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2017-01. Military Tobacco 21

Submitted by: Bob Koshnick, MD

Outcome: ADOPTED AS AMENDED

WHEREAS tobacco kills 480,000 people a year in our country;
WHEREAS tobacco products are often sold considerably under market prices at military commissaries and exchanges;
WHEREAS many young people pick up the smoking habit while in the service;
WHEREAS people that have had military service have higher smoking rates than the civilian population (32.2% among military personnel versus 21% civilian rate in 2005);
WHEREAS military personnel are expected to be in top physical condition and smoking has known effects on health;
WHEREAS soldiers have many other requirements regarding weight, fitness and cardiovascular health;
WHEREAS allowing tobacco use devalues the service members long term quality of life;
WHEREAS the submarine fleet has already established a smoke-free policy in 2010 without any notable negative consequences;
WHEREAS the current tobacco-free basic training has already provided a starting point for the implementation of such a policy;

BE IT RESOLVED that the MAFP ask the AAFP to adopt a policy position and lobby the United States congress to pass a law that makes it illegal for military commissaries to sell tobacco products to those under 21.
2017-02. Support Employed Physicians’ Involvement in the MAFP and AAFP

Submitted by: Julie Anderson, MD

Outcome: ADOPTED

WHEREAS, as of 12/2016, 67.8% of AAFP members are currently employed;

WHEREAS it is important for the AAFP to continue to have members as well as a pipeline for engaged membership;

WHEREAS it is sometimes challenging for employed physicians to demonstrate the value of the AAFP to their employer in a way that the employer would understand;

WHEREAS some employers pay for membership dues to the AAFP and some do not;

WHEREAS similar struggles occur at the state organizational level;

BE IT RESOLVED that the MAFP work with the AAFP to create tools that employed member physicians can use to demonstrate the return on investment that MAFP/AAFP dues provide;

BE IT FURTHER RESOLVED that the MAFP work with the AAFP to create documents that members can use to demonstrate the value of involvement in leadership roles at the MAFP and AAFP.
2017-03. Replace the Foundation’s Dues Allocation with an Annual Gift and Matching Grant

Submitted by: Board of Directors

Outcome: ADOPTED AS AMENDED

WHEREAS, on April 12, 2000, the MAFP House of Delegates adopted a resolution approving an increase in each MAFP active member’s dues by $20 that will be allocated to support the philanthropic efforts of the MAFP Foundation to improve the quality of health care in Minnesota;

WHEREAS the MAFP Strategic Plan approved in 2015 included a goal to develop a comprehensive and coordinated fundraising and charitable contribution plan to support the work of the MAFP Foundation that will lead to financial self-sustainability for the Foundation;

WHEREAS the current allocation process creates an administrative burden in our accounting and audit function;

WHEREAS the staff support that what the MAFP provides to the Foundation has increased significantly, allowing the Foundation to experience a decrease in administrative expenses;

WHEREAS the MAFP has incorporated the Foundation efforts into all of our programs and services, increasing awareness and fundraising opportunities;

WHEREAS there is opportunity to allocate the $20 to other important Academy priorities that align with the mission of the Foundation, such as current programs that are managed by the Academic Affairs and Research and Quality Improvement Committees;

BE IT RESOLVED that the MAFP discontinue allocating $20 of active members’ dues starting in FY 2017;

BE IT FURTHER RESOLVED that the MAFP provide the Foundation with up to $20,000 annual matching grant to encourage individual giving in 2017 with the amount to be adjusted annually during the budgeting process;

BE IT FURTHER RESOLVED that the MAFP provide an additional $25,000 annual gift to the Foundation with the amount to be adjusted annually during the budgeting process.
2017-04. Bylaws Update

Submitted by: Board of Directors

Outcome: NOT ADOPTED

WHEREAS our current bylaws require the House of Delegates to approve any bylaw change;

WHEREAS, by definition, bylaws are the rules and regulations enacted by an organization to provide a framework for its operation and management;

WHEREAS the role of the Board of Directors is to govern and manage;

WHEREAS it can be difficult as a delegate to vote on bylaws without feeling informed and being part of the strategic discussion about the change;

BE IT RESOLVED that the MAFP Bylaws be amended as shown by tracked changes in the attached draft.

