2016 Open Issues: Panel Recommendations to Policy Council

Note: please refer to the document, "2016 Open Issues: Original Submissions" for the requests and rationale from the open issue authors.

Open Issue #1:

Topic: Minor consent for HPV vaccination

Panel's Policy Recommendation:
The MMA supports legislation that would add HPV vaccination to the list of health services to which minors can consent. The MMA further encourages all individuals and organizations that provide immunizations to children and adults to report immunizations to the Minnesota Immunization Information Connection (MIIC) to allow for accurate, up-to-date immunization records.

Brief Background/Information from MMA Staff

Under Minnesota law (M.S. § 144.341-144.347), minors can consent to health services for pregnancy testing, prenatal care, STIs, alcohol and other drug abuse, and Hepatitis B vaccination. The law does not explicitly allow minors to consent for STI *prevention* services. HPV vaccination is strongly recommended, but not required as part of Minnesota's school vaccination law.[1]

In Minnesota, the 2015 vacation rates for three doses of the HPV vaccine for females and males were 44.5 percent and 22.4 percent, respectively; nationally, the rates ranged from 68% (RI) to 24.4% (MS) for females and 58% (RI) to 16% (TN) for males; the overall US rates were 41.9% (females) and 28.1% (males).[2]

California and several other states have expanded their laws to allow minors to consent to HPV vaccination and/or to consent to STI prevention services. In some states, legislative involvement on the HPV vaccine (ranging from mandating its use to prohibiting a mandate) has generated strong involvement from some religious and conservative groups.

The current Advisory Committee on Immunization Practices (ACIP) recommendation is as follows: "ACIP recommends that routine HPV vaccination be initiated at age 11 or 12 years. The vaccination series can be started beginning at age 9 years. Vaccination is also recommended for females aged 13 through 26 years and for males aged 13 through 21 years who have not been vaccinated previously or who have not completed the 3-dose series (1). Males aged 22 through 26 years may be vaccinated. Vaccination of females is recommended with 2vHPV, 4vHPV (as

[1] Minnesota Rules, Sections 4604.0100-4604.1020.

[2] Minnesota Department of Health. Minnesota adolescent immunization rates for Tdap and meningococcal are strong; HPV still lagging. August 30, 2016 press release. Based on CDC data from the National Immunization Survey–Teen (NIS-Teen), United States, 2015.

long as this formulation is available), or 9vHPV. Vaccination of males is recommended with 4vHPV (as long as this formulation is available) or 9vHPV."[3]

During testimony at the open issues forum, there was a comment raised regarding confidentiality issues related to vaccination reporting to the Minnesota Immunization Information Connection (MIIC), specifically the lack of HPV reporting by Planned Parenthood. In subsequent conversations between MMA and Planned Parenthood and health department staff, some new information was obtained:

- Given that Hep B is most often administered today to infants, the impact of the current law allowing minors to consent to Hep B has not surfaced with respect to MIIC reporting and data privacy
- Planned Parenthood began reporting HPV vaccines to MIIC in September 2016
- Minnesota law, and HIPAA, allow vaccine reporting to MIIC without patient consent
- Patients/parents can manage data privacy in MIIC today in 3 ways: 1) decline immunization reminders from MDH/county health departments; 2) limit access to a defined provider/entity; 3) opt out (record is not deleted, but no one can access it). There is not currently a way to suppress specific data elements.
- Consent to obtain/administer vaccines, is distinct from immunization reporting to MIIC
- Physicians and other providers, payers, schools, child care facilities, MDH, and community health boards may exchange immunization data with each other, without patient consent, provided that requesting party provides services on behalf of the patient
- Additional data privacy and legal considerations may need to be considered should this proposal advance

MMA Policy

HPV Vaccination (530.97)

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.

[3] Petrosky E, Bocchini JA, Hariri S, Chesson H, Curtis CR, Saraiya M, et al. Use of 9-Valent Human Papillomavirus (HPV) Vaccine: Updated HPV Vaccination Recommendations of the Advisory Committee on Immunization Practices *MMWR*. 2015;64(11);300-304.

Open Issue #2
Topic: Pornography

Panel's Policy Recommendation:
The MMA acknowledges the importance of healthy sexual activity and healthy relationship choices and recognizes that widespread use of pornography has become a public health issue of concern. The MMA urges healthcare professionals to communicate the risks of pornography use to patients and their families and to offer resources both to protect adults and children and to treat individuals suffering from its negative effects.

