RESOLUTION
15-01

SUBJECT: **Simplify or Eliminate MOC**

SUBMITTED BY: **Gabriel R. Guardarramas MD**

WHEREAS certification by specialty boards, formerly a diploma requiring no renewal, has become time limited, usually for ten years,

WHEREAS specialty boards have developed and implemented varying maintenance of certification requirements, often including closed-book examinations, chart audits, etc., all of which drain physician time and money without demonstrated improvement in patient care,

WHEREAS medical knowledge has increased beyond any reasonable expectation that anyone can be expected to know or retain facts that may be needed to inform the care of a particular patient,

WHEREAS medical facts can be retrieved easily online from dependable sources, albeit requiring interpretation and evaluation for relevance and use in patient care,

WHEREAS maintenance of certification is occurring while many millions of people have acquired health insurance and the health care industry is changing and consolidating, leading many physicians to have to deal with multiple training and privileging requirements from multiple sources,

WHEREAS shortages of physicians have become so acute that recent graduates increasingly take jobs advertised for “board eligible” rather seeking initial board certification and funding agencies increasingly are satisfied with noncertified physician-extenders to whom a wide range of clinical interventions are allowed with requiring continuing education or any sort of certification, now therefore be it

RESOLVED that the New York State Academy of Family Physicians delegation to the American Academy of Family Physicians Congress of Delegates is instructed to introduce a resolution to compel the AAFP to introduce or, if such resolution is introduced by someone else, to support a resolution at the American Medical Association House of Delegates to reduce maintenance of specialty board certification requirements to a) a simple open book examination that demonstrates ability to retrieve and apply medical knowledge, OR b) demonstrated continued medical education or meeting equivalent mandated quality improvement requirements, OR c) none.

Attachment(s):

Please click here for ABFM 2009 990 Tax Return

Please click here for MSSNY Resolution in Opposition to MOC and MOL

RESOLUTION
15-02

Subject: **Resolution Nuclear Disarmament COD 2015**

Submitted by: **Public Health Commission**

Author: **Bill Klepack, MD**

WHEREAS nuclear weapons have public health effects devastating in their scope, and

WHEREAS, a December, 2013 report from Physicians for Social Responsibility (PSR) documents that even in a nuclear exchange between countries with fewer nuclear weapons (e.g. India and Pakistan) that up to two Billion people worldwide would be at risk for nuclear famine with impacts felt worldwide including in the state of New York. Such impacts would be climate changes affecting the growing season and crop yields and disruptions in the worldwide agricultural markets resulting in mismatches between supply and demand in addition to inadequate worldwide supplies (2), and

WHEREAS, an accidental nuclear war could be initiated by misinformation, fear, human error, and/ or computer malfunction, and

WHEREAS, nuclear weapons have proven to have limited military utility and this new data emphasizes that all nuclear nations and warheads pose a threat to all of us, even if used in a "limited" way, and

WHEREAS, the AAFP has taken a policy position on this topic in 1987 and 2011 which did not address elimination of weapons (7), and

WHEREAS, the new data referenced above should prompt new action on this topic, therefore be it

RESOLVED, that the NYSAFP supports the elimination of nuclear weapons, and be it further

RESOLVED, that the NYSAFP will communicate its support in favor of the elimination of nuclear weapons to the New York Chapter of Physicians for Social Responsibility, and be it further

RESOLVED, that the NYSAFP delegation to the next AAFP Congress of Delegates introduce a resolution that the AAFP support the elimination of nuclear weapons.

Footnotes

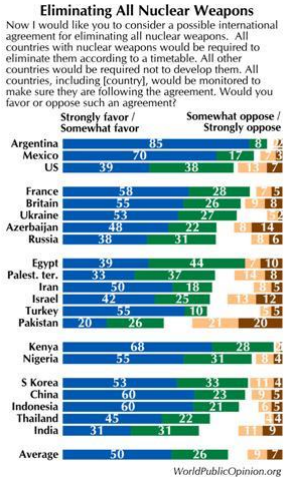
1 Bulletin of the Atomic Scientists Nuclear Notebook

2 Nuclear famine: Two billion People at Risk?, second edition, Hefland MD, International Physician for the Prevention of Nuclear War and Physician for Social Responsibility

3 http://www.worldpublicopinion.org/pipa/articles/international_security_bt/577.php?lb=btis&pnt=577&nid=&id= (21 nations from around the world finds that people in every country favor an international agreement for eliminating all nuclear weapons.,

Respondents were asked to consider an agreement that specified "all countries with nuclear weapons would be required to eliminate them according to a timetable" while "all other countries would be required not to develop them." Respondents were also told that all countries, including their own, "would be monitored to make sure they are following the agreement."
In 20 of the 21 countries large majorities, ranging from 62 to 93 percent, favor such an agreement. The only exception is Pakistan, where a plurality of 46 percent favors the plan while 41 percent are opposed. All nations known to have nuclear weapons were included in the poll, except North Korea where public polling is not available.

The poll of 19,142 respondents across 21 countries was conducted between January 10 and August 29, 2008 by WorldPublicOpinion.org, a collaborative research project involving research centers from around the world and managed by the Program on International Policy Attitudes (PIPA) at the University of Maryland. Margins of error range from +/- 2 to 4 percentage points. The study included all nations with nuclear weapons (except North Korea) and the following non-nuclear nations: Argentina, Azerbaijan, Egypt, Indonesia, Iran, Kenya, Mexico, Nigeria, the Palestinian territories, South Korea, Thailand, Turkey, and Ukraine. The nations included represent 62 percent of the world population.



The idea of pursuing the elimination of nuclear weapons has gained increased visibility lately since a bipartisan group of four former US senior officials, George Schultz, Henry Kissinger, William Perry, and Sam Nunn published an influential article in 2007 titled "A World Free of Nuclear Weapons" endorsing the goal of eliminating nuclear weapons.

4 — United **Nations General Assembly 1st Committee 124** Nations *Joint Statement on the Humanitarian Consequences of Nuclear Weapons* Delivered by the ambassador from New Zealand October 21, 2013

"The only way to guarantee that nuclear weapons will never be used again is through their total elimination."

5 **Nobel Peace Laureates' Statement:** Nuclear Abolition is a Humanitarian Imperative October 24, 2013

"Nuclear weapons are an existential threat to humanity, and must never be used again, under any circumstances. We therefore welcome the recent shift in the international discourse about nuclear weapons towards the recognition by a number of States that the catastrophic and irremediable consequences of the use of nuclear weapons require decisive action to outlaw and eliminate them

6 attached

7 Nuclear, Biological and Chemical (NBC) Warfare

The American Academy of Family Physicians endorses the concept of worldwide, verifiable moratorium on testing, production and deployment of nuclear, biological, and chemical weapons.
(1987) (2011 COD)

RESOLUTION
15-03

SUBJECT: **Immunization Exemptions**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Bill Klepack, MD Linda Prine, MD**

WHEREAS, Immunization is of major importance in protecting an individual's and the public's health and in preventing or curtailing outbreaks from becoming epidemics, and

WHEREAS, the granting of a medical exemption from an immunization for school attendance is certainly reasonable when an immunization is deemed to pose an unacceptable medical risk to an individual, and

WHEREAS, exemptions have been granted for non-medical reasons which have allowed children to attend school without immunizations, therefore, be it

RESOLVED that the NYSAFP advocates that only medical exemptions be allowed for ACIP recommended childhood vaccines.

