



2018 Agenda for the Reference Committee on Advocacy

National Conference of Constituency Leaders — Sheraton Kansas City Hotel at Crown Center

<u>Item No.</u>	<u>Resolution Title</u>
1. Resolution No. 1001	Decriminalization of Non-disclosure of HIV Status
2. Resolution No. 1002	Support Creation of Physician Union Constructs Within Antitrust
3. Resolution No. 1003	Intimate Partner Violence as a Cause of Maternal Mortality
4. Resolution No. 1004	Transportation of Drug Overdose Patients
5. Resolution No. 1005	Oppose “Fetal Personhood” Terminology in Governmental Policies and Legislation
6. Resolution No. 1006	Opioid Advertising Ban
7. Resolution No. 1007	Removing REMS Categorization on Mifepristone
8. Resolution No. 1008	Oppose the Criminalization of Self-Induced Abortion
9. Resolution No. 1009	Removing Gag Clauses from PBM Contracts
10. Resolution No. 1010	Reinforce Support of Ensuring Accurate Medical Information at Crisis Pregnancy Centers (CPCs)
11. Resolution No. 1011	New Approaches to Gun Violence Prevention
12. Resolution No. 1012	AAFP Statement on Nondiscrimination
13. Resolution No. 1013	Advocating for Equitable Pay for Women and Minority Family Physicians
14. Resolution No. 1014	Address Institutional Racism in the Health Care System



Resolution No. 1001

2018 National Conference of Constituency Leaders — Sheraton Kansas City Hotel at Crown Center

1 Decriminalization of Non-disclosure of HIV Status

2
3 Submitted by: Marty Player, MD, LGBT
4 Brent Suigmoto, MD, MPH, LGBT
5 Tisha Boston, MD, FAAFP, Minority
6 Cathleen London, MD, Women

7
8 WHEREAS, Twenty-five states have laws criminalizing non-disclosure of HIV status to sexual
9 partners even when there is no intent to harm, and

10
11 WHEREAS, purposeful or malicious transmission of HIV with the intent to harm others is a rare and
12 separate issue, and already covered by existing criminal laws, and

13
14 WHEREAS, there are no scientific studies showing that HIV-specific non-disclosure laws
15 encourage people to disclose their HIV status, nor do they decrease the spread of HIV, and

16
17 WHEREAS, such laws actually harm public health by increasing HIV stigma, which has been
18 associated with less effective HIV prevention and treatment, and

19
20 WHEREAS, HIV disclosure has been shown to increase the risk of intimate partner violence for
21 disclosing women and men, and

22
23 WHEREAS, enforcement of such laws disproportionately affects people of color, and

24
25 WHEREAS, the following organizations already oppose such laws: American Medical Association,
26 HIV Medicine Association, Infectious Disease Society of America, American Psychological
27 Association, Association of Nurses in AIDS Care, and the National Alliance of State and Territorial
28 AIDS Directors, now, therefore, be it

29
30 RESOLVED, That the American Academy of Family Physicians, in order to support HIV prevention
31 efforts, adopt a policy recommending the decriminalization of HIV and the repeal or reform of these
32 laws to eliminate HIV-specific criminal penalties, and be it further

33
34 RESOLVED, That the American Academy of Family Physicians create a State Legislative Issue
35 Backgrounder recommending the decriminalization of HIV and the repeal or reform of these laws to
36 eliminate HIV-specific criminal penalties.



