Resident 3
Agenda and Resolutions

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

1. Resolution No. R3-601	Eliminating the Gender Salary Wage Gap
2. Resolution No. R3-602	Uniformed Service Student Dual Membership
3. Resolution No. R3-603	Uniformed Services members Self-Identification
4. Resolution No. R3-604	Advocate for Medication Coverage Until Prior Authorization is Decided
5. Resolution No. R3-605	Protecting Resident Education By Limiting Time Spent on Prior Authorizations
6. Resolution No. R3-606	Asking Gender Identity and the Clinic Experience of Transgender Patients
7. Resolution No. R3-607	Enhanced Understanding of MACRA, Medicare Access and CHIP Reauthorization Act of 2015, for Resident and Student AAFP Members
8. Resolution No. R3-608	Climate Change Policy Adjustments
9. Resolution No. R3-609	Policy Recommendations on Men Who Have Had Sex With Men (MSM) Blood Donation
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12. Resolution No. R3-612	Lobby to End Step 2 CS and Level PE
13. Resolution No. R3-613	Student Debt Reform
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15. Resolution No. R3-615	Climate Change Advocacy
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18. Resolution No. R3-618	Enacting a Divestment Strategy
19. Resolution No. R3-619	Public Facility Use and Transphobia
20. Resolution No. R3-620	Supporting Medicare Drug Negotiating Powers
21. Resolution No. R3-621	Protecting Rural Family Medicine Training Programs During the AOA/ACGME Merger
22. Resolution No. R3-622	Promoting the Resident and Student Discussion Forum

RESOLUTION NO. R3-601

Eliminating the Gender Salary Wage Gap

Introduced by: Jessica Tucker, Athens, OH
Scott Morris, Columbus, OH

WHEREAS, The percentage of women in medicine has been on the rise since the 70's and,

WHEREAS, women currently compose half of all U.S. medical school graduates, and

WHEREAS, the salary discrepancy between genders in 2016 of newly trained physicians in New York State has increased from $3,600 in 1999 to $16,819 in 2008, and

WHEREAS, a recently published study in *JAMA* evaluating over 24 U.S. public medical schools found that female physicians made markedly less than male physicians despite multivariable adjustments including age, experience, specialty, faculty rank, and measures of research productivity and clinical revenue with an absolute difference of $19,878, and

WHEREAS, the gap that exists between male and female earnings cannot be explained by productivity or any other professional factors, and

WHEREAS, the American Academy of Family Physicians (AAFP) has existing policy supporting the principle that hiring, credentialing, and privileging decisions for physicians should be based solely on verifiable professional criteria, and

WHEREAS, the AAFP has existing policy endorsing the goal of equitable representation of women as medical students, staff and leadership positions in academic medicine, and

WHEREAS, the AAFP has already published a strategic objective to improve payment equity for family physicians by reducing the income gap between family physicians and subspecialties now, therefore, be it

RESOLVED, That the American Academy of Family Physicians (AAFP) develop a strategic objective to the AAFP strategic plan to improve payment equity for female family physicians by advocating for the elimination of the income gap between male and female family physicians, and be it further

RESOLVED, That the American Academy of Family Physicians advocate to eliminate payment inequity between male and female family physicians, and be it further

RESOLVED, That the American Academy of Family Physicians discuss and promote existing and potential programs to eliminate payment inequity between male and female family physicians.

RESOLUTION NO. R3-602

Uniformed Service Student Dual Membership

Introduced by: Brittany Herits, DO, Camp Ujeure, NC
Alex Knoblock, MD, Eglen AFB, FL
Stephen Young, MD, Fort Bragg, NC

WHEREAS, There is currently no ability for medical students to obtain a secondary membership with the Uniformed Services Academy of Family Physicians, and

WHEREAS, there is currently no student delegate to the Uniformed Services chapter as the position was unable to be filled, now, therefore, be it

RESOLVED, That medical students who self-identify as active duty, reserve, or receipt of a Health Professions Scholarship be able to obtain a secondary membership to the Uniformed Services Academy of Family Physicians in addition to their primary state chapter members.

RESOLUTION NO. R3-603

Uniformed Services Members Self-Identification

Introduced by: Brittany Herits, DO, Camp Lejeune, NC
Alex Knobloch, MD, Eglin AFP, FL
Stephen Young, MD, Fort Bragg, NC

WHEREAS, There is currently no mechanism to self-identify as active duty, reserve, or recipient of a Health Professions Scholarship, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians investigate the feasibility of a mechanism of self-identification as active duty, reserve or recipient of a Health Professions Scholarship for the purposes of increasing awareness and membership in the Uniformed Services Academy of Family Physicians.

