2019 AMAM March 9-11, 2019
The Citizen Hotel
926 J Street, Sacramento, 95814
Phone 916-447-2700

California Academy of Family Physicians

2019 All Member Advocacy Meeting

2019 Participants' Handbook

CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

We've Got an App for That!

We've created a mobile event app to help bring your AMAM experience to a new level!

The free app will be available to download February 28. All AMAM registrants will receive an email invitation with a link to download the app.

You may also download it directly from iTunes or Google Play by searching for "CAFP Events."

The AMAM app lets you do more and get more value from the event – right from your mobile device:

- See the full AMAM schedule sorted by day, speaker, track and rate the sessions directly on the app.
- Connect and exchange contact details with other attendees.
- Share your event experiences on Facebook, Twitter and LinkedIn.
- Follow the events on Twitter at #amam2019.
- Find sessions and locations with maps of session rooms.
- Catch notifications about networking opportunities, contests and other breaking event news sent directly to your device.

This app performs optimally with or without an Internet connection. When connected, the app downloads updates (such as a schedule or room change). Once downloaded, the data is stored locally on the device, so it's accessible even if there's no Wi-Fi or cellular connection.

If you have any questions, please contact Morgan Cleveland at mcleveland@familydocs.org or give us a shout at 415-345-8667.

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Message to Delegates, Alternates and Participants – What the AMAM Is and Does

We are very pleased you have chosen to join your family medicine colleagues and friends for this important weekend in Sacramento, sharing, learning, advocating, being inspired, having fun and renewing your spirit at CAFP's All Member Advocacy Meeting (AMAM). Some attendees may wonder what the AMAM is and does – the answer is three-fold:

1. AMAM intends to develop successive waves of family physicians trained and dedicated to being the most effective advocates possible for their patients and specialty – whether in their own communities, in Sacramento or even in Washington, D.C.
2. AMAM seeks to ensure our family physician advocates are conversant and comfortable with the key issues confronting family medicine and health care; and
3. AMAM provides the opportunity for family physicians to bring policy issues of urgent concern to the Academy for its consideration, oversee the Academy's policy work and elect the Academy's leaders for the coming year.

Let us also mention what the AMAM is <u>not</u>:

1. AMAM is not a clinical education opportunity – CAFP's Family Medicine Clinical Forum (March 29-31 in Monterey this year) is the CAFP's primary venue for excellent continuing professional development programming – the AMAM sticks to policy issues affecting the practice of medicine and care of patients, although from time-to-time, a CME opportunity may be piggybacked with the AMAM. We very much hope to see you in Monterey.
2. AMAM is not a partisan debating society – we are here to help find solutions and make certain CAFP's policies serve our members and their patients well. Opinions differ, of course, but discussion and dialogue are respectful and civil.

Aside from topical presentations on key health care issues, participants will learn about the disposition of every resolution and policy proposal submitted to CAFP's Board of Directors over the past year and have the opportunity to testify on policy resolutions submitted to the Board at this AMAM. The AMAM Delegates will vote on CAFP's slate of officers for the coming year.

So, fasten your seatbelts, it's going to be a terrific ride! Mark your calendars now for the <u>2020 AMAM and Family Medicine Lobby Day March 7-9, 2020</u>.

David Bazzo, MD, Speaker *Shannon Connolly, MD, Vice Speaker*

Detailed Schedule of Events

David Bazzo, MD, Speaker and Shannon Connolly, MD, Vice Speaker

Saturday, March 9, 2019 **Open the Door to Leadership: A Workshop for Medical Students and FM Residents** **YEA Room – 9:30 – 11:30am**	
9:30 – 11:30 am	Open the Door to Leadership Drs. Lance Fuchs, David Bazzo, Lee Ralph and Shelly Rodrigues, CAE
Saturday, March 9, 2018 | Opening Session **Metropolitan Terrace – 11:30 am – 5:00 pm** *The AMAM has been reviewed and approved for up to 6.25 Prescribed credits by the AAFP.*	
11:30 am – 12:45 pm	**All Member Advocacy Meeting (AMAM) Registration – Box Lunch**
1:00 – 1:10 pm	**Opening Session of the All Member Advocacy Meeting** - Certification of Delegates - Presentation of Election Slate - Nominations from the floor, if any
1:10 – 1:20 pm	**Setting Expectations – What Is the AMAM and What Will We Do in the Next Two Days?** David Bazzo, MD, Speaker
1:20 am – 1:30 pm	**Welcome by the President** Lisa Ward, MD, MScPH, MS
1:30 – 2:30 pm	**Keynote** Reid Blackwelder, MD, Past President, AAFP Dr. Blackwelder will engage attendees in a discussion about advocacy and family physicians' opportunities to address policy makers, the public and patients in health care conversations. He'll explore barriers to leadership and advocacy, provide critical engagement data points, and help attends develop a toolbox of approaches to use on Lobby Day and beyond.
2:30 – 3:30 pm	**Legislative Briefing on Key CAFP Issues** Carla Kakutani, MD, Adam Francis and Jodi Hicks CAFP Legislative Committee Chair, Staff and Legislative Advocate
3:30 – 4:00 pm	**BREAK**
4:00 – 5:00 pm	**Panel Discussion – TBD**
5:00 pm	**RECESS**
6:15 pm	**Dine Around Dinners****

