# Student 2
# Agenda and Resolutions

National Conference of Family Medicine Residents and Medical Students
July 28 - 30, 2016 – Kansas City, MO

1. Resolution No. S2-201 — Incorporating Health Policy Education Into Medical Schools and Residency Programs
2. Resolution No. S2-202 — Policy Recommendations on Men Who Have Had Sex With Men (MSM) Blood Donation
3. Resolution No. S2-203 — Importance of Oral Health in Medical Practice
4. Resolution No. S2-204 — Investigating Supplemental Nutrition Assistance Program Block Grants
5. Resolution No. S2-205 — Increase in Supplemental Nutrition Assistance Program (SNAP) Funding
6. Resolution No. S2-206 — Climate Change Policy Adjustments
7. Resolution No. S2-207 — Physician Suicide Prevention
8. Resolution No. S2-208 — A Shot in the Dark: The Lack of Gun Violence Research is a Public Health Issue
9. Resolution No. S2-209 — Supporting Common Sense Gun Legislation
10. Resolution No. S2-210 — Improving Mental Health Care in the Primary Care Setting
11. Resolution No. S2-211 — No Child "Lead" Behind – Improving Awareness, Detection and Prevention of Lead Contamination
12. Resolution No. S2-212 — Climate Change Advocacy
13. Resolution No. S2-213 — Against Public Funding of Crisis Pregnancy Centers
14. Resolution No. S2-214 — Ending Direct Consumer Adverting
15. Resolution No. S2-215 — Improving Medical Care in Immigrant Detention
16. Resolution No. S2-216 — Improving Anal Cancer Care
17. Resolution No. S2-217 — Revisiting the Creation of an Electronic Health Record by the American Academy of Family Physicians

**RESOLUTION NO. S2-201**

**Incorporating Health Policy Education Into Medical Schools and Residency Programs**

Introduced by: Laura Doan, MD, Los Angeles, CA
Jeremy Mosher, Vallejo, CA
Megan Chock, San Diego, CA
Redmond Finney, Baltimore, MD
Abeer Mousa, Tucson, AZ

WHEREAS, Evidence shows that medical students have significant gaps in knowledge concerning the U.S. health-care system, and

WHEREAS, evidence shows that most medical students perceive that these deficiencies are not adequately addressed in the medical school curriculum, and

WHEREAS, 96 percent of surveyed medical students felt that knowledge of health policy is important to their career, and

WHEREAS, there have been several recent calls for increased attention to health policy in medical education, both in the undergraduate and post-graduate education of physicians, and

WHEREAS, the Accreditation Council for Graduate Medical Education (ACGME) endorses "systems-based practice," which requires a broader knowledge of the health-care system, as one of the six general competencies expected of all residents, and

WHEREAS, the Society of General Internal Medicine Task Force for Residency Reform recommended increased training to reduce health disparities, which should include curricular focus to address social and cultural issues of care, health policy, and health economics, and

WHEREAS, there is a growing awareness that doctors need more training in the non-clinical parts of health care, and

WHEREAS, there are several excellent and long-standing health policy courses educating residents on health policy topics applicable to daily physician practices, exposing residents to health policy careers through visits with policy makers and analysts, and promoting personal engagement in health policy, now, therefore, be it

RESOLVED That the American Academy of Family Physicians (AAFP) explore a model two-to-four week or longitudinal health policy curriculum that can be modified by chapters based on local policies, and that medical schools and residency training programs can use to teach students and residents, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) ask the Liaison Committee on Medical Education (LCME) and American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) to consider using the AAFP's model curriculum as part of their accreditation guidelines for medical schools, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) ask the Accreditation Council for Graduate Medical Education (ACGME) to consider using the AAFP's model curriculum as part of their accreditation guidelines for family medicine residency programs.

1 **RESOLUTION NO. S2-202**

2 **Policy Recommendations on Men Who Have Had Sex With Men (MSM) Blood Donation**

3 Introduced by: Diana Huang, Philadelphia, PA
4 Kyle Gleaves, Scranton, PA
5 Margot Brown, MD, Scranton, PA
6 Matt Mullane, MD, Denver, CO
7
8 WHEREAS, The American Academy of Family Physicians (AAFP) Commission on Health of the
9 Public and Science has previously agreed that the Food and Drug Administration (FDA) lifetime
10 ban on men who have had sex with men (MSM) discriminated against gay men as potential
11 donors, and
12
13 WHEREAS, the AAFP has previously written letters to the FDA encouraging it to repeal the
14 lifetime ban on blood donation by MSM, and
15
16 WHEREAS, in December 2015, the FDA overturned its previous policy of lifetime ban for MSM
17 and replaced it with a 12-month deferral period, and
18
19 WHEREAS, on July 28, 2016, the FDA opened a request for comments on the Federal Register
20 on "scientific evidence such as data from research regarding potential blood donor deferral
21 policy options to reduce the risk of HIV transmission, including the feasibility of moving from the
22 existing time-based deferrals related to risk behaviors to alternate deferral options, such as the
23 use of individual risk assessments, and
24
25 WHEREAS, comments are invited regarding the design of potential studies to evaluate the
26 feasibility and effectiveness of such alternative deferral options," now, therefore, be it
27
28 RESOLVED, That the American Academy of Family Physicians develop policy
29 recommendations for blood donation by men who have had sex with other men (MSM) by
30 studying the risks and benefits of changing the Food and Drug Administration's current 12-
31 month deferral policy on MSM blood donation and consider potential alternative deferral options,
32 such as the use of individual risk assessments, and be it further
33
34 RESOLVED, That the American Academy of Family Physicians advocate for the Food and Drug
35 Administration to adopt blood donation policies that protect the safety of blood donation while
36 avoiding discrimination towards presumed risk groups such as men who have had sex with
37 men.

