



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
10. Resolution No. R3-610 Discontinuation of Discriminating Native American Imagery
11. Resolution No. R3-611 Partnerships in Developing a Rural Training Database
12. Resolution No. R3-612 Lobby to End Step 2 CS and Level PE
13. Resolution No. R3-613 Student Debt Reform
14. Resolution No. R3-614 No Child “Lead” Behind – Improving Awareness, Detection and Prevention of Lead Contamination



Resident 3 Agenda and Resolutions

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15. Resolution No. R3-615 Climate Change Advocacy
16. Resolution No. R3-616 Researching Publicly-financed, Privately-delivered
National Health Care Systems
17. Resolution No. R3-617 Advocation of Lesbian, Gay, Bisexual, Transgender
Non-Discrimination Policies Within Residency Contracts
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

1 **RESOLUTION NO. R3-601**

2 **Eliminating the Gender Salary Wage Gap**

3 Introduced by: Jessica Tucker, Athens, OH
4 Scott Morris, Columbus, OH
5

6 WHEREAS, The percentage of women in medicine has been on the rise since the 70's and,
7

8 WHEREAS, women currently compose half of all U.S. medical school graduates, and
9

10 WHEREAS, the salary discrepancy between genders in 2016 of newly trained physicians in
11 New York State has increased from \$3,600 in 1999 to \$16,819 in 2008, and
12

13 WHEREAS, a recently published study in *JAMA* evaluating over 24 U.S. public medical schools
14 found that female physicians made markedly less than male physicians despite multivariable
15 adjustments including age, experience, specialty, faculty rank, and measures of research
16 productivity and clinical revenue with an absolute difference of \$19,878, and
17

18 WHEREAS, the gap that exists between male and female earnings cannot be explained by
19 productivity or any other professional factors, and
20

21 WHEREAS, the American Academy of Family Physicians (AAFP) has existing policy supporting
22 the principle that hiring, credentialing, and privileging decisions for physicians should be based
23 solely on verifiable professional criteria, and
24

25 WHEREAS, the AAFP has existing policy endorsing the goal of equitable representation of
26 women as medical students, staff and leadership positions in academic medicine, and
27

28 WHEREAS, the AAFP has already published a strategic objective to improve payment equity for
29 family physicians by reducing the income gap between family physicians and subspecialties
30 now, therefore, be it
31

32 RESOLVED, That the American Academy of Family Physicians (AAFP) develop a strategic
33 objective to the AAFP strategic plan to improve payment equity for female family physicians by
34 advocating for the elimination of the income gap between male and female family physicians,
35 and be it further
36

37 RESOLVED, That the American Academy of Family Physicians advocate to eliminate payment
38 inequity between male and female family physicians, and be it further
39

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

1 **RESOLUTION NO. R3-602**

2 **Uniformed Service Student Dual Membership**

3 Introduced by: Brittany Herits, DO, Camp Ujeure, NC
4 Alex Knoblock, MD, Eglen AFB, FL
5 Stephen Young, MD, Fort Bragg, NC
6

7 WHEREAS, There is currently no ability for medical students to obtain a secondary membership
8 with the Uniformed Services Academy of Family Physicians, and
9

10 WHEREAS, there is currently no student delegate to the Uniformed Services chapter as the
11 position was unable to be filled, now, therefore, be it
12

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

1 **RESOLUTION NO. R3-603**

2 **Uniformed Services Members Self-Identification**

3

4 Introduced by: Brittany Herits, DO, Camp Lejeune, NC
5 Alex Knobloch, MD, Eglin AFB, FL
6 Stephen Young, MD, Fort Bragg, NC

7

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

10

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

1 **Resolution NO. R3-604**

2 **Advocate for Medication Coverage Until Prior Authorization is Decided**

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

5
6 WHEREAS, Family physicians act in the best interest of their patients, and

7
8 WHEREAS, 69% of physicians wait several days to receive prior authorizations from an insurer
9 for medications, while 10% wait more than a week, and

10
11 WHEREAS, delay in patient care leads to increased emergency room visits and costs, and

12
13 WHEREAS, delay in patient care leads to poor patient outcomes, including an increase in
14 morbidity and mortality, now, therefore, be it

15
16 RESOLVED, That the American Academy of Family Physicians advocate that patients receive
17 medications until their prior authorizations are resolved.

1 **RESOLUTION NO. R3-605**

2 **Protecting Resident Education By Limiting Time Spent on Prior Authorizations**

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

5
6 WHEREAS, Family resident physicians act in the best interest of their patients, and

7
8 WHEREAS, insurance companies have decided upon certain prescription drug formularies in
9 order to control their costs, and

10
11 WHEREAS, the residents have discovered that the responsibility of completing the intricate prior
12 authorization process falls upon themselves and their support staff, and

13
14 WHEREAS, the resident spends approximately three hours per week interacting with these
15 health plans, and

16
17 WHEREAS, insurance companies have no investment to reduce loss of clinical education of the
18 resident, now, therefore, be it

19
20 RESOLVED, That the American Academy of Family Physicians improve patients' access to the
21 medication they need, and be it further

22
23 RESOLVED That the American Academy of Family Physicians reduce the amount of time
24 residents spend on administrative tasks related to prior authorizations.

