



# Student 3 Agenda and Resolutions

---

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

---

1. Resolution No. S3-301 Support a Study on Minimum Competencies and Scope of Medical Scribe Utilizations
2. Resolution No. S3-302 Support of the Research of the Efficacy of Situational Judgment Testing (SJT) /Computer-Based Assessment for Sampling Personal Characteristics (CASPer) in the Evaluation of Medical School Applicants
3. Resolution No. S3-303 Evaluation of The Healer's Art Course in Building Compassion in Medical Students
4. Resolution No. S3-304 Transparency of Procedural Expectations and Conscience Policies in the Residency Application Process
5. Resolution No. S3-305 A Virtual Platform for Wellness and Burnout Prevention
6. Resolution No. S3-306 Enhanced Understanding of MACRA, Medicare Access and CHIP Reauthorization Act of 2015, for Resident and Student AAFP Members
7. Resolution No. S3-307 Talking Explicitly About Impact Bias
8. Resolution No. S3-308 Lobby to End Step 2 CS and Level PE
9. Resolution No. S3-309 Partnerships in Developing a Rural Training Database
10. Resolution No. S3-310 Recycling at National Conference
11. Resolution No. S3-311 The American Academy of Family Physicians to Support Accreditation Council for Graduate Medical Education Accredited Residencies in obtaining Osteopathic Recognition
12. Resolution No. S3-312 Student Debt Reform
13. Resolution No. S3-313 Offering Guidance to the ABFM Regarding the Maintenance of Certification Family Practice (MC-FP)

14. Resolution No. S3-314 Supporting Medicare Drug Negotiating Powers
15. Resolution No. S3-315 Protecting Rural Family Medicine Training Programs During the AOA/ACGME Merger
16. Resolution No. S3-316 Promoting the Resident and Student Discussion Forum
17. Resolution No. S3-317 Promoting Cross-Cultural and Linguistic Education for Residents and Medical Students About Hispanic and Latino Populations to Improve Health Care Communications

1 **RESOLUTION NO. S3-301**

2 **Support a Study on Minimum Competencies and Scope of Medical Scribe Utilizations**

3 Introduced by: Kyle Gleaves, Scranton, PA  
4 Elisa Giusto, Philadelphia, PA  
5

6 WHEREAS, Nearly 1 in 5 physicians currently employ medical scribes who are unlicensed  
7 workers hired to enter patient history and physical exam findings into the electronic health  
8 record (EHR) at the direction of a physicians or practitioner and,  
9

10 WHEREAS, while medical scribes were initially used in emergency rooms and urgent care  
11 centers, they are now currently used throughout hospitals and every type of clinic, and  
12

13 WHEREAS, several studies suggest that medical scribes improve clinical satisfaction,  
14 productivity, time-related efficiencies, revenue, and patient-clinician interactions since EHR-use  
15 can be cumbersome and time-consuming, and  
16

17 WHEREAS, federal law inhibits medical scribes from entering certain patient information  
18 including but not limited to prescription medication and lab and imaging orders, but there is no  
19 enforcement mechanism to ensure adherence, and  
20

21 WHEREAS, the use of medical scribes can pose potential risks to patients if they are allowed to  
22 enter orders into the EHR and the risk of such action is high, and  
23

24 WHEREAS, ScribeAmerica, one of the dozens of companies employing scribes and the largest  
25 professional medical scribe training and management company in the United States, only  
26 provides two weeks of training for new medical scribes, and  
27

28 WHEREAS, because medical scribes have no patient care responsibilities, they are not  
29 currently required to undergo specific training or meet any background requirements prior to  
30 starting their positions, and  
31

32 WHEREAS, only one-third of the current 15,000 medical scribes in America are certified by the  
33 American College of Medical Scribes Specialists, created by ScribeAmerica's founders in 2012,  
34 and  
35

36 WHEREAS, there has been skepticism among ScribeAmerica's s competing medical scribe  
37 training and management companies regarding the legitimacy of this certification, and  
38

39 WHEREAS, there will be an estimated 100,000 medical scribes in 2020 with no national  
40 standardization of training in place, and  
41

42 WHEREAS, individual institutions, such as The Mayo Clinic, have resorted to developing  
43 custom training curricula to address shortcomings in medical scribe training, now, therefore, be  
44 it  
45

46 RESOLVED, That the American Academy of Family Physicians partner with The Joint  
47 Commission and other stakeholders to study the minimum skills and competencies required of a  
48 medical scribe regarding documentation performance and clinical boundaries of medical scribes  
49 utilization.