1 **RESOLUTION NO. S2-203**

2 **Importance of Oral Health in Medical Practice**

3 Introduced by: Caroline Yang, Norcester, MA
4 Allen Rodriquez, Los Angeles, CA
5 Ben Meyernik, Sioux Falls, SD
6
7 WHEREAS, Although oral health is part of general health, medical and dental care have long
8 functioned separately, and
9
10 WHEREAS, Healthy People 2020 made oral health one of its top nine health indicators, yet in
11 2012 (the most recent year recorded), only 42.1% of people age two years and older had a
12 dental visit during the past 12 months, and half of the U.S seniors perceive their dental health as
13 poor or very poor, and
14
15 WHEREAS, the high cost and poor coverage of dental services is a large barrier to getting
16 proper oral care, particularly for vulnerable populations including children, the elderly, and the
17 socially and economically disadvantaged, and
18
19 WHEREAS, approximately 108 million people in the U.S. (nearly 35% of the population) do not
20 have dental insurance – more than three times the number of Americans who lack medical
21 insurance, and
22
23 WHEREAS, although Medicaid provides dental benefits for all children, only 15 state Medicaid
24 programs provide a comprehensive dental benefit for adults, and “routine dental care” is
25 explicitly excluded from Medicare by federal statue, and
26
27 WHEREAS, periodontal disease affects 743 million people worldwide, making it the sixth-most
28 common chronic condition, and affects about half of all adults in the United States, and
29
30 WHEREAS, bacteria normally found in the mouth can migrate throughout the body and affect
31 other systems, having isolated brain abscesses, placenta, and atherosclerotic plaques in
32 coronary arteries, and
33
34 WHEREAS, poor oral health can elevate risks for chronic conditions such as diabetes and heart
35 disease, and can lead to lost workdays, reduced employability, and the preventable use of
36 costly acute care, and
37
38 WHEREAS, children with poor oral health status have substantially more school absences and
39 significantly poorer academic performance compared to their peers, independent of
40 socioeconomic factors and race, and
41
42 WHEREAS, total spending on dental services reached $113.5 billion in 2014 in the United
43 States, with significant spending on restorative care for oral disease that could have been
44 prevented or diagnosed and treated more expediently, and
45
46 WHEREAS, in a national survey of pediatricians, one of the most common barriers to
47 participating in oral health-related activities was lack of training, which was endorsed by 35.4%
48 of respondents, and
49

50 WHEREAS, delivering oral health preventative care in the primary care setting offers the
51 opportunity to expand access for nearly all patients, particularly high-risk and vulnerable
52 patients who bear the greatest burden of oral disease, and
53
54 WHEREAS, Oral Health in America: A Report of the Surgeon General, published in 2000, called
55 for all healthcare providers to participate in oral healthcare, a call to action reaffirmed by the
56 Institute of Medicine in 2010 and the Health Resources and Services Administration (HRSA) in
57 2014, and
58
59 WHEREAS, HRSA developed the Integration of Oral Health and Primary Care Practice
60 (IOHPCP) initiative aimed at expanding oral health clinical competency of primary care
61 clinicians to improve early detection and preventive interventions of oral conditions, ultimately
62 leading to improved oral health, and
63
64 WHEREAS, in 2014, the American Academy of Family Physicians, the American Academy of
65 Pediatrics, and the American Academy of Pediatric Dentistry released a report entitled
66 "Interprofessional Study of Oral Health in Primary Care" with the goal of identifying elements
67 that lead to successful promotion of oral health services in primary care offices, and
68
69 WHEREAS, with appropriate training, non-dental healthcare professionals, such as physicians,
70 nurses, pharmacists, and physicians assistants, can screen for oral diseases and deliver
71 preventive care services, and
72
73 WHEREAS, it is critical for primary care providers to be educated on common oral conditions,
74 risk factors, and health behaviors along with the medical, functional, emotional, and social
75 consequences of poor oral health, now, therefore, be it
76
77 RESOLVED, That the American Academy of Family Physicians recognize the importance of
78 managing oral health as part of overall patient care, and be it further
79
80 RESOLVED, That the American Academy of Family Physicians support efforts to educate
81 physicians on oral condition screening and management, as well as the consequences of poor
82 oral hygiene on overall health, and be it further
83
84 RESOLVED, That the American Academy of Family Physicians encourage closer collaboration
85 of physicians with dental providers to provide comprehensive medical care, and be it further
86
87 RESOLVED, That the American Academy of Family Physicians support efforts to increase
88 access to oral health services.