Resolution No. 1002

2018 National Conference of Constituency Leaders — Sheraton Kansas City Hotel at Crown Center

1 Support Creation of Physician Union Constructs Within Antitrust

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3 Submitted by: Harshini Jayasuriya, MD, Minority
4 Micheline Epstein, MD, Minority

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6 WHEREAS, Physician groups are currently siloed with little to no agency to advocate directly to
7 employers on work conditions, and

8
9 WHEREAS, we see physician burnout as a consistent pillar of discussion across platforms, and

10
11 WHEREAS, improvements in labor laws/rights as defined as work hours, overtime expectations,
12 vacation, break times, employer expectations, non-punitive mental health support, and workplace
13 safety, administrative time, and

14
15 WHEREAS, unions can be created outside payment, compensation, financial bargaining or "price
16 fixing", but on work conditions and standards, and

17
18 WHEREAS, physicians need to speak the language of business and organize to represent
19 themselves, now, therefore, be it

20
21 RESOLVED, That the American Academy of Family Physicians support the creation of physician
22 unions through platform or campaign, and be it further

23
24 RESOLVED, That the American Academy of Family Physicians support the creation of physician
25 unions through platform or campaign and gather the support of other organizations such as
26 American Medical Association to push forth this initiative in grassroots, statewide, and national
27 activities.



Resolution No. 1003

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1 Intimate Partner Violence as a Cause of Maternal Mortality

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3 Submitted by: Mary Harrel, MD, Women
4 Katherine Jacobson, MD, Women
5 Sarah Ledger, DO, Women

6
7 WHEREAS, Maternal death or pregnancy related death is defined by the Centers for Disease
8 Control and Prevention (CDC) as "the death of a woman while pregnant or within one year of
9 termination of pregnancy – regardless of outcome, duration or site of pregnancy- from any cause
10 related to or aggravated by the pregnancy or its management but not from accidental or incidental
11 causes," and

12
13 WHEREAS, the CDC does not delineate intimate partner violence as a cause of maternal mortality
14 consistently, and

15
16 WHEREAS, intimate partner violence increases during pregnancy and is a cause of maternal
17 death, now, therefore, be it

18
19 RESOLVED, That the American Academy of Family Physicians promote and advocate for research
20 and data collection regarding intimate partner violence related maternal mortality.



Resolution No. 1004

2018 National Conference of Constituency Leaders — Sheraton Kansas City Hotel at Crown Center

1 Transportation of Drug Overdose Patients

2
3 Submitted by: Kevin Wong, MD, CMD, FAAFP, Minority
4 Tasha Starks, MD, Minority
5 Harshini Jayasuriya, MD, Minority

6
7 WHEREAS, First responders treating narcotic overdose patients with narcan cannot force them to
8 be transported to an Emergency Room, and

9
10 WHEREAS, recurrent drug overdoses are becoming common events, sometimes the same patient
11 in the same day and sometimes with fatal results, and

12
13 WHEREAS, getting instant access and follow up for medication-assisted treatment may decrease
14 recurrences and fatalities, now, therefore, be it

15
16 RESOLVED, That the American Academy of Family Physicians work with US Department of
17 Health and Human Services to educate first responders about the importance of transporting a
18 narcotic overdose patient to an emergency room after administering treatment, and be it further

19
20 RESOLVED, That emergency room providers, once verifying the patient had a narcotic overdose,
21 initiate medication assisted treatment in an emergency room, and be it further

22
23 RESOLVED, That emergency room staff arrange next day follow up for the medication-assisted
24 patient to help minimize the risk of recurrent narcotic overdose.



Resolution No. 1005

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1 **Oppose “Fetal Personhood” Terminology in Governmental Policies and Legislation**

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3 Submitted by: Tabatha Wells, MD, FAAFP, New Physician
4 Betsy Gilbertson, MD, New Physician
5 Emily Young, DO, MPH, MA, New Physician
6 Cathleen London, MD, Women
7 Ivonne McLean, MD, New Physician
8 Martha Simmons, MD, General Registrant
9 Nicole Chaisson, MD, Women

10
11 WHEREAS, Fetal personhood is not a medical term, and

12
13 WHEREAS, current politicians have used the following language in multiple proposed bills on the
14 state and national levels: “fetal personhood”, “child in utero”, “unborn child”, “a human being at any
15 stage of development”, and