References and Supporting Information

ARTICLE VII - DELEGATES

CURRENT LANGUAGE:

SECTION 1. The control and direction of this organization shall be vested in the House of Delegates. Affirmative action from the House of Delegates is needed for:

a. Changes in dues
b. Special or additional assessments
c. Amendments to the Bylaws
d. Election of officers

PROPOSED CHANGE:

Strike “c. Amendments to the Bylaws”

ARTICLE XIII - AMENDMENTS

CURRENT LANGUAGE:

Any committee, chapter or delegate may propose amendments to the Bylaws, which will be submitted to the Executive Vice President at least 60 days prior to the meeting at which the amendments are to be considered. These amendments will be given to all of the delegates at least 30 days prior to the meeting at which the amendments are to be considered. An affirmative vote of at least two-thirds of the delegates present and voting will constitute adoption.

PROPOSED CHANGE:

Replace the paragraph with: “Pursuant to Minn. Stat. §317A, the power to adopt, amend or repeal provisions in the Bylaws or Articles of Incorporation is vested in the Board of Directors. Any committee, chapter or delegate may propose amendments to the Bylaws, which shall be submitted to the Executive Vice President for consideration at the next meeting of the Board of Directors. An affirmative vote of at least two-thirds of the Board of Directors present and voting shall constitute adoption.”
2017-05. Request for Strengthening Minnesota Environmental Regulations to Require the Completion of a Health Impact Assessment (HIA) for All Projects Requiring an Environmental Assessment Worksheet (EAW) or Environmental Impact Statement (EIS)

Submitted by: Lake Superior Chapter

Outcome: ADOPTED AS AMENDED

WHEREAS Minnesota government officially espouses a “health in all policies” approach including review of projects that affect the environment;

WHEREAS, in 2015, the MAFP supported the “completion of a Human Health Impact Assessment for mining projects so that both health professionals and the public can make informed decisions” (Resolution 3);

WHEREAS, in 2016, the MAFP supported “the preparation of a comprehensive, independently produced Health Impact Assessment (HIA) for all sulfide mining projects requiring the completion of an environmental assessment worksheet (EAW) or an environmental impact statement (EIS)” and further supported “changing Minnesota Administrative Rules in Chapter 4410 to include the requirement that a comprehensive and independent HIA be prepared for all sulfide mining projects requiring and EAW or EIS” (Resolution 3);

WHEREAS the Minnesota Environmental Quality Board (MN EQB), which is charged with rulemaking under Minnesota Administrative Rules, is unlikely to approve the change in rule supported by the MAFP;

WHEREAS, in the course of testimony at the MN EQB by the MAFP in October 2016, the question was raised whether the MAFP would support an HIA more broadly applicable to environmental review;

BE IT RESOLVED that the MAFP support the completion of a Health Impact Assessment (HIA) for all projects proposed in Minnesota which require the completion of an environmental assessment worksheet (EAW) or an environmental impact statement (EIS) and will propose this to the MN (Environmental Quality Board) EQB or appropriate Minnesota State Authority;

BE IT FURTHER RESOLVED that the MAFP support the requirement that all federal environmental impact statements be required to include a comprehensive and independently produced Health Impact Assessment. The MAFP will submit this to the AAFP for its consideration.
2017-06. Support Placement and Coverage of Long-Acting Reversible Contraceptives (LARC) in the Early Postpartum Period

Submitted by: West Metro Chapter

Outcome: ADOPTED

WHEREAS providing women with early postpartum access to LARC methods significantly reduces the risk of unplanned pregnancies and improves the health of newborns and mothers by facilitating healthy spacing between pregnancies [1];

WHEREAS birth intervals less than 18 months are associated with poor perinatal outcomes including preterm birth and low birth weight [2,3];

WHEREAS women who used LARC methods have many-fold increased likelihood of achieving optimal birth interval compared to women using other methods [2];

WHEREAS the ability to control the timing of her pregnancies is crucial to a woman’s socioeconomic advancement as it affects her education, employment, mental health, and ability to care for existing children [4];