1 **RESOLUTION NO. S2-204**

2 **Investigating Supplemental Nutrition Assistance Program Block Grants**

3 Introduced by: Kandis Samuale-Leutzinger, New Castle, DE
4 Paige Ely, Yakima, WA
5
6 WHEREAS, Children and adolescents who eat a healthful diet are more likely to reach and
7 maintain a healthy weight, achieve normal growth and development, and have strong immune
8 systems, and
9
10 WHEREAS, adults who eat a healthful diet and stay physically active can decrease their risk of
11 a number of adult-onset health conditions and diseases, including heart disease and diabetes,
12 and
13
14 WHEREAS, the Supplemental Nutrition Assistance Program (SNAP) is the largest program in
15 the domestic hunger safety net that offers nutrition assistance to millions of eligible, low-income
16 individuals and families, and
17
18 WHEREAS, the SNAP program is administered by the state which has considerable discretion
19 to adapt the program, and
20
21 WHEREAS, in 2015 SNAP provided $4.23 per person per day, and
22
23 WHEREAS, under a block grant, some states facing large budget shortfalls may shift funds from
24 food assistance to other programs including non-food components such as job training and
25 related childcare, now, therefore, be it
26
27 RESOLVED, That the American Academy of Family Physicians research the effects of block
28 grants on patient health, and be it further
29
30 RESOLVED, That the American Academy of Family Physicians oppose the implementation of
31 the Supplemental Nutrition Assistance Program (SNAP) becoming funded through block grants
32 if it decreases funding to the program.

1 **RESOLUTION NO. S2-205**

2 **Increase in Supplemental Nutrition Assistance Program (SNAP) Funding**

3 Introduced by: Paige Ely, Yakima, WA
4 Kandis Samuels-Leutzinger, New Castle DE
5
6 WHEREAS, One in five children in the United States lives in a household that worries where
7 their next meal will come from, and
8
9 WHEREAS, the Supplemental Nutrition Assistance Program (SNAP) provides nutrition
10 assistance to low-income families so that children can have proper nutrition to have adequate
11 health and succeed in school, and
12
13 WHEREAS, SNAP funding has been cut the last three years, and
14
15 WHEREAS, millions of low-income families who are struggling to put food on the table are
16 ineligible for SNAP, and
17
18 WHEREAS, of those who receive SNAP, the average amount of nutrition assistance is now only
19 $4.23 per person per day, or $1.41 per person per meal, and
20
21 WHEREAS, SNAP funding is projected to continue to decrease in coming years, now, therefore,
22 be it
23
24 RESOLVED, That the American Academy of Family Physicians lobby to maintain current
25 Supplemental Nutrition Assistance Program funding, and be it further
26
27 RESOLVED, That the American Academy of Family Physicians lobby to increase future
28 Supplemental Nutrition Assistance Program funding.

## RESOLUTION NO. S2-206

## Climate Change Policy Adjustments

Introduced by: Stewart Decker, MD, Klamath Falls, OR
Redmond Finney, Baltimore, MD

WHEREAS, The 2015 American Academy of Family Physicians (AAFP) Congress of Delegates reaffirmed the 1969 policy, “On Climate Change and Air Pollution,” stating “In recognition of the numerous and serious adverse health consequences resulting from pollution, climate change, and ozone-layer depletion, the AAFP recommends strong action on all public and private levels to limit and correct the pollution of our land, atmosphere and water,” and

WHEREAS, greenhouse gas emissions from human activities are generally recognized as the primary causative factor in modern climate change, and

WHEREAS, it is important for a medical organization such as the AAFP to specifically identify causative factors in order to better focus intervention, and

WHEREAS, the controversy surrounding greenhouse emissions from human activities is political and economic rather than scientific, and

WHEREAS, the AAFP ought to base policy on sound science and resist scientific misinformation that has a direct effect on the health of our population, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians (AAFP) update their climate change and air pollution policy to specifically include language about “greenhouse emissions from human activities,” i.e. “In recognition of the numerous and serious health consequences resulting from pollution, greenhouse emissions from human activities, climate change, and ozone layer depletion, the American Academy of Family Physicians (AAFP) recommends strong action on all public and private levels to limit and correct the pollution of our land, atmosphere and water.”

1 **RESOLUTION NO. S2-207**

2 **Physician Suicide Prevention**

3 Introduced by: Joseph Brodine, Washington, DC
4 Kristina Dakis, MD, Chicago, IL
5 Mary Warren, Washington, DC
6 Emily Graber, Chicago, IL
7
8 WHEREAS, Physicians are two-three times more likely to commit suicide compared to the
9 general U. S. population, and
10
11 WHEREAS, 10 percent of medical students and residents have experienced suicidal ideation in
12 the last year, and
13
14 WHEREAS, physicians need to care for themselves in order to be fit to care of patient, now,
15 therefore, be it
16
17 RESOLVED, That the American Academy of Family Physicians create an evidence-based
18 online toolkit for medical students, residents, and practicing physicians for suicide prevention.