Resolution NO. R3-604

Advocate for Medication Coverage Until Prior Authorization is Decided

Introduced by: Marcus Wing, DO, Columbus, OH
Scott Morris, DO, Columbus, OH

WHEREAS, Family physicians act in the best interest of their patients, and

WHEREAS, 69% of physicians wait several days to receive prior authorizations from an insurer for medications, while 10% wait more than a week, and

WHEREAS, delay in patient care leads to increased emergency room visits and costs, and

WHEREAS, delay in patient care leads to poor patient outcomes, including an increase in morbidity and mortality, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians advocate that patients receive medications until their prior authorizations are resolved.

RESOLUTION NO. R3-605

Protecting Resident Education By Limiting Time Spent on Prior Authorizations

Introduced by: Scott Morris, D.O., Columbus, OH
Marcus Wing, D.O., Columbia, OH

WHEREAS, Family resident physicians act in the best interest of their patients, and

WHEREAS, insurance companies have decided upon certain prescription drug formularies in order to control their costs, and

WHEREAS, the residents have discovered that the responsibility of completing the intricate prior authorization process falls upon themselves and their support staff, and

WHEREAS, the resident spends approximately three hours per week interacting with these health plans, and

WHEREAS, insurance companies have no investment to reduce loss of clinical education of the resident, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians improve patients' access to the medication they need, and be it further

RESOLVED That the American Academy of Family Physicians reduce the amount of time residents spend on administrative tasks related to prior authorizations.

RESOLUTION NO. R3-606

Asking Gender Identity and the Clinic Experience of Transgender Patients

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

WHEREAS, The importance of transgender-inclusive health care is widely recognized, and

WHEREAS, the American Academy of Family Physicians (AAFP) supports Lesbian-Gay-Bisexual-Transgender-Questioning inclusive health care, and

WHEREAS, the Health Resources and Services Administration's (HRSA) most recent Uniform Data System reporting change mandates that Federally Qualified Health Centers (FQHC) report all patients' sex assigned at birth as distinct from their gender identify, and

WHEREAS, the gender identity of transgender and gender non-binary patients continues to be in effectively ascertained in clinics and recorded in most electronic medical records, often being confused with sex, and

WHEREAS, "misgendering" (the act of referring to someone by gender pronouns other than the ones they prefer) in healthcare settings continues to occur, and

WHEREAS, "misgendering" in healthcare settings continues to alienate transgender and gender non-binary patients and hinder their ability to form trusting relationships with healthcare providers, and

WHEREAS, transgender individuals feel that the majority of healthcare professionals are inadequately equipped to care for their specific health needs, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians (AAFP) collaborate with partner organizations to develop best practices with regard to making clinics a safe place for transgender and gender non-binary patients and publish them on the AAFP's website (aafp.org), and be it further

RESOLVED, That these best practices include asking the gender identity of all patients as a distinct entity from their sex assigned at birth in accordance with the most recent Health Resources and Services Administration (HRSA) policy, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) approach electronic health record vendors about including a designated space in their demographic sections to specifically ask patients' gender identity as distinct from their sex assigned at birth in the medical record.

RESOLUTION NO. R3-607

Enhanced Understanding of MACRA, Medicare Access and CHIP Reauthorization Act of 2015, for Resident and Student AAFP Members

Introduced by: Elizabeth Pionk, D.O., Bay City, MI
Daniel Edmondson, Reno, NV

WHEREAS, Medicare Access and CHIP Reauthorization Act of 2015 implements many changes and adopts a quality payment program (QPP) that utilizes a merit-based payment system (MIPS), and alternative payment programs (APMs), and

WHEREAS, medical school and residency programs rarely incorporate payment programs and reform routinely in lectures and curriculum, and

WHEREAS, the American Academy of Family Physicians website addresses practice based learning and physician leadership in patient centered medical homes in recommended curriculum for residency program directors and staff, but neither address MACRA, and

WHEREAS, centralized sources of information regarding payment programs and reform that are dependable, unbiased, and applicable to family medicine resident and medical students are scarce, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians (AAFP) create an online module, handout, or webinar addressing Medicare Access and CHIP Reauthorization Act of 2015 and its quality payment programs (QPP), merit-based payment system (MIPS) and alternative payment programs (APMs), at the appropriate level and context for family medicine residents and medical students on the AAFP website as well as on the Family Medicine Interest Group (FMIG) Network, and be it further

RESOLVED That the American Academy of Family Physicians offer Medicare Access and CHIP Reauthorization Act of 2015 based informative lectures for family medicine residents and medical students at the National Conference for Family Medicine Residents and Medical Students.

RESOLUTION NO. R3-608

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."