RESOLUTION
15-04

SUBJECT: **Climate Change**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Bill Klepack, MD**

WHEREAS, climate change produces weather patterns and climactic changes that affect the earth's flora and fauna and have implications for coastal infrastructure,

WHEREAS, the majority of scientific opinion favors human activity as a significant causative factor (97 percent of those scientists specializing in climate change agree with the concept of man-made climate change, according to a survey published by the National Academy of Sciences. (1), and

WHEREAS, the response to climate change requires both individual and community actions, and

WHEREAS, effective community actions require governmental action ranging from local to state to federal level, and

WHEREAS, physicians have a duty to protect the health of the public, and physician leadership on the issue of climate change is necessary to assure that public and political opinion is fully informed, and

WHEREAS, climate change is projected to cause the incidence of the following conditions to rise beyond present levels: injuries and fatalities (due to severe weather), asthma and cardiovascular disease (from air pollution), malaria, dengue, encephalitis, hantavirus, Rift Valley fever, Lyme disease, Chikungunya and West Nile virus (from changes in vector ecology), Respiratory allergies and asthma (from increasing allergens), Cholera, cryptosporidiosis, campylobacter, leptospirosis and harmful algal blooms (from water quality impacts), malnutrition and diarrheal disease (from water and food supply impacts), forced migration, civil conflict and mental health impacts (from environmental degradation), and illness and death and cardiovascular failure (from extreme heat), and

WHEREAS, the medical community's response to health problems (3) created by climate change are likely to prove inadequate to fully mitigate its effects, and

WHEREAS, other professional bodies have voiced concern such as the AMA in 2009 when it took the position of urging the president to take a: "strong and visionary stand

for human health and the environment" by supporting robust climate change policies. (4), and

WHEREAS, heretofore, the NYSAFP has had no position on this topic, and

WHEREAS, the AAFP has only a fairly general statement on the subject (5), therefore be it now

RESOLVED, that NYSAFP concurs with the overwhelming majority of scientists that human behavior contributes significantly to climate change, and be it further

RESOLVED, that the NYSAFP support public policies in NY that limit and monitor the use of fossil fuels and the production of pollutants therefrom which contribute to climate change., and be it further

RESOLVED, that similar language for federal policy be reflected in a resolution, which our delegates will introduce at the AAFP COD (appended below[5]).

1. Anderegg WR, Prall JW, Harold J, Schneider SH. Expert credibility in climate change. Proc Natl Acad Sci U S A. 2010;107(27):12107–12109. http://www.pnas.org/cgi/. Accessed January 28, 2012.

2. http://www.cdc.gov/climateandhealth/effects/ accessed April 3,2015

3. Slowing Global Warming: Benefits for Patients and the Planet CINDY L. PARKER, MD, MPH, *Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland* *http://www.aafp.org/afp/2011/0801/p271.pdf accessed February 22, 2015*

4. "The AMA has also adopted far-reaching policies that comprehensively address healthy food issues (13. American Medical Association. Report 8 of the Council on Science and Public Health (A-09). Sustainable food. 2009. http://www.ama-assn.org/resources/doc/csaph/csaph-rep8-a09.pdf. Accessed June 23, 2011) and call for active engagement of physicians in other efforts to prevent and mitigate climate change (American Medical Association. Report 1 of the Council on Science and Public Health (I-08). Green initiatives and the health care community. 2008. http://www.ama-assn.org/resources/doc/csaph/csaph1i08.pdf. Accessed June 23, 2011). This was underscored by a November 19, 2009, letter from the AMA to President Obama citing the

"significant public health implications" of climate change, and urging him to take a "strong and visionary stand for human health and the environment" by supporting robust climate change policies. "
Source:
Editorials
The Physician's Role in Efforts to Slow Global Warming
ROBERT M. GOULD, MD, Physicians for Social Responsibility, San Francisco, California
Am Fam Physician. 2011 Aug 1;84(3):256-257.
http://www.aafp.org/afp/2011/0801/p256.html

and in editor's comment regarding letters to the editor re an article by Parker
http://www.aafp.org/afp/2012/0301/p427.html

5. Climate Change and Air Pollution
"In recognition of the numerous and serious adverse health consequences resulting from pollution, climate change and ozone layer depletion, the AAFP recommends strong action on all public and private levels to limit and correct the pollution of our land, atmosphere and water. (1969) (2010 COD)"
http://www.aafp.org/about/policies/all/climate-pollution.html accessed Jan 16 2015

RESOLUTION
15-05

SUBJECT: **Support Placement and Coverage of Long-Acting Reversible Contraceptives (LARC) in the Early Postpartum Period**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Linda Prine, MD**

WHEREAS, providing women with early postpartum access to LARC methods significantly reduces the risk of unplanned pregnancies and improves the health of newborns and mothers by facilitating healthy spacing between pregnancies.[1]

WHEREAS, birth intervals less than 18 months are associated with poor perinatal outcomes including preterm birth and low birth weight.[2,3]

WHEREAS, women who used LARC methods have many fold increased likelihood of achieving optimal birth interval compared to women using other methods.[2]

WHEREAS, the ability to control the timing of her pregnancies is crucial to a woman's socioeconomic advancement as it affects her education, employment, mental health, and ability to care for existing children. [5]

WHEREAS, ensuring prompt access to LARC would result in fewer unintended pregnancies, better health outcomes, and considerable cost savings for the healthcare system. [6]

WHEREAS, placement of LARC is safe for women, with minimal effect on breastfeeding, good continuation rates and decreased pregnancy rates. [2,4,7]

WHEREAS, currently the most significant barriers to providing postpartum LARC are related to billing and payment from Medicaid and private insurance, with few states assuring coverage separate from the global fee. 8,9

WHEREAS, although New York State Medicaid has agreed to reimburse for the devices, few New York hospitals have initiated stocking the devices and providing the service,

WHEREAS, the AAFP has supported past resolutions to reduce barriers to LARC access for women,[10] now therefore be it

RESOLVED, that the New York State Academy of Family Physicians (NYSAFP) support a policy that LARC methods be a recommended option for postpartum women prior to hospital discharge, and be it further

RESOLVED, that the NYSAFP support a policy assuring coverage of LARC device and placement prior to hospital discharge, separate from the global fee, for all women who select these methods, and be it further

RESOLVED, that the NYSAFP submit a resolution asking the AAFP to support a policy that LARC methods be a recommended option for postpartum women prior to hospital discharge, and be it further

RESOLVED, that this resolution also ask the AAFP to support a policy assuring coverage of LARC device and placement, separate from the global fee, prior to hospital discharge for all women who select these methods.

REFERENCES

1. ACOG, "Medicaid reimbursemet for immediate post-partum LARC" https://www.acog.org/~/media/Departments/LARC/HMAPostpartumReimbursmentResource.pdf

2. Thiel de Bocanegra H, Chang R, Howell M, Darney P. Interpregnancy intervals: impact of postpartum contraceptive effectiveness and coverage. Am J Obstet Gynecol 2014; 210(4): 311.e1-8.

3. Conde-Agudelo, A., Rosas-Bermúdez, A., & Kafury-Goeta, A. C. (2006). Birth spacing and risk of adverse perinatal outcomes: a meta-analysis. *JAMA*, *295*(15), 1809-1823.

4. Rodriguez MI, Evans M, Espey E. Advocating for immediate postpartum LARC: increasing access, improving outcomes, and decreasing cost. Contraception 2014 in press. Available online athttp://www.sciencedirect.com/science/journal/aip/00107824.

5. Sonfield A, Hasstedt K, Kavanaugh ML, Anderson R. The Social and Economic Benefits of Women's Ability To Determine Whether and When to Have Children. Guttmacher Institute, March 2013. http://www.guttmacher.org/pubs/social-economic-benefits.pdf

6. Eisenberg, D., McNicholas, C., & Peipert, J. F. (2013). Cost as a barrier to long-acting reversible contraceptive (LARC) use in adolescents. *Journal of Adolescent Health*, *52*(4), S59-S63.

7. Potter JE, Hopkins K, Aiken AR, Lopez CH, Stevenson AJ, White K, Grossman D. Unmet demand for highly effective postpartum contraception in Texas. Contraception 2014 in press. Available online athttp://www.sciencedirect.com/science/journal/aip/00107824.

8. Aiken ARA, Creinin MD, Kaunitz AM, Nelson AL, Trussell J. Global fee prohibits postpartum provision of the most effective reversible contraceptives. Contraception 2014;90: 466-467.

9. ACOG: http://www.acog.org/-/media/Departments/LARC/HMAPostpartumReimbursmentResource.pdf, ACOG practice bulletin LARC 2011

10. AAFP Resolution 305, End of prior approval for contraceptive devices, 2013.

RESOLUTION
15-06

SUBJECT: **Health Impact of Gentrification**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Venis Wilder, MD**

WHEREAS, There is a phenomenon of gentrification in large cities in the United States in which poorer minority communities are being displaced from urban centers[1], and

WHEREAS, as per the Center for Disease Control, displacement has many health implications that contribute to the health of special populations such as women, children, the elderly, and the members of racial/ethnic minority groups[2], and

WHEREAS, studies indicate vulnerable populations typically have shorter life expectancy, greater infant mortality, and higher rates of chronic diseases such as asthma, diabetes, and cardiovascular disease[3], and

WHEREAS, other health effects of displacement include limited access to healthy housing, food choices, quality schools, transportation, exercise facilities, and social networks, and

WHEREAS, local investment includes newer housing and food options which result in increased cost of living without directly increasing the financial opportunity of poorer communities, now, therefore, be it

RESOLVED, The NYSAFP introduce a resolution to the American Academy of Family Physicians requesting that the Robert Graham Center for Policy Studies in Family Medicine and Primary Care investigate how the process of gentrification impacts health outcomes and create potential policy recommendations that could improve the health of the most vulnerable.