16
17 WHEREAS, the establishment of fetal rights is in direct conflict with the constitutional rights of the
18 pregnant person, and

19
20 WHEREAS, “the unborn have never been recognized in the law as persons in the whole sense”
21 and have not been afforded rights as an entity separate from the pregnant person, and

22
23 WHEREAS, fetal personhood language included in legislation is designed to undermine women’s
24 rights and access to abortion, and

25
26 WHEREAS, the use of fetal personhood terminology in legislation has far reaching implications on
27 the bodily autonomy of the pregnant person, for instance, patient access to safe and effective
28 assisted reproductive technologies, such as in vitro fertilization and selective reduction, and

29
30 WHEREAS, the use of fetal personhood terminology has additional implications on the bodily
31 autonomy and safety of the pregnant person including, but not limited to, access to abortion and
32 the ability of a pregnant person to make medical decisions surrounding birth, now, therefore, be it

33
34 RESOLVED, That the American Academy of Family Physicians publicly oppose the use of fetal
35 personhood language in policies and legislative initiatives, and be it further

36
37 RESOLVED, That the American Academy of Family Physicians develop appropriate materials for
38 the state advocacy website to assist members to advocate their opposition to fetal personhood
39 language in policies and legislative initiatives at the state and national level.



Resolution No. 1006

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1 Opioid Advertising Ban

8 WHEREAS, 40 people die every day from overdoses involving prescription opioids, and

10 WHEREAS, 11.5 million Americans engaged in non-medical use of prescription opioids in 2016,
11 and

12 WHEREAS, 249 million prescriptions for opioid pain medication were written by health-care
13 providers in 2013, and

15
16 WHEREAS, Americans, aged 12 or older, either abused or were dependent on prescriptions
17 opioids in 2014, and

18 WHEREAS, opioids killed more than 42,000 people in 2016, of which 40% involved a prescription
19 opiate and
20

21
22 WHEREAS opioid medications are addictive and

23
24 WHEREAS, the American Academy of Family Physicians direct-to-consumer advertising policy
25 states "Advertisements should not promote the use of products that have addictive or abuse
26 potential," and

28 WHEREAS, the Opioid Advertising and Prescriber Prohibition Act of 2018 is being introduced to
29 Congress, which will ban direct-to-consumer (DTC) pharmaceutical company advertising of opioid
30 drugs and opioid receptor antagonists, now, therefore, be it

32 RESOLVED, That the American Academy of Family Physicians actively support legislation
33 prohibiting direct-to-consumer pharmaceutical company advertising of opioid drugs and opioid
34 receptor antagonists, now, be it further
35

36 RESOLVED, That the American Academy of Family Physicians actively support legislation
37 prohibiting promotion of opioid drugs and opioid receptor antagonists to health-care providers.



Resolution No. 1007

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1 Removing REMS Categorization on Mifepristone

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3 Submitted by: Carrie Pierce, MD, Women
4 Anna Lowell, DO, MPH, Minority
5 Natalie Hinchcliffe, DO, BA, LGBT
6 Brian Frank, MD, New Physician
7 Ike Okwuwa, MD, FAAFP, IMG
8

9 WHEREAS, The Food and Drug Administration (FDA) uses the Risk Evaluation and Mitigation
10 Strategies (REMS) classification to impose restrictions on only the most dangerous drugs with
11 known or suspected serious complications or contraindications, and

12 WHEREAS, mifepristone is part of the safest and most effective medication abortion regimen
13 currently available, and

14 WHEREAS, although the current FDA label for mifepristone was modified in 2016 to reflect more
15 evidenced-based dosing and gestational limits, the label still includes a REMS classification
16 requiring three provisions to “assure safe use,” including that 1) mifepristone be dispensed in a
17 healthcare setting under supervision from 2) a provider who is registered and has signed a
18 provider agreement with the pharmaceutical distributor, and 3) the patient sign an FDA-approved
19 Patient Agreement Form, and