WHEREAS ensuring prompt access to LARC would result in fewer unintended pregnancies, better health outcomes, and considerable cost savings for the healthcare system [5,6];

WHEREAS placement of LARC is safe for women, with minimal effect on breastfeeding, good continuation rates and decreased pregnancy rates [2,6,7];

WHEREAS, currently, the most significant barriers to providing postpartum LARC are related to billing and payment from Medicaid and private insurance, with few states assuring coverage separate from the global fee [8,9,10];

WHEREAS the AAFP has supported past resolutions to reduce barriers to LARC access for women [11] and to expand insurance coverage for the full array of available contraceptive methods (including payment for IUDs and contraceptive implants and their insertion) [12];

BE IT RESOLVED that the Minnesota Academy of Family Physicians (MAFP) support a policy that LARC methods be a recommended option for postpartum women prior to hospital discharge;

BE IT FURTHER RESOLVED that the MAFP support a policy assuring coverage of LARC device and placement prior to hospital discharge, separate from the global fee, for all women who select these methods;

BE IT FURTHER RESOLVED that the MAFP advocate for Minnesota State Medicaid reform to allow for coverage and reimbursement of LARC device and placement prior to hospital discharge, separate from the global fee, for women who select these methods.

References and Supporting Information
1. ACOG, “Medicaid reimbursement for immediate post-partum LARC”
https://www.acog.org~/media/Departments/LARC/HMAPostpartumReimbursementResource.pdf


11. AAFP Resolution 305, End of prior approval for contraceptive devices, 2013.

12. AAFP Resolution 502, Remove barriers to contraceptive access, 2008.
2017-07. Advocating for Healthy Communities

Submitted by: Brandon Ng, MD; Kate Howard, MD; Kriti Choudhary, MD

Outcome: ADOPTED

WHEREAS the MAFP advocates for the health of all of our communities in Minnesota;
WHEREAS coverage of health care provision is an important factor in determining the health of our communities;
WHEREAS the recent Medicaid expansion increased coverage of health care provisions for our communities;
WHEREAS the coverage of health care provisions promotes a healthier workforce and economic productivity;
WHEREAS it is important to maintain our momentum of increasing coverage of health care provisions for our communities;

BE IT RESOLVED that the MAFP will perpetuate our current Medicaid and MNSure coverage levels for our communities;

BE IT FURTHER RESOLVED that the MAFP will support the continued expansion of Medicaid and MNSure coverage levels for our communities.
2017-08. Support Community Health Workers to Improve Refugee/Immigrant Health

Submitted by: Jenny Zhang; Jeff Sachs, MD; Zia Okocha, MD; Lauren Williams, MD; Angela Smithson, MD

Outcome: ADOPTED AS SUBSTITUTE RESOLUTION

WHEREAS Minnesota has a rapidly increasing refugee and immigrant population [1];

WHEREAS significant disparities have been shown between immigrant populations and general population in completion rates of many preventative health services, and higher utilization of primary care services has been shown to improve these rates [2];

WHEREAS individuals from cultures outside of the US may have a different understanding of health and healthcare delivery systems [3];

WHEREAS community health workers have been shown to reduce barriers to marginalized populations’ access to services [4] and reduce healthcare costs [5];

BE IT RESOLVED that the MAFP explore ways to increase sustainable funding avenues to support and expand community health care workers in underserved communities;

BE IT FURTHER RESOLVED that the MAFP write a letter to Minnesota colleges to advocate for expanding community health worker training programs and to encourage increasing diversity among enrollees in the programs;

BE IT FURTHER RESOLVED that the MAFP develop educational materials/resource guide to assist with the integration of community health workers into healthcare homes.