Adapted from a resolution submitted and approved by the AAFP NCSC in 2014.

[1]Causa Justa. Development without Displacement: Resisting Gentrification in the Bay Area. http://www.acphd.org/media/341554/development-without-displacement.pdf
[2]Center for Disease Control – Health Effects of Gentrification
http://www.cdc.gov/healthyplaces/healthtopics/gentrification.htm
[3]Center for Disease Control – Health Effects of Gentrification
http://www.cdc.gov/healthyplaces/healthtopics/gentrification.htm

RESOLUTION
15-07

SUBJECT: **Legalization of Marijuana for Personal Use**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Heather Paladine, MD**

WHEREAS drug-related crimes were the single largest reason for arrest in the United States in 2013, according to the Federal Bureau of Investigation, and marijuana possession accounts for over 40% of drug-related arrests (1).

WHEREAS, a study by a Harvard professor of economics estimated that legalization of marijuana would save the government 8.7 billion dollars per year (2),

WHEREAS, in 2010, there were over 100,000 marijuana arrests in New York, 97% of which were for possession, and costing New York taxpayers $670 million according to a study conducted by the American Civil Liberties Union (3);

WHEREAS, in 2010, in New York City alone there were 40,000 - 50,000 arrests for marijuana, 85% of which were arrests of African-American or Latino people;

WHEREAS imprisonment for drug offenses can have additional negative health consequences, including exposure to tuberculosis, worsened mental health, and overall decreased life expectancy.

WHEREAS laws that legalize only medical marijuana use may put physicians in the position of being asked to prescribe or approve marijuana for indications that are not supported by scientific evidence,

WHEREAS substance abuse treatment is underfunded, therefore, be it

RESOLVED that the NYSAFP support laws to legalize possession and cultivation of marijuana for personal use for people over age 21 in New York state, and

RESOLVED, that the NYSAFP introduce a resolution to the AAFP COD to support removal of marijuana from the federal Drug Enforcement Agency's List of Schedule 1 Controlled Substances.

RESOLVED, that if future NY state laws are passed regarding the taxation of marijuana, that the NYSAFP advocate for a percentage of those funds to be used for substance abuse treatment.

References:

1) http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2013/crime-in-the-u.s.-2013/persons-arrested/persons-arrested

2) The Budgetary Impact of Ending Drug Prohibition, Jeffrey A. Miron and Katherine Waldock
http://www.cato.org/sites/cato.org/files/pubs/pdf/DrugProhibitionWP.pdf

3) The War on Marijuana in Black and White, Amercan Civil Liberties Union: https://www.aclu.org/sites/default/files/field_document/1114413-mj-report-rfs-rel1.pdf

RESOLUTION
15-08

SUBJECT: **Resolution to Oppose the Mandatory Drug Testing of Pregnant Women**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Linda Prine, MD**

WHEREAS drug use and addiction is a public health issue, not a criminal one, and needs to be dealt with accordingly[i,ii], and

WHEREAS between 1973-2005 there have been over 400 cases of arrests of and forced interventions on pregnant women[iii] and more than 300 additionally since 2005[iv], and

WHEREAS 15 states require health care professionals to report pregnant women they suspect to use drugs and 4 states require health care professionals to test for drug exposure,[v] and

WHEREAS it has been documented that the practice of drug testing pregnant women does not decrease rates of drug use, but instead results in the avoidance of prenatal care[vi,vii], and

WHEREAS the American Medical Association[viii], the American Academy of Pediatrics[ix], and the American College of Obstetricians and Gynecologists[x], the American Public Health Association[xi], the American Nurses Association[xii], have all opposed mandatory drug testing of pregnant women, and

WHEREAS the women who may be tested for drug use during pregnancy are the same women who especially need prenatal care because they often are also drinking alcohol, have little access to healthy foods, are smoking cigarettes, and are not taking or do not have access to prenatal vitamins[xiii,xiv], and

WHEREAS negative birth outcomes are generally more a reflection of poverty-associated deprivations than drug exposure[xv], and

WHEREAS while the intention of the physician may be to improve the woman's health through testing and reporting, it will most likely affect her eligibility for state assistance which in turn could gravely affect her health and access to care[xvi], and

WHEREAS when medical professionals become involved in criminalizing their patients, the doctor-patient relationship is compromised[xvii], and

WHEREAS the NYSAFP has policies supporting the autonomy of medical practice from legislative mandates that are not evidence-based[xviii, xix,] and

WHEREAS when women do test positive for drugs during pregnancy, they are often sent to jail or required to attend a rehabilitation program[xx], and

WHEREAS very few rehabilitation programs will accept pregnant patients because there is high liability associated[xxi], and

WHEREAS for women who are sentenced to jail, the risk of miscarriage increases to one in three women[xxii], and

WHEREAS for women sentenced to prison, in addition to the risk of miscarriage, many women who do give birth in prison are either shackled or chained for all or most of the delivery process[xxiii], now therefore be it,

RESOLVED that in the interest of both patients and providers, the New York State Academy of Family Physicians opposes the creation of legislation that requires physicians do mandatory drug testing on pregnant women and be it further, be it

RESOLVED that the NYSAFP's delegates to the AAFP Congress of Delegates will present a resolution for the AAFP to oppose the practice of mandatory drug testing women during pregnancy.

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[i] Lynn M. Paltrow and Jeanne Flavin, "Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health," *Journal of Health Politics, Policy and Law*, January 15, 2013, 1966324, doi:10.1215/03616878-1966324.

[ii] Cheryl S. Broussard et al., "Maternal Treatment with Opioid Analgesics and Risk for Birth Defects," *American Journal of Obstetrics and Gynecology* 204, no. 4 (April 2011): 314.e1–314.e11, doi:10.1016/j.ajog.2010.12.039.

[iii] Paltrow and Flavin, "Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005."

[iv] Lynn M. Paltrow and Jeanne Flavin, "Pregnant, and No Civil Rights," *The New York Times*, November 7, 2014, http://www.nytimes.com/2014/11/08/opinion/pregnant-and-no-civil-rights.html.

[v] "State Policies in Brief: Substance Abuse During Pregnant" (Guttmacher Institute, March 1, 2015), http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf

[vi] D. Orentlicher, "Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women," *JAMA-Journal of the American Medical Association* 264, no. 20 (1990): 2663–70.

[vii] Committee on Sstance Abuse, "Drug-Exposed Infants," *Pediatrics* 86, no. 4 (October 1, 1990): 639–42.

[viii] Orentlicher, "Legal Interventions During Pregnancy-Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women."

[ix] Abuse, "Drug-Exposed Infants."

[x] American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women, "AGOG Committee Opinion No. 473: Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-gynecologist," *Obstetrics and Gynecology* 117, no. 1 (January 2011): 200–201, doi:10.1097/AOG.0b013e31820a6216.

[xi] American Public Health Association, "Illicit Drug Use by Pregnant Women, Policy Statement No. 9020, (8) *American Journal of Public Health* 240 (1990.)

[xii] American Nurses Association, "Position Statement on Opposition to Criminal Prosecution of Women for Use of Drugs While Pregnant and Support for Treatment Services for Alcohol and Drug Dependent Women of Childbearing Age." April 1991.

[xiii] Michael C. Lu and Neal Halfon, "Racial and Ethnic Disparities in Birth Outcomes: a Life-course Perspective," *Maternal and Child Health Journal* 7, no. 1 (2003): 13–30.

[xiv] Enid Logan, "The Wrong Race, Committing Crime, Doing Drugs, and Maladjusted for Motherhood: The Nation's Fury over' Crack Babies'," *Social Justice*, 1999, 115–38.

[xv] Ibid.

[xvi] Meda Chesney-Lind and Marc Mauer, *Invisible Punishment: The Collateral Consequences of Mass Imprisonment* (New Press, The, 2003), https://books.google.com/books?hl=en&lr=&id=RFERBgAAQBAJ&oi=fnd&pg=PR7&dq=Invisible+Punishment:+The+Collateral+Consequences+of+Mass+Imprisonment.&ots=kZmO7kAiAA&sig=2KGTOEqldelD6C9_JfqBbe2gf_s.

[xvii] Abuse, "Drug-Exposed Infants."

[xviii] "Family Medicine, Quality Health Care in -- AAFP Policies -- AAFP," accessed February 25, 2014, http://www.aafp.org/about/policies/all/fm-quality-care.html.