1 **Resolution NO. S2-208**

2 **A Shot in the Dark: The Lack of Gun Violence Research is a Public Health Issue**

3 Introduced by: Meray Ohanassian, Gainsville, FL
4 Ashlin Mountjoy, MD, Seattle, WA
5 Alexander Langley, MD, Seattle, WA
6
7 WHEREAS, Gun violence accounts for 33,000 deaths and 76,000 non-fatal gun injuries each
8 year in the United States, and
9
10 WHEREAS, the United States has a homicide rate from gun violence that is 25.2 times greater
11 than other high-income developed countries, and
12
13 WHEREAS, there remains a ban on research determining the cause of this disparity, and
14
15 WHEREAS, Japan, Germany, Australia, and the United Kingdom have developed stricter gun
16 laws and decreased the homicide rates due to gun violence, and
17
18 WHEREAS, the United States has no evidence that previously implemented gun control policies
19 have had a similar effect, and
20
21 WHEREAS, public health research into motor vehicle accidents and tobacco use has guided
22 evidence-based interventions and policies to reduce the disease burden from these issues, and
23
24 WHEREAS, gun violence continues to be a key political issue with significant uncertainty
25 regarding the best solutions, and
26
27 WHEREAS, the American Academy of Family Physicians (AAFP) has policies on the prevention
28 of gun violence, violence as a public health concern, and firearms and safety issues, and
29
30 WHEREAS, the AAFP has partnered with other organizations to author a letter to US
31 Representatives and Senators requesting removal of restrictions on gun violence research by
32 the Centers for Disease Control and Prevention, and
33
34 WHEREAS, there has still not been action on this issue by the US Congress, now, therefore, be
35 it
36
37 RESOLVED, That the American Academy of Family Physicians continue to partner with other
38 health organizations and the Fam Med PAC to actively lobby for the removal of restrictions on
39 gun violence research.

**RESOLUTION NO.** S2-209

**Supporting Common Sense Gun Legislation**

Introduced by: Stewart Decker, MD, Klamath Falls, OR
Redmond Finney, Baltimore, MD
Maya Siegel, Baltimore, MD

WHEREAS, There were 33,636 gun deaths in the United States in 2013, which is a representative number over the last decade, and

WHEREAS, 62 percent of these deaths were completed suicides, 36 percent were homicides, and 2 percent were accidental deaths, and

WHEREAS, only 5.6 percent of all suicide attempts are with firearm, but 51-55 percent of completed suicides are with firearm, meaning that suicide attempts by firearm are 85 percent fatal, and

WHEREAS, firearms were used in 69.9 percent of all homicides in 2012, again a representative number, and

WHEREAS, if a person's preferred suicide method is unavailable, it is unlikely they will switch to a different one, and

WHEREAS, in the first week after the purchase of a handgun, the rate of suicide by means of firearms among purchasers was 57 times higher than the general population, and

WHEREAS, in the 11 states that have "waiting periods" there is a lower overall suicide rate (P=.001), a lower firearms suicide rate (P<.001), and a lower proportion of suicide deaths resulting from firearms, and

WHEREAS, in the year immediately following the repeat of their 48-hour waiting period law, South Dakota saw a 7.6-percent increase in its overall suicide rate compared with 3.3 percent for the United States in general, and

WHEREAS, in the year following implementation of a law that extended the waiting period for acquiring a handgun, Washington, DC, saw a 2.2-percent decrease in their overall suicide rate compared with a 2.1-percent increase in the United States overall, and

WHEREAS, states with laws that required background checks at the point of transfer or before obtaining a permit to purchase a handgun from a private seller exhibited a lower overall suicide rate (P<.001), a lower firearms suicide rate (P<.001), and a lower proportion of suicide deaths resulting from firearms (36.8 percent vs. 58.8 percent, P<.001), and

WHEREAS, when threatening intimate partners, gun owners are 7.8 times more likely to threaten their partners with a gun than non-gun owners, and

WHEREAS, family and intimate partner assaults with firearms are 12 more times likely to result in death than non-firearm assaults, and

49 WHEREAS, the American Academy of Family Physicians (AAFP) currently “supports increased
50 research,” “supports strong and robust enforcement of existing federal, state, and local laws and
51 regulations regarding the manufacture, sale and possession of funds,” “supports legislation
52 restricting unsupervised access to both firearms and ammunition by children,” and “opposes
53 private ownership of weapons designed primarily to fire multiple (greater than 10) rounds
54 quickly,” and
55
56 WHEREAS, the AAFP has also stated that the “background-check requirement should be
57 expanded to include the sale of firearms at gun shows, over the Internet and in classified ads,
58 and has “call(ed) for ‘an elimination of the ban on federal funding for objective, scientific
59 research on gun violence,’” and
60
61 WHEREAS, the AAFP has been uncharacteristically silent on gun control interventions such as
62 waiting periods and laws about removing guns from homes with domestic violence claims, now,
63 therefore, be it
64
65 RESOLVED, That the American Academy of Family Physicians (AAFP) support gun laws that
66 demonstrably decrease morbidity and mortality associated with gun violence in any of its forms,
67 including but not limited to a receipt of a gun-waiting period and allowance for removal of guns
68 from houses during domestic violence complaints.