1 **RESOLUTION NO. S3-302**

2 **Support of the Research of the Efficacy of Situational Judgment Testing (SJT)**  
3 **/Computer-Based Assessment for Sampling Personal Characteristics (CASPer) in the**  
4 **Evaluation of Medical School Applicants**

5 Introduced by: Jennifer Soloman, Johnson City, TN  
6 Kaitlyn Jongkind, Johnson City, TN  
7 Margaret Smith, Johnson City, TN  
8 Katelin McCall, Johnson City, TN  
9

10 WHEREAS, The American Academy of Family Physicians (AAFP) promotes the Patient  
11 Centered Medical Home (PCMH) model, which emphasizes physician-led practice, and  
12

13 WHEREAS, these practices require physicians with leadership qualities, who exhibit excellent  
14 communication and interpersonal skills with a strong moral and ethical foundation, and  
15

16 WHEREAS, few medical schools in the United States actively cultivate the communication and  
17 leadership skills required of physicians in the PCMH, and  
18

19 WHEREAS, medical schools emphasize the importance of strong academic performance in  
20 medical school admissions, yet few have a model for selecting students with the necessary  
21 morals and ethics for physicianship, and  
22

23 WHEREAS, Computer-Based Assessment for Sampling Personal Characteristics (CASPer) is a  
24 form of electronic Situational Judgement Testing (STJ) to evaluate a medical school applicant's  
25 character and judgement skills prior to the admission interview , and  
26

27 WHEREAS, SJT/CASPer provides medical admissions committees with information on an  
28 applicant's personal morals and ethics, now, therefore, be it  
29

30 RESOLVED, That the American Academy of Family Physicians encourage partner  
31 organizations, such as the Association of American Medical Colleges, to research the efficacy of  
32 Situational Judgment Testing/Computer-Based Assessment for Sampling Personal  
33 Characteristics with regards to medical school admissions.

1 **RESOLUTION NO. S3-303**

2 **Evaluation of The Healer’s Art Course in Building Compassion in Medical Students**

3 Introduced by: Jennifer Solomon, Johnson City, TN  
4 Kaitlyn Jongkind, Johnson City, TN  
5 Margaret Smith, Johnson City, TN  
6 Katelin McCall, Johnson City, TN  
7

8 WHEREAS, The American Academy of Family Physicians (AAFP) supports the Quadruple Aim,  
9 which promotes physician and student physician satisfaction through work-life balance and self-  
10 care, and

11  
12 WHEREAS, The Healer’s Art course is a class that fosters self-care through introspection,  
13 values’ clarification, and exploration of the relationship between clinician and patient, and  
14

15 WHEREAS, the Center for Evaluation of Healer’s Art has evaluated and published peer-  
16 reviewed studies demonstrating the effectiveness of the course in empathy, commitment and  
17 humanism in medical students, now, therefore, be it  
18

19 RESOLVED, That the American Academy of Family Physicians (AAFP) evaluate The Healer’s  
20 Art course as a valid opportunity for students to build compassion and self-care in medical  
21 education.

1 **RESOLUTION NO. S3-304**

2 **Transparency of Procedural Expectations and Conscience Policies in the Residency**  
3 **Application Process**

4 Introduced by: Cecilia Jojola, M.D., M.A., Sacramento, CA  
5 Lauren Weasler, Milwaukee, WI  
6 Brianna Wynne, Milwaukee, WI  
7

8 WHEREAS, Medical students may select a residency based on the ability of the program to  
9 teach competency in a given procedure, and

10

11 WHEREAS, medical students may select a residency based on the presence of a program  
12 conscience policy, and

13

14 WHEREAS, unclear expectations for procedural competencies have led to ethical dilemmas for  
15 as many as 68% (n=140) of surveyed family medicine residents, and

16

17 WHEREAS, some residencies have developed accessible policies for procedural expectations  
18 and conscience policies, and

19

20 WHEREAS, not all residency programs currently accessibly list the procedural competencies or  
21 conscience policies of their program, now, therefore, be it

22

23 RESOLVED, That the American Academy of Family Physicians endorse a policy of  
24 transparency in the residency application process by writing a letter to the Association of Family  
25 Medicine Residency Directors encouraging residency programs to a) list the procedural  
26 expectations of the residency program and b) list the conscience policies of the residency  
27 program in a way that is easily accessible to residency applicants.