RESOLUTION NO. R3-609

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

Introduced by: Diana Huang, Philadelphia, PA
Kyle Gleaves, Scranton, PA
Margot Brown, MD, Scranton, PA
Matt Mullane, MD, Denver, CO

WHEREAS, The American Academy of Family Physicians (AAFP) Commission on Health of the Public and Science has previously agreed that the Food and Drug Administration (FDA) lifetime ban on men who have had sex with men (MSM) discriminated against gay men as potential donors, and

WHEREAS, the AAFP has previously written letters to the FDA encouraging it to repeal the lifetime ban on blood donation by MSM, and

WHEREAS, in December 2015, the FDA overturned its previous policy of lifetime ban for MSM and replaced it with a 12-month deferral period, and

WHEREAS, on July 28, 2016, the FDA opened a request for comments on the Federal Register on "scientific evidence such as data from research regarding potential blood donor deferral policy options to reduce the risk of HIV transmission, including the feasibility of moving from the existing time-based deferrals related to risk behaviors to alternate deferral options, such as the use of individual risk assessments, and

WHEREAS, comments are invited regarding the design of potential studies to evaluate the feasibility and effectiveness of such alternative deferral options," now, therefore, be it

RESOLVED, That the American Academy of Family Physicians develop policy recommendations for blood donation by men who have had sex with other men (MSM) by studying the risks and benefits of changing the Food and Drug Administration's current 12-month deferral policy on MSM blood donation and consider potential alternative deferral options, such as the use of individual risk assessments, and be it further

RESOLVED, That the American Academy of Family Physicians advocate for the Food and Drug Administration to adopt blood donation policies that protect the safety of blood donation while avoiding discrimination towards presumed risk groups such as men who have had sex with men.

Resolution NO. R3-610

Discontinuation of Discriminating Native American Imagery

Introduced by: Emilia Vesper, Minneapolis, MN
Lauren Williams, MD, Minneapolis, MN

WHEREAS, The American Academy of Family Physicians values healthy families and communities, and

WHEREAS, the suicide rate amongst Native American youth is rising with a current rate of 18% of suicide deaths this year, and

WHEREAS, Native American men are five times as likely to commit suicide, and

WHEREAS, imagery in the form of “native” names, mascots, negative imagery in sports teams perpetuates negative racial stereotypes, and

WHEREAS, the American Psychological Association recognized that racism and racial discrimination are attitudes and behaviors that are earned and threaten human development, and

WHEREAS, perpetuation of negative imagery and lack of positive imagery leads to low self-esteem of native youth, contributing to suicide, as well as predisposes native youth to physical violence and bullying from others, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians support discontinuation of disparaging Native American imagery in the form of “native” names and mascots of sport teams, schools, and athletic programs.

RESOLUTION NO. R3-611

Partnerships in Developing a Rural Training Database

Introduced by: Matthew Peters, Boise, ID
Julie Petersen, DO, Columbus, OH

WHEREAS, The American Academy of Family Physicians has a large number of members who practice in rural settings, and

WHEREAS, rural practice presents unique challenges and opportunities to family physicians and trainees in family medicine, and

WHEREAS, it is challenging for medical students and residents to find opportunities for rural training unless such offerings are provided by their program or institution, and

WHEREAS, organizations such as Rural Training Track Collaborative and National Rural Health Association are seeking to expand rural training options for students, residents, and practicing family physicians, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians collaborate with the Rural Training Track Collaborative and National Rural Health Association to help develop a database of rural training opportunities for family physicians, residents, and medical students.

RESOLUTION NO. R3-612

Lobby to End Step 2 CS and Level PE

Introduced by: Matthew Peters, Boise, ID
Victoria Boggiano, Palo Alto, CA
John Nguyen, MD, Tucson, AZ
Kyle Gleaves, Scranton, PA
Alex Mroszczyk-McDonald, MD, Fontana, CA

WHEREAS, The United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills exam was originally designed to assess the English proficiency, clinical skills, and communication skills of foreign medical graduates who desired to complete residency training in the United States, and

WHEREAS, data from the National Board of Medical Examiners (NBME) demonstrates that pass rates for medical students at United States and Canadian medical schools have been greater than or equal to 95% since 2004, and

WHEREAS, research to date has not shown significant correlations between Step 2 Clinical Skills results and improved patient safety, and

WHEREAS, studies demonstrate clinical skills scores added no additional predictive value beyond the written USMLE exams, and

WHEREAS, a recent study suggested the true cost for detecting a “double failure” (a student who failed the Step 2 CS 2- 3 times and failed to graduate from medical school) may be high as $1.1 million, which does not include cost of travel, lodging, or preparation materials, and

WHEREAS, the USMLE Step 2 Clinical Skills exam costs each student $1,275 for registration (plus travel costs), cumulatively adding approximately $36 million dollars per year to medical students’ already growing debt burden, and

WHEREAS, over 80% of American medical schools currently require that medical students complete an internally-designed clinical skills examination in their third or fourth year of medical school to assess clinical competency, and

WHEREAS, the USMLE Step 2 Clinical Skills exam is graded in a pass/fail system that rarely impacts residency selection for United States medical students, and