1 **RESOLUTION NO. S2-210**

2 **Improving Mental Health Care in the Primary Care Setting**

3 Introduced by: Sway Wu, MD, Detroit, MI
4 Katie Zurek, MD, Traverse City, MI
5 Michael Collins, MD, Flint, MI
6 Max Weston, MD, Seattle, WA
7
8 WHEREAS, 43.8 million (about 20%) of adults in the United States experiences mental illness in
9 any given year, and
10
11 WHEREAS, only half of the patients with a mental health disorder are diagnosed, and
12
13 WHEREAS, only half of diagnosed patients are effectively treated, and
14
15 WHEREAS, access to mental health care is of significant national public health concern, now,
16 therefore, be it
17
18 RESOLVED, That the American Academy of Family Physicians provide a liaison to the
19 American Psychiatric Association to facilitate cohesion between mental health and family
20 medicine patient care, and be it further
21
22 RESOLVED, That the American Academy of Family Physicians website provide links to the
23 American Psychiatric Association for physician use in identifying mental health disorders, and
24 be it further
25
26 RESOLVED, That the American Academy of Family Physicians provide continuing medical
27 education at such events as Family Medicine Experience and the National Conference of Family
28 Medicine Residents and Medical Students to improve physician diagnosis of mental health
29 disorders.

1 **RESOLUTION NO. S2-211**

2 **No Child "Lead" Behind – Improving Awareness, Detection and Prevention of Lead**
3 **Contamination**

4 Introduced by: Allen Rodriguez, Los Angeles, CA
5 Michael Collins, MD, Grand Blanc, MI
6 Ben Meyernik, Sioux Falls, SD
7
8 WHEREAS, No safe level of lead for human consumption has ever been determined, and
9
10 WHEREAS, lead poisoning has severe adverse health effects for children and adults, including
11 impaired cognitive and behavioral development, hypertension, cardiovascular disease, toxicity
12 to the reproductive organs, miscarriages and birth complications, kidney damage, and cancer,
13 and
14
15 WHEREAS, the present value of economic losses associated with early exposure to lead,
16 including increased rates of criminality, drug abuse, incarceration, lower wages, diminished
17 lifetime earning power, and the burden of chronic diseases, is estimated at $43.4 billion
18 annually, and
19
20 WHEREAS, the Centers for Disease Control and Prevention (CDC) recognizes that reducing
21 water lead levels is an important step to primary prevention of lead exposure and elevated blood
22 lead levels in children, and
23
24 WHEREAS, the 1974 Safe Drinking Water Act authorizes the Environmental Protection Agency
25 (EPA) to establish minimum treatment and testing standards to protect tap water, require all
26 owners or operators of public water systems to comply with health-related standards, and grant
27 primary enforcement responsibility to states to implement safe drinking water standards on
28 behalf of the EPA, and
29
30 WHEREAS, public water systems are responsible for collective drinking water samples, sending
31 samples for analysis by laboratories certified by the state or EPA, and reporting water quality
32 parameters, including lead and c copper levels, to the state, and
33
34 WHEREAS, states and the EPA are jointly responsible for working with public water systems to
35 take steps to prevent or remove contaminants and notify consumers when water-testing results
36 indicate that a contaminant exceeds federal standards under the Safe Drinking Water Act, and
37
38 WHEREAS, EPA water testing requirements set by the 2005 Lead and Copper Rule specify
39 lead levels must be tested in one liter of first-draw water taken after the water has been standing
40 in the pipes for at least six hours, and
41
42 WHEREAS, public water systems across the Eastern U.S. have adopted methods, including
43 pre-flushing taps before gathering testing samples, in order to lower the amount of lead
44 detected in water contaminant tests, and
45
46 WHEREAS, public officials at the state and municipal level have 1) failed to adequately test for
47 lead in water, 2) failed to mitigate lead contamination in water despite knowledge of exposure,
48 and 3) failed to mitigate lead contamination in water to the public (e.g. Flint, MI and Newark, NJ