1 **RESOLUTION NO. S3-305**

2 **A Virtual Platform for Wellness and Burnout Prevention**

3 Introduced by: Joseph Brodine, Washington, DC  
4 Emily Graber, Chicago, IL  
5 Mary "Molly" Warren, Washington, Dc  
6 Kristina Dakis, MD, Chicago, IL  
7

8 WHEREAS, Forty-nine percent of medical students and 50 percent of residents report  
9 symptoms of burnout, and

10  
11 WHEREAS, 9.3 percent of medical students and 8.7 percent of residents report suicidal ideation  
12 in the last 12 months, and

13  
14 WHEREAS, physicians need to care for themselves in order to be fit to care for patients, now,  
15 therefore, be it

16  
17 RESOLVED, That the American Academy of Family Physicians (AAFP) create a comprehensive  
18 online platform for medical students, residents, and attending faculty to enter into an open forum  
19 for discussion and prevention of burnout, and be it further

20  
21 RESOLVED, That an online platform for medical students, residents, and attending faculty to  
22 enter into an open forum for discussion and prevention and burnout offer resources, discussion  
23 blogs, and webinars to address burnout prevention and wellness promotion, and be it further

24  
25 RESOLVED, That an online platform for medical students, residents, and attending faculty to  
26 enter into an open forum for discussion and prevention and burnout, provide a platform for  
27 conducting research that aims to elucidate effective interventions for preventing burnout and  
28 promoting resilience among medical students, residents, and attending faculty.  
29

1 **RESOLUTION NO. S3-306**

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. S3-307**

2 **Talking Explicitly About Impact Bias**

3 Introduced by: Ashlin Mountjoy, Seattle, WA  
4 Jeremy Mosher, Vallejo, CA  
5 Michael Collins, MD, Grand Blanc, MI  
6 Max Weston, MD, Seattle WA  
7

8 WHEREAS, Medical students hold both negative implicit and explicit biases about groups,  
9 which can negatively impact physician-patient interactions, and  
10

11 WHEREAS, high levels of implicit bias among physicians produces more negative interactions  
12 with patients, and  
13

14 WHEREAS, implicit bias interventions can be an effective way to reduce biases, and  
15

16 WHEREAS, while the American Academy of Family Physicians has acknowledged the effects of  
17 racism on health, there are no formal recommendations for addressing this, and  
18

19 WHEREAS, The Joint Commission has issued an advisory brief with proposed solutions, now,  
20 therefore, be it  
21

22 RESOLVED, That the American Academy of Family Physicians publish a position paper on the  
23 impact of implicit bias in health care, and be it further  
24

25 RESOLVED, That the American Academy of Family Physicians prioritize research on the impact  
26 of implicit bias and effective interventions for reducing implicit bias in health care, and be it  
27 further  
28

29 RESOLVED, That the American Academy of Family Physicians (AAFP) ask the Accreditation  
30 Council for Graduated Medical Education to consider using AAFP's model curriculum on implicit  
31 bias in health care as part of their accreditation guidelines for family medicine residency  
32 programs, and be it further  
33

34 RESOLVED, That the American Academy of Family Physicians (AAFP) ask the Liaison  
35 Committee on Medical Education and Commission on Osteopathic College Accreditation to  
36 consider using the AAFP's model curriculum on implicit bias in health care as part of their  
37 accreditation guidelines for medical schools.