1 **RESOLUTION NO. R3-606**

2 **Asking Gender Identity and the Clinic Experience of Transgender Patients**

3 Introduced by: Naomi Gorfinkle, Baltimore, MD
4 Maya Siegel, Baltimore, MD
5 Stewart Decker, MD, Klamath Falls, OR
6

7 WHEREAS, The importance of transgender-inclusive health care is widely recognized, and
8

9 WHEREAS, the American Academy of Family Physicians (AAFP) supports Lesbian-Gay-
10 Bisexual-Transgender-Questioning inclusive health care, and
11

12 WHEREAS, the Health Resources and Services Administration's (HRSA) most recent Uniform
13 Data System reporting change mandates that Federally Qualified Health Centers (FQHC)
14 report all patients' sex assigned at birth as distinct from their gender identify, and
15

16 WHEREAS, the gender identity of transgender and gender non-binary patients continues to be
17 in effectively ascertained in clinics and recorded in most electronic medical records, often being
18 confused with sex, and
19

20 WHEREAS, "misgendering" (the act of referring to someone by gender pronouns other than the
21 ones they prefer) in healthcare settings continues to occur, and
22

23 WHEREAS, "misgendering" in healthcare settings continues to alienate transgender and gender
24 non-binary patients and hinder their ability to form trusting relationships with healthcare
25 providers, and
26

27 WHEREAS, transgender individuals feel that the majority of healthcare professionals are
28 inadequately equipped to care for their specific health needs, now, therefore, be it
29

30 RESOLVED, That the American Academy of Family Physicians (AAFP) collaborate with partner
31 organizations to develop best practices with regard to making clinics a safe place for
32 transgender and gender non-binary patients and publish them on the AAFP's website
33 (aafp.org), and be it further
34

35 RESOLVED, That these best practices include asking the gender identity of all patients as a
36 distinct entity from their sex assigned at birth in accordance with the most recent Health
37 Resources and Services Administration (HRSA) policy, and be it further
38

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

1 **RESOLUTION NO. R3-607**

2 **Enhanced Understanding of MACRA, Medicare Access and CHIP Reauthorization Act of**
3 **2015, for Resident and Student AAFP Members**

4 Introduced by: Elizabeth Pionk, D.O., Bay City, MI
5 Daniel Edmondson, Reno, NV
6

7 WHEREAS, Medicare Access and CHIP Reauthorization Act of 2015 implements many
8 changes and adopts a quality payment program (QPP) that utilizes a merit-based payment
9 system (MIPS), and alternative payment programs (APMs), and
10

11 WHEREAS, medical school and residency programs rarely incorporate payment programs and
12 reform routinely in lectures and curriculum, and
13

14 WHEREAS, the American Academy of Family Physicians website addresses practice based
15 learning and physician leadership in patient centered medical homes in recommended
16 curriculum for residency program directors and staff, but neither address MACRA, and
17

18 WHEREAS, centralized sources of information regarding payment programs and reform that are
19 dependable, unbiased, and applicable to family medicine resident and medical students are
20 scarce, now, therefore, be it
21

22 RESOLVED, That the American Academy of Family Physicians (AAFP) create an online
23 module, handout, or webinar addressing Medicare Access and CHIP Reauthorization Act of
24 2015 and its quality payment programs (QPP), merit-based payment system (MIPS) and
25 alternative payment programs (APMs), at the appropriate level and context for family medicine
26 residents and medical students on the AAFP website as well as on the Family Medicine Interest
27 Group (FMIG) Network, and be it further
28

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

1 **RESOLUTION NO. R3-608**

2 **Climate Change Policy Adjustments**

3 Introduced by: Stewart Decker, MD, Klamath Falls, OR
4 Redmond Finney, Baltimore, MD
5

6 WHEREAS, The 2015 American Academy of Family Physicians (AAFP) Congress of Delegates
7 reaffirmed the 1969 policy, "On Climate Change and Air Pollution," stating "In recognition of the
8 numerous and serious adverse health consequences resulting from pollution, climate change,
9 and ozone-layer depletion, the AAFP recommends strong action on all public and private levels
10 to limit and correct the pollution of our land, atmosphere and water," and
11

12 WHEREAS, greenhouse gas emissions from human activities are generally recognized as the
13 primary causative factor in modern climate change, and
14

15 WHEREAS, it is important for a medical organization such as the AAFP to specifically identify
16 causative factors in order to better focus intervention, and
17

18 WHEREAS, the controversy surrounding greenhouse emissions from human activities is
19 political and economic rather than scientific, and
20

21 WHEREAS, the AAFP ought to base policy on sound science and resist scientific
22 misinformation that has a direct effect on the health of our population, now, therefore, be it
23