49 where health departments were aware of dangerous levels of contamination for months before
50 taking action), and
51
52 WHEREAS, an Associated Press analysis of EPA data found that nearly 1,400 water systems
53 serving 3.6 million Americans exceeded the federal lead limit of 15 parts per billion at least once
54 between January 1, 2013 and September 30, 2015, including both public and private water
55 systems in 41 states, and
56
57 WHEREAS, a Today analysis of EPA data showed 350 schools and child care facilities
58 exceeded the federal lead limit a total of 470 times from 2012 to 2015, and
59
60 WHEREAS, 90,000 public schools and 500,000 child care facilities are not regulated under the
61 Safe Drinking Water Act because they rely on municipal water utilities instead of maintaining
62 their own water supplies and are, therefore, not required to test drinking water quality, and
63
64 WHEREAS, lead is the most prevalent toxicant in U.S. school drinking water, and
65
66 WHEREAS, children in low-income families tend to reside in older houses, which are more likely
67 to contain lead pipes, and experience a significantly greater burden of lead poisoning than their
68 peers, and
69
70 WHEREAS, it is difficult to fully assess the effect of water lead levels on blood lead levels of
71 children and other at-risk populations, as current water sampling protocols were designed to
72 assess water treatment, not the level of human exposure to lead, now, therefore, be it
73
74 RESOLVED, That the American Academy of Family Physicians support future research
75 collaborations with other epidemiological and public health organizations regarding water
76 sampling techniques and reporting protocols to better detect and how to reduce human
77 exposure to lead at the point of consumption, and be it further
78
79 RESOLVED, That the American Academy of Family Physicians support innovative testing
80 practices for water utilities and at risk populations, such as schools and child care facilities, to
81 accurately measure and reflect lead contamination levels in water, incorporating Environmental
82 Protection Agency testing guidelines, and be it further
83
84 RESOLVED, That the American Academy of Family Physicians support improved open public
85 access to testing data on water lead levels by requiring all public water system testing results be
86 posted on a publicly available website in an appropriate and timely fashion, and be it further
87
88 RESOLVED, That the American Academy of Family Physicians support federal legislation to
89 reduce, and ultimately, remove lead from the country's public and private water infrastructure,
90 especially focusing on low-income areas, which have the highest burden of lead poisoning, and
91 be it further
92
93 RESOLVED, That the American Academy of Family Physicians support efforts by the
94 Environmental Protection Agency (EPA) to examine compliance with the Safe Drinking Water
95 Act for appropriate water utilities and to exercise the EPA's oversight and enforcement authority
96 to ensure public protection from lead contamination, and be it further
97
98 RESOLVED, That the American Academy of Family Physicians support research and
99 collaboration with the Environmental Protection Agency (EPA) and other public health

100 stakeholders into the development of a standardized national reporting procedure for blood
101 levels of toxic metals.

**RESOLUTION NO. S2-212**

**Climate Change Advocacy**

Introduced by: Stewart Decker, MD, Klamath Falls, OR
Redmond Finnery, Baltimore, MD
Maya Siegel, Baltimore, MD

WHEREAS, The health implications of climate change have a profound direct and indirect effect on the health of our patients, and

WHEREAS, the Lancet Commission on Climate Change and Health states that "..tackling climate change could be the greatest global health opportunity of the 21st century" and "(t)he effects of climate change are being felt today, and future projections represent an unacceptably high and potentially catastrophic risk to human health;", and

WHEREAS, the World Health Organization estimates that between 2030 and 2050 climate change is expected to cause approximately 250,000 additional deaths per year, from malnutrition, malaria, diarrhea, and heat stress, and

WHEREAS, direct damage costs to health is estimated to be between U.S. $2-4 billion/year by 2030, and

WHEREAS, the 2015 United Nations Framework Convention on Climate Change (UNFCCC) Conference of Parties 21 (COP21) resulted in the Paris Agreement, in which government agreed to:

1. "aim to limit [global average temperature] increase(s) to 1.5C, since this would significantly reduce risks and the impacts of climate change;"
2. Peak global emissions as soon as possible,
3. Utilize the best current science utilizing carbon sinks to decrease net emission reduction,
4. Utilize systems of accountability and transparency to assure goals are met,
5. Support climate action in developing countries, and

WHEREAS, the agreement will open for ratification between April 2016-2017 and will only become binding if 55 countries that produce at least 55% of the world's greenhouse gas emissions ratify the agreement, and

WHEREAS, the United States was the second largest producer of greenhouse gasses in 2010, responsible for 15.6% of global production, and

WHEREAS, the Paris Agreement utilizes Nationally Determined Contributions (NDCs) to quantify and make binding an individual country's emission reduction targets but does not detail how to do so, and

WHEREAS, the United States' NDC is to achieve an economy-wide reduction of its greenhouse gas emissions by 26-28% below its 2005 level in 2025, and

WHEREAS, health professionals have an obligation to advocate for efforts to improve the health of our patients, now, therefore, be it

50 RESOLVED, That the American Academy of Family Physicians endorse U.S. efforts to develop
51 and implement national policies that facilitate U.S. compliance with the 2015 United Nations
52 Framework Convention on Climate Change international agreement reached by over 190
53 countries in Paris, and be it further
54
55 RESOLVED, That the American Academy of Family Physicians recommend to medical schools,
56 National Board of Medical Examiners (NBME), the Liaison Committee on Medical Education
57 (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the American
58 Board of Family Medicine that medical education curricula, core competencies and/or
59 milestones should include the effects of climate change on human health, including on the
60 social determinants of health, and be it further
61
62 RESOLVED, That the American Academy of Family Physicians support local and national
63 climate change mitigation and adaptation strategies which seek to realize the United States'
64 Nationally Determined Contribution by (1) endorsing state and federal legislation and
65 regulations to curb greenhouse gas emissions and (2) collaborating with other health
66 professional and environmental organizations to promote ambitious national and international
67 action on climate change, and be it further
68
69 RESOLVED, That the American Academy of Family Physicians provide education to its
70 members on methods for achieving environmental sustainability of medical workplaces (e.g.
71 reducing energy use, increasing energy efficiency, etc.), and be it further
72
73 RESOLVED, That the American Academy of Family Physicians express to appropriate entities
74 in writing its support for the prioritization of epidemiological, translational, clinical and basic
75 science research necessary for evidence-based global climate change policy decisions related
76 to health care and treatment.