References and Supporting Information
1. http://www.mncompass.org/immigration/overview
2017-09. Climate Change

Submitted by: Lake Superior Chapter

Outcome: ADOPTED AS AMENDED

WHEREAS climate impacts are known to affect health through seven main areas including temperature impacts, air quality impacts, extreme events, vector-borne diseases, water related illnesses, nutrition and food safety, and mental health—all of which threaten the health of Minnesotans;

WHEREAS disadvantaged populations, including communities of color, the elderly, children, and those living in poverty are particularly vulnerable to the impacts of climate change;

BE IT RESOLVED that the MAFP will facilitate efforts to educate family physicians about climate change’s health effects and to provide guidance on the reduction or mitigation of such effects;

BE IT FURTHER RESOLVED that the MAFP support efforts to communicate with local, state and national legislators about the need to take action to adapt to and mitigate the adverse health effects of climate change;

BE IT FURTHER RESOLVED that the MAFP will encourage health care institutions to review, report and improve their carbon footprint and that of their supply chain and also encourage them to prepare for climate impacts.
2017-10. Increasing Minnesota Immunization Rates Through Physician Education and Routine Reassessment of Patient Vaccination Status

Submitted by: Elizabeth Fairbairn, Gretchen Colbenson, Stephanie Perez Kerkvliet, Kristen Bastug, Rose Olson, Emilia Vesper; University of Minnesota Medical School, Minnesota Medical Association - Medical Student Section, University of Minnesota Family Medicine Interest

Outcome: ADOPTED AS AMENDED

WHEREAS as many as 40% of parents choose to delay or refuse the ten recommended childhood vaccinations, and these parents are significantly less likely to believe that vaccines are necessary to protect the health of their children and less likely to believe that their child might get a disease if they are not vaccinated [1];

WHEREAS the proliferation of false information regarding vaccines, including a link between vaccines and autism, is increasing in specific communities, especially the Somali community, and MMR immunization rates are subsequently decreasing [2];

WHEREAS as many as 60-70% of parents have some degree of concern regarding the safety or health benefits of vaccinations, and top concerns from parents that expressed vaccine hesitancy included pain associated with multiple injections, unease about receiving too many vaccines in one visit, and fear that vaccines lead to autism, and that a compassionate conversation and effective portrayal of known research and information from doctor to patient can remedy many of these concerns [3,4];

WHEREAS the American Academy of Family Physicians has highly recommended a vaccination schedule to all medically eligible individuals [5,6];

WHEREAS professional medical organizations such as the American Academy of Pediatrics have published proven guidelines and models, including the CASE method, to effectively educate and discuss vaccines with hesitant parents; however, these models are not often used [3,6];

WHEREAS the Minnesota Academy of Family Physician's Spring Refresher serves as a premiere, annual event which hundreds of Minnesota family physicians and trainees attend to expand their knowledge of medical practice [7];

WHEREAS less than one third of general internists and family medicine physician members of the American College of Physicians and the American Academy of Family Physicians report routinely assessing vaccination status in their patients [5];

WHEREAS MIIC is a tremendous cost-saving tool for raising immunization rates by allowing easy access to the most complete immunization records for patients, with no “membership fee,” and is funded through federal, state, and local public health dollars;

WHEREAS data for the 2001 birth cohort showed that every dollar spent towards the 7 common vaccines program saved individuals $5 and saved about $11 dollars in additional cost to society [9];

WHEREAS family physicians have the unique privilege and responsibility to develop the trust needed for successful vaccine hesitant conversations, and a dedication to community health that encourages immunization and promotes the health of not only the individuals, but also the communities for which they serve;
BE IT RESOLVED that the MAFP recommend that members utilize the MIIC reporting system to document all vaccinations administered and verify new patient immunization status;

BE IT FURTHER RESOLVED that the MAFP implement an immunization curriculum regarding best practices for discussing vaccines with hesitant patients at the MAFP 2018 Spring Refresher;

BE IT FURTHER RESOLVED that the MAFP recommend that our MAFP members utilize best practices to repeatedly engage vaccine hesitant patients and guardians for the health of our patients and the wider health of the community.