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

1 **RESOLUTION NO. R3-609**

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

3 Introduced by: Diana Huang, Philadelphia, PA
4 Kyle Gleaves, Scranton, PA
5 Margot Brown, MD, Scranton, PA
6 Matt Mullane, MD, Denver, CO
7

8 WHEREAS, The American Academy of Family Physicians (AAFP) Commission on Health of the
9 Public and Science has previously agreed that the Food and Drug Administration (FDA) lifetime
10 ban on men who have had sex with men (MSM) discriminated against gay men as potential
11 donors, and
12

13 WHEREAS, the AAFP has previously written letters to the FDA encouraging it to repeal the
14 lifetime ban on blood donation by MSM, and
15

16 WHEREAS, in December 2015, the FDA overturned its previous policy of lifetime ban for MSM
17 and replaced it with a 12-month deferral period, and
18

19 WHEREAS, on July 28, 2016, the FDA opened a request for comments on the Federal Register
20 on “scientific evidence such as data from research regarding potential blood donor deferral
21 policy options to reduce the risk of HIV transmission, including the feasibility of moving from the
22 existing time-based deferrals related to risk behaviors to alternate deferral options, such as the
23 use of individual risk assessments, and
24

25 WHEREAS, comments are invited regarding the design of potential studies to evaluate the
26 feasibility and effectiveness of such alternative deferral options,” now, therefore, be it
27

28 RESOLVED, That the American Academy of Family Physicians develop policy
29 recommendations for blood donation by men who have had sex with other men (MSM) by
30 studying the risks and benefits of changing the Food and Drug Administration’s current 12-
31 month deferral policy on MSM blood donation and consider potential alternative deferral options,
32 such as the use of individual risk assessments, and be it further
33

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

1 **Resolution NO. R3-610**

2 **Discontinuation of Discriminating Native American Imagery**

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

5
6 WHEREAS, The American Academy of Family Physicians values healthy families and
7 communities, and

8
9 WHEREAS, the suicide rate amongst Native American youth is rising with a current rate of 18%
10 of suicide deaths this year, and

11
12 WHEREAS, Native American men are five times as likely to commit suicide, and

13
14 WHEREAS, imagery in the form of “native” names, mascots, negative imagery in sports teams
15 perpetuates negative racial stereotypes, and

16
17 WHEREAS, the American Psychological Association recognized that racism and racial
18 discrimination are attitudes and behaviors that are earned and threaten human development,
19 and

20
21 WHEREAS, perpetuation of negative imagery and lack of positive imagery leads to low self-
22 esteem of native youth, contributing to suicide, as well as predisposes native youth to physical
23 violence and bullying from others, now, therefore, be it

24
25 RESOLVED, That the American Academy of Family Physicians support discontinuation of
26 disparaging Native American imagery in the form of “native” names and mascots of sport teams,
27 schools, and athletic programs.

1 **RESOLUTION NO. R3-611**

2 **Partnerships in Developing a Rural Training Database**

3 Introduced by: Matthew Peters, Boise, ID
4 Julie Petersen, DO, Columbus, OH
5

6 WHEREAS, The American Academy of Family Physicians has a large number of members who
7 practice in rural settings, and
8

9 WHEREAS, rural practice presents unique challenges and opportunities to family physicians
10 and trainees in family medicine, and
11

12 WHEREAS, it is challenging for medical students and residents to find opportunities for rural
13 training unless such offerings are provided by their program or institution, and
14

15 WHEREAS, organizations such as Rural Training Track Collaborative and National Rural Health
16 Association are seeking to expand rural training options for students, residents, and practicing
17 family physicians, now, therefore, be it
18

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

1 **RESOLUTION NO. R3-612**

2 **Lobby to End Step 2 CS and Level PE**

3 Introduced by: Matthew Peters, Boise, ID
4 Victoria Boggiano, Palo Alto, CA
5 John Nguyen, MD, Tucson, AZ
6 Kyle Gleaves, Scranton, PA
7 Alex Mroszczyk-McDonald, MD, Fontana, CA
8

9 WHEREAS, The United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills
10 exam was originally designed to assess the English proficiency, clinical skills, and
11 communication skills of foreign medical graduates who desired to complete residency training in
12 the United States, and
13

14 WHEREAS, data from the National Board of Medical Examiners (NBME) demonstrates that
15 pass rates for medical students at United States and Canadian medical schools have been
16 greater than or equal to 95% since 2004, and
17

18 WHEREAS, research to date has not shown significant correlations between Step 2 Clinical
19 Skills results and improved patient safety, and
20

21 WHEREAS, studies demonstrate clinical skills scores added no additional predictive value
22 beyond the written USMLE exams, and
23

24 WHEREAS, a recent study suggested the true cost for detecting a “double failure” (a student
25 who failed the Step 2 CS 2- 3 times and failed to graduate from medical school) may be high as
26 \$1.1 million, which does not include cost of travel, lodging, or preparation materials, and
27