WHEREAS, over 90% of all U.S. and Canadian medical schools currently administer an Objective 16 Structured Clinical Examination (OSCE) or variant on this principle, and 74% of all U.S. and Canadian medical schools require a passing score for graduation, and

WHEREAS, over 16,500 individuals, including students, residents, fellows, and attending physicians, have signed an ongoing petition to “End Step 2 CS,” and

WHEREAS, on May 7th, 2016, the Massachusetts Medical Society of House of Delegates voted overwhelmingly in favor of a resolution urging the state’s Board of Registration in Medicine to eliminate the Step 2 clinical skills (CS) exam as a license requirement for graduates of U.S. medical schools who pass their school’s clinical skills exam, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians lobby the Federation of State Medical Boards and their member licensing boards to advocate for elimination of the United States Medical Licensing Examination (USMLE) Step 2 CS and the COMLEX Level 2 PE as a requirement for Liaison Committee on Medical Education accredited and Commission on Osteopathic College Accreditation accredited medical school graduates who have passed a school-administered clinical skills examination.

RESOLUTION NO. R3-613

Student Debt Reform

Introduced by: Matthew Varallo, D.O., Rancho Mirage, CA
Nida Naqui, M.D., Wilmington, DE
Julie Powers, Burlington, VT
Uloma Ebere, M.D., Cheverly, MD

WHEREAS, The total outstanding debt from student loans currently exceeds $1.4 trillion, surpassing outstanding car loan and credit card debt, and

WHEREAS, of the 43.3 million borrowers with outstanding federal student loans, 1.8 percent, or 779,000 people owe $150,000, with 346,000 owing more than $200,000, and

WHEREAS, the average undergraduate who borrows, leaves school with about $30,000 in debt, and

WHEREAS, the median education debt for indebted medical school graduates in 2012 was $170,000, and

WHEREAS, eighty-six percent of medical school graduates report having education debt, and

WHEREAS, medical school tuition has quadrupled in the past 20 years, and

WHEREAS, there is critical and worsening shortage of primary care physicians which is projected to reach a shortage of 20,400 physicians by 2020, and

WHEREAS, the large economic burden of student debt is a significant obstacle to pursuing a career in primary care, and

WHEREAS, high financial debt burden is leading to many primary care physicians to no longer treat patients with insurance plans with low reimbursement rates, such as Medicare and Medicaid, and

WHEREAS, the Federal Reserve offers large financial institutions loans at 0.75% interest rate, and

WHEREAS, the prime rate is the most widely used benchmark in setting home equity and credit card rates, and

WHEREAS, as of 2015, the current prime rate is 3.5%, and

WHEREAS, the current average student loan interest rate is 7%, and

WHEREAS, the current adjusted gross income limit to qualify for student loan interest payment deductions are $80,000 for a single individual, and $160,000 for those who file jointly, and

WHEREAS, there is no current adjusted gross income limit to qualify for home mortgage loan interest payment, and

WHEREAS, there is inadequate funding to cover the costs of medical school with discounted primary care student loans, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians use its legislative advocacy and lobbying efforts to support legislation that reduces the debt burden of past and current student borrowers, and be it further

RESOLVED, That the American Academy of Family Physicians use its legislative advocacy to influence the U.S. Congress to enact policies that would curb the growth of tuition, and be it further

RESOLVED, That the American Academy of Family Physicians use its legislative advocacy to influence the U.S. Congress to increase the funding to student loans at a discounted interest rate for medical students who commit to specializing in family medicine, and be it further

RESOLVED, That the American Academy of Family Physicians use its legislative advocacy and lobbying efforts to support legislation that reduces the interest rate of student loans, and be it further

RESOLVED, That the American Academy of Family Physicians use its legislative advocacy and lobbying efforts to support legislation that removes the adjusted gross income cap to qualify for student loan interest payment tax deduction.

RESOLUTION NO. R3-614

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

Introduced by: Allen Rodriguez, Los Angeles, CA
Michael Collins, MD, Grand Blanc, MI
Ben Meyernik, Sioux Falls, SD

WHEREAS, No safe level of lead for human consumption has ever been determined, and

WHEREAS, lead poisoning has severe adverse health effects for children and adults, including impaired cognitive and behavioral development, hypertension, cardiovascular disease, toxicity to the reproductive organs, miscarriages and birth complications, kidney damage, and cancer, and

WHEREAS, the present value of economic losses associated with early exposure to lead, including increased rates of criminality, drug abuse, incarceration, lower wages, diminished lifetime earning power, and the burden of chronic diseases, is estimated at $43.4 billion annually, and

WHEREAS, the Centers for Disease Control and Prevention (CDC) recognizes that reducing water lead levels is an important step to primary prevention of lead exposure and elevated blood lead levels in children, and

WHEREAS, the 1974 Safe Drinking Water Act authorizes the Environmental Protection Agency (EPA) to establish minimum treatment and testing standards to protect tap water, require all owners or operators of public water systems to comply with health-related standards, and grant primary enforcement responsibility to states to implement safe drinking water standards on behalf of the EPA, and