References and Supporting Information

2017-11. Point of Care Physician Input on Governmental Health Care Committees

Submitted by: Central Chapter

Outcome: Referred to Board of Directors

WHEREAS governmental committees making decisions and recommendations on health care policy often lack significant input from actual practicing physicians (Point of Care Providers);

WHEREAS that lack of real-world input often results in policies, laws, and rules that have significant, avoidable, unintended negative consequences on the provision of health care at the Point of Care level (i.e. in the office, physician to patient interaction);

WHEREAS study of these events suggests a significant component of governmental “not knowing what it doesn’t know”;

WHEREAS it is unlikely that a single educational effort aimed at the government is likely to effect significant change;

BE IT RESOLVED that the MAFP adopt the legislative policy of continuously using any available opportunity to advise the State Government on the wisdom and efficiency of having a Point of Care (preferably Family Physician) Provider on the committee roster for any governmental committees making decisions affecting health care delivery;

BE IT FURTHER RESOLVED that the MAFP forward a companion resolution to the AAFP for application on the national level.
2017-12. Exclude First Degree Family Members from HIPAA Requirements

Submitted by: Bob Koshnick, MD

Outcome: NOT ADOPTED

WHEREAS the family is an important source of patient information;

WHEREAS often we do not know what family members have been signed up as permissible for doctor-family member information exchange;

WHEREAS the threat of HIPAA violations often results in poor communication with family members in both directions;

WHEREAS family members are legitimately concerned with the health of their immediate family;

WHEREAS the penalties for violations are extreme: $50,000 for the first violation and up to $1.5 million for identical provisions during a calendar year;

BE IT RESOLVED that the MAFP ask the AAFP to lobby the CMS to change the HIPAA regulations to exclude legal spouses and adult children from the HIPAA punitive regulations.
2017-13. Meatless Mondays

Submitted by: Lake Superior Chapter

Outcome: ADOPTED AS AMENDED

WHEREAS climate change impacts are known to affect human physical and mental health, and disadvantaged populations are particularly vulnerable to the impacts of climate change;

WHEREAS a high level of meat consumption is one modifiable contributor to climate change;

WHEREAS high levels of meat consumption are directly related to increased risk of adverse health outcomes including vascular disease, obesity, cancer, and diabetes;

BE IT RESOLVED that the MAFP will educate family physicians statewide about the health benefits of a plant based diet (such as Meatless Mondays program developed in conjunction with Johns Hopkins School of Public Health, www.meatlessmonday.com) and encourage physicians to recommend a plant-based diet to patients to improve patients’ overall health and help manage chronic disease.
2017-14. Transfer of Jurisdiction Over Required Clinical Skills Examinations to U.S. Medical Schools

Submitted by: Emma Sieling, MS4; Jennifer St. Peter, MS2

Outcome: Filed for Information

WHEREAS the USMLE Step 2 Clinical Skills (CS) examination was launched in 2004 to serve as a communication competency exam;

WHEREAS American Medical Association Policy H275.956 states, “It is the policy of the AMA to recognize that clinical skills assessment is best performed using a rigorous and consistent examination administered by medical schools”;

WHEREAS over 90% of U.S. medical schools currently administer an objective structured clinical examination (OSCE) or variant on this principle, and 74% of these schools require a passing score for graduation [1];

WHEREAS medical students from across the country must travel to one of only five standardized-testing centers in the US to take the Step 2 CS exam;

WHEREAS the current registration fee for the Step 2 CS is $1,275 [2], plus the costs of travel and lodging;

WHEREAS, in 2014, 19,801 medical students took the Step 2 CS exam, amounting to $25,246,275 in exam fees alone [1];

WHEREAS students incur more debt in paying for the examination with loans, leading to a more accurate calculation of the cost of the exam of $36.2 million annually [3];

WHEREAS there was a reported 96% pass rate amongst first time test takers, and examinees required to retake the test had a pass rate of 84%. This amounts to 1 double-failed student for every 156 students who take the test, or roughly $200,000 to identify each unskilled graduate in exam fees alone [4];

WHEREAS recent studies found weak correlations between Step 2 CS scores and end-of-year evaluations of internal medicine interns, while clinical skills scores added no additional predictive value beyond the written USMLE exams [5,6,7];

WHEREAS all Minnesota medical schools, University of Minnesota Medical School - Twin Cities Campus, University of Minnesota Medical School - Duluth Campus, and Mayo Medical School, offer a more rigorous form of the clinical skills exam multiple times throughout undergraduate medical education;