[xix] "Clinical Practice Guidelines -- AAFP Policies -- AAFP," accessed February 25, 2014, http://www.aafp.org/about/policies/all/clinical-guidelines.html.

[xx] Jeanne Flavin and Lynn M. Paltrow, "Punishing Pregnant Drug-Using Women: Defying Law, Medicine, and Common Sense," *Journal of Addictive Diseases* 29, no. 2 (April 16, 2010): 231–44, doi:10.1080/10550881003684830.

[xxi] Ibid.

[xxii] Anannya Bhattacharjee and Jael Silliman, eds., *Policing the National Body: Race, Gender and Criminalization in the United States* (Cambridge, Mass: South End Press, 2002).

[xxiii] "Shackling Incarcerated Pregnant Women: Shackling Incarcerated Pregnant Women," *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 40, no. 6 (November 2011): 817–18, doi:10.1111/j.1552-6909.2011.01300.x.

RESOLUTION
15-09

SUBJECT: **Raising the Minimum Wage**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Venis Wilder, MD**

WHEREAS, Poverty is one of the major social determinants of health, and

WHEREAS, the current minimum wage of New York State is $8.75 and is projected to only reach a maximum of $9.00 by December 31, 2015[1], and

WHEREAS, the current federal minimum wage of $7.25 is worth roughly 25 percent less than the minimum wage in 1968 and a person earning the current minimum wage 40 hours per week for 50 weeks of the year grosses $14,500 in earnings[2], and

WHEREAS, the federal poverty level for a family of two in 2015 is $15,930, and for a family of four is $24,250[3], and

WHEREAS, the current inflation-adjusted federal minimum wage would be $10.90 per hour[4], and

WHEREAS, the current minimum wage disproportionately affects youth and women[5], and

WHEREAS, Americans in poverty are more likely than those who are not to struggle with a wide array of chronic health problems – including depression, obesity, asthma, diabetes, hypertension, and cardiac disease[6] and now therefore, be it

RESOLVED, the NYSAFP lobby the New York state legislature to increase the state minimum wage as a means of decreasing health disparities, and be it further,

RESOLVED, the NYSAFP introduce a resolution to the American Academy of Family Physicians to advocate for Congress to pass legislation to raise the federal minimum wage to keep up with inflation in order to decrease health disparities, and be it further

RESOLVED, this resolution be referred to the AAFP Congress of Delegates.

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[1]New York State Department of Labor, http://www.labor.ny.gov/workerprotection/laborstandards/workprot/minwage.shtm

[2] The White House, Raise the Wage - http://www.whitehouse.gov/raise-the-wage

[3] United States HHS – 2015 Poverty Guidelines - http://aspe.hhs.gov/poverty/15poverty.cfm

[4] Minimum Wage Inflation - http://www.raisetheminimumwage.com/facts/entry/amount-with-inflation/

[5] Pew Research Center – Who makes minimum wage? http://www.pewresearch.org/fact-tank/2014/09/08/who-makes-minimum-wage/

[6] http://www.gallup.com/poll/158417/poverty-comes-depression-illness.aspx?utm_source=alert&utm_medium=email&utm_campaign=syndication&utm_content=morelink&utm_term=All%20Gallup%20Headlines

RESOLUTION
15-10

SUBJECT: **Increasing Limits on Buprenorphine Patients**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Ray Harvey, MD**

WHEREAS the United States is suffering from a prescription opioid epidemic, and recently an increase in heroin abuse/dependence, and

WHEREAS there is a treatment gap in that while about 22 million people are in need of substance abuse treatment in the United States, about 2 million people successfully access that care annually, and

WHEREAS the DATA 2000 Act sets limits of 30 patients in the first year, and 100 patients after that, and

WHEREAS there exists a growing body of board certified addiction specialists, and

WHEREAS the lack of access to treatment is contributing to the ongoing and unacceptable opioid overdose mortality rate, therefore be it

RESOLVED that NYS AFP send a resolution to the AAFP to advocate that ASAM (The American Society for Addiction Medicine) and SAMHSA (The Substance Abuse and Mental Health Services Administration) develop criteria whereby those physicians with added qualifications, for example board certification or fellowship training in addiction medicine, can exceed the limit of 100 patients treated with buprenorphine.

References:
http://www.casacolumbia.org/addiction-research/reports/addiction-medicine
http://buprenorphine.samhsa.gov/fulllaw.html

RESOLUTION
15-11

SUBJECT: **ISTOP exclusions**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Ray Harvey, MD**

WHEREAS the United States is in the midst of a prescription drug epidemic related in part to increased prescribing of opioid medication, and

WHEREAS New York State has responded by enacting progressive legislation to mandate reporting prescriptions filled, and requiring providers to access that information prior to prescribing a controlled substance, and

WHEREAS the system has been effective in providing information and in some cases changing the providers' actions, and

WHEREAS the Veterans Administration is exempt from mandatory reporting, and

WHEREAS methadone dispensed at programs is also exempt from reporting, and

WHEREAS the information not available because of this oversight might put our veterans and people in treatment for opioid dependence at risk, therefore be it

RESOLVED that the NYSAFP petition OASAS and the Bureau of Narcotics Enforcement, as well as the Veterans Administration to correct this omission.

References:
http://www.gao.gov/new.items/d09341.pdf
http://www.pdmpassist.org/pdf/PPTs/National2014/1-04_OLeary.pdf

https://www.federalregister.gov/articles/2013/02/11/2013-03001/disclosures-to-participate-in-state-prescription-drug-monitoring-programs

RESOLUTION
15-12

SUBJECT: **Safe Use of Methadone for Pain Management**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Ray Harvey, MD**

WHEREAS the United States is in the midst of a prescription drug abuse epidemic related to a campaign to improve the management of pain, as reported by the Center for Disease Control, and

WHEREAS an unintended consequence of these efforts is a dramatic rise in overdose deaths, with a rate paralleling the rate of increased prescribing, and

WHEREAS methadone, despite accounting for about 2 % of opioid prescriptions in the US, is implicated in 1/3 of the opioid overdose deaths due to its unique pharmacology, and

WHEREAS 33 states have methadone listed on their Medicaid formularies as a preferred medication, and

WHEREAS states with methadone as a preferred agent for pain have a disproportionately high percentage of methadone deaths, as seen in the example of Washington state, and

WHEREAS the information has been available and broadly disseminated with inadequate penetration to affect the rate of methadone-related deaths, and

WHEREAS the Risk Evaluation and Mitigation Strategies enforced by the FDA have questionable efficacy, for example the extended-release REMS has the goal of only 60% of prescribers voluntarily remediated 4 years after its introduction, and

Appreciating that methadone has been, and continues to be, an important medication in the treatment of opioid dependence and is currently the gold standard in medication-assisted treatment for opioid dependence, and

Further appreciating that the main benefit of methadone over other opioids in the management of chronic pain is in the subpopulation either currently addicted or at risk for

addiction, pain and addiction being areas in which the average Family Medicine Physician often feels underprepared,

We conclude that methadone, while an important medication, rises to the level where action needs to be taken, and therefore be it

RESOLVED

1) That NYS AFP advocate that the Medicaid formulary be amended to require prior authorization for methadone when prescribed for pain
2) That NYS AFP send a resolution to the AAFP to advocate that states remove methadone from their preferred medication list and require prior authorization
3) That NYS AFP send a resolution to the AAFP to advocate that the FDA develop a REMS to establish minimal competency for those who elect to prescribe methadone for pain.

References:

The Evidence Against Methadone as a Preferred Analgesic, A position paper from the American Academy of Pain Medicine, 2014

Centers for Disease Control and Prevention. Vital signs: Prescription painkiller overdoses: use and abuse of methadone as a painkiller. July 2012

Centers for Disease Control and Prevention. Vital signs. Risk for Overdose from Methadone Used for Pain Relief, United States 1999-2010. MMWR , 2012:61(26): 493-7.