WHEREAS, public water systems are responsible for collective drinking water samples, sending samples for analysis by laboratories certified by the state or EPA, and reporting water quality parameters, including lead and c copper levels, to the state, and

WHEREAS, states and the EPA are jointly responsible for working with public water systems to take steps to prevent or remove contaminants and notify consumers when water-testing results indicate that a contaminant exceeds federal standards under the Safe Drinking Water Act, and

WHEREAS, EPA water testing requirements set by the 2005 Lead and Copper Rule specify lead levels must be tested in one liter of first-draw water taken after the water has been standing in the pipes for at least six hours, and

WHEREAS, public water systems across the Eastern U.S. have adopted methods, including pre-flushing taps before gathering testing samples, in order to lower the amount of lead detected in water contaminant tests, and

WHEREAS, public officials at the state and municipal level have 1) failed to adequately test for lead in water, 2) failed to mitigate lead contamination in water despite knowledge of exposure, and 3) failed to mitigate lead contamination in water to the public (e.g. Flint, MI and Newark, NJ

where health departments were aware of dangerous levels of contamination for months before taking action), and

WHEREAS, an Associated Press analysis of EPA data found that nearly 1,400 water systems serving 3.6 million Americans exceeded the federal lead limit of 15 parts per billion at least once between January 1, 2013 and September 30, 2015, including both public and private water systems in 41 states, and

WHEREAS, a Today analysis of EPA data showed 350 schools and child care facilities exceeded the federal lead limit a total of 470 times from 2012 to 2015, and

WHEREAS, 90,000 public schools and 500,000 child care facilities are not regulated under the Safe Drinking Water Act because they rely on municipal water utilities instead of maintaining their own water supplies and are, therefore, not required to test drinking water quality, and

WHEREAS, lead is the most prevalent toxicant in U.S. school drinking water, and

WHEREAS, children in low-income families tend to reside in older houses, which are more likely to contain lead pipes, and experience a significantly greater burden of lead poisoning than their peers, and

WHEREAS, it is difficult to fully assess the effect of water lead levels on blood lead levels of children and other at-risk populations, as current water sampling protocols were designed to assess water treatment, not the level of human exposure to lead, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians support future research collaborations with other epidemiological and public health organizations regarding water sampling techniques and reporting protocols to better detect and how to reduce human exposure to lead at the point of consumption, and be it further

RESOLVED, That the American Academy of Family Physicians support innovative testing practices for water utilities and at risk populations, such as schools and child care facilities, to accurately measure and reflect lead contamination levels in water, incorporating Environmental Protection Agency testing guidelines, and be it further

RESOLVED, That the American Academy of Family Physicians support improved open public access to testing data on water lead levels by requiring all public water system testing results be posted on a publicly available website in an appropriate and timely fashion, and be it further

RESOLVED, That the American Academy of Family Physicians support federal legislation to reduce, and ultimately, remove lead from the country's public and private water infrastructure, especially focusing on low-income areas, which have the highest burden of lead poisoning, and be it further

RESOLVED, That the American Academy of Family Physicians support efforts by the Environmental Protection Agency (EPA) to examine compliance with the Safe Drinking Water Act for appropriate water utilities and to exercise the EPA's oversight and enforcement authority to ensure public protection from lead contamination, and be it further

RESOLVED, That the American Academy of Family Physicians support research and collaboration with the Environmental Protection Agency (EPA) and other public health

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

RESOLUTION NO. R3-615

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

RESOLVED, That the American Academy of Family Physicians endorse U.S. efforts to develop and implement national policies that facilitate U.S. compliance with the 2015 United Nations Framework Convention on Climate Change international agreement reached by over 190 countries in Paris, and be it further

RESOLVED, That the American Academy of Family Physicians recommend to medical schools, National Board of Medical Examiners (NBME), the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the American Board of Family Medicine that medical education curricula, core competencies and/or milestones should include the effects of climate change on human health, including on the social determinants of health, and be it further

RESOLVED, That the American Academy of Family Physicians support local and national climate change mitigation and adaptation strategies which seek to realize the United States' Nationally Determined Contribution by (1) endorsing state and federal legislation and regulations to curb greenhouse gas emissions and (2) collaborating with other health professional and environmental organizations to promote ambitious national and international action on climate change, and be it further

RESOLVED, That the American Academy of Family Physicians provide education to its members on methods for achieving environmental sustainability of medical workplaces (e.g. reducing energy use, increasing energy efficiency, etc.), and be it further

RESOLVED, That the American Academy of Family Physicians express to appropriate entities in writing its support for the prioritization of epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

RESOLUTION NO. R3-616

Researching Publicly-financed, Privately-delivered National Health Care Systems

Introduced by: Stewart Decker, MD, Klamath Falls, OR
Elizabeth Wiley, MD, JD, MPH, Baltimore, MD