WHEREAS all Minnesota medical schools require a passing grade for the school-administered clinical skills exam at the end of MS3 as a graduation criterion;

WHEREAS each Minnesota medical schools’ clinical skills requirement fulfills the guidelines outlined by the Liaison Committee on Medical Education;

WHEREAS the 2015-2017 strategic plan of the Minnesota Academy of Family Physicians includes a vision of being a driving force in the transformation of policies and education that support current and future family physicians in providing the highest quality healthcare in all Minnesota communities; and the MAFP strategic plan also prioritizes values including excellence in modeling enlightened governance practices, leadership in advocating
passionately for the specialty of family medicine for current and future family physicians, aid in the development of enlightened physician leaders and recognition of their achievements, advocacy for the continual betterment of healthcare, the support of science and technology-based decision making, anticipation and meeting of the changing needs of its members, and service through support of family medicine innovation, research, medical student experience and community engagement;

WHEREAS the Step 2 CS Exam offered by the NBME is an extraneous financial burden and an unnecessary redundancy;

BE IT RESOLVED that the MAFP advocate for the Minnesota Board of Medical Practice to eliminate the Step 2 CS Exam requirement for U.S. Medical Graduates who have passed a school-administrated clinical skills examination.

References and Supporting Information

Submitted by: Central Chapter

Outcome: ADOPTED AS AMENDED

WHEREAS the prior authorization process continues to cause delays in patient acquisition of needed medications;

WHEREAS the prior authorization process continues to consume uncompensated time and effort by physician offices;

WHEREAS poor quality information from the insurance companies and PBMs continues to be the greatest hindrance to physicians trying to get patients the least expensive medication that will work for them;

WHEREAS the MMA legislative efforts on prior authorization have been trimmed to focusing on limits to formulary changes during a plan year and easier patient access to real cost formulary information;

BE IT RESOLVED that the MAFP work through non-legislative means toward moving insurance companies and PBMs to always include in their “non-coverage notices” the specific reason a drug is not approved, and list formulary medications in the same class.
2017-16. Request for Increasing Emphasis on End of Life Care Planning

Submitted by: Paul Stadem MAFP student member; Libby McNiven, MD, MAFP resident member

Outcome: ADOPTED AS AMENDED

WHEREAS family physicians are uniquely poised to have end of life care discussions with patients;

WHEREAS it is important to have end of life care discussions in the clinic prior to hospitalization for serious illness;

WHEREAS about 55% of initial end of life discussions occur in the hospital [1];

WHEREAS the median time before death of the first end of life care discussion is about 33 days [1];

WHEREAS earlier conversations about patient goals and priorities for living with serious illness is associated with improved quality of life, reduced suffering, better patient and family coping, and higher patient satisfaction [2];

WHEREAS the Twin Cities Medical Society - Honoring Choices campaign already promotes advanced care planning in the community and has developed informational resources the MAFP can use at no cost;

WHEREAS the MAFP has worked with the Honoring Choices campaign in the past, but is not listed as a nonprofit “partner” on the Honoring Choices website;

BE IT RESOLVED that the MAFP become a nonprofit partner of the Twin Cities Medical Society - Honoring Choices campaign (as listed on the Honoring Choices website), which is a no-cost action that emphasizes the importance the MAFP realizes in end of life care planning;

BE IT FURTHER RESOLVED that the MAFP incorporate end of life care planning into topics at the Spring Refresher or other appropriate MAFP sponsored continuing medical educational activities.

References and Supporting Information


2017-17. Minor Consent for HPV Vaccination

Submitted by: Allison Spicher, Gretchen Colbenson, Phillip Plager; University of Minnesota Medical School, MAFP student members, Family Medicine Interest Group

Outcome: ADOPTED

WHEREAS the Advisory Committee on Immunization Practices (ACIP) recommends the HPV vaccination be initiated at 11 or 12 years of age until 26 years of age [1];

WHEREAS human papillomavirus is associated with 38,000 new cancer diagnoses nationally each year, consisting of cervical, vaginal, vulvar, anal, oral and throat cancers, of which more than 73% could be prevented by the 9-valent HPV vaccine [2];