	Join your fellow delegates and alternates for Dutch treat dining at one of several Sacramento restaurants. Sign-ups are available in the Metropolitan Terrace. Dining groups can be organized by region or practice type or issue area if desired.

Sunday, March 10, 2019 | All Member Advocacy Meeting Reconvenes Metropolitan Terrace – 7:30 am – 1:00 pm	
7:30 – 8:15 am	**All Member Advocacy Meeting** **Registration and Continental Breakfast**
8:15 am	**All Member Advocacy Meeting Reconvenes**
8:15 – 8:20 am	**Certification of Delegates/Instructions to Delegates**
8:20 – 8:25 am	**Election of Officers, AAFP Delegates and Alternates for 2019-20, Nominating Committee Member 2019-20** Election of Secretary/Treasurer* **Elected by the Board of Directors only*
8:25 – 8:40 am	**FP PAC Report** Jay W. Lee, MD, MPH, FP-PAC Chair
8:40 – 8:50 am	**Hero of Family Medicine Award Presentation** Presentation by Lisa Ward, MD, CAFP President
8:50 – 9:00 am	**Report of the CAFP Foundation** Marianne McKennett, MD, CAFP Foundation President
9:00 – 9:45 am	**Public Charge and Immigration Issues: Panel Discussion** Michelle Quiogue, MD, CAFP immediate past president, Ignatius Bau, JD, formerly of the California Endowment, and Altaf Saadi, MD, UCLA will have an open discussion on the issues of the public charge rules, and the roles and responsibilities family physicians face with addressed immigration issues such as family separation and ICE threats.
9:45 – 10:30 am	**Review of CAFP Board 2018-2019 Policies and Actions on 2018 Resolutions**
10:30 – Noon	**Resolutions Hearing – Speaker and Vice Speaker of the of the AMAM and CAFP Board of Directors** Presentation of testimony to the Board of Directors concerning proposed policies developed by members and chapters. Elections, bylaws changes, dues/special assessment changes and memorial resolutions will be considered and voted on by the Delegates to the All Member Advocacy Meeting. The CAFP Board will hear all other proposals, take action on them over the course of the year, and report back to the AMAM on their disposition at the next meeting. All members are invited to speak. Issues/resolutions may be brought to the CAFP Board at any time during the year. An electronic form for submission is available.

Noon	**Adjournment and Lunch**
12:15 pm	**Keynote Speaker and Champion of Family Medicine Awardee** Introduction and Presentation of Award by Lisa Ward, MD, President
1:15 – 5:00 pm	**Training Tracks**
Track 1 1:30 – 3:00 pm	**Crafting Your Message and Telling Your Story** Louise Aronson, MD, MFA, UCSF Dr. Aronson is Professor of Medicine at the University of California San Francisco (UCSF) where she cares for frail older adults in the Care at Home Program and directs the Northern California Geriatrics Education Center and UCSF Medical Humanities. She is particularly interested in the use of writing to harness the expertise and unique experiences of clinicians and medical scientists in service of health and health care. https://louisearonson.com/
3:00 – 3:15 pm	**BREAK**
Track 2 3:15 – 5:00 pm	**Advocacy – How to Meet with Your Legislator – Metropolitan Terrace** Adam Francis CAFP Director of Government Relations Jodi Hicks, CAFP Legislative Advocate Learn how easy and fun it can be to have a successful meeting with your legislator, whether it's on CAFP's Lobby Day or back home in your district. We'll give you all the tools you need to be a true Family Medicine Revolutionary!
5:00 – 7:00 pm	**Special FP-PAC Donor Reception – Scandal Lounge** Open to all 2019 FP-PAC contributors at no additional cost
7:00 pm	**Evening Free – Dine Around Sacramento** (Meet in the lobby at 7) Share an exciting dining experience with fellow CAFP delegates and alternates. CAFP is *tentatively* holding a reservation for up to 20 guests at 7:15 pm. Staff will accompany dining groups.