20 WHEREAS, the American Academy of Family Physicians (AAFP) “supports a woman's access to
21 reproductive health services and opposes non-evidence-based restrictions on medical care and
22 the provision of such services,” and

23 WHEREAS, the REMS restrictions on mifepristone are not based on scientific evidence and cause
24 significant barriers to accessing abortion care, such as landlords whose leases don't allow
25 abortions to be done on site, managers who won't allow stocking of mifepristone, and colleagues
26 who object to provision, and

27 WHEREAS, stocking mifepristone in the office causes an upfront expense and financial burden
28 which can be difficult for small practitioners to bear, further decreasing access for patients who
29 might prefer to go to their own physician, and for rural patients who have no other access points
30 beyond their local physician, and

31 WHEREAS, There are 16 years of data proving an outstanding safety record of mifepristone,
32 including a 0.05% risk of major complications, and

33 WHEREAS, other drugs with higher complication rates, such as acetaminophen, aspirin,
34 loratadine, and sildenafil, do not have REMS restrictions, and

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43 WHEREAS, the REMS classification contributes to delays in care, thereby increasing second-
44 trimester and surgical abortions, both of which have increased complication rates, and
45
46 WHEREAS, the REMS classification creates a barrier to safe and effective off-label uses of
47 mifepristone, such as for anti-corticoid treatment of Cushing's disease, term labor induction, and
48 miscarriage management, and
49
50 WHEREAS, the American College of Obstetricians and Gynecologists (ACOG) "believes that a
51 Risk Evaluation and Mitigation Strategy (REMS) is no longer necessary for mifepristone, given its
52 history of safe use, and
53
54 WHEREAS, the REMS requirement is inconsistent with requirements for other drugs with similar or
55 greater risks, especially in light of the significant benefit that mifepristone provides to patients,"
56 now, therefore, be it
57
58 RESOLVED, That the American Academy of Family Physicians endorse the principle that the Risk
59 Evaluation and Mitigation Strategies (REMS) classification on mifepristone is not based on
60 scientific evidence and limits access to abortion care, and be it further,
61
62 RESOLVED, That the American Academy of Family Physicians engage in advocacy and lobbying
63 efforts to overturn the Risk Evaluation and Mitigation Strategies (REMS) classification on
64 mifepristone.



Resolution No. 1008

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1 Oppose the Criminalization of Self-Induced Abortion

2
3 Submitted by: Natalie Hinchcliffe, DO, BA, LGBT
4 Martha Simmons, MD, General Registrant
5 Sheleatha Taylor-Bristus, MD, New Physician
6 Wayne Forde, MD, FAAFP, Minority
7 Hannah Biederman, MD, Women
8 Julie Johnston, MD, FAAFP, General Registrant
9 Carrie Pierce, MD, Women
10 Mark McLoney, MD, FAAFP, General Registrant
11 Amanda Meegan, DO, LGBT
12 Anna Lowell, DO, MPH, Minority

13
14 WHEREAS, Self-induced abortion involves patients attempting to induce abortion without medical
15 assistance, and

16
17 WHEREAS, laws criminalizing self-induced abortion increase health risks and deter patients from
18 seeking necessary health care services related to self-induced abortion or miscarriage, and

19
20 WHEREAS, laws criminalizing patients who self-induce abortion lead to increased suspicion
21 towards patients presenting to health care providers for miscarriage, and

22
23 WHEREAS, from the beginning of 2011 through July 2016, states enacted 334 new legal
24 restrictions on abortion, further limiting access to abortion care, and

25
26 WHEREAS, in 2018 alone, 695 provisions have already been introduced to further restrict abortion,
27 and

28
29 WHEREAS, national studies of abortion patients have shown that approximately 2% of patients
30 attempted to self induce an abortion at some point in their lives, and