1 **RESOLUTION NO. S3-308**

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 7<sup>th</sup>, 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. S3-309**

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. S3-310**

2 **Recycling at National Conference**

3 Introduced by: Megan Chock, MD, San Diego, CA  
4 Stewart Decker, MD, Klamath Falls, OR  
5 Redmond Finney, MD  
6

7 WHEREAS, The American Academy of Family Physicians (AAFP) clearly supports the health of  
8 communities as evidence by its efforts of “Family Medicine for America’s Health” and its  
9 associated “Health is Primary Campaign”, and  
10

11 WHEREAS, the environment may arguable represent the largest asset of a healthy community,  
12 and  
13

14 WHEREAS, according to the most recent Environmental Protection Agency (EPA) report, “in  
15 2013, Americans generated about 254 million tons of trash and recycled and composted about  
16 87 million ton of this material, equivalent to a 34.3 percent recycling rate”, and  
17

18 WHEREAS, on average, each American generates 4.40 pounds of waste and recycled and/or  
19 composted 1.51 pounds of our individual waste, and  
20

21 WHEREAS, according to Chaz Miller of the National Waste & Recycling Association, a key  
22 component of improving the overall recycling rate is “further penetration of programs in rural  
23 areas and in commercial and multi-family buildings, and  
24

25 WHEREAS, as of 2016, there is no official recycling system in place at the American Academy  
26 of Family Physicians’ National Conference of Family Medicine Residents and Medical Students,  
27 and  
28

29 WHEREAS, there are many organizations and programs, including those sponsored by the EPA  
30 such as WasteWise5, which focuses on reducing waste, practice environmental stewardship  
31 and incorporate sustainable materials management, and  
32

33 WHEREAS, Americans have a great opportunity to increase their recycling rates at both societal  
34 and individuals levels, now, therefore, be it  
35

36 RESOLVED, That the American Academy of Family Physicians work to implement a recycling  
37 program at National Conference of Family Medicine Residents and Medical Students, and be it  
38 further  
39

40 RESOLVED, That the goal of the recycling program be to produce a recycling rate of greater  
41 than 40% during the AAFP National Conference of Family Medicine Residents and Medical  
42 Students, and be it further  
43

44 RESOLVED, That a recycling program at the National Conference of Family Medicine  
45 Residents and Medical Students be in place and achieve its goal by 2020.

1 **RESOLUTION NO. S3-311**

2 **The American Academy of Family Physicians to Support Accreditation Council for**  
3 **Graduate Medical Education Accredited Residencies in obtaining Osteopathic**  
4 **Recognition**

5 Introduced by: Matthew Varallo, DO, Rancho Mirage, CA  
6 Jeremy Mosher, Vallejo, CA  
7 Stewart Decker, MD, Klamath Falls, OR  
8

9 WHEREAS, The American Osteopathic Association (AOA) and the Accreditation Council for  
10 Graduate Medical Education (ACGME) have signed a memorandum of Understanding to create  
11 a single accreditation system, and  
12

13 WHEREAS, all family medicine residencies will be accredited by the ACGME and AOA  
14 accreditation will no longer exist, and  
15

16 WHEREAS, there is strong evidence that Osteopathic Manipulative Treatment can help to treat  
17 acute low back pain and provides relief of chronic musculoskeletal pain, and  
18

19 WHEREAS, Osteopathic Manipulative Treatment is a sought after skill by both MD and DO  
20 residents to help diagnose and treat musculoskeletal pain, and  
21

22 WHEREAS, residency programs certified with ACGME Osteopathic Recognition would  
23 incorporate training of osteopathic principles to both MD and DO residents, now, therefore, be it  
24

25 RESOLVED, That the American Academy of Family Physician (AAFP) create a statement of  
26 support regarding residency programs seeking to obtain osteopathic recognition, and be it  
27 further  
28

29 RESOLVED, That the American Academy of Family Physician create and make available a  
30 "How to Guide" on how to achieve osteopathic recognition for residency programs and list  
31 mentors available to serve as a resource in the process.  
32

1 **RESOLUTION NO. S3-312**

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. S3-313**

2 **Offering Guidance to the ABFM Regarding the Maintenance of Certification Family**  
3 **Practice (MC-FP)**

4 Introduced by: Alex Mroszczyk-McDonald, MD, Fontana, CA  
5 Matthew Peters, Boise, ID  
6

7 WHEREAS, The American Academy of Family Physicians (AAFP) member physicians join the  
8 American Board of Family Medicine (ABFM) in supporting lifelong learning that reinforces and  
9 updates medical knowledge critical to patient safety and professional excellence, and  
10