Brief Background/Information from MMA Staff
Although sexual violence is not the only focus of the original open issue, the CDC identifies exposure to sexually explicit media as one of 13 individual risk factors for such violence. The CDC further notes that "risk factors are contributing factors and might not be direct causes"; and, a "combination of individual, relational, community, and societal factors contribute to the risk of becoming a perpetrator of sexual violence. Understanding these multilevel factors can help identify various opportunities for prevention."[4] The CDC did conduct a systematic review of sexual violence risk factors (available at: http://tva.sagepub.com/content/14/2/133 [gated]).

There is also debate about whether excessive use of pornography ("sex addiction" or "hypersexual disorder") is a diagnosable condition. To date, the American Psychiatric Association has rejected attempts to include such conditions in the D*iagnostic and Statistical Manual of Mental Disorders* (DSM) for lack of evidence.

The issue generated recent attention when it was added to the Republican Party's national platform at the 2016 national convention.

The American Academy of Pediatrics issued an updated statement on the impact of pornography on children in June 2016 and "urges healthcare professionals to communicate the risks of pornography use to patients and their families and to offer resources both to protect children from viewing pornography and to treat individuals suffering from its negative effects." The full statement can be found at https://www.acpeds.org/the-college-speaks/position-statements/the-impact-of-pornography-on-children.

The AMA also has policy on the impact of pornography on children and youth (H-60.934) as follows: "Our AMA: (1) Recognizes the positive role of the Internet in providing health information to children and youth. (2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography. (3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet. (4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their

[4] Centers for Disease Control and Prevention. Sexual Violence: Risk and Protective Factors. Website accessed September 2016 at http://www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html.

children about safe Internet and social media use. (5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use."

MMA Policy
None

Open Issue #3

Topic: Chemical abuse as a chronic condition

Panel's Policy Recommendation:
The MMA identifies substance use disorders as chronic conditions that are both preventable and treatable. Greater attention and increased resources are needed for substance use disorder prevention, treatment, and recovery services in Minnesota.

Brief Background/Information from MMA Staff:

The US Substance Abuse and Mental Health Services Administration (SAMHSA) identifies substance use disorders as chronic conditions that are both preventable and treatable. SAMHSA defines a substance use disorder as occurring when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.[5]

In 2014, about 21.5 million Americans age 12 and older (8.1%) were classified with a substance use disorder in the past year. Of those, 2.6 million abused both alcohol and drugs, 4.5 million abused drugs but not alcohol, and 14.4 million abused alcohol only.[5]

Minnesota has high prevalence rates for alcohol use disorders and lower rates for illicit drug use disorders.[6]

The Governor's Task Force on Mental Health (convened in July 2016, with recommendations expected by December 2016/January 2017) has identified, "reforms needed to support timely and successful transition between levels of care, including early intervention services and substance abuse services" as one of its areas of focus.

MMA Policy:

MMA policy does not explicitly define substance use/chemical dependency as a chronic disease, but there is somewhat related policy as follows:

> MMA Promotion of Addiction Awareness and Community Collaborations (50.27)
> 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

[5] Data accessed online at SAMHSA.gov.

[6] National Survey on Drug Use and Health. The NSDUH Report: Substance Use Disorders in Substate Regions: 2008 to 2010. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. September 18, 2012.

encourage primary and secondary schools and colleges to provide chemical dependency education programs as part of their curricula. (HD-R204-2009)

Existing MMA policy on treatment, payment and coverage is as follows:

Funding For Chemical Dependency Medical Services (50.23)
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)

Insurance Parity for Mental Health and Chemical Dependency (400.26)
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)

Carveouts of Mental Health and Chemical Dependency Benefits (630.434)
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)

Open Issue #4

Topic: Pharmacist Prescribing of Hormonal Contraceptives

Panel's Proposed Policy Options:

The panel was unable to reach agreement on a specific recommendation. Rather, the following three options are presented to the Council for consideration and potential action:

1. Consistent with the position of the American College of Obstetricians and Gynecologists, the MMA supports efforts to move oral contraceptives to over-the-counter status, noting that the benefits in terms of unintended pregnancy outweigh the risks of OTC access and broader use.
2. The MMA supports the ability of pharmacists to prescribe self-administered hormonal contraceptives as a means of expanding access to contraceptives.
3. The MMA believes that increased access to self-administered hormonal contraceptives can best be accomplished through existing law that allows pharmacists to initiate, manage, modify, and discontinue drug therapy according to a written protocol or collaborative practice agreement with a physician or other prescriber. The MMA does not support independent prescribing by pharmacists.