31
32 WHEREAS, that number is higher in states such as Texas with stricter legal restrictions on
33 abortion, where one study showed that 7% of patients attempted some method to end their
34 pregnancy before presenting to the clinic, and

35
36 WHEREAS, Google search trends from 2005 and 2015 have shown a relative increase in searches
37 for self-induced abortion that correlate with state-based abortion restrictions, and

38
39 WHEREAS, including a recent online study of 1,235 people who google searched “self-abortion”,
40 of whom almost three-quarters (73%), indicated that they were searching for information because
41 they were pregnant and did not or may not want to be, and

42

43 WHEREAS, the ability and willingness to access medical care if complications relating to self-
44 induced abortion arise is essential for patient safety, and
45
46 WHEREAS, people of color are disproportionately targeted for prosecution and criminalization
47 related to pregnancy outcomes, and
48
49 WHEREAS, the Academy of Obstetricians and Gynecologists (ACOG) has taken a very strong
50 position that patients should not be prosecuted for trying to end their own pregnancies, and
51
52 WHEREAS, ACOG additionally opposes forcing physicians to share information about patients due
53 to its burdensome interference in the patient-provider relationship, now, therefore, be it
54
55 RESOLVED, That the American Academy of Family Physicians advocate and lobby against
56 legislative efforts to criminalize self-induced abortion.



Resolution No. 1009

2018 National Conference of Constituency Leaders — Sheraton Kansas City Hotel at Crown Center

1 Removing Gag Clauses from PBM Contracts

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3 Submitted by: David Hoelting, MD, LGBT
4 Tiffany Leonard, MD, FAAFP, LGBT
5 Chad Douglas, MD, LGBT

6

7 WHEREAS, Pharmacy Benefits Managers (PBMs) can currently impose "gag clauses" within their
8 pharmacy contracts banning pharmacists from telling patients when the out-of-pocket cost of drugs
9 is less than the copay through their insurance, and

10

11 WHEREAS, PBMs may end contracts with, or impose penalties on, pharmacists who violate the
12 "gag clause," and

13

14 WHEREAS, these "gag clauses" are believed to contribute to the rising cost of health care for
15 patients, and

16

17 WHEREAS, these "gag clauses" also limit transparency and patient autonomy in making medical
18 decisions, and

19

20 WHEREAS, multiple states have already passed laws that prohibit such "gag clauses", including
21 Arizona, Florida, Mississippi, Missouri, New Hampshire, New York, Pennsylvania, South Carolina,
22 Virginia, and Washington, and

23

24 WHEREAS, there are currently two bills before the Senate (S. 2553 "Know the Lowest Price Act of
25 2018" and S. 2554 "Patient Right to Know Drug Prices Act") aimed at prohibiting such "gag
26 clauses" within Medicare and Marketplace plans now, therefore, be it

27

28 RESOLVED, That the American Academy of Family lobby for passage of legislation, inclusive of
29 but not limited to S. 2553 ("Know the Lowest Price Act of 2018") and S. 2554 ("Patient Right to
30 Know Drug Prices Act"), which prohibit Pharmacy Benefits Managers from including "gag clauses"
31 in their contracts on a national level, and be it further

32

33 RESOLVED, That the American Academy of Family Physicians develop a tool kit to offer to the
34 chapters to better enable them to promote open communication between pharmacists and patients
35 regarding medication pricing.



Resolution No. 1010

2018 National Conference of Constituency Leaders Sheraton Kansas City Hotel at Crown Center

1 Reinforce Support of Ensuring Accurate Medical Information at Crisis Pregnancy Centers (CPCs)

2
3 Submitted by: Anna Sliwowska, MD, Women
4 Anna Lowell, DO, MPH, Minority

5 Tabatha Wells, MD, FAAFP, New Physician
6 Martha Simmons, MD, General Registrant
7 Hannah Biederman, MD, Women

8
9 WHEREAS, The Congress of Delegates adopted substitute Resolution No. 502 (New York B)
10 entitled Ensure Accurate Medical Information at Crisis Pregnancy Centers (CPCs) in 2011, and