28 WHEREAS, the USMLE Step 2 Clinical Skills exam costs each student \$1,275 for registration
29 (plus travel costs), cumulatively adding approximately \$36 million dollars per year to medical
30 students’ already growing debt burden, and
31

32 WHEREAS, over 80% of American medical schools currently require that medical students
33 complete an internally-designed clinical skills examination in their third or fourth year of medical
34 school to assess clinical competency, and
35

36 WHEREAS, the USMLE Step 2 Clinical Skills exam is graded in a pass/fail system that rarely
37 impacts residency selection for United States medical students, and
38

39 WHEREAS, over 90% of all U.S. and Canadian medical schools currently administer an
40 Objective 16 Structured Clinical Examination (OSCE) or variant on this principle, and 74% of all
41 U.S. and Canadian medical schools require a passing score for graduation, and
42

43 WHEREAS, over 16,500 individuals, including students, residents, fellows, and attending
44 physicians, have signed an ongoing petition to “End Step 2 CS,” and
45

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

50

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

1 **RESOLUTION NO. R3-613**

2 **Student Debt Reform**

3 Introduced by: Matthew Varallo, D.O., Rancho Mirage, CA
4 Nida Naqui, M.D., Wilmington, DE
5 Julie Powers, Burlington, VT
6 Uloma Ebere, M.D., Cheverly, MD
7

8 WHEREAS, The total outstanding debt from student loans currently exceeds \$1.4 trillion,
9 surpassing outstanding car loan and credit card debt, and
10

11 WHEREAS, of the 43.3 million borrowers with outstanding federal student loans, 1.8 percent, or
12 779,000 people owe \$150,000, with 346,000 owing more than \$200,000, and
13

14 WHEREAS, the average undergraduate who borrows, leaves school with about \$30,000 in debt,
15 and
16

17 WHEREAS, the median education debt for indebted medical school graduates in 2012 was
18 \$170,000, and
19

20 WHEREAS, eighty-six percent of medical school graduates report having education debt, and
21

22 WHEREAS, medical school tuition has quadrupled in the past 20 years, and
23

24 WHEREAS, there is critical and worsening shortage of primary care physicians which is
25 projected to reach a shortage of 20,400 physicians by 2020, and
26

27 WHEREAS, the large economic burden of student debt is a significant obstacle to pursuing a
28 career in primary care, and
29

30 WHEREAS, high financial debt burden is leading to many primary care physicians to no longer
31 treat patients with insurance plans with low reimbursement rates, such as Medicare and
32 Medicaid, and
33

34 WHEREAS, the Federal Reserve offers large financial institutions loans at 0.75% interest rate,
35 and
36

37 WHEREAS, the prime rate is the most widely used benchmark in setting home equity and credit
38 card rates, and
39

40 WHEREAS, as of 2015, the current prime rate is 3.5%, and
41

42 WHEREAS, the current average student loan interest rate is 7%, and
43

44 WHEREAS, the current adjusted gross income limit to qualify for student loan interest payment
45 deductions are \$80,000 for a single individual, and \$160,000 for those who file jointly, and
46

47 WHEREAS, there is no current adjusted gross income limit to qualify for home mortgage loan
48 interest payment, and
49

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

52

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

56

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

60

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

64

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

68

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

1 **RESOLUTION NO. R3-614**

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

4 Introduced by: Allen Rodriguez, Los Angeles, CA
5 Michael Collins, MD, Grand Blanc, MI
6 Ben Meyernik, Sioux Falls, SD
7

8 WHEREAS, No safe level of lead for human consumption has ever been determined, and
9

10 WHEREAS, lead poisoning has severe adverse health effects for children and adults, including
11 impaired cognitive and behavioral development, hypertension, cardiovascular disease, toxicity
12 to the reproductive organs, miscarriages and birth complications, kidney damage, and cancer,
13 and
14

15 WHEREAS, the present value of economic losses associated with early exposure to lead,
16 including increased rates of criminality, drug abuse, incarceration, lower wages, diminished
17 lifetime earning power, and the burden of chronic diseases, is estimated at \$43.4 billion
18 annually, and
19

20 WHEREAS, the Centers for Disease Control and Prevention (CDC) recognizes that reducing
21 water lead levels is an important step to primary prevention of lead exposure and elevated blood
22 lead levels in children, and
23

24 WHEREAS, the 1974 Safe Drinking Water Act authorizes the Environmental Protection Agency
25 (EPA) to establish minimum treatment and testing standards to protect tap water, require all
26 owners or operators of public water systems to comply with health-related standards, and grant
27 primary enforcement responsibility to states to implement safe drinking water standards on
28 behalf of the EPA, and
29

30 WHEREAS, public water systems are responsible for collective drinking water samples, sending
31 samples for analysis by laboratories certified by the state or EPA, and reporting water quality
32 parameters, including lead and copper levels, to the state, and
33

34 WHEREAS, states and the EPA are jointly responsible for working with public water systems to
35 take steps to prevent or remove contaminants and notify consumers when water-testing results
36 indicate that a contaminant exceeds federal standards under the Safe Drinking Water Act, and
37