Brief Background/Information from MMA Staff

It is difficult to obtain information regarding self-administered oral contraceptive use. Data on unintended pregnancies, however, is available. According to the CDC, the family planning goals identified in *Healthy People 2020* has an objective to increase the proportion of pregnancies that are intended to 56% (unintended to 44%).[7] Although state-specific data have not been identified, the CDC notes that women more likely to experience unintended births include unmarried women, black women, and women with less education or income.[7]

In 2010, 40% of all pregnancies (38,000) in Minnesota were unintended – a rate of 36 per 1,000 women aged 15–44.[8] Nationally, rates among the states ranged from a low of 32 per 1,000 in New Hampshire to a high of 62 per 1,000 in Delaware.[8]

The teen pregnancy rate in Minnesota was 31 per 1,000 women aged 15–19 in 2010; the national teen pregnancy rate was 57 per 1,000, ranging from 28 per 1,000 in New Hampshire to 80 per 1,000 in New Mexico.[9]

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[7] Centers for Disease Control and Prevention. Unintended Pregnancy Prevention. Accessed online at https://www.cdc.gov/reproductivehealth/unintendedpregnancy/

[8] Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002* New York: Guttmacher Institute, 2015, http://www.guttmacher.org/pubs/StateUP10.pdf.

[9] Guttmacher Institute, *U.S. Teenage Pregnancies, Births and Abortions, 2011: State Trends by Age, Race and Ethnicity*, New York: Guttmacher Institute, 2016, http://www.guttmacher.org//report_downloads/us-teen-pregnancy-state-trends-2011.

The MMA has generally opposed prescribing authority for pharmacists, but recognizes the evolving role of team-based care and has supported changes to pharmacy practice to allow broader roles in drug therapy management via physician (or other prescriber) protocol.

California, Oregon and Washington have adopted laws to allow access to contraceptives directly from pharmacists.

There has been some evaluation of pharmacist provision of hormonal contraceptive methods. As reported by ACOG:

> "In the Direct Access Study in Washington State, several pharmacists received specialized education in the provision of hormonal contraceptive methods and were authorized to provide hormonal contraception including, OCs, the contraceptive patch, and the contraceptive vaginal ring (24). Pharmacists successfully used checklists to identify women without contraindications to OCs according to the World Health Organization's Medical Eligibility Criteria for Contraceptive Use; blood pressure and body mass index also were measured (24). Continuation of use through 12 months was fairly high (70% of 127 women), although most women were continuing users (either currently using OCs or had used hormonal contraceptives in the past), and only 65% (127 of 195 women) completed the 12-month interview. Acceptability also was high, although most women had to pay out-of-pocket for the pharmacist evaluation because most insurance providers did not cover that service (24)."[10]

The recommendation adopted by ACOG concluded the following:

> "In the interest of increasing access to contraception, and based on the available data, the American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice makes the following conclusions and recommendations:
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> - Weighing the risks versus the benefits based on currently available data, OCs should be available over-the-counter.
> - Women should self-screen for most contraindications to OCs using checklists.
> - There are concerns about payment for pharmacist services, payment for over-the-counter OCs by insurers, and the possibility of pharmacists inappropriately refusing to provide OCs.
> - Screening for cervical cancer or STIs is not medically required to provide hormonal contraception.
> - Continuation rates of OCs are higher in women who are provided with multiple pill packs at one time."[10]

[10] American College of Obstetricians and Gynecologists. Committee Opinion: Over-the-Counter Access to Oral Contraceptives. Number 544, December 2012. And referring (24) to: Gardner JS, Miller L, Downing DF, Le S, Blough D, Shotorbani S. Pharmacist prescribing of hormonal contraceptives: results of the Direct Access study. J Am Pharm Assoc (2003) 2008;48:212–26.

In 2013, the AMA adopted policy (D-75.995) to recommend that the FDA encourage manufacturers of oral contraceptives to submit the required application and supporting evidence for a switch in status from prescription to over-the-counter for such products. In addition, the AMA, "opposes federal and state legislation allowing pharmacists to independently prescribe or dispense prescription medication without a valid order by, or under the supervision of, a licensed doctor of medicine, osteopathy, dentistry or podiatry."[11]

MMA Policy
None

[11] AMA Policy D-35.987, Evaluation of the Expanding Scope of Pharmacists' Practice (in part). 2012.

Open Issue #5
Topic: Firearm Safety

Panel's Policy Recommendation:
The MMA reaffirms existing MMA policy (260.07) as follows: 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.

The MMA promotes responsible gun ownership and supports changes to law that would require criminal background checks on all purchases and transfers/exchanges of firearms, with reasonable exceptions for immediate family and law enforcement and military acting in an official capacity.