11
12 WHEREAS, the American Academy of Family Physicians (AAFP) sent a letter to the Secretary of
13 HHS on July 20, 2012, and

14
15 WHEREAS, a letter dated November 7, 2012 from Secretary Sebeluis' office was received at
16 AAFP in response to the AAFP letter of July 20, 2012, and

17
18 WHEREAS, CPCs continue to proliferate since 2012, and it is estimated that there are between
19 2,500 and 4,000 centers across the United States compared to approximately 800 abortion clinics,
20 and

21
22 WHEREAS, women are entitled to comprehensive and unbiased medical information and CPCs
23 have been shown to intentionally mislead women with inaccurate or incomplete medical
24 information, and

25
26 WHEREAS, CPCs are not required to employ staff who are medically trained or appropriately
27 qualified to diagnose and accurately date pregnancy, and

28
29 WHEREAS, CPCs continue to secure public money without public accountability, as an example
30 Pennsylvania gave more than \$30 million from 2012 to 2017 to Real Alternatives, a network of
31 pregnancy centers and, now, therefore, be it

32
33 RESOLVED, That the American Academy of Family Physicians support efforts to hold crisis
34 pregnancy centers accountable for false or misleading advertising about the pregnancy-related
35 services they offer, and be it further

36
37 RESOLVED, That the American Academy of Family Physicians engage in advocacy and lobbying
38 efforts to support legislation mandating that crisis pregnancy centers disclose whether or not there
39 is a licensed medical provider on staff and to disclose that they do not provide or refer for
40 contraception or abortion services, and be it further

41
42 RESOLVED, That the American Academy of Family Physicians oppose the use of federal funds to
43 support crisis pregnancy centers, and be it further, and be it further

44 RESOLVED, That the American Academy of Family Physicians support efforts to hold crisis
45 pregnancy centers accountable for false or misleading advertising about the pregnancy-related
46 services they offer.



Resolution No. 1011

2018 National Conference of Constituency Leaders — Sheraton Kansas City Hotel at Crown Center

1 New Approaches to Gun Violence Prevention

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3 Submitted by: Nicole Boersma, MD, Women
4 Kristin Mack, DO, Women
5 Bridget Lynch, MD, Women
6 Cadey Harrel, Women
7 Sarah Ledger, Women
8 Lindsey Kурделwood, Women
9

10 WHEREAS, The American Academy of Family Physicians (AAFP) policy statement entitled
11 "Violence as a Public Health Concern" recognizes that violence in all forms is a public health
12 concern germane to the sphere of influence of family medicine, and

13 WHEREAS, the AAFP policy statement entitled "Firearms and Safety Issues" states that the
14 Academy "supports strong and robust enforcement of existing federal, state, and local laws
15 regarding the manufacture, sale, and possession of guns" as well as "strongly supports legislation
16 restricting unsupervised access to both firearms and ammunition by children," and

17 WHEREAS, the AAFP policy statement entitled "Prevention of Gun Violence" states that "The
18 federal requirement for an on-site background check should ensure that those who have been
19 convicted of a violent criminal offense and those who have been involuntarily committed to a
20 mental institution or otherwise adjudicated to be suffering a severe mental condition posing a
21 danger to others or themselves are not able to purchase firearms," and

22 WHEREAS, domestic violence assaults involving firearms are twelve times more likely to result in
23 death than assaults without them, and

24 WHEREAS, studies have demonstrated that the major risk factor for intimate partner homicide is
25 prior domestic violence, and

26 WHEREAS, the Brady Amendment to the Federal Gun Control Act of 1968 bars the possession of
27 firearms by individuals convicted of misdemeanor or felony crimes of domestic violence, but
28 provides no mechanism by which these firearms are to be removed from the offender, and