**RESOLUTION NO. S2-213**

**Against Public Funding of Crisis Pregnancy Centers**

Introduced by: Maya Siegel, Baltimore, MD
Naomi Gorfinkle, Baltimore, MD
Redmond Finney, Baltimore, MD
Stewart Decker, MD, Klamath Falls, OR

WHEREAS, The importance of the patient-physician relationship is integral to patient health, trust of physicians, and the health care system as a whole, and

WHEREAS, “crisis pregnancy centers” often masquerade as women’s health clinics, misleading women in relation to their reproductive health, while often not having a physician or nurse on staff, and

WHEREAS, many of these centers choose names similar to women’s health clinics to confuse patients, and

WHEREAS, these centers often try to frighten patients with misleading films or pictures to influence women seeking abortion care against obtaining an abortion, and

WHEREAS, these centers are known to give incomplete or misleading information about pregnancy options including abortion, adoption, and parenting, and

WHEREAS, many states have introduced legislation that would require women to attend these centers prior to obtaining an abortion, and

WHEREAS, these centers have been known to misinform women of their pregnancy status and dating thereby leading women to think they are earlier along in their pregnancy, and

WHEREAS, these efforts to misinform can divert women from accessing comprehensive and timely care from appropriately trained and licensed medical providers, and

WHEREAS, the American Academy of Family Physicians policy states that “the woman considering an elective abortion should be informed adequately of the potential health risks of both abortion and continued pregnancy”, and

WHEREAS, women who go to one of these centers often feel mislead and may lose trust in medical providers as a whole, and

WHEREAS, 12 states provide public funding to these centers, and

WHEREAS, 20 states refer women to crisis pregnancy centers or compel physicians to provide a list of these centers to patients, and

WHEREAS, the public funding of these centers indicates a public support of these institutions, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians oppose funding of “crisis pregnancy centers” at the national level and other organizations that mislead patients to further

50 a political or religious agenda, or to delay them from getting adequate reproductive care, and be
51 it further
52
53 RESOLVED, That the American Academy of Family Physicians oppose legislation that requires
54 women to attend crisis pregnancy centers prior to obtaining an abortion or requires physicians
55 to provide information about crisis pregnancy centers.

1 **RESOLUTION NO. S2-214**

2 **Ending Direct Consumer Adverting**

3 Introduced by: Stewart Decker, MD, Klamath Falls, OR
4 Redmond Finny, Baltimore, MD
5
6 WHEREAS, The United States (U.S.) and New Zealand are the only two countries in the world
7 that allow direct-to-consumer advertising (DTCA) of prescription drugs, and
8
9 WHEREAS, DTCA spending in the U.S. was $4.23 billion in 2014, up from 18% from $3.83
10 billion in 2013, and
11
12 WHEREAS, drug spending increased 86% between 1997 and 2001, up about 18% from $3.83
13 billion in 2013, and
14
15 WHEREAS, increases in DTCA between 1999 and 2000 accounted for 12% of drug sales
16 growth during that period, resulting in an additional $2.6 billion in drug spending in 2000, and
17
18 WHEREAS, physicians wrote 34.2% more prescriptions in 1999 than in 1998 for the 25 most
19 DTCA – promoted drugs, and
20
21 WHEREAS, physicians wrote only 5.1% more prescriptions for all other prescription drugs, and
22
23 WHEREAS, the Food and Drug Administration (FDA) is charged with regulation of the accuracy,
24 honesty, and legality of DTCA but is increasingly unable to do so efficiently due to underfunding
25 despite expansion of responsibilities, resulting in a decreased number of regulatory letters and
26 delay in receipt of them (the FDA sees the ads after they air, when the public does), and
27
28 WHEREAS, 78% of physicians believe their patients understand the possible benefits of
29 advertised drugs very well or somewhat well but only 40% believe their patients understand the
30 possible risks, and
31
32 WHEREAS, 65% of physicians believe DTC ads confuse patients about the relative risks and
33 benefits of prescription drugs, and
34
35 WHEREAS, 75% of physicians believed that DTC ad cause patients to think that the drug works
36 better than it does, and
37
38 WHEREAS, 58% of physicians agreed strongly that DTC ads make the drugs seem better than
39 they really are, and
40
41 WHEREAS, the success or failure of a pharmaceutical should depend on its safety and efficacy
42 rather than the skill of its marketing team, and
43
44 WHEREAS, the American television viewer watches as many as nine drug ads a day, totaling
45 16 hours per year, which far exceeds the amount of time the average individual spends with a
46 primary care physician, and
47
48 WHEREAS, in November 2015 the American Medical Association called for “Ban on Direct to
49 Consumer Advertising of Prescription Drugs and Medical Devices” by convening a physician