38 WHEREAS, EPA water testing requirements set by the 2005 Lead and Copper Rule specify
39 lead levels must be tested in one liter of first-draw water taken after the water has been standing
40 in the pipes for at least six hours, and
41

42 WHEREAS, public water systems across the Eastern U.S. have adopted methods, including
43 pre-flushing taps before gathering testing samples, in order to lower the amount of lead
44 detected in water contaminant tests, and
45

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

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

51
52 WHEREAS, an Associated Press analysis of EPA data found that nearly 1,400 water systems
53 serving 3.6 million Americans exceeded the federal lead limit of 15 parts per billion at least once
54 between January 1, 2013 and September 30, 2015, including both public and private water
55 systems in 41 states, and

56
57 WHEREAS, a Today analysis of EPA data showed 350 schools and child care facilities
58 exceeded the federal lead limit a total of 470 times from 2012 to 2015, and

59
60 WHEREAS, 90,000 public schools and 500,000 child care facilities are not regulated under the
61 Safe Drinking Water Act because they rely on municipal water utilities instead of maintaining
62 their own water supplies and are, therefore, not required to test drinking water quality, and

63
64 WHEREAS, lead is the most prevalent toxicant in U.S. school drinking water, and

65
66 WHEREAS, children in low-income families tend to reside in older houses, which are more likely
67 to contain lead pipes, and experience a significantly greater burden of lead poisoning than their
68 peers, and

69
70 WHEREAS, it is difficult to fully assess the effect of water lead levels on blood lead levels of
71 children and other at-risk populations, as current water sampling protocols were designed to
72 assess water treatment, not the level of human exposure to lead, now, therefore, be it

73
74 RESOLVED, That the American Academy of Family Physicians support future research
75 collaborations with other epidemiological and public health organizations regarding water
76 sampling techniques and reporting protocols to better detect and how to reduce human
77 exposure to lead at the point of consumption, and be it further

78
79 RESOLVED, That the American Academy of Family Physicians support innovative testing
80 practices for water utilities and at risk populations, such as schools and child care facilities, to
81 accurately measure and reflect lead contamination levels in water, incorporating Environmental
82 Protection Agency testing guidelines, and be it further

83
84 RESOLVED, That the American Academy of Family Physicians support improved open public
85 access to testing data on water lead levels by requiring all public water system testing results be
86 posted on a publicly available website in an appropriate and timely fashion, and be it further

87
88 RESOLVED, That the American Academy of Family Physicians support federal legislation to
89 reduce, and ultimately, remove lead from the country's public and private water infrastructure,
90 especially focusing on low-income areas, which have the highest burden of lead poisoning, and
91 be it further

92
93 RESOLVED, That the American Academy of Family Physicians support efforts by the
94 Environmental Protection Agency (EPA) to examine compliance with the Safe Drinking Water
95 Act for appropriate water utilities and to exercise the EPA's oversight and enforcement authority
96 to ensure public protection from lead contamination, and be it further

97
98 RESOLVED, That the American Academy of Family Physicians support research and
99 collaboration with the Environmental Protection Agency (EPA) and other public health

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

1 **RESOLUTION NO. R3-615**

2 **Climate Change Advocacy**

3 Introduced by: Stewart Decker, MD, Klamath Falls, OR
4 Redmond Finney, Baltimore, MD
5 Maya Siegel, Baltimore, MD
6

7 WHEREAS, The health implications of climate change have a profound direct and indirect effect
8 on the health of our patients, and
9

10 WHEREAS, the Lancet Commission on Climate Change and Health states that “..tackling
11 climate change could be the greatest global health opportunity of the 21st century” and “(t)he
12 effects of climate change are being felt today, and future projections represent an unacceptably
13 high and potentially catastrophic risk to human health;”, and
14

15 WHEREAS, the World Health Organization estimates that between 2030 and 2050 climate
16 change is expected to cause approximately 250,000 additional deaths per year, from
17 malnutrition, malaria, diarrhea, and heat stress, and
18

19 WHEREAS, direct damage costs to health is estimated to be between U.S. \$2-4 billion/year by
20 2030, and
21

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

- 25 1. “aim to limit [global average temperature] increase(s) to 1.5C, since this would
26 significantly reduce risks and the impacts of climate change;”
- 27 2. Peak global emissions as soon as possible,
- 28 3. Utilize the best current science utilizing carbon sinks to decrease net emission
29 reduction,
- 30 4. Utilize systems of accountability and transparency to assure goals are met,
- 31 5. Support climate action in developing countries, and
32

33 WHEREAS, the agreement will open for ratification between April 2016-2017 and will only
34 become binding if 55 countries that produce at least 55% of the world’s greenhouse gas
35 emissions ratify the agreement, and
36

37 WHEREAS, the United States was the second largest producer of greenhouse gasses in 2010,
38 responsible for 15.6% of global production, and
39