WHEREAS Minnesota youth remain largely unvaccinated despite this national recommendation with only 44.5 percent of females and 22.4 percent of males completing the three-shot series [3];

WHEREAS family physicians are uniquely positioned to see patients during their entire eligibility window;

WHEREAS concerns about this vaccination causing earlier onset of sexual activity [4] and increased incidence of sexually transmitted infections [5] have been shown to be unfounded;

WHEREAS the HPV vaccination has been proven safe with over 60 million doses administered [6];

WHEREAS requiring parental consent for the three-vaccination series creates unnecessary complications for patients who do not present to clinic with a legal guardian;

WHEREAS Minnesota youth have been allowed to consent for the Hepatitis B vaccination, another sexually transmitted disease, since 1993 [7];

WHEREAS the MAFP supports family physician health care delivery at the heart of which is preventative medicine through vaccination;

WHEREAS parental consent for the HPV vaccination is a barrier for a subset of individuals leading to lack of access to this safe and effective vaccination;

BE IT RESOLVED that the MAFP support legislation giving minors the ability to consent for the human papillomavirus vaccination.

References and Supporting Information


7. Minnesota Statutes 2016, section 144.3441

*Further support:*

1. California law (AB499 or Chapter 652, Statutes of 2011) expanded the legal authority of minors 12 years and older to provide consent for medical services that prevent sexually transmitted diseases without the need for parental consent.
2017-18. Support for the Direct Primary Care Bill

Submitted by: Bob Koshnick, MD

Outcome: REFERRED TO BOARD OF DIRECTORS

WHEREAS the burnout in primary care is over 50% and climbing;

WHEREAS one of the primary reasons for burnout is that physicians have experienced a loss of autonomy to directly control their practice activities because of the interference by insurance companies and hospital based systems;

WHEREAS direct primary care (DPC) is a primary care medical practice model that eliminates third party payers from the primary care provider-patient relationship;

WHEREAS DPC depends on a contractual agreement with patients who agree to pay a monthly fee to the primary care provider for primary care services;

WHEREAS at least 16 other states have declared that DPCs are not insurance products;

BE IT RESOLVED that the MAFP support state and national legislation that would ensure that DPC options are available to consumers buying coverage in health care exchanges, that DPCs be defined as a healthcare service outside the scope of state insurance regulations, that payments to DPC physicians be allowed as a “qualified medical expense” by the IRS that would allow HSA monies to be used for DPCs, and that would allow Medicare and Medicaid beneficiaries to participate in DPCs with their government benefits.
2017-19. Pregnant Women Civil Commitment

Submitted by: Rory Fleming, JD; Huiying Guo, MD

Outcome: FILED FOR INFORMATION

WHEREAS ProPublica reported in 2015 that Minnesota is one of only three states (including Wisconsin and South Dakota) where involuntary civil commitment is extended to “chemically dependent” pregnant women and girls;

WHEREAS more than a third of reproductive-aged women enrolled in Medicaid and more than a quarter of those with private insurance filled a prescription for an opioid pain medication each year during 2008-2012;

WHEREAS the United States is currently suffering an opioid abuse crisis, many people in the United States use opioids without a prescription, and chief local prosecutors (including Amy Weirich in Memphis, TN, and Brian McVeigh in Calhoun County, AL) have abused their discretion to incarcerate and detain addicted pregnant women on a theory of fetal assault;

WHEREAS, as reported by Andy Mannix in the Minneapolis City Pages in 2012, when civil commitment court proceedings are initiated in Minnesota, inmates often wait weeks or months before they are transferred to a facility equipped to provide adequate mental health care;

WHEREAS “cold-turkey” withdrawal from opioids (more likely in the jail or prison setting) leads to health impacts including hallucinations, seizures, severe abdominal pain, severe anxiety, and even death;

WHEREAS pressure to report “chemically dependent” mothers might place enhanced stress on the doctor-patient relationship and eschew prenatal care in favor of the initiation of civil commitment proceedings, despite the fact that the lack of prenatal care is proven to be correlated with high risk births;