RESOLUTION
15-13

SUBJECT: **Discriminatory Policing is a Public Health Concern**

SUBMITTED BY: **Public Health Commission**

Authors: **Daniel Neghassi, MD and Venis Wilder, MD**

WHEREAS, police brutality is defined as excessive or unnecessary force used by law enforcement when dealing with civilians,[1] and

WHEREAS, the excessive force used by law enforcement disproportionately affects communities of color demonstrating (1) an attack against individual human rights and community civil rights and (2) bias against minorities,[2-6] and

WHEREAS, police brutality is identified by the American Public Health Association as a public health issue that disproportionately affects minorities,[7] and

WHEREAS, discriminatory policing practices such as "stop and frisk" in New York were only recently found unconstitutional in 2013 by a federal judge,[8] and

WHEREAS, organizations such as Amnesty International have asked for a societal response to police brutality in the United States,[9] and

WHEREAS, the End Racial Profiling Act of 2013 was reintroduced in the United States Senate as S.1038 (2013-14) to prohibit any law enforcement agent or agency from engaging in racial profiling and to require federal, state, or local law enforcement agencies to maintain adequate policies and procedures to eliminate racial profiling and to cease existing practices that permit racial profiling,[10] and

WHEREAS, community policing, an approach which includes building relationships with community members, involvement of the police in community problem solving, partnerships between police and community organizations, training in de-escalation tactics, a prohibition against use of lethal force absent threat of serious harm, and avoiding arrests for minor offenses, has been shown to increase the community's trust in the police and decrease crime,[11] and

WHEREAS, the Right to Know Act, introduced to the New York City Council in 2014, is legislation that would (1) require officers to identify themselves to the subjects of law enforcement activity and explain why they are being stopped, and (2) require officers to explain that a person has the right to refuse a search when there is no legal justification for the search, and to obtain objective proof that the person gave informed and voluntary consent, similar to laws

existing in Colorado, Arkansas and elsewhere, with the goal of reducing hostile street incidents and protecting New Yorkers against coercive "consent" searches,[12] therefore be it

RESOLVED, that *the NYSAFP write a resolution asking the AAFP to* form a policy statement recognizing police brutality against minority communities as a serious, ongoing public health issue that requires nationwide medical and legal investigation and action, and be it further

RESOLVED, that the NYSAFP write a letter encouraging the national AAFP body to recognize police brutality as a form of collective violence in its current position paper on violence, and be it further

RESOLVED, the NYSAFP advocate for the abolition of discriminatory law enforcement strategies such as racial profiling (e.g. supporting the End Racial Profiling Act of 2013 or similar legislation) by lobbying our state representatives and senators, and by submitting a resolution to the AAFP to lobby Congress, and be it further

RESOLVED, that the NYSAFP support efforts to enact community policing in the New York Police Department and other police departments throughout the State, and be it further

RESOLVED, that the NYSAFP lobby for the Right to Know Act before the New York City Council and support similar legislation throughout the State.

References:

1. Police Brutality Definition. *The Law Dictionary*. http://thelawdictionary.org/article/what-is-police-brutality/
2. Amnesty International. "Police Brutality and Excessive Force in the New York City Police Department." 1996.
3. Lersch KM, Feagin JR. Violent Police-Citizen Encounters: An analysis of major newspaper accounts. *Critical Sociology*. 1996; 22:29-49.
4. New York Civil Liberties Union. "Stop-and-Frisk Data." http://www.nyclu.org/content/stop-and-frisk-data. Updated in 2014.
5. McEwen T. "National Data Collection on Police Use of Force." Washington, DC: US Department of Justice, 1996.
6. Center for Juvenile and Criminal Justice. "Who Are Police Killing?" http://www.cjcj.org/news/8113. 2014.
7. APHA. "Impact of Police Violence on Public Health." http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/11/14/16/impact-of-police-violence-on-public-health, 1998.
8. Center for Constitutional Rights. "Floyd, et al. v. City of New York, et al." http://ccrjustice.org/floyd

9. Amnesty International. “Police and Human Rights.” http://www.amnestyusa.org/our-work/issues/military-police-and-arms/police-and-human-rights.
10. Cardin, BL. “S.1038 - End Racial Profiling Act of 2013.” https://www.congress.gov/bill/113th-congress/senate-bill/1038/all-info
11. Center for Evidence Based Crime Policy. “Community Policing and Procedural Justice.” http://cebcp.org/evidence-based-policing/what-works-in-policing/research-evidence-review/community-policing/
12. Communities United for Police Reform. “The Right to Know Act.” http://changethenypd.org/right-know-act.

Related AAFP policy:

Violence as a public health concern:
The American Academy of Family Physicians recognizes violence as a major public health concern. Members are best able to adequately counsel patients when they are aware of the various manifestations of violence (including sexual violence), both risk and protective factors related to violence and of available services for survivors of violence in their community. Experts suggest that violence is related to a plethora of environmental factors including pervasive media images that violent responses are acceptable means of addressing problems. Another factor is the remarkable availability of handguns and ammunition. The Academy believes it is important to address these factors by supporting the efforts of those attempting to reduce the level of all violence and encouraging members to become actively involved with such activities. (1987) (2011 COD)

Hate Crimes:
The AAFP acknowledges that hate crimes directed against protected classes, including race, color, religion, gender, sexual orientation, and disability status pose specific and distinct health risks for our patients. The AAFP supports the development and implementation of anti-discrimination and hate crime laws that seek to protect victims from perpetrators. The AAFP further supports research and educational programs directed at the prevention of hate crimes, and promotes interventions that address the health needs of hate crime survivors. (2003) (2014 COD)

Except from Violence (position paper):
Collective violence is composed of many individual acts of interpersonal violence organized within a larger social and cultural context, and includes gang violence, hate crimes, mob behavior, human trafficking, sexual exploitation, and slavery. Also included within the scope of collective violence is oppression based upon gender, race, sexual orientation, social class, national origin or religion, and state-sponsored violence such as terrorism, genocide, war, and war-associated rape.

RESOLUTION
15-14

SUBJECT: **Clogging the School-to-Prison Pipeline**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Daniel Neghassi, MD**

WHEREAS access to education is recognized as a social determinant of health by AAFP Policy,[1] and

WHEREAS the school-to-prison pipeline (STPP) is the system of policies that encourage police presence at schools, and harsh tactics including physical restraint and suspensions for minor infarctions,[2] and

WHEREAS the STPP has the effect of pushing students out of school and into the criminal legal system, either directly by arrests resulting from pat-downs or metal detectors, or indirectly through suspensions which put students at risk for incarceration and other bad outcomes as an adult,[3] and

WHEREAS the best demographic indicators of children who will be suspended are not the type or severity of the crime, but the students' race and special education status, the school they go to, and whether they have been suspended before,[4] and

WHEREAS, according to the National Association of School Psychologists, metal detectors in schools do not reduce violence, and schools in New York City that have police presence have seen higher rates of suspensions and truancy compared with control schools,[5] and

WHEREAS school-wide positive behavior support (SWPBS) provides an alternative approach to punishment that focuses on the prevention of problem behavior by teaching and reinforcing student social skills,[6] and

WHEREAS the American Academy of Pediatrics released a policy statement in 2013 stating that "so-called zero-tolerance policies and out-of-school suspension and expulsion that are used too readily are ineffective deterrents to inappropriate behavior and are harmful and counterproductive to the student, the family, the school district, and the community as a whole, both short- and long-term", and instead recommends evidence-based approaches to discipline such as SWPBS,[7] therefore be it

RESOLVED that the NYSAFP lobby for elimination of zero-tolerance policies in schools in New York State, for decreasing police presence in schools, and for implementation of evidence-based alternatives to discipline such as school-wide positive behavior support, and be it further

RESOLVED that the NYSAFP submit a resolution to the AAFP requesting that it endorse the American Academy of Pediatrics 2013 Policy Statement on Out-of-School Suspension and Expulsion.

1. AAFP Policies. "Social Determinants of Health" http://www.aafp.org/about/policies/all/social-determinants.html. BOD 2012, COD 2013.
2. Teaching Tolerance. "The School-to-Prison Pipeline." http://www.tolerance.org/magazine/number-43-spring-2013/school-to-prison
3. The Advancement Project. "Opportunities Suspended: The Devastating Consequences of Zero Tolerance and School Discipline." 2000. p. 13.
4. Russell Skiba and M. Karega Rausch. "Zero Tolerance, Suspension, and Expulsion: Questions of Equity and Effectiveness." *Handbook of Classroom Management: Research, Practice, and Contemporary Issues.* 2006
5. National Association of School Psychologists. "Research on School Security: The Impact of Security Measures on Students." http://www.nasponline.org/advocacy/schoolsecurity.pdf. 2013
6. Association for Positive Behavior Support. "Schools and Districts: Brief Overview." http://www.apbs.org/new_apbs/schools-and-districts.html
7. Council on School Health, AAP. "Policy Statement: Out-of-School Suspension and Expulsion." *Pediatrics.* Vol. 131 No. 3 March 1, 2013. pp. e1000-e1007

RESOLUTION
15-15

SUBJECT: **Decrease the Adverse Impact of Baby Formula Marketing on Breastfeeding Rates**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Emily Holt, DO**

WHEREAS, breastfeeding is the physiologic norm and is widely recognized by the medical community as the optimal nutrition source for newborns;

WHEREAS, breastfeeding, especially exclusive breastfeeding, is a key public health priority that improves both infant and maternal health and reduces healthcare costs;

WHEREAS, the AAFP recommends that "all babies, with rare exceptions, be breastfed and/or receive expressed human milk exclusively for the first six months of life."