40 WHEREAS, the Paris Agreement utilizes Nationally Determined Contributions (NDCs) to
41 quantify and make binding an individual country’s emission reduction targets but does not detail
42 how to do so, and
43

44 WHEREAS, the United States’ NDC is to achieve an economy-wide reduction of its greenhouse
45 gas emissions by 26-28% below its 2005 level in 2025, and
46

47 WHEREAS, health professionals have an obligation to advocate for efforts to improve the health
48 of our patients, now, therefore, be it
49

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

54
55 RESOLVED, That the American Academy of Family Physicians recommend to medical schools,
56 National Board of Medical Examiners (NBME), the Liaison Committee on Medical Education
57 (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the American
58 Board of Family Medicine that medical education curricula, core competencies and/or
59 milestones should include the effects of climate change on human health, including on the
60 social determinants of health, and be it further

61
62 RESOLVED, That the American Academy of Family Physicians support local and national
63 climate change mitigation and adaptation strategies which seek to realize the United States'
64 Nationally Determined Contribution by (1) endorsing state and federal legislation and
65 regulations to curb greenhouse gas emissions and (2) collaborating with other health
66 professional and environmental organizations to promote ambitious national and international
67 action on climate change, and be it further

68
69 RESOLVED, That the American Academy of Family Physicians provide education to its
70 members on methods for achieving environmental sustainability of medical workplaces (e.g.
71 reducing energy use, increasing energy efficiency, etc.), and be it further

72
73 RESOLVED, That the American Academy of Family Physicians express to appropriate entities
74 in writing its support for the prioritization of epidemiological, translational, clinical and basic
75 science research necessary for evidence-based global climate change policy decisions related
76 to health care and treatment.

1 **RESOLUTION NO. R3-616**

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

3 Introduced by: Stewart Decker, MD, Klamath Falls, OR
4 Elizabeth Wiley, MD, JD, MPH, Baltimore, MD
5
6

7 WHEREAS, The American Academy of Family Physicians supports universal access to basic
8 health care services for all people and believes this goal can be attained with a pluralistic
9 approach to the financing, organization, and delivery of health care, and
10

11 WHEREAS, despite the implementation of the Affordable Care Act, which utilizes a pluralistic
12 approach to health insurance, 48 million Americans lacked health insurance in 2012 and an
13 estimated 31 million Americans will remain uninsured in 2023, and
14

15 WHEREAS, in 2007, 59% of physicians, including >50% of family physicians, support
16 government legislation to establish national health insurance and only 32% oppose it, and
17

18 WHEREAS, the United States consistently ranks poorly among developed nations concerning
19 health care outcomes, notably ranking last out of 19 high-income countries in preventing deaths
20 amenable to medical care before age 75, and
21

22 WHEREAS, medical bills contribute to 62% of all personal bankruptcies, and
23

24 WHEREAS, Medical bankruptcy did not fall in Massachusetts after that state's implementation
25 of reform in 2006, and
26

27 WHEREAS, a national publicly-financed, privately-delivered health care system could control
28 costs through proven-effective mechanisms such as global budgets for hospitals and negotiated
29 drug prices, thereby making health care financing sustainable, and
30

31 WHEREAS, current payment reform models, like value-based payments or capitation, could
32 easily be utilized in a system affording universal national healthcare coverage, and
33

34 WHEREAS, any system actually guaranteeing universal health care coverage would reduce
35 malpractice lawsuits and insurance costs because injured patients would not need to sue for
36 coverage of future medical expenses, and
37

38 WHEREAS, a national publicly-financed, privately-delivered health care system would
39 dramatically reduce, although not eliminate, health disparities, and
40

41 WHEREAS, the passage of Medicare in 1965 led to the rapid desegregation of 99.6% of U.S.
42 hospitals, and
43

44 WHEREAS, there is currently legislation in the U.S. House of Representatives, entitled
45 Expanded & Improved Medicare for All Act (H.R. 676), and
46

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

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WHEREAS, several states, including Minnesota, New York, Kansas, Colorado, California, Georgia, Missouri, Rhode Island, Maryland, Maine, and 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, Germany, 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.

1 **RESOLUTION NO. R3-617**

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

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

5

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

8

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

12

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

15

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

1 **RESOLUTION NO. R3-618**

2 **Enacting a Divestment Strategy**

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

5
6 WHEREAS, The American Academy of Family Physicians' (AAFP) vision is to "transform health
7 care to achieve optimal health for everyone," and

8
9 WHEREAS, the AAFP has a moral obligation to avoid supporting things that are demonstrably
10 detrimental to the health of our communities, and

11
12 WHEREAS, "divestment," which is a form of dissent in which stockholders intentionally sell their
13 assets from a corporation in order to enact social change, is effective, as evidenced by the
14 effects of American divestment during South Africa's struggle with apartheid, and

15
16 WHEREAS, divestment is also a strategy utilized by the American Medical Association,
17 especially concerning tobacco, with complete divestment enacted in 1986 and calls for global
18 divestment made as early as 1993, and