29 WHEREAS, an Extreme Risk Protection Order (ERPO) or Gun Violence Restraining Order (GVRO)
30 is a gun violence prevention law that permits police or family members to petition a state court to
31 order the temporary removal of firearms from a person who may present a danger, and

32 WHEREAS, family physicians are a point of contact for persons affected by domestic violence in its
33 early stages, and are in a position to provide resources to and promote the safety of persons so
34 affected, and

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43 WHEREAS, five states have passed some version of ERPO/GVRO laws and as of as of 2018, 32
44 additional ERPO/GVRO bills were being considered in 19 states plus Washington, DC, and
45

46 WHEREAS, ERPO/GVRO laws have been conditionally supported by the National Rifle
47 Association (NRA) as of March, 2018, and have seen bipartisan support in legislation, now,
48 therefore, be it

49
50 RESOLVED, That the American Academy of Family Physicians strongly support gun violence
51 prevention laws that permit police or family members to petition a state court to order the
52 temporary removal of firearms from a person who may present a danger to others or themselves,
53 and be it further

54
55 RESOLVED, That the American Academy of Family Physicians develop or collect and disseminate
56 education regarding gun violence prevention laws to its membership.



Resolution No. 1012

2018 National Conference of Constituency Leaders — Sheraton Kansas City Hotel at Crown Center

1 AAFP Statement on Nondiscrimination

2 Submitted by: Joe Freund, MD, FAAFP, LGBT

3 Shannon Bentley, MD, LGBT

4 Mark McLoney, MD, General Registrant

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6 WHEREAS, Current policy of the American Academy of Family Physicians (AAFP) includes
7 equality for same-gendered families, and

8

9 WHEREAS, the AAFP definition of a family includes same-gendered families, and

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11 WHEREAS, the AAFP has a policy against discrimination in health care, and

12

13 WHEREAS, there is already a deficiency in services for families and providers to care for children
14 in foster care, now, therefore, be it

15

16 RESOLVED, That the American Academy of Family Physicians (AAFP) Board of Directors publicly
17 oppose any changes to federal policy which conflicts with AAFP's non-discrimination policy
18 regarding healthcare and adoption, and be it further

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20 RESOLVED, The American Academy of Family Physicians Board of Directors release an
21 immediate statement in opposition to Senate Bill 811 and House Bill 1881 which allows for
22 discrimination regarding adoption.

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Resolution No. 1013

2018 National Conference of Constituency Leaders — Sheraton Kansas City Hotel at Crown Center

1 Advocating for Equitable Pay For Women and Minority Family Physicians

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3 Submitted by: Brian Frank, MD, New Physician
4 Jewell Carr, MD, New Physician

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6 WHEREAS, The American Academy of Family Physicians (AAFP) has renewed its dedication to
7 equity with the creation of a Center for Diversity and Health Equity, and

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9 WHEREAS, we know that income disparity is a key component of societal inequity that directly
10 impacts health and

11
12 WHEREAS, the AAFP supports transparency and equity in physician compensation, and

13
14 WHEREAS, the AAFP recommends expanding efforts to increase the representation of women
15 and minorities in medicine, and

16
17 WHEREAS, the AAFP supports equal social, economic and professional opportunity for all
18 members, and

19
20 WHEREAS, the AAFP is committed to positioning itself in a leadership role to create a medical
21 workforce reflective of the patient populations family physicians serve, and

22
23 WHEREAS, patient/provider race congruence leads to greater patient satisfaction and higher
24 utilization of timely, recommended care, and

25
26 WHEREAS, student loan debt disproportionately affects racial minorities, and

27
28 WHEREAS, gender and racial pay gaps persist in the medical profession, now, therefore, be it

29
30 RESOLVED, That the American Academy of Family Physicians create a policy statement
31 supporting equitable pay for women and minority family physicians, and be it further

32
33 RESOLVED, That the American Academy of Family Physicians (AAFP) advocate for legislation for
34 equitable pay for women and minority family physicians, which will ultimately benefit both of these
35 constituency groups within the AAFP.