WHEREAS, unnecessary formula supplementation interferes with on-demand feeding and stimulation of the mother's milk supply;

WHEREAS, promotion of infant formula in the hospital interferes with breastfeeding and distribution of infant formula at hospital discharge can deter exclusive breastfeeding by new mothers;

WHEREAS, formula marketing such as displays of posters, products or decorations in patient areas, and the distribution in the hospital of promotional items from infant formula companies, convey the impression that the medical establishment favors formula feeding over breastfeeding, and that formula feeding is an acceptable alternative norm to breastfeeding;

WHEREAS, in accordance with Great Beginnings NY, The Future Starts with Breastfeeding, an initiative of the NY State Department of Health, as of February 2014, only 67 of 139 hospitals providing maternity care services in New York State agreed to voluntarily discontinue the distribution of free infant formula, including discharge packs, and infant formula promotional materials in any hospital location as part of patient education. Therefore, be it

RESOLVED that:

1) the NYSAFP advocates the elimination from all patient care areas of all advertising for formula, bottles, and nipples; and be it further RESOLVED

2) the NYSAFP advocates that if a hospital provides discharge packs, they will use commercial-free bags and materials free of trademarks or brand names.

RESOLUTION
15-16

SUBJECT: **Promoting Transparency in Medical Education and Access to Training in Settings Affiliated with Religious Healthcare Organizations**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Linda Prine, MD**

WHEREAS, under healthcare reform, hospital consolidations have led to an increasing number of affiliations and mergers with religiously affiliated hospitals around the country, and

WHEREAS, one in nine hospital beds in the United States is supervised by Catholic affiliated or sponsored health systems in 2011,1 which often decreases access to key reproductive health services like contraception, tubal ligation and abortion and

WHEREAS, physicians, including trainees, treating patients at religiously affiliated healthcare institutions often must follow certain guidelines, such as the Ethical and Religious Directives for Catholic Health Care (ERDs) issued by the US Conference of Catholic Bishops, and

WHEREAS, ERDs may include limitations on the provision of health care services prescribed by a physicians, including but not limited to reproductive services, sexual health, treatment of pregnancy complications, end of life care, and healthcare services for the LGBTQ community,2,3 and

WHEREAS, increasing numbers of medical schools and Graduate Medical Education (GME) training programs around the country have made affiliations with religiously affiliated organizations,4,5 and

WHEREAS, the scope and quality of medical training may be limited by religious guidelines for trainees (students, residents, and fellows) at religiously affiliated training programs, be it

RESOLVED, that the NYSAFP strongly encourages medical schools and graduate medical education training programs in New York state to communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities at their respective institutions; and be it further

RESOLVED, that the NYSAFP MSSNY delegate introduce a resolution to have information on religious affiliation listed in the Freida database and be it further

RESOLVED, that the NYSAFP will ask the AAFP to include information on the religious affiliation of residency programs on the AAFP Family Medicine Residency Directory (https://nf.aafp.org/Directories/Residency/Search) (Directive to take action), and be it further

RESOLVED, that the NYSAFP asks the AAFP to work with the ACGME and other appropriate stakeholders to support transparency within medical education, recommending that medical schools and graduate medical education training programs communicate with current and prospective medical students, residents, fellows and faculty about how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities.

1. Uttley L, Reynertson S, Kenny L, Melling L. Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care. ACLU FoundationThe Merger Watch Project. December 2013. Accessed at: https://www.aclu.org/sites/default/files/assets/growth-of-catholic-hospitals-2013.pdf (7/28/14).
2. Stulberg DB, Lawrence RE, Shattuck J, Curlin FA. Religious hospitals and primary care physicians: conflicts over policies for patient care. J Gen Intern Med. 2010;25(7):725-730.
3. United States Conference of Catholic Bishops. Ethical and Religious Directives for Catholic Hospital Services. Nov 2009. Fifth Edition. Accessed at: http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf (7/28/14).
4. Ostrom C. Ties between UW, PeaceHealth worry medical trainees, grad students. The Seattle Times. July 6, 2014.
5. Abelson R. Catholic Hospitals Expand, Religious Strings Attached. New York Times. February 20, 2012.

RESOLUTION
15-17

SUBJECT: **Human Trafficking Education and Training for Family Medicine Physicians**

SUBMITTED BY: **Anita Ravi, MD**

AUTHOR: **Anita Ravi, MD**

WHEREAS, human trafficking involves the use of force, fraud or coercion to lure victims, including children under the age of 18, into commercial sexual or labor exploitation[1] , and

WHEREAS, in the United States, human trafficking occurs in cities, suburbs, and rural areas across all 50 US states, with more than 2,500 children exploited annually for commercial sexual activity in New York State[2] , and

WHEREAS, the health outcomes associated with human trafficking include infectious diseases such as tuberculosis and human immunodeficiency virus (HIV)/AIDS, malnutrition, reproductive health problems, substance abuse, mental health problems including posttraumatic stress disorder, depression, and suicidal ideation, traumatic brain injury and physical injuries from violence[3] , and

WHEREAS, health care professions are among the few professions that interact with trafficking victims while enslaved, with a 2011 study showing that 50% of trafficking survivors interviewed reported visiting a physician while trafficked[4] , and

WHEREAS, low awareness and a lack of guidance or protocols for responding to human trafficking in the health care setting present significant barriers to an optimal health sector response[5] , triggering the creation of the US Department of Health and Human Services' "Stop, Observe, Ask, and Respond"(SOAR) to Health and Wellness Network to educate health care professionals on how to identify and serve victims of trafficking and,

WHEREAS, data shows that a brief educational intervention for health professionals increased their knowledge about human trafficking, as well as self-reported recognition of human trafficking victims[6] , and

WHEREAS, professional medical organizations, including the American Academy of Pediatrics and the American College of Obstetrics and Gynecology have put forth position papers calling for increased educational training of medical professionals with regard to health and human trafficking[3], and

WHEREAS, the issue of human trafficking fulfills criteria for the Liaison Committee on Medical Education's core educational objective: "The curriculum of a medical education program must prepare medical students for their role in addressing the medical consequences of common societal problems" [7] , the National Board of Medical Examiners and the Federation of State Medical Boards of the United States' necessary content for the US Medical Licensing Examination Step 1 examination, the Accreditation Council on Graduate Medical Education Common Program Requirements, and the violence and abuse content requirements for the American Board of Family Medicine's certification examination, therefore be it

RESOLVED, that the NYSAFP provide human trafficking-related healthcare education, including identification and management information, in at least one NYSAFP conference workshop, and be it further

RESOLVED, that the NYSAFP write a letter to the Society of Teachers of Family Medicine encouraging the integration of the subject of human trafficking into the education of medical students, residents and fellows, and be it further

RESOLVED, that the NYSAFP will instruct its delegates to bring this resolution forward to the American Academy of Family Physicians (AAFP) Congress of Delegates (COD) to request that the AAFP investigate the feasibility of human trafficking related CME, including but not limited to live presentations at the Family Medicine Experience and the National Conference of Students and Residents, and be it further

RESOLVED, that the NYSAFP will instruct its delegates to bring this resolution forward to the AAFP COD to request that the AAFP develop a position statement on human trafficking

[1] http://www.dhs.gov/definition-human-trafficking

[2]Memorandum in Support, A.8679/ S.5902, reproduced at McKinney's Session Laws of N.Y., L. 2007, c. 74, p. 1603

[3] Grace AM, Ahn R, Macias Konstantopoulos W., Integrating curricula on human trafficking into medical education and residency training. JAMA Pediatr. 2014 Sep;168(9):793-4.