19
20 WHEREAS, the Canadian Medical Association, British Medical Association and the Royal
21 Australian College of Physicians have moved to "divest [their] holdings in all companies whose
22 business is linked to fossil fuels," and

23
24 WHEREAS, tobacco use is associated with 480,000 deaths in the United States annually, as
25 well as 6 million deaths annually worldwide, and

26
27 WHEREAS, small arms, commonly known as firearms or guns, are used to kill as many as
28 1,000 people each day worldwide, and

29
30 WHEREAS, the minerals TIN, TANTALUM, TUNGSTEN and GOLD are considered "conflict
31 minerals" and, along with "conflict diamonds," provide a major source of funding for warlords in
32 the Democratic Republic of Congo region whose atrocities have created a massive
33 humanitarian crisis and a death toll of 5.5 million, and

34
35 WHEREAS, in 2012 the Securities and Exchange Commission (SEC) enacted a section of the
36 Dodd-Frank Act that requires companies to publicly disclose their use of conflict minerals, and

37
38 WHEREAS, excessive alcohol use led to approximately 88,000 deaths and 2.5 million years of
39 potential life lost (YPLL) each year in the United States from 2006-2010, and

40
41 WHEREAS, according to the 2012 Institute of Medicine report on obesity, rising consumption of
42 sugary drinks has been a major contributor to the obesity epidemic, and

43
44 WHEREAS, some pharmaceutical companies have, on the power of monopoly, drastically
45 increased the price of medications as needed increased, most famously naloxone and Daraprim
46 (Martin Shkreli/Turing Pharmaceuticals) thus limiting access to lifesaving medications, and

47
48 WHEREAS, investments in private health insurance companies could be considered a conflict
49 of interest for an organization like the AAFP, and

50 WHEREAS, the AAFP has encourage divestment previously, as evidenced by a 1998 AAFP
51 Congress of Delegates resolution that read: “RESOLVED, That the American Academy of
52 Family Physicians continue moving towards complete divestiture of all tobacco and/or tobacco-
53 related companies,” and
54

55 WHEREAS, there currently does not exist publicly available policy guiding AAFP investment
56 practices, now, therefore be it
57

58 RESOLVED, That the American Academy of Family Physicians develop policy and/or a
59 committee to guide future investment practices, and be it further
60

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

1 **RESOLUTION NO. R3-619**

2 **Public Facility Use and Transphobia**

3 Introduced by: Juan Carlos Venis, MD, MPH, Muncie, IN
4 Stewart Decker, MD, Klamath Falls, Oregon
5 Vivian Jiang, MD, Rochester, NY
6 Aisha Harris, Washington, DC
7

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

11
12 WHEREAS, gender dysphoria intensifies over time and, when inadequately treated, can lead to
13 clinically significant psychological distress, dysfunction, debilitating depression, self-surgery and
14 suicidality, and

15
16 WHEREAS, in order to adequately treat gender dysphoria, transgender women must live fully
17 as females and transgender men must live fully as men in society, and

18
19 WHEREAS, all people share the real human need for access to safe restroom facilities, and

20
21 WHEREAS, being required to use a public facility that does not correspond with gender identity
22 is a health issue that negatively affects transgender people by increasing their risk of
23 experiencing sexual, verbal, and physical harassment and violence, and

24
25 WHEREAS, inability to access restroom facilities and avoidance of restroom use is a health
26 issue that has been shown to lead to health problems including dehydration, kidney infections
27 and urinary tract infections, and

28
29 WHEREAS, nine bills have been introduced in various states across the United States in
30 January 2016 dictating the use of public facilities, such as restrooms and locker rooms, and

31
32 WHEREAS, these bills require people to use public facilities that correspond with their biological
33 sex identified at birth and/or chromosomes instead of their gender identity, and

34
35 WHEREAS, proposed legislation effectively makes it illegal for transgender people to live as the
36 gender which they identify, which, as described above, has significant health implications and
37 furthermore sends the message to transgender people that they are unwanted, misunderstood,
38 and unprotected, and

39
40 WHEREAS, current federal nondiscrimination laws covering public facilities cover only race,
41 color, religion, national origin and disability, and does not prohibit discrimination based on sex,
42 gender identity or sexual orientation in public facilities, now, therefore, be it

43
44 RESOLVED, That the American Academy of Family Physicians endorse existing state and
45 federal laws that protect people from discrimination based on gender expression and identity,
46 and oppose laws that compromise the safety and health of transgender people by failing to
47 provide this protection, and be it further
48

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

1 **Resolution NO. R3-620**

2 **Supporting Medicare Drug Negotiating Powers**

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

5
6 WHEREAS, Medicare Part D plans pay for some outpatient prescription drugs and are operated
7 by private insurance companies with oversight by Medicare, and

8
9 WHEREAS, Medicare Part D costs \$67.67 billion in 2014, \$88 billion in 2016 and is projected to
10 double in cost between 2012 and 2022 in part due to an aging population and in part due to
11 improving coverage, and