WHEREAS, The American Academy of Family Physicians supports universal access to basic health care services for all people and believes this goal can be attained with a pluralistic approach to the financing, organization, and delivery of health care, and

WHEREAS, despite the implementation of the Affordable Care Act, which utilizes a pluralistic approach to health insurance, 48 million Americans lacked health insurance in 2012 and an estimated 31 million Americans will remain uninsured in 2023, and

WHEREAS, in 2007, 59% of physicians, including >50% of family physicians, support government legislation to establish national health insurance and only 32% oppose it, and

WHEREAS, the United States consistently ranks poorly among developed nations concerning health care outcomes, notably ranking last out of 19 high-income countries in preventing deaths amenable to medical care before age 75, and

WHEREAS, medical bills contribute to 62% of all personal bankruptcies, and

WHEREAS, Medical bankruptcy did not fall in Massachusetts after that state's implementation of reform in 2006, and

WHEREAS, a national publicly-financed, privately-delivered health care system could control costs through proven-effective mechanisms such as global budgets for hospitals and negotiated drug prices, thereby making health care financing sustainable, and

WHEREAS, current payment reform models, like value-based payments or capacitation, could easily be utilized in a system affording universal national healthcare coverage, and

WHEREAS, any system actually guaranteeing universal health care coverage would reduce malpractice lawsuits and insurance costs because injured patients would not need to sue for coverage of future medical expenses, and

WHEREAS, a national publicly-financed, privately-delivered health care system would dramatically reduce, although not eliminate, health disparities, and

WHEREAS, the passage of Medicare in 1965 led to the rapid desegregation of 99.6% of U.S. hospitals, and

WHEREAS, there is currently legislation in the U.S. House of Representatives, entitled Expanded & Improved Medicare for All Act (H.R. 676), and

WHEREAS, U.S. Senator Bernie Sanders, a former 2016 presidential candidate, has stated in no uncertain terms that, "we must move toward a single-payer system," indicating that this is a prescient issue that the AAFP ought to comment on, and

WHEREAS, several states, including Minnesota, New York, Kansas, Colorado, California, Georgia, Missouri, Rhode Island, Maryland, Maine, a Massachusetts have performed economic impact studies indicating that state-based single-payer health insurance systems would be the most economically beneficial system for those states, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians create and disseminate a brief survey designed to gauge member support for “government legislation to establish national health insurance” in order to achieve actual universal health coverage, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) create a task force to study the various possible mechanisms to achieve actual universal health coverage, and issue a report at several AAFP venues throughout the 2016-2017 year, including but not limited to the National Conference of Family Medicine Residents and Medical Students, Congress of Delegates, and Family Medicine Experience (FMX), and be it further

RESOLVED, That the American Academy of Family Physicians ask the Robert Graham Center to study the effect of various health care systems (Canada, Germans, U.S.A, etc.) on those countries’ primary care outcomes, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) include lectures and continuing medical education, including but not limited to, AAFP FMX and National Conference of Family Medicine Residents and Medical Students, focusing on comparing, contrasting, and analyzing the overlap between various currently popular models of payment reform, including but not limited to direct primary care, publicly-financed, privately-delivered national health care, and complete free market insurance.

RESOLUTION NO. R3-617

Advocation of Lesbian, Gay, Bisexual, Transgender Non-Discrimination Policies Within Residency Contracts

Introduced by: Elizabeth Pionk, D.O., Bay City, MI

WHEREAS, The American Academy of Family Physicians (AAFP) encourages diversity among its work force in family medicine training, residencies, and medical schools, and

WHEREAS, the AAFP has recommended curriculum guidelines for family medicine residents defining a training strategy to address the needs of the lesbian, gay, bisexual, transgender patient population, and

WHEREAS, the AAFP currently has a non-discrimination policy regarding lesbian, gay, bisexual, and transgender patients, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians encourage family medicine residency programs and program directors to advocate for a lesbian, gay, bisexual, transgender non-discrimination policy within resident contracts at their respective institutions.

RESOLUTION NO. R3-618

Enacting a Divestment Strategy

Introduced by: Stewart Decker, MD, Klamath Falls, OR
Elizabeth Wiley, MD, JD, MPH, Baltimore, MD

WHEREAS, The American Academy of Family Physicians' (AAFP) vision is to "transform health care to achieve optimal health for everyone," and

WHEREAS, the AAFP has a moral obligation to avoid supporting things that are demonstrably detrimental to the health of our communities, and

WHEREAS, "divestment," which is a form of dissent in which stockholders intentionally sell their assets from a corporation in order to enact social change, is effective, as evidenced by the effects of American divestment during South Africa's struggle with apartheid, and

WHEREAS, divestment is also a strategy utilized by the American Medical Association, especially concerning tobacco, with complete divestment enacted in 1986 and calls for global divestment made as early as 1993, and