[4] Baldwin SB, Eisenman DP, Sayles JN, Ryan G, Chuang KS. Identification of human trafficking victims in health care settings. *Health Hum Rights*. 2011;13(1):E36-E49

[5] Macias Konstantopoulos W, Ahn R, Alpert EJ, et al. An international comparative public health analysis of sex trafficking of women and girls in eight cities: achieving a more effective health sector response. *J Urban Health*. 2013;90(6):1194-1204

[6] Grace AM, Lippert S, Collins K, Pineda N, Tolani A, Walker R, Jeong M, Trounce MB, Graham-Lamberts C, Bersamin M, Martinez J, Dotzler J, Vanek J, Storfer-Isser A, Chamberlain LJ, Horwitz SM. Educating health care professionals on human trafficking. Pediatr Emerg Care. 2014 Dec;30(12):856-61.

[7] Accreditation Council on Graduate Medical Education. *ACGME common program requirements.http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs2013.pdf*. Most recently effective: July 1, 2013. Accessed December 1, 2013

RESOLUTION
15-18

SUBJECT: **Bylaws Amendment to Increase Resident & Student Representation on the Board**

SUBMITTED BY: **Francesca Decker, MD, Resident Representative to the Board**

AUTHOR: **Francesca Decker, MD, Resident Representative to the Board**

WHEREAS, the New York State Academy of Family Physicians (NYSAFP) represents Resident Members and Student Members from throughout New York State and

WHEREAS, the experiences of Residents and Students in upstate areas differs significantly from that of Residents and Students in downstate areas and

WHEREAS, representation of Residents and Students on the NYSAFP board of directors by a single representative does not assure that the differences in experience of Residents and Students residing in upstate and downstate areas will be adequately reflected in the representation provided by the single representative, therefore be it

RESOLVED, that Chapter 1, section 2, paragraphs E. Resident Members and F. Student Members of the bylaws are amended to read as follows (material to be deleted is crossed out and material to be added is underscored):

E. Resident Members.

1. Eligibility. Resident members shall be:
    a. physicians in training in:
        (1) an ACGME-approved family medicine residency; or
        (2) an AOA-approved rotating general or family medicine internship; or
        (3) an AOA approved general or family medicine residency; or
    b. graduates of ACGME-approved family medicine residencies; or AOA-approved general or family medicine residencies who extend their training immediately upon completion of residency training and who serve full time in extended, structured, supervised programs of at least one year duration to gain additional skills in research, administration and teaching or a specific clinical area of interest.
2. Application and Approval. Applications for resident membership shall be in a form prescribed by the Board. Election to resident membership shall be made by the Board or its designee.
    a. Election to resident membership shall be for the duration of one's residency or extended training.

b. Upon completion of their residency training, and upon verification of eligibility for active membership, resident members shall be automatically transferred to active membership.

3. Privileges.

a. Resident members may serve on national, state and chapter commissions and committees as determined by the applicable Board. Resident members who are appointed to serve on national commissions and committees have the right to vote in such bodies but are not eligible to serve as chair.

b. Two resident members shall be selected to serve on the Board pursuant to a process provided for in the Operations manual. One such representative shall be from residency programs located in upstate NY and one shall be from programs located downstate.

c. The resident members of the Board shall have full voting privileges on the Board.

d. Two resident members elected as delegates to the Congress of Delegates have the privilege of the floor and the right to vote. The two resident members elected as alternates to the Congress of Delegates have the privilege of the floor without the right to vote. Resident delegates and alternates shall be elected pursuant to the same process as resident members of the Board as provided for in paragraph (b) herein.

e. Otherwise, resident members shall not be entitled to hold office in the AAFP, but shall have voice in reference committees.

F. Student Members.

1. Eligibility. Student members shall be students enrolled in accredited schools of medicine or osteopathy. Membership shall terminate upon graduation or withdrawal from medical school.

2. Application and Approval. Applications for student membership shall be in a form prescribed by the Board. Election to student membership shall be made by the Board or its designee.

3. Requirements. Students applying for student membership must be enrolled in a school of medicine or osteopathy approved by an appropriate United States accrediting institution as defined by the AAFP Commission on Education.

4. Privileges.

a. Student members may serve on national, state and chapter commissions and committees as determined by the applicable Board. Student members who are appointed to serve on national commissions and committees have the right to vote in such bodies but are not eligible to serve as chair.

b. Two student members shall be selected to serve on the Board pursuant to a process provided for in the Operations manual. One such representative shall be from medical schools located in upstate NY and one shall be from medical schools located in downstate NY.

c. The student members of the Board shall have full voting privileges on the Board.

d. Two student members elected as delegates to the Congress of Delegates have the privilege of the floor and the right to vote. The two student members elected as alternates to the Congress of Delegates have the privilege of the floor without the right to vote. Student delegates and alternates shall be elected pursuant to the same process as resident members of the Board as provided for in paragraph (b) herein.

e. Otherwise, student members shall not be entitled to hold office in the AAFP but shall have a voice in reference committees. be it further

RESOLVED, that Article 6 of the Bylaws shall be amended as follows:

ARTICLE 6
Board of Directors

Subject to the action of the Congress of Delegates and during the interim between meetings of the Congress of Delegates, the control and administration of the Academy shall be vested in a Board of Directors composed of nine (9) elected directors-at-large, the President, President-Elect, Vice President, Secretary, Treasurer, Speaker of the Congress of Delegates, Vice Speaker of the Congress of Delegates, the Immediate Past President, two (2) Delegates and two (2) Alternate Delegates to the Congress of Delegates of the American Academy of Family Physicians, one (1) Delegate to MSSNY one (1) Alternate Delegate to MSSNY, one (1) New Physician Delegate, two (2) Resident Representatives and two (2) Student Representatives.

and be it finally

RESOLVED, that the process articulated in the operations manual pursuant to this resolution for election of resident and student representatives to the Board and delegates to the Congress, shall be reviewed at the next Congress. If the process is determined at that time to be effective then it shall be incorporated into the Bylaws.

RESOLUTION
15-19

SUBJECT: **Implementation of Non-discrimination in Healthcare**

SUBMITTED BY: **Sylvia H. Chudy MD**

AUTHOR: **Sylvia H. Chudy MD**

WHEREAS, a growing number of patients in the US are seeking complementary therapies such as acupuncture, chiropractic, massage therapy, and nutrition counseling with and without the knowledge of their family physicians(1),

WHEREAS, as family physicians, we strive to provide our patients with direct and affordable access to various treatment therapies which we feel are safe, effective, cost-containing, and complement clinical management of our patients,

WHEREAS, many complementary therapies are being implemented for the adjunct treatment of conditions such as, but not limited to, various types of chronic pain syndromes, post-traumatic stress disorder, and cancer and its treatment side effects,

WHEREAS, under the Affordable Care Act Section 2706, effective January 1st, 2014, "a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law."(2,3)

WHEREAS, many patients, primary care providers, and health insurance regulators are unaware of this provider nondiscrimination provision that should encompass a much wider variety of health services than are currently being covered, therefore, be it

RESOLVED, that the NYSAFP support the initiative to proactively promote the awareness of Section 2706 through state-wide information exchange of digital and printed media for providers and patients alike(4), and be it

RESOLVED, that the NYSAFP lobby in New York State for broader healthcare coverage by insurance providers in compliance with Section 2706, and be it further

RESOLVED, that the NYSAFP send a resolution to the AAFP to requesting that AAFP lobby for broader healthcare coverage of complementary therapies at the national level.

(1) https://nccih.nih.gov/health/integrative-health
(2) http://www.ihpc.org/wp-content/uploads/section-2706-faq.pdf
(3) http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html
(4) http://www.covermycare.org/cmc/

RESOLUTION
15-20

SUBJECT: **Family Medicine Rotation as a Medical License Requirement**

PRESENTED BY: **Suffolk County Chapter**

AUTHOR: **Raymond Ebarb, MD**

WHEREAS, there is a critical shortage of primary care physicians in New York State and

WHEREAS, study after study proves that patients who have a primary care physician have statistically significant favorable morbidity and mortality rates and

WHEREAS, countries worldwide who base their healthcare model on primary care demonstrate not only more efficient utilization of health care monies per capita but also superior health of the population to the United States and

WHEREAS, the U.S healthcare system is specialist/subspecialty and procedurally based and

WHEREAS, New York State medical students continue to choose specialties/subspecialties due to multiple factors not the least of which is inadequate exposure to Family Medicine and

WHEREAS, less than 10% of medical students who complete a Internal Medicine Residency do not subspecialize and practice primary care

WHEREAS, 75% of medical students who complete a Family Medicine Residency practice primary care and

WHEREAS, in order to address this situation, the Medical Board of California has defined Family Medicine as a clinical core course and requires a minimum of a 4 week rotation supervised by a board certified/eligible Family Physician, be it

RESOLVED, that the New York State Academy of Family Physicians enlist and collaborate with a New York State Assembly Member & a New York State State Senator to introduce a bill in their respective legislative bodies that would require a minimum 4 week Family Medicine rotation as

a requirement for medical licensure and be modeled after the California Business and Professions Code, Division 2. Chapter 5. Article 4.Sec 2089.5. Be it further

RESOLVED, that the requirement go into effect a maximum of 4 years from the time of passage of the bill.