BE IT RESOLVED that the MAFP study the risks of opioid withdrawal on maternal health and fetal health in the context of civil commitment procedures and accompanying wait times in the local jail system for “chemically dependent” pregnant girls and women.
2017-20. Oppose Legislative Restrictions on Health Centers Receiving Title X and Medicaid Funding

Submitted by: West Metro Chapter

Outcome: ADOPTED

WHEREAS Title X provides preventive health care to five million Americans through sexually transmissible infections (STI) screening, cancer screenings, HIV testing, and contraceptive care [1];

WHEREAS Title X of the Public Health Service Act is the only federal program devoted specifically to supporting family planning services [2];

WHEREAS 99 percent of reproductive age women who have ever had sexual intercourse have used at least one contraceptive method at some point in their lifetimes [3];

WHEREAS more than 50 percent of the 38 million women in need of contraceptive care rely on public funding from Medicaid, state appropriations and Title X [4];

WHEREAS federally qualified health centers do not have the capacity to be the sole providers of services funded by Title X due to workforce shortages [5];

WHEREAS Planned Parenthood provides crucial healthcare services to one third of Title X clients;

WHEREAS members of the Minnesota Academy of Family Physicians (MAFP) work for Planned Parenthood and many family medicine residents in the state of Minnesota get part of their training in Planned Parenthood clinics;

WHEREAS the AAFP already supports a woman’s access to reproductive health services and opposes non-evidence-based restrictions on medical care and the provision of such services [6];

WHEREAS the AAFP already resolved to oppose national legislative efforts to restrict federal funding within Medicaid and Title X from qualified providers [7];

BE IT RESOLVED that the MAFP lobby the State Congress to oppose legislation that diminishes funding and/or access to preventive and reproductive health services for women and men;

BE IT FURTHER RESOLVED that, as a matter of policy, the MAFP support maintaining Medicaid and Title X funding of all providers or clinics that otherwise meet usual standards for eligibility.

References and Supporting Information


7. AAFP Resolution 512, Oppose Legislative Restrictions on Health Centers Receiving Title X and Medicaid Funding, 2015.
2017-21. Make Birth Control Pills an OTC Drug

Submitted by: Heart of the Lakes Chapter

Outcome: ADOPTED

WHEREAS about 45% of all pregnancies are unwanted or mistimed;
WHEREAS nearly 5% of reproductive age women have an unintended pregnancy each year;
WHEREAS our unintended pregnancy rate is higher than in many other developed countries;
WHEREAS unintended pregnancies have a significant public health impact such as delayed prenatal care, premature birth, abortions, and other negative physical and mental health effects on the children;
WHEREAS unintended pregnancy rates are highest among poor, low income, young and those without a high school degree who also have poor access to medical care;
WHEREAS the lack of easily available effective birth control adversely affects the autonomy of women;
WHEREAS men are less likely to live with a child from a mistimed pregnancy, which has enormous future consequences on both the father and the child;
WHEREAS in September of 2014 the American Congress of Obstetricians and Gynecologists supported making oral contraceptives available over-the-counter (OTC);

BE IT RESOLVED that the MAFP ask the AAFP to appeal to the FDA to approve oral contraceptives for over-the-counter (OTC) use.
2017-22. Request for Policy Supporting Access for All Women to Scientifically Based Reproductive Care

Submitted by: Lindsay Williams, MD, Resident member; Jennifer Schildmeyer, student member

Outcome: ADOPTED

WHEREAS there is great diversity in health education a woman receives related to reproduction and reproductive health;

WHEREAS the topic of women’s reproductive health is politically divisive;

WHEREAS the insurance coverage for women’s reproductive health is not guaranteed;

WHEREAS high-intensity scientifically based counseling leads to lower rates of sexually transmitted infections [1];

BE IT RESOLVED that the MAFP develop a policy statement supporting all women’s access to facilities that provide scientifically based information about contraception, reproductive health and safety regardless of a woman’s insurance or ability to pay.

References and Supporting Information


The American Academy of Family Physicians (AAFP) supports a woman’s access to reproductive health services and opposes non-evidence-based restrictions on medical care and the provision of such services. (2014 COD)