Student 1
Agenda and Resolutions

National Conference of Family Medicine Residents and Medical Students
July 27 -29, 2017 – Kansas City, MO

1. Resolution No. S1-101 — Expanding “Housing First” Programs for People Experiencing Homelessness
2. Resolution No. S1-102 — Healthcare is a Human Right
3. Resolution No. S1-103 — Maximizing Representation of Racial and Ethnic Health Subpopulations in Data
4. Resolution No. S1-104 — Electronic Health Record Optimization Through Interoperabilty
5. Resolution No. S1-105 — Electronic Medical Records and Clinical Photography
6. Resolution No. S1-106 — Improving EHR Inter-Operability via Smart Card Technology
7. Resolution No. S1-107 — Combine NCSM and NCFMR
8. Resolution No. S1-108 — Improved and Expanded Medicare for All (Single Payer)
9. Resolution No. S1-109 — Actively Improving the Ethnic and Gender Diversity of the AAFP Board of Directors

Resolution NO. S1-101

Expanding “Housing First” Programs for People Experiencing Homelessness

Introduced by: Paige Ely, Mt Vernon, Washington
Lara Wilson, Seattle, Washington
Roxanne Hicks, Seattle, Washington

WHEREAS, In a single night in 2016, 549,928 people were experiencing homelessness in the United States, and

WHEREAS in 2014, it was estimated that 7 million people were staying with friends and family temporarily and at risk of homelessness, and

WHEREAS, people experiencing homelessness are at two to five times higher risk of death compared to people with housing of the same age, and

WHEREAS, supportive housing policies such as “Housing First” policies that combine rapid access to permanent housing with community-based, integrated treatment, rehabilitation and support services have been shown to improve the health of people experiencing homelessness and may also reduce their overall use of medical services, and

WHEREAS, Housing First programming for the chronically homeless in Seattle has been shown to save $2449 per person per month after accounting for housing costs, with similar findings of cost savings in other states, and

WHEREAS, the Centers for Medicare and Medicaid Services recognizes that providing housing-related activities and services for persons experiencing chronic homelessness is cost-effective, and other states have made efforts to use Medicaid funds to help people, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians advocate for the expansion of “Housing First” programs that provide affordable, accessible, and secure housing options for people experiencing homelessness or at risk of homelessness, combining rapid access to permanent housing with community-based, health rehabilitation and support services.

Resolution NO. S1-102

Healthcare is a Human Right

Introduced by: Kale Flory, St. Joseph, Missouri
Keanan McGonigle, New Orleans, Louisiana

WHEREAS, The American Academy of Family Physicians strategic objectives include the advancement of health care for all, and

WHEREAS, the current health care financing system has inherent barriers that can make patient care unaffordable, inequitable, and fragmented, and

WHEREAS, the United States is one of the only industrialized nations that doesn't provide universal access to health care, and

WHEREAS, the United States has the highest cost per capita of any industrialized nation but still ranks last among the industrialized nations in healthcare outcomes, and

WHEREAS, nearly 30 million Americans are still uninsured after full implementation of the Affordable Care Act (ACA), and

WHEREAS, many Americans die each year because they lack health insurance, as the uninsured have an increased risk of death compared to the insured, and

WHEREAS, insurance coverage does not mean patients have access to care if the premiums, co-pays, and deductibles are not affordable to families in need, and the narrower networks being provided further limit access, and

WHEREAS, the American Health Care Act proposed by the current administration in Washington dismantles the ACA and will likely lead to an additional 24 million people without health insurance, and

WHEREAS, the editor-in–chief of the Journal of the American Medical Association exhorts professional societies to speak with a single voice and say that health care should be a basic right for every person, and not a privilege, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians recognize that health care is a basic human right for every person and not a privilege.

Resolution NO. S1-103

Maximizing Representation of Racial and Ethnic Health Subpopulations in Data

Introduced by: Emmeline Ha, Washington, DC
Jamie Majdi, Washington, DC
Dylan Nehrenberg, Kent, Washington
Linda Ataifo, Washington, DC
Lucia Xiong, Albuquerque, New Mexico

WHEREAS, Data collected by federal agencies, including data on health care, education, and housing, must comply to standards governed by the White House Office of Management and Budget, whose “Standards for the Classification of Federal Data on Race and Ethnicity” has not been revised since 1997, and

WHEREAS, the Office of Management and Budget’s standards currently include five categories for self-reporting data on race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White; and two categories for ethnicity: Hispanic or Latino and Not Hispanic or Latino, and