11 WHEREAS, the Winter 2016 ABFM newsletter “The Phoenix” was a welcome indicator of the  
12 ABFM’s openness to listen to and collaborate with physicians in evolving the Maintenance of  
13 Certification for Family Physicians (MC-FP) process to better meet the above mentioned goals,  
14 and  
15

16 WHEREAS, based on current estimates, 60% of family physicians are employed, and  
17

18 WHEREAS, physician employers report Accountable Care Organizations (ACO), meaningful use,  
19 Physician Quality Reporting System (PQRS) and Patient-Centered Medical Home (PCMH) to  
20 payer agencies making Performance in Practice Modules redundant for the majority of family  
21 physicians, and  
22

23 WHEREAS, the current self-assessment activities covering three topics in three years are too  
24 limited and does not reinforce or update the broad range of topics encountered by family  
25 physicians, and  
26

27 WHEREAS, a yearly review of a broad range of topics regularly encountered by family  
28 physicians based on literature from recognized family medicine journals would be more useful,  
29 and  
30

31 WHEREAS, multiple, frequent clinically based assessments over time and are more effective  
32 learning opportunities than a single, high-stakes examination, and  
33

34 WHEREAS, family physicians should be free to schedule their MC-FP time commitment, and  
35

36 WHEREAS, the ABFM could simplify Maintenance of Certification (MOC) for physicians by  
37 allowing the AAFP to accredit activities that will count for MOC, and  
38

39 WHEREAS, there is a precedent for such a change as the American Board of Internal Medicine  
40 has recently revised their standards for MOC in partnership with the Accreditation Council for  
41 Continuing Medical Education (ACCME), now, therefore be it  
42

43 RESOLVED, That the American Academy of Family Physicians recommend the American  
44 Board of Family Medicine reevaluate Maintenance of Certification requirements to be more  
45 succinct while utilizing current evidence on adult learning modalities and catering to multiple  
46 learning preferences, and be it further  
47

48 RESOLVED, That the American Academy of Family Physicians recommend that the American  
49 Board of Family Medicine allow the AAFP credit system to certify continuing medical education

50 (CME) events as meeting Maintenance of Certification requirements provided they meet  
51 mutually agreed upon standards.

1 **Resolution NO. S3-314**

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. S3-316**

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.

1 **RESOLUTION NO. S3-317**

2 **Promoting Cross-Cultural and Linguistic Education for Residents and Medical Students**  
3 **About Hispanic and Latino Populations to Improve Health Care Communications**

4 Introduced by: Hilary Hopkins, San Antonio, TX  
5 Matt Mullane, Denver, CO  
6

7 WHEREAS, Hispanics and Latinos comprise nearly 16% of the United States population, and is  
8 predicted to increase to 30% by 2050, and  
9

10 WHEREAS, existing Spanish language and cross-cultural sensitivity programs have been  
11 recognized for their usefulness in improving patient-physician interactions, and  
12

13 WHEREAS, 23% of Hispanics and Latinos in the United States live in poverty, and  
14

15 WHEREAS, many resident physicians believe that limited English proficiency parents of  
16 pediatric patients “never” or “only sometimes” understood medication instructions, discharge  
17 instructions, or their child’s diagnosis, and  
18

19 WHEREAS, medical conference and CME programs often do not provide dedicated programs  
20 concerning cross-cultural and linguistic education, and  
21

22 WHEREAS, Hispanics and Latinos of Mexican and Central American origin face significant  
23 obstacle, including language barriers, to obtaining health care, now, therefore, be it  
24

25 RESOLVED, That the American Academy of Family Physicians (AAFP) provide a focused  
26 cross-cultural and linguistic educational session at AAFP national conferences to improve  
27 communication between physicians and Hispanic and Latino population with limited English  
28 proficiency, and be it further  
29

30 RESOLVED, That the American Academy of Family Physicians disseminate cross-cultural and  
31 linguistic education resources to Family Medicine Interest Groups across the country to improve  
32 communication between physicians and Hispanic and Latino populations with limited English  
33 proficiency.