Resolution No. 1014

2018 National Conference of Constituency Leaders — Sheraton Kansas City Hotel at Crown Center

1 Address Institutional Racism in the Health Care System

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3 Submitted by: Daniel Neghassi, MD, Minority
4 Ivonne McLean, MD, New Physician
5 Martha Simmons, MD, General Registrant
6 Brian Frank, MD, New Physician
7 Natalie Hinchcliffe, DO, BA, LGBT
8 Hannah Biederman, MD, Women
9 Wayne Forde, MD, FAAFP, Minority

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11 WHEREAS, The American Academy of Family Physicians (AAFP) recognizes that "health is a
12 basic human right" and opposes racial and other forms of discrimination against patients, and

13
14 WHEREAS, health care has been historically racially segregated, and

15
16 WHEREAS, during the Jim Crow era, most hospitals explicitly did not accept patients of color or
17 only had few beds in a separate substandard section, and

18
19 WHEREAS, despite the civil rights movement and the implementation of Medicare which forced
20 hospitals to accept patients of color, racial segregation in health care exists to this day and

21
22 WHEREAS, even after controlling for insurance status, black residents of New York City were only
23 half as likely as White residents to get their care in academic medical centers, a difference not
24 explained by hospital location, and

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26 WHEREAS, black and Latinx people are more likely than white people to be uninsured or to
27 receive Medicaid with Latinx nonelderly adults are nearly two and half times as likely to be
28 uninsured than nonelderly white adults, and

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30 WHEREAS, racial segregation also exists within single institutions, often "under the guise of
31 segregation by insurance status," and

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33 WHEREAS, many hospitals have different outpatient settings for different "types" of patients (i.e.,
34 clinics for Medicaid and uninsured patients, and faculty practices for privately insured patients),
35 and

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37 WHEREAS, clinics tend to be staffed by physicians-in-training and lack continuity of care, and they
38 have much longer wait times than faculty practices, and

39
40 WHEREAS, many outcomes are poorer among people of color compared with white people with
41 maternal mortality over three times higher for black women compared with white women, and

42
43 WHEREAS, Medicaid fee structures have different reimbursements for different practice types, and

44 WHEREAS, in New York State, clinics are reimbursed at higher rates by Medicaid than faculty or
45 private practices which encourages hospitals to have separate clinics for Medicaid, and

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47 WHEREAS, indigent care funds are inequitably distributed among hospitals, such that academic
48 medical centers and other private hospitals that provide care to few uninsured patients tend to
49 receive disproportionate amount of funds, now, therefore, be it

50
51 RESOLVED, That the American Academy of Family Physicians adopt a policy opposing
52 segregation of patient care within the health care system and within health care institutions by
53 race, insurance status, or other demographics, and be it further

54
55 RESOLVED, That the Center for Diversity and Health Equity develop materials and provide
56 education to increase awareness of how racism is manifested through institutional policies and
57 how segregated care within the health care system is a cause of racial disparities in health
58 outcomes, and be it further

59
60 RESOLVED, That the American Academy of Family Physicians advocate for equal payment for
61 health care services regardless of insurance status of the patient and regardless of practice type,
62 immediately by restoring the provisions of the Patient Protection and Affordable Care Act which
63 mandated an increase in Medicaid rates, and be it further

64
65 RESOLVED, That the American Academy of Family Physicians advocate for fair allocation of
66 indigent care funds either by allocating funds to hospitals proportional to the amount of charity care
67 provided or, in the future, by attaching those funds directly to assist patients in accessing care, and
68 be it further

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70 RESOLVED, That the American Academy of Family Physicians advocate for policies that mandate
71 hospitals to track and report accurate data on out-patient visits, appointment waiting times,
72 utilization of high-tech resources and patient satisfaction by patients' race and insurance status.