WHEREAS, the Office of Management and Budget race standards do not adequately address those of Middle Eastern, North African, or combined race descent and do not recognize the distinct ethnicities within race, and

WHEREAS, policy decisions, federal funding programs, and research should depend on meaningful granular data to address disparities within the population, and

WHEREAS, racial minorities are known to experience different health outcomes due to disparities in access to care, health literacy, and socioeconomic constraints, and

WHEREAS, specific subpopulations within racial groups face disproportionate health disparities; for example, data in 2010 showed that overall uninsured rate for Asians was around 15%, but Cambodians were uninsured at a rate of 21%, Bangladeshis and Koreans at 22%, and Pakistanis at 23%, and

WHEREAS, some federal agencies, including the United States Census Bureau and Department of Health and Human Services, have expanded the Office of Management and Budget’s standards for race and ethnicity data collection to be more inclusive and

WHEREAS, the AAFP Center for Diversity and Health Equity was created in 2016 to strive for health equity and has a goal of advocating for policies that address social determinants of health, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians Center for Diversity and Health Equity create a public statement of support for changes to data collection so that subpopulations are identified in order to acknowledge and mitigate distinct health disparities, and be it further

RESOLVED, That the American Academy of Family Physicians advocate for the amendment and expansion of the White House Office of Management and Budget’s “Standards for the Classification of Federal Data on Race and Ethnicity” to have federal data collection reflect the actual racial and ethnic demographics in America.

Resolution NO. S1-104

Electronic Health Record Optimization Through Interoperabilty

Introduced by: Jenna Schmidt, Nome, Alaska
Rebekah Fabela, Pikeville, Kentucky

WHEREAS, Electronic health record use has been as high as 78% in 2013, and

WHEREAS, electronic health record interoperabilty does not fully include data interface via finding, sending, receiving, and integration of data from external systems, and

WHEREAS, interoperability improves care coordination between hospital and state networks, reduces costs, and may improve patient outcomes, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians will advocate for legislation to mandate electronic health record (EHR) interoperability through a simple, secure interface.

Resolution NO. S1-105

Electronic Medical Records and Clinical Photography

Introduced by: Rebekah Fabela, Pikeville, Kentucky
Jenna Schmidt, Nome, Alaska

WHEREAS, Not all electronic health record systems in use have direct image capabilities, and

WHEREAS, the use of clinical photography and diagnostic imaging has increased dramatically over the past decade in screening, surveying, diagnosis, and treatment, and

WHEREAS, the American Academy of Family Physicians supports innovation to improve the healthcare of patients, families, and communities, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians actively encourages and initiates conversation with electronic health record system providers as well as implementation of clinical image photography capabilities in all electronic health record systems nationwide.

Resolution NO. S1-106

Improving EHR Inter-Operability via Smart Card Technology

Introduced by: Adam Bortner, Baltimore, Maryland

WHEREAS, The American Academy of Family Physicians (AAFP) supports inter-operability of electronic health records (EHR) and connected care that benefits patients and their primary care physicians, and

WHEREAS, many health systems in countries outside the United States (U.S.) have used the implementation of providing patients with encrypted smart cards to allow all doctors involved in a patient's care to have immediate access to their complete medical record, and

WHEREAS, such access could save valuable time in primary care, improve patient safety by reducing omissions from oral histories, and minimize wasteful and harmful duplication of exams, laboratory studies, imaging, and prescriptions, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians investigate and create policy related to using smart card technology in the hands of patients as a means to improve electronic health record system inter-operability in the United States health system.

1 **Resolution NO. S1-107**
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3 **Combine NCSM and NCFMR**
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5 Introduced by: Matthew Peters, Klamath Falls, Oregon
6 Laura Ruhl, Flemington, New Jersey
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8 WHEREAS, the American Academy of Family Physicians (AAFP) has run separate a National
9 Congress of Student Members (NCSM) and a National Congress for Family Medicine Residents
10 (NCFMR) for at least 35 years, and
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12 WHEREAS, a large fraction of resolutions each year are duplicated between the National
13 Congress of Student Members (NCSM) and National Congress for Family Medicine Residents
14 (NCFMR), and
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16 WHEREAS, a large majority of resolutions from NCSM and NCFMR have historically applied to
17 both medical students and residents, and
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19 WHEREAS, a combined body of medical students and family medicine residents could reduce
20 redundancy, simplify logistics, and reduce costs for the AAFP, and
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22 WHEREAS, a combined body of medical students and family medicine residents could allow
23 AAFP staff and resources to be reallocated to other programs supporting family medicine
24 residents and students, and
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26 WHEREAS, a combined body of medical students and family medicine residents could create
27 more opportunities for mentorship between family medicine residents and medical students from
28 respective constituencies, and
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30 WHEREAS, a combined body of medical students and family medicine residents would more
31 closely mirror the two delegate per constituency structure of Congress of Delegates, now,
32 therefore, be it
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34 RESOLVED, That the American Academy of Family Physicians consider combining the National
35 Congress of Student Members and National Congress of Family Medicine Residents to form a
36 unified voting body for voting on resolutions.