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

Brief Background/Information from MMA Staff
Federal law requires federally-licensed firearms dealers (but not private sellers) to initiate a background check on the purchaser prior to sale of a firearm. Federal law gives states the option of serving as a state "point of conduct" and conducting their own background checks using state, as well as federal, records and databases or having the checks performed by the FBI using only the National Instant Criminal Background Check System (NICS) database. Minnesota is one of 36 states to rely solely on the federal NICS system.[12]

Minnesota law requires local law enforcement to perform an additional background check in certain situations – with some exceptions, if a person wishes to acquire a handgun or semiautomatic military-style assault weapon from a federally licensed dealer, but does not have a transferee permit or a permit to carry a handgun, state law requires the dealer to file a report with the local police chief or sheriff, who then performs a background check (private sellers are excluded).[13,14]

As the open issue panelists were deliberating on this topic, the practical question was raised of how background checks associated with gun transfers would be conducted. Kim Tjaden, MD reached out to staff with Everytown for Gun Safety (who had presented at a recent MMA Public Health Committee meeting) for clarification:

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[12] Federal Bureau of Investigation. About NICS. Accessed online at: https://www.fbi.gov/services/cjis/nics/about-nics
[13] M.S. § 624.7132, Subd. 1, 2; M.S. § 624.7132, Subd. 12(1).
[14] Law Center to Prevent Gun Violence. Background Checks in Minnesota. Accessed online at http://smartgunlaws.org/gun-laws/state-law/minnesota/

- In Minnesota, approximately 65-70% of gun sales happen through a licensed dealer. The remainder of gun sales happen at gun shows or between friends/family members – these are the transfers avoided under current law.
- Proposed legislation to address the transfers "gap" would define exemptions for certain groups, such as immediate family members. A transfer or exchange happens if you "loan" your gun to a friend. You may not know his criminal history or intent. A background check helps to protect the person who loaned/transferred the gun. Individuals who do not do a background check can be held responsible for damages caused by the person who obtains the gun.
- The background checks can be done for a small fee at any licensed gun dealer and about 90% of these take only 90 seconds to transact – so they are not expected to be burdensome.

The role of injury prevention research – and the role of the CDC, in particular – is a topic that is often raised when discussing firearm safety. Of note, Congress included language in the 1996 Omnibus Consolidated Appropriations Bill that "none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used to advocate or promote gun control." Referred to as the Dickey amendment (the language author, former U.S. House Representative Jay Dickey (R-AR)), this language did not explicitly ban research on gun violence. But, Congress also cut $2.6 million from the CDC's budget — the amount the CDC had invested in firearm injury research the previous year. Although the language is somewhat unclear, it appears that the CDC has avoided firearm research in part to preserve its other funding. A CDC spokeswoman was quoted in a June 16, 2016 ABC News report as saying, "The CDC still focuses on surveillance of firearm deaths, but the steps taken by Congress have effectively blocked expansive CDC research on the public health effects of firearms." In 2012, Congress applied the language of the Dickey amendment to activities at the National Institutes of Health, although the NIH has not taken the same zero-research approach as the CDC.

The CDC does collect surveillance data on gun injuries and deaths, but it has not funded a study aimed at reducing harm from guns since 2001. Such surveillance systems include the National Electronic Injury Surveillance System–All Injury Program (NEISS-AIP), which tracks data on all injuries nationwide, including firearm-related ones; the National Vital Statistics System; and, the National Violent Death Reporting System.

The Minnesota Department of Health collects firearm-related injury data from Minnesota hospitals (e-codes) and the data is available through the department's Minnesota Injury Data Access System (MIDAS). In 2015, Minnesota received federal (CDC) funding to participate in the National Violent Death Reporting System. Minnesota Law (§ 144.05, Subd. 5) does prohibit the health department from collecting data on individuals regarding firearm ownership.

In June 2016, the AMA adopted policy to actively lobby Congress to repeal the firearm research "ban."

MMA Policy

Firearm Related Deaths and Injuries (260.02)

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)

Firearms and Dangerous Weapons (260.07)

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)

Public Education about Firearm Injuries and Death (260.08)

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)

Firearms and Dangerous Weapons (260.1)

The MMA supports federal legislation addressing the following: 1) the federal government should resume asking questions in the National Health Interview Survey about firearm-related injury as was done prior to 1972; 2) Congress should mandate that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and 3) the National Electronic Injury Surveillance System should expand its activities to begin tracking firearm-related injuries. The MMA encourages the appropriate state agency to collect data and develop a study on the number of firearms in schools and the misuse of firearms by Minnesota youth and encourage the state to share the results of such a study with the MMA. (HD-SR31-1994; Retained as edited BT 01-15))

Firearm Locks (260.11)
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)

Gun Control (260.12)
The MMA reaffirms its support for stricter enforcement of existing firearm laws and advocates for tighter handgun control laws. (HD-R38-1995; Retained 2005)

Permit to Carry a Concealed Weapon (260.13)
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)

Firearm Mortality Surveillance System (260.17)
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)