WHEREAS, the Canadian Medical Association, British Medical Association and the Royal Australian College of Physicians have moved to "divest [their] holdings in all companies whose business is linked to fossil fuels," and

WHEREAS, tobacco use is associated with 480,000 deaths in the United States annually, as well as 6 million deaths annually worldwide, and

WHEREAS, small arms, commonly known as firearms or guns, are used to kill as many as 1,000 people each day worldwide, and

WHEREAS, the minerals TIN, TANTALUM, TUNGSTEN and GOLD are considered "conflict minerals" and, along with "conflict diamonds," provide a major source of funding for warlords in the Democratic Republic of Congo region whose atrocities have created a massive humanitarian crisis and a death toll of 5.5 million, and

WHEREAS, in 2012 the Securities and Exchange Commission (SEC) enacted a section of the Dodd-Frank Act that requires companies to publicly disclose their use of conflict minerals, and

WHEREAS, excessive alcohol use led to approximately 88,000 deaths and 2.5 million years of potential life lost (YPLL) each year in the United States from 2006-2010, and

WHEREAS, according to the 2012 Institute of Medicine report on obesity, rising consumption of sugary drinks has been a major contributor to the obesity epidemic, and

WHEREAS, some pharmaceutical companies have, on the power of monopoly, drastically increased the price of medications as needed increased, most famously naloxone and Daraprim (Martin Shkreli/Turing Pharmaceuticals) thus limiting access to lifesaving medications, and

WHEREAS, investments in private health insurance companies could be considered a conflict of interest for an organization like the AAFP, and

WHEREAS, the AAFP has encourage divestment previously, as evidenced by a 1998 AAFP Congress of Delegates resolution that read: "RESOLVED, That the American Academy of Family Physicians continue moving towards complete divestiture of all tobacco and/or tobacco-related companies," and

WHEREAS, there currently does not exist publicly available policy guiding AAFP investment practices, now, therefore be it

RESOLVED, That the American Academy of Family Physicians develop policy and/or a committee to guide future investment practices, and be it further

RESOLVED, That the American Academy of Family Physicians' investment goal be to eliminate investment in companies or mutual funds including companies that produce or utilize tobacco, conflict minerals, conflict diamonds, weapons of war or defense, guns, alcohol, sugar sweetened beverages, fast food companies, candy making companies, fossil fuel companies that do not have clean energy divisions, pharmaceutical companies engaging in unethical price adjustments, and private health insurance.

RESOLUTION NO. R3-619

Public Facility Use and Transphobia

Introduced by: Juan Carlos Venis, MD, MPH, Muncie, IN
Stewart Decker, MD, Klamath Falls, Oregon
Vivian Jiang, MD, Rochester, NY
Aisha Harris, Washington, DC

WHEREAS, Transgender people experience worse health compared with cisgender people due to avoidance of care, stress from discrimination and alienation, and higher rate of sexual and physical violence, and

WHEREAS, gender dysphoria intensifies over time and, when inadequately treated, can lead to clinically significant psychological distress, dysfunction, debilitating depression, self-surgery and suicidality, and

WHEREAS, in order to adequately treat gender dysphoria, transgender women must live fully as females and transgender men must live fully as men in society, and

WHEREAS, all people share the real human need for access to safe restroom facilities, and

WHEREAS, being required to use a public facility that does not correspond with gender identity is a health issue that negatively affects transgender people by increasing their risk of experiencing sexual, verbal, and physical harassment and violence, and

WHEREAS, inability to access restroom facilities and avoidance of restroom use is a health issue that has been shown to lead to health problems including dehydration, kidney infections and urinary tract infections, and

WHEREAS, nine bills have been introduced in various states across the United States in January 2016 dictating the use of public facilities, such as restrooms and locker rooms, and

WHEREAS, these bills require people to use public facilities that correspond with their biological sex identified at birth and/or chromosomes instead of their gender identity, and

WHEREAS, proposed legislation effectively makes it illegal for transgender people to live as the gender which they identify, which, as described above, has significant health implications and furthermore sends the message to transgender people that they are unwanted, misunderstood, and unprotected, and

WHEREAS, current federal nondiscrimination laws covering public facilities cover only race, color, religion, national origin and disability, and does not prohibit discrimination based on sex, gender identity or sexual orientation in public facilities, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians endorse existing state and federal laws that protect people from discrimination based on gender expression and identity, and oppose laws that compromise the safety and health of transgender people by failing to provide this protection, and be it further

RESOLVED, That the American Academy of Family Physicians actively support the ability of transgender people to use the public facilities of the gender with which they identify and actively oppose any legislation which would infringe upon that ability.