1 **Resolution NO. S1-108**
2
3 **Improved and Expanded Medicare for All (Single Payer)**
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5 Introduced by: Kale Flory, St. Joseph, Missouri
6 Keanan McGonigle, New Orleans, Louisiana
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8 WHEREAS, The cornerstone of a well-functioning heath care system requires a robust primary
9 care work force that provides timely, cost effective, comprehensive care to the entire
10 community, and
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12 WHEREAS, the multiple different third party payment systems currently in place in the United
13 States further compounds the problems of physician burnout, quality, access, and cost
14 (administrative costs estimated to consume 25-30% of all health care spending), and
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16 WHEREAS, despite improvements and gains made with full implementation of the Affordable
17 Care Act of 2010, roughly 27 million Americans remain uninsured and 43 million under age 65
18 are underinsured, and
19
20 WHEREAS, it has been estimated that for every one million people who are uninsured,
21 approximately 1,000 will die because of not having health insurance, and
22
23 WHEREAS, most Americans cite medical bills as a leading cause of filing for bankruptcy, while
24 most of those who claim medical reasons, had private health insurance, and
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26 WHEREAS, one in three Americans cite financial reasons for not seeking medical care in a
27 timely basis, while increased participation in both employer-based and directly-purchased High
28 Deductible High Co-pay (HDHP) Health Plans, creates a growing number of people who delay
29 care regardless of income level, and
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31 WHEREAS, the current congressional efforts regarding health care reform do not address
32 administrative complexities and cost barriers, and could further erode funding and access for
33 low income, medically complex, disabled, and elderly citizens, now, therefore, be it
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35 RESOLVED, That the American Academy of Family Physicians will endorse a privately
36 delivered, publicly funded system that will expand and improve our current Medicare program,
37 while specifically avoiding grouping people based on age, income, medical complexity,
38 employment status, disability, or geographic location, and be it further
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40 RESOLVED, That although the the American Academy of Family Physicians acknowledges the
41 insurance industry may play a role in administering such a plan, it will specifically avoid investor
42 owned corporations from being involved in any medically necessary care, and be it further
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44 RESOLVED, That the American Academy of Family Physicians will utilize its resources, draw
45 upon its knowledge of population health, and capitalize on its political influence to advocate for
46 Improved Medicare for All with our colleagues, the public, and our legislators.

1 **Resolution NO. S1-109**
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3 **Actively Improving the Ethnic and Gender Diversity of the AAFP Board of Directors**
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5 Introduced by: Devesh (Dev) Vashishtha, San Diego, California
6 Allen Rodriguez, Los Angeles, California
7 Antoinette Mason, San Diego, California
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9 WHEREAS, Family physicians in the United States are an increasingly diverse group of
10 individuals by various categories including gender, race/ethnicity, and sexuality, and
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12 WHEREAS, diversity in leadership increases the availability of new ideas and fosters
13 innovation, and
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15 WHEREAS, the American Academy of Family Physicians (AAFP) Board of Directors has a total
16 of 18 members, of whom 5 are women, 3 are people of color and none are of Asian or Hispanic
17 origin, and
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19 WHEREAS, a substitute resolution adopted during the 2017 business session of the National
20 Conference of Constituency Leaders asked the AAFP to add a seat to its Board of Directors to
21 represent the women, minority, IMG and LGBT member constituencies, and
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23 WHEREAS, one seat is insufficient to meet the requirements for a diverse board, now,
24 therefore, be it
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26 RESOLVED, That the student and resident branches of the American Academy of Family
27 Physicians (AAFP) release a statement on the importance of diversity in AAFP leadership, and
28 be it further
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30 RESOLVED, That the American Academy of Family Physicians make further efforts to recruit
31 and retain women and people of color in positions of leadership, and be it further
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33 RESOLVED, That the American Academy of Family Physicians Congress Delegates consider
34 diversity when electing the board of directors.