Attachment(s):
Click here for 15-20 Business Code
Click here for 15-20 6520

RESOLUTION
15-21

SUBJECT: **Alessandro Bertoni, MD**

PRESENTED BY: **NYS Academy of Family Physicians**

AUTHOR: **Vito Grasso, MPA, CAE**

WHEREAS, Dr. Alessandro Bertoni passed away on February 20, 2015 at the age of 87 and is survived by his wife, Elizabeth, and sons Guido and Mario, and

WHEREAS, Dr. Bertoni was a member of the American Academy of Family Physicians and the NYS Chapter for many years and served with dedication and distinction as president of the NYS Academy of Family Physicians in 1996-97, and

WHEREAS, Dr. Bertoni received his medical degree from the University of Bologna Medical School in 1952 and was awarded a Fulbright Scholarship to continue his medical education at Saint John's Long Island City Hospital in New York and completed his residency training at Highland Hospital in Rochester, New York, and

WHEREAS, Dr. Bertoni opened a medical practice in Rochester and maintained privileges at Park Ridge Hospital and Rochester General Hospital before retiring in 1994, and

WHEREAS, Dr. Bertoni was involved with many civic, professional and community organizations including the Sports Car Club of America Finger Lakes Chapter and the CASA Italiana at Nazareth College, be it

RESOLVED, that the New York State Academy of Family Physicians hereby acknowledges and acclaims Dr. Bertoni's numerous contributions to Family Medicine and to the Academy and be it further

RESOLVED, that copies of this resolution be sent to the American Academy of Family Physicians for recognition at their 2015 Congress of Delegates and to Dr. Bertoni's family as an expression of condolences from his friends and colleagues with the Academy.

RESOLUTION
15-22L

SUBJECT: **Necessity of a Specific State Law Regarding Violence Against Physicians**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Sneha Chacko, MD**

WHEREAS, statistics and data show that majority of non---fatal assaults in the workplace are attributed to healthcare workers (as per Bureau of Labor Statistics, 70---74%), and

WHEREAS, this data has been established in the face of under reporting, (indicating that the numbers are much higher), as many physicians have resigned their thinking, that dealing with combatant disorderly patients is part of their job, and

WHEREAS, there are already laws in place in 31 states including NY where it is a felony to assault a nurse, and in ALL states to assault a police officer, fireman, etc., and

WHEREAS, there are no specific laws stating that it is a felony to assault a physician on duty, thereby jeopardizing physicians safety with little or no consequence to the perpetrator, and

WHEREAS, a law against assault and violence toward a physician on duty should include spitting, biting, hitting, shoving, and purposely causes the person's bodily fluid (including, but not limited to feces, urine, blood, saliva, etc.) to make physical contact with the physician, now, therefore, be it

RESOLVED, that the NYSAFP advocate for the passage of legislation to make it a felony to assault a physician who is functioning in that capacity.

REFERENCES:

1. ScientificAmerican: http://www.scientificamerican.com/article/epidemic---of---violence---against---health---workers---plagues---hospitals/: December 2014

2. Bureau of Labor Statistics: U.S. Department of Labor: Workplace Safety and Health in the Health Care and Social Assistance Industry, 2003---2007: August 2010

http://www.bls.gov/opub/mlr/cwc/workplace---safety---and---health---in---the---health---care---and---social---assistance---industry---2003---07.pdf

3. Occupational Safety & Health Administration (OHSA): ENFORCEMENT PROCEDURES FOR INVESTIGATING OR INSPECTING WORKPLACE VIOLENCE INCIDENTS: September 2011.

https://www.osha.gov/OshDoc/Directivepdf/CPL02---01---052.pdf

4. CDC : Department of Health and Human Services, National Institute for Occupational Safety and Health (NIOSH): Publication No. 2002---101, April 20002: http://www.cdc.gov/niosh/docs/2002---101/

5. New York State Senate: Senate Acts To Protect Nurses From Violence; January 2010

http://www.nysenate.gov/press---release/senate---acts---protect---nurses---violence

6. Emergency Nurses Association: 50 State Survey: Criminal Laws Protecting Health Professionals Updated January 2013---2014. https://www.ena.org/government/State/Documents/StateLawsWorkplaceViolenceSheet.pdf

RESOLUTION
15-23L

SUBJECT: **Access to All FDA- Approved Contraception Methods for Medicare Patients**

SUBMITTED BY: **Public Health Commission**

AUTHOR: **Heather Paladine, MD**

WHEREAS the ability to prevent unintended pregnancy is an important social determinant of health[1], and

WHEREAS many men and women who are disabled and rely on Medicare for health coverage cannot afford the out of pocket expenses for contraceptives[2], yet pregnancy is sometimes a health risk for them[3], and

WHEREAS although the Affordable Care Act mandates coverage of all FDA- approved methods of contraception as preventive medical care[4], contraception is not included in the preventative and screening services of Medicare for men and women of reproductive age[5], now, therefore, be it

RESOLVED that the New York State Academy of Family Physicians supports Medicare coverage for all FDA-approved methods of contraception, and be it further,

RESOLVED that the NYSAFP's delegates to the AAFP Congress of Delegates will present a resolution for the AAFP to write a letter to the Center for Medicare and Medicaid Services advocating for full coverage of all contraceptive options for men and women of reproductive age.

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[1] Shawn Malarcher, L. G. Olson, and Norman Hearst, "Unintended Pregnancy and Pregnancy Outcome: Equity and Social Determinants," *Equity, Social Determinants and Public Health Programmes*, 2010, 177.
[2] Oct 01 and 2004, "Health Care and the 2004 Elections: Health Care for Americans with Disabilities," 200, accessed May 18, 2015, http://kff.org/medicaid/issue-brief/health-care-and-the-2004-elections-health/.
[3] Lisa I. Iezzoni et al., "General Health, Health Conditions, and Current Pregnancy among U.S. Women with and without Chronic Physical Disabilities," *Disability and Health Journal* 7, no. 2 (April 2014): 181–88, doi:10.1016/j.dhjo.2013.12.002.
[4] "State Policies in Brief: Insurance Coverage of Contraceptives" (Guttmacher Institute, May 1, 2015), http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf.
[5] "Preventive & Screening Services | Medicare.gov," accessed May 21, 2015, http://www.medicare.gov/coverage/preventive-and-screening-services.html.

RESOLUTION
15-24L

SUBJECT: **Resolution for the Establishment of Family Medicine Departments in all Private Medical Schools**

SUBMITTED BY: **Raymond Ebarb, MD**

Whereas, one of the most critical health care issues in New York State is access to primary care due to a workforce deficiency in primary care and

Whereas, New York State has attempted to address this issue by instituting law that requires public medical schools to establish a Family Medicine Department chaired by a board certified Family Physician and

Whereas, there are private, medical schools that receive public monies in various forms that do not have a Family Medicine department and

Whereas, less than 10% of medical students who complete an Internal Medicine Residency do not sub-specialize and primarily practice primary care

Whereas, 75% of medical students who complete a Family Medicine Residency practice primary care and

Whereas, the medical schools in New York State that do not have a Family Medicine Department or do not provide a well planned Family Medicine clinical rotation supervised by a board certified Family Physician produce primary care physicians at a rate significantly below the state average and,

Whereas, the contribution of the medical schools in New York State, without a Family Medicine Department, in addressing New York State's most pressing issue of primary care access is insignificant,

Be it resolved, that the New York State Academy of Family Physicians enlist and collaborate with a New York State Assembly Member and a New York State Senator to introduce a bill in their respective legislative bodies that would require all private medical schools in New York State to be held to the same standard as the public medical schools in addressing the primary care shortage.

Be it further resolved, that the legislation shall require the formation of a full Family Medicine Department in each medical school, that negotiates a budget with the medical school in a similar fashion to other departments and chaired by a board certified Family Physician.

Be it further resolved, the legislation should be introduced to require all private medical schools without a Department of Family Medicine to submit, within one year, a timeline for the establishment of such a department, and to file annual progress reports with the goal of ensuring that within five years from the time of the passage of the bill a Family Medicine department is fully operational with a Family Medicine board certified physician as Chair.