12
13 WHEREAS, Medicare Part D is currently prohibited from negotiating drug prices using the
14 leverage of 39.1 million enrollee's, and

15
16 WHEREAS, the Veteran Benefits Administration (VBA) and Medicaid are allowed to negotiate
17 drug prices, and

18
19 WHEREAS, Medicare Part D pays on average 73% more than Medicaid and 80% more than
20 VBA for brand-name drugs, and

21
22 WHEREAS, 58% of Medicare Part D expenditures went to brand-name drugs in 2011, and

23
24 WHEREAS, Medicare Part D would save from \$15.2 billion to \$16 billion a year if it could secure
25 the same prices that Medicaid or VBA, respectively, receives on the same brand-name drugs,
26 and

27
28 WHEREAS, a common argument against allowing price negotiation is the so called "innovation
29 crisis" in which profits become so low that innovation halts, and

30
31 WHEREAS, the cost of new drug discovery is often cited at \$1.3 billion, however, after breaking
32 down the accounting, the actual cost is ~\$60 million, and

33
34 WHEREAS, pharmacy companies devote 1.3% of revenues to discovering new molecules while
35 25% is spent on marketing and promotion, meaning they spend 19 times more money on
36 marketing than research, and

37
38 WHEREAS, Minnesota Senator Amy Klobchar has introduced a bill entitled "The Medicare
39 Prescription Drug Price Negotiation Act" in 2013 and 2015 intending to allow Medicare Part D to
40 begin negotiating drug prices, now, therefore, be it

41
42 RESOLVED, That the American Academy of Family Physicians create policy in support of
43 allowing Medicare Part D to negotiate for drug prices, and be it further

44
45 RESOLVED, That the American Academy of Family Physicians write a letter to the appropriate
46 senators, and representatives, encouraging them to support legislation that would allow
47 Medicare Part D to negotiate for drug prices.

1 **RESOLUTION NO. S3-315**

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

3 Introduced by: Julie Petersen, DO, Columbus, OH
4 Ann Askari, Columbus, OH
5

6 WHEREAS, The Accreditation Council for Graduate Medical Education (ACGME) and American
7 Osteopathic Association (AOA) signed a Memorandum of Understanding for the creation of a
8 single accreditation system by 2020, and
9

10 WHEREAS, the AOA currently accredits 257 family medicine residencies, the majority of which
11 are in rural areas or community hospitals, and
12

13 WHEREAS, osteopathic programs are reporting potentially program-ending logistical and
14 financial barriers in meeting or even defining the requirements of the ACGME and are often
15 finding existing consultative services to be cost prohibitive, and
16

17 WHEREAS, the Centers of Medicare and Medicaid Services established Medicare Resident
18 Limits (caps) in 1997, and
19

20 WHEREAS, many AOA-accredited programs were capped at a level below the Accreditation
21 Council for Graduate Medical Education Family Medicine Review Committee requirement of a
22 minimum of four per class, and
23

24 WHEREAS, the Rural Training Track Collaborative and National Rural Health Association
25 (NRHA) have existing resources to develop rural training tracts in Family Medicine residencies,
26 and
27

28 WHEREAS, rural areas contain 25 percent of the United States population but only 10 percent
29 of the physicians, and
30

31 WHEREAS, rural training programs place physicians in rural practices at much higher rates than
32 urban programming, and
33

34 WHEREAS, at the 2016 Family Medicine Congressional Conference, the American Academy of
35 Family Physicians (AAFP) devoted ones of its lobbying “asks” to advocate for rural family
36 medicine training programs through Teaching Health Centers, now, therefore, be it
37

38 RESOLVED, That the American Academy of Family Physicians (AAFP) advocate for continued
39 viability of traditionally osteopathic family medicine residencies throughout the United States,
40 especially in the rural areas, and be it further
41

42 RESOLVED, That the American Academy of Family Physicians (AAFP) advocate for expansion
43 of Centers of Medicare and Medicaid Services (CMS) resident caps to allow funding for the full,
44 four-resident class required by the Accreditation Council of Graduate Medical Education
45 (ACGME), and be it further
46

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

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

53

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

1 **RESOLUTION NO. R3-622**

2 **Promoting the Resident and Student Discussion Forum**

3 Introduced by: Chetan Patel, MD, Columbus, GA
4 Kyle Gleaves, Scranton, PA
5

6 WHEREAS, Students and residents tend to work within silos comprised by the community in
7 their city, state, medical school, residency program and rotation site, and
8

9 WHEREAS, improved communication and idea exchange between members from these various
10 silos can improve the efficacy and efficiency of identifying and addressing areas of concern, and
11

12 WHEREAS, the idea exchange can help students and residents engage with and improve their
13 local and state medical societies, now, therefore, be it
14

15 RESOLVED, That the American Academy of Family Physicians work with chapters, residency
16 programs and medical schools to increase awareness and promote the American Academy of
17 Family Physicians resident and student discussion group to exchange ideas and information.
18