50 task force and launching an advocacy campaign to promote prescription drug affordability
51 through pushes for greater transparency from drug makers in how they price their medicines,
52 and
53
54 WHEREAS, The American Academy of Family Physicians (AAFP) policy on DTCA currently
55 states “The AAFP supports efforts by manufacturers of prescription pharmaceuticals,
56 nonprescription medications, health care devices and health related products and services to
57 provide general health information to the public. At the same time, the AAFP urges that any
58 direct-to-consumer advertising of prescription drugs by pharmaceutical companies be based on
59 disease state only, without mention of a specific drug by name,” and includes a list of conditions
60 that must be met to maintain acceptability, now, therefore, be it
61
62 RESOLVED, The American Academy of Family Physicians change its policy to support a ban
63 on and/or limitations on direct-to-consumer advertising of prescription drugs and medical
64 devices, and be it further
65
66 RESOLVED, That the American Academy of Family Physicians reach out to the American
67 Medical Association to coordinate on efforts to advocate in support of a ban on and/or limitation
68 on direct to consumer advertising.
69

**Resolution NO. S2-215**

**Improving Medical Care in Immigrant Detention**

Introduced by: Sean McClellan, Chicago, IL
Lauren Williams, MD, Minneapolis, MN

WHEREAS, Resolution No. 410 “Addressing Immigrant Discrimination and Health Disparities” adopted at the 2014 Congress of Delegates resolved “That the American Academy of Family Physicians support policies to reduce health disparities borne by immigrants, refugees or asylees,” and

WHEREAS, the United States has the capacity to hold more than 34,000 non-citizens a night in civil detention, and

WHEREAS, studies by Human Rights Watch and other independent organizations have demonstrated that medical care in immigrant detention centers is substandard, and

WHEREAS, medical neglect has led to at least 7 of 18 deaths reviewed by medical experts between 2013 and 2015, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians advocate through appropriate channels for detained immigrants to receive healthcare to meet or exceed Commission on Correctional Health Care standards for prison and jail healthcare, and be it further

RESOLVED, That the American Academy of Family Physicians advocate through appropriate channels to reduce immigrant detention by releasing people with serious medical and mental health needs, particularly when individuals require higher-level care, and be it further

RESOLVED, That the American Academy of Family Physicians advocate channels to shift current funding for detention to community based alternatives which will allow people to seek medical attention and receive support from family, legal counsel and community, and be it further

RESOLVED, That the American Academy of Family Physicians advocate to remove supervision of medical care in immigrant detention centers from Immigration and Customs Enforcement to maintain clinical independence, and be it further

RESOLVED, That the American Academy of Family Physicians advocate to ensure that inspections of medical care at immigrant detention centers provide meaningful oversight.

1 **RESOLUTION NO. S2-216**

2 **Improving Anal Cancer Care**

3 Introduced by: William Guerin, Lebanon, NH
4 Pie Pichetsurnthorn, Wichita, KS
5 Jerry Abraham, MD, Los Angeles, CA
6 Matt Mullane, MD, Denver, CO
7
8 WHEREAS, Anal cancer is a preventable, treatable, deadly disease with a rising rate of
9 incidence and mortality, and
10
11 WHEREAS, the United States Preventive Services Task Force, American Cancer Society,
12 Centers for Disease Control and Prevention, and the Infectious Society of America make no
13 recommendations regarding screening for anal care, and
14
15 WHEREAS, the American Academy of Family Physicians is uniquely positioned to serve the
16 needs of members of high-risk communities like people living with human immunodeficiency
17 virus/acquired immunodeficiency syndrome, men who have sex with men, and people with a
18 history of anoreceptive intercourse, now, therefore, be it
19
20 RESOLVED, That the American Academy of Family Physicians educate its members about anal
21 cancer and the risks and benefits of screening, diagnosis, and treatment, and be it further
22
23 RESOLVED, That the American Academy of Family Physicians develop clinical practice
24 guidelines for family physicians in the screening, diagnosis, and treatment of anal cancer.

1 **RESOLUTION NO. S2-217**

2 **Revisiting the Creation of an Electronic Health Record by the American Academy of**
3 **Family Physicians**


4 Introduced by: Daniel E. Edmondson, Reno, NV
5 Elizabeth P. Pionk, DO, Bay City, MI
6 Travis Walker, MD, Reno, NV


7

8 WHEREAS, Electronic health records are intended to enhance quality of patient care by
9 reducing medical costs, and
10
11 WHEREAS, the efficacy of electronic health records are limited by the availability of these
12 records across many different healthcare systems nationally, and
13
14 WHEREAS, current electronic health record system use has been found to be associated with
15 increased physician stress and burnout, as well as decreased physician satisfaction, and
16
17 WHEREAS, the American Academy of Family Physicians has in the past considered creating an
18 electronic health record system, now, therefore, be it
19
20 RESOLVED, That the American Academy of Family Physicians create their own electronic
21 health record system, particularly developed for family physicians, and be it further
22
23 RESOLVED, That the American Academy of Family Physicians develop and publish person
24 centric guidelines of what should be included in an electronic health record.