaths.

[12] and [13] Giffords Law Center to Prevent Gun Violence. http://lawcenter.giffords.org/facts/research

[14] Americans for Responsible Solutions. http://americansforresponsiblesolutions.org/files/2016/04/Polling-Memo-1.pdf.

Protect the Future of Family Physicians and Our Patients

Submitted by Julie Anderson, MD

WHEREAS, since 2012, nurse practitioners (NPs) no longer require a collaborative agreement to practice in the state of Minnesota;

WHEREAS, NPs are currently practicing medicine without a license to do so;

WHEREAS, multiple recent studies as well as two high-profile lawsuits in Minnesota have highlighted the concern about lack of physician oversight of this practice of medicine;

WHEREAS, many NP schools are 100% online with extremely limited clinical experience and there is little consistency in the required educational experience and, therefore, clinical ability upon matriculation;

WHEREAS, NPs are currently licensed under the Minnesota Board of Nursing despite practicing medicine;

WHEREAS, employed family physicians are often required to provide oversight to NPs and student NPs without compensation and are being replaced by NPs as they leave the organization;

BE IT RESOLVED that the MAFP and the AAFP encourage employers to pay physicians for nurse practitioners/physician assistants oversight and end mandatory oversight practices;

BE IT FURTHER RESOLVED that the MAFP lobby the Minnesota legislature to move the oversight of nurse practitioners (NPs) to be under the Minnesota Board of Medical Practice;

BE IT FURTHER RESOLVED that the MAFP lobby the Minnesota legislature to extend the required training of NPs in the field of family medicine to three (3) years prior to allowing for independent practice;

BE IT FURTHER RESOLVED that, in the matter of public interest, that the MAFP lobby the Minnesota legislature to end the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery and not be allowed to call themselves "physician";

BE IT FURTHER RESOLVED that the MAFP and the AAFP support the HR 3928, Truth in Healthcare Marketing Act of 2017.

Support Legislation in Minnesota that Protects Access to Contraception

Submitted by Nicole Chaisson, MD, MPH

WHEREAS, the MAFP promotes the specialty of family medicine in Minnesota and supports family physicians as they provide high quality, comprehensive and continuous medical care for patients of all ages;

WHEREAS, the AAFP "supports a woman's access to reproductive health services and opposes non-evidence based restrictions on medical and the provision of such services" [1];

WHEREAS, 51 percent of physician visits are to primary care providers and 19.5 percent (the highest proportion) are with family medicine physicians [2];

WHEREAS, an estimated 17.9 percent of outpatient visits are by women of reproductive age, with preconception or contraceptive counseling integral aspects of these visits [2];

WHEREAS, the current Administration has issued new regulations that harm women's access to birth control, creating a sweeping religious exemption to the Affordable Care Act's (ACA) birth control benefit [3] [4];

WHEREAS, the AAFP has joined with other medical organizations to speak against these exemptions stating in a letter to the administration that "Contraception is an integral part of preventive care and a medical necessity for women during approximately 30 years of their lives [and access] to no-copay contraception leads to healthier women and families. Any move to decrease access to these vital services would have damaging effects on public health" [5];

BE IT RESOLVED that the MAFP will support legislative action in Minnesota to require all insurers that cover prescription drugs to also provide coverage of FDA-approved prescription contraceptive drugs and devices;

BE IT FURTHER RESOLVED that the MAFP will advocate for and support access to no-cost birth control coverage in Minnesota.

References and Supporting Information

[1] American Academy of Family Physicians. Women's Healthcare, Family Physician Providing (2015 COD). http://www.aafp.org/about/policies/all/womens-health-care.html. November 1, 2017

[2] Institute of Medicine. Clinical preventive services for women: closing the gaps. Washington, DC: The National Academies Press; 2011.

[3] Internal Revenue Service, Employee Benefits Security Administration and Department of Health and Human Services. Religious Exemptions and Accommodation for Coverage of Certain Preventive Services Under Affordable Care Act. October, 2017. https://www.federalregister.gov/documents/2017/10/13/2017-21851/religious-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the

[4] Internal Revenue Service, Employee Benefits Security Administration and Department of Health and Human Services. Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act. October, 2017. https://www.federalregister.gov/documents/2017/10/13/2017-21852/moral-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the-affordable

[5] AAFP, AAP, ACOG, ACP, AOA, APA. Letter to President Trump. October 6, 2017. https://www.aafp.org/dam/AAFP/documents/advocacy/coverage/aca/LT-Group6-President-ContraceptionIFRs-100617.pdf

The Unique Role of Family Physicians

Submitted by Glenn Nemec

WHEREAS, family physicians are different in that we take the science of medicine and apply it not to a particular organ system but to the entire "bio-psycho-social" environment of the patient;

WHEREAS, family physicians receive three years of residency training on the whole patient;

WHEREAS, access to primary care helps patients live longer, healthier lives (The Commonwealth Fun, "Health Reform and You");

WHEREAS, health care in the United States is more expensive and worse performing than other first world countries;

WHEREAS, U.S. adults who have a primary care physician have 33 percent lower health care costs (The Commonwealth Fund, "Health Reform and You");

BE IT RESOLVED that the MAFP work to educate policy makers and the public on the unique role of family physicians. That we are different. That we bring a unique value and cost-savings to the healthcare system while achieving better patient outcomes.

Resolution to Fortify Immunization Administration in Minnesota

Submitted by Dave Bucher, MD and the East Metro Chapter

WHEREAS, decades of efforts to provide universal childhood immunizations to prevent illness due to communicable childhood diseases have substantially eliminated the incidence of most of these life-altering and life-threatening diseases;

WHEREAS, successful Public Health programs and approaches to disease prevention require participation by all members of the target population;

WHEREAS, misinformation spread by some persons directed at vulnerable communities have reduced immunization rates, threatening the health of these communities and other populations in the state of Minnesota;

BE IT RESOLVED that the Minnesota Academy of Family Physicians, partnering with our primary care colleagues, shall work vigorously with our government officials in the executive and legislative branches in the state to fortify and strengthen the universality of childhood immunizations. This shall include stricter state law and limitations on ability of parents and care-givers to decline childhood immunizations.