Monday, March 11, 2019 | Family Medicine Lobby Day Breakfast and Briefing Metropolitan Terrace – 7:30 – 9:00 am	
7:30 – 9:00 am	**Breakfast and Legislative Issues Orientation** CAFP Director of Government Relations Adam Francis, Director of Health Policy and Legislative Advocate Jodi Hicks, Mercury Public Affairs
8:45 am	**Group Photo**
9:00 am – 12:00 pm	**Legislative Visits at the Capitol**
12:00-1:00 pm	**Debrief and Adjournment**

Mark Your Calendar! March 7-9, 2020

2020 All Member Advocacy Meeting

Roster of 2019 Delegates and Alternates

As of February 14, 2019

County/Chapter	Delegates	Alternates
Alameda/Contra Costa (5)	Rusty Renner Travis Bias Elizabeth Iten Kristina Moeller Ana Coutinho	Sumedh Mankar Emily Guh
Amador (1)		
Butte-Glenn-Tehama (1)		
Fresno-Kings-Madera (1)	Michael Moyer Robin Linscheid	
Humboldt-Del Norte (1)		
Imperial (1)		
Inyo-Mono-Alpine (1)		
Kern (2)	Jasmeet Bains * Nadeem Goraya *	
Lassen-Plumas-Modoc-Sierra (1)		
Los Angeles (12)	Jerry Abraham Rebecca Bertin Mark Dressner Monique George Nzinga Graham Emma Hiscocks Po-Yin Samuel Huang Kelly Jones Elisabeth Kalve Daniel Pio Stacey Ludwig Greg Lewis	Felix Aguilar Frank Aliganga Evan Bass Daniel Castro Francine Frater Chris Hiromura Jay Iinuma Katrina Miller Gil Solomon Shabana Tariq
Mendocino-Lake (1)		
Merced-Mariposa (1)		
Monterey (2)		
Napa (1)	Tessa Stecker	
North Bay (3)	Toni Ramirez * Panna Losey * Veronica Jordan *	

County/Chapter	Delegates	Alternates
Orange (5)	Thomas Bent Christina Deckert Jorge Galdamez Karina Melgar Duy Nguyen William Woo	Anupam Gupta Sofia Meraz Jenny Tan Matthew Varallo Jay Lee Thomas Badin
Placer-Nevada (2)		
Riverside-San Bernardino (6)	Ngozi Margarete Ezinwa Shayne Poulin Prashanth Bhat Elizabeth Dameff Nazmeen Khan Merfeld Maisara Rahman	Ecler Jaqua Nadia Khan
Sacramento-El Dorado (4)		
San Diego (6)	Patrick Yassini Lance Fuchs Albert Ray Randy Swartz Michelle Cao Heidi Meyer	Steven Green Cecilia Gutierrez Brad Stiles Daniel Slater Merritt Matthews Joeseph Leonard
San Francisco (2)		
San Joaquin-Calavaras-Tuolomne (2)		
San Luis Obispo (2)		
San Mateo (2)	Steven Howard Alex Moldanado	Karen Jackson
Santa Barbara (2)		
Santa Clara (3)		
Santa Cruz (2)	Jeannine Rodems *	
Shasta-Trinity (2)		
Siskiyou (1)		
Solano (2)	Matt Symkowick Yasmin Bains	
Stanislaus (2)		
Tulare (1)		
Ventura (2)		
Yolo (2)	Erika Roshanrovan *	
Yuba-Sutter-Colusa (1)		

The deadline to report Delegates/Alternates was December 16, 2018.