Resolution NO. R3-620

Supporting Medicare Drug Negotiating Powers

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

WHEREAS, Medicare Part D plans pay for some outpatient prescription drugs and are operated by private insurance companies with oversight by Medicare, and

WHEREAS, Medicare Part D costs $67.67 billion in 2014, $88 billion in 2016 and is projected to double in cost between 2012 and 2022 in part due to an aging population and in part due to improving coverage, and

WHEREAS, Medicare Part D is currently prohibited from negotiating drug prices using the leverage of 39.1 million enrollee's, and

WHEREAS, the Veteran Benefits Administration (VBA) and Medicaid are allowed to negotiate drug prices, and

WHEREAS, Medicare Part D pays on average 73% more than Medicaid and 80% more than VBA for brand-name drugs, and

WHEREAS, 58% of Medicare Part D expenditures went to brand-name drugs in 2011, and

WHEREAS, Medicare Part D would save from $15.2 billion to $16 billion a year if it could secure the same prices that Medicaid or VBA, respectively, receives on the same brand-name drugs, and

WHEREAS, a common argument against allowing price negotiation is the so called "innovation crisis" in which profits become so low that innovation halts, and

WHEREAS, the cost of new drug discovery is often cited at $1.3 billion, however, after breaking down the accounting, the actual cost is ~$60 million, and

WHEREAS, pharmacy companies devote 1.3% of revenues to discovering new molecules while 25% is spent on marketing and promotion, meaning they spend 19 times more money on marketing than research, and

WHEREAS, Minnesota Senator Amy Klobchar has introduced a bill entitled "The Medicare Prescription Drug Price Negotiation Act" in 2013 and 2015 intending to allow Medicare Part D to begin negotiating drug prices, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians create policy in support of allowing Medicare Part D to negotiate for drug prices, and be it further

RESOLVED, That the American Academy of Family Physicians write a letter to the appropriate senators, and representatives, encouraging them to support legislation that would allow Medicare Part D to negotiate for drug prices.

RESOLUTION NO. S3-315

Protecting Rural Family Medicine Training Programs During the AOA/ACGME Merger

Introduced by: Julie Petersen, DO, Columbus, OH
Ann Askari, Columbus, OH

WHEREAS, The Accreditation Council for Graduate Medical Education (ACGME) and American Osteopathic Association (AOA) signed a Memorandum of Understanding for the creation of a single accreditation system by 2020, and

WHEREAS, the AOA currently accredits 257 family medicine residencies, the majority of which are in rural areas or community hospitals, and

WHEREAS, osteopathic programs are reporting potentially program-ending logistical and financial barriers in meeting or even defining the requirements of the ACGME and are often finding existing consultative services to be cost prohibitive, and

WHEREAS, the Centers of Medicare and Medicaid Services established Medicare Resident Limits (caps) in 1997, and

WHEREAS, many AOA-accredited programs were capped at a level below the Accreditation Council for Graduate Medical Education Family Medicine Review Committee requirement of a minimum of four per class, and

WHEREAS, the Rural Training Track Collaborative and National Rural Health Association (NRHA) have existing resources to develop rural training tracts in Family Medicine residencies, and

WHEREAS, rural areas contain 25 percent of the United States population but only 10 percent of the physicians, and

WHEREAS, rural training programs place physicians in rural practices at much higher rates than urban programing, and

WHEREAS, at the 2016 Family Medicine Congressional Conference, the American Academy of Family Physicians (AAFP) devoted ones of its lobbying “asks” to advocate for rural family medicine training programs through Teaching Health Centers, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians (AAFP) advocate for continued viability of traditionally osteopathic family medicine residencies throughout the United States, especially in the rural areas, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) advocate for expansion of Centers of Medicare and Medicaid Services (CMS) resident caps to allow funding for the full, four-resident class required by the Accreditation Council of Graduate Medical Education (ACGME), and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) collaborate with interested organizations such as the American Osteopathic Association (AOA), Association of Family Medicine Residency Directors (AFMRD), and the American College of Osteopathic

Family Physicians (ACOFP) to expand existing resources for financially accessible consultative services for traditionally osteopathic programs to help understand and achieve requirements set by the ACGME for accreditation, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) collaborate with organizations such as the Rural Training Track Collaborative and National Rural Health Association (NRHA) to facilitate interested rural family medicine programs in adapting to become rural training tracts of existing larger urban programs.

RESOLUTION NO. R3-622

Promoting the Resident and Student Discussion Forum

Introduced by: Chetan Patel, MD, Columbus, GA
Kyle Gleaves, Scranton, PA

WHEREAS, Students and residents tend to work within silos comprised by the community in their city, state, medical school, residency program and rotation site, and

WHEREAS, improved communication and idea exchange between members from these various silos can improve the efficacy and efficiency of identifying and addressing areas of concern, and

WHEREAS, the idea exchange can help students and residents engage with and improve their local and state medical societies, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians work with chapters, residency programs and medical schools to increase awareness and promote the American Academy of Family Physicians resident and student discussion group to exchange ideas and information.