County/Chapter	Delegates	Alternates
Residents (2)		
Students (2)		

**Asterisked Delegates and Alternates indicate those whose names were submitted after the deadline.*

CAFP Officers and Board of Directors – 2018-2019	
Lisa Ward, MD, MScPH, MS	President
Walter Mills, MD, MBA	President-Elect
Michelle Quiogue, MD	Immediate Past President
David Bazzo, MD	Speaker
Shannon Connolly, MD	Vice Speaker
Lauren Simon, MD, MPH	Secretary-Treasurer
Carol Havens, MD	AAFP Delegate
Jeffrey Luther, MD	AAFP Delegate
Jay W. Lee, MD, MPH	AAFP Alternate Delegate**
Lee Ralph, MD	AAFP Alternate Delegate**
Marianne McKennett, MD	CAFP-F President
Anthony "Fatch" Chong, MD	District I
Sofia Meraz, MD	District II (Interim Director)
Kevin Rossi, MD	District III
Arthur Ohannessian, MD	District IV
Lauren Simon, MD	District V
Raul Ayala, MD	District VI
Grace Yu, MD	District VII
Jeremy Fish, MD	District VIII
Ron Labuguen, MD	District IX
Nate Hitzeman, MD	District X
Steve Harrison, MD	Rural Director
Alex McDonald, MD	Young Physician Director
Brent Sugimoto, MD, MPH	*CFP* Editor**
Rob Assibey, MD	Resident Co-Director***
Cynthia Chen-Joea, DO	Resident Co-Director***
Andrea Banuleos-Mota	Student Co-Director***
Zachary Nicholas	Student Co-Director***

* *Names submitted after deadline; must be approved by the Delegates of the AMAM.*

*** Non-voting member*

**** One resident and one student Co-Director serve as Delegates at the AMAM.*

2019 Instructions to Delegates and Alternates
CAFP All Member Advocacy Meeting

It is important that all Delegates and Alternates read this section to learn about or refresh knowledge about their duties and responsibilities, especially under the new All Member Advocacy Meeting format.

Introduction:

As a Delegate to the All Member Advocacy Meeting (AMAM), you are charged with important responsibilities. The following information is intended as a guide for members of the AMAM of the California Academy of Family Physicians. Its purpose is to explain some of the major rules and procedures designed to promote effectiveness in the work of the AMAM. **In short, the duties of Delegates are: 1) Vote upon proposals to increase dues or create special assessments; 2) Elect the officers of the Academy; 3) Review resolutions and policies adopted over the course of the year by the Board of Directors; 4) In appropriate circumstances, submit referenda to the members of the Academy; and 5) Propose policies or programs to the Board of Directors for discussion and consideration.**

Function: The AMAM of the California Academy of Family Physicians proposes policies for consideration by the Board of Directors, reviews policies adopted by the Board of Directors at the time of the annual meeting and approves dues increases and special assessments for the members of the Academy. As a member of the AMAM, you are charged with the responsibility of seeing that the business of the California Academy of Family Physicians is conducted in a manner that will best serve the interests of its members, the medical profession and the people of California.

Advance Preparation: In this Handbook, you will find the Report of Actions of the 2018 All Member Advocacy Meeting and how to access 2018 reports about the CAFP and the CAFP Foundation. Please read the Report of Actions carefully so you will be familiar with the previous actions of the AMAM, the policies considered.

Policies for consideration by the Board of Directors may have citations from the CAFP Policy Digest referring to existing policy or to resolutions previously acted upon by the former Congresses of Delegates. The Policy Manual of the CAFP may be requested from CAFP at cafp@familydocs.org. Resolutions are also posted on CAFP's website at http://www.familydocs.org/all-member-advocacy-meeting for member comment. Delegates are encouraged to visit familydocs.org, to review these comments. A copy of the CAFP Bylaws may be requested at cafp@familydocs.org. If you have any questions about the role of the AMAM or how the meeting is conducted, please contact Lisa Folberg, MPP, CAFP Chief Executive Officer, 415-345-8667 or contact her at cafp@familydocs.org.

What to Do on Site:

1. **Registration:** Your first official responsibility as a delegate or alternate is to register with the CAFP AMAM staff just prior to each session of the AMAM.

2. **Certification of Delegates:** CAFP bylaws require that Delegates to AMAM must be reported to the secretary/treasurer sixty (60) working days prior to AMAM (December 16, 2018). Names of Delegates and Alternates reported after that deadline must be accepted as the first action of the AMAM, by a two-thirds (2/3) vote.

3. **Seating:** When you register with the CAFP AMAM staff, your name will be placed on the roll of the AMAM for that session. According to CAFP bylaws, to be seated, a Delegate must be in good standing in the Academy, i.e., dues paid, continuing education credits obtained, no licensure issues, etc. In the event that no certified Delegate or Alternate for a particular county is present at the meeting of the AMAM, a member or members of that county unit may be seated upon recommendation of the District Director, with a two-thirds (2/3) affirmative vote of the AMAM. If a Delegate is compelled to leave the session before adjournment, his or her seat may be filled by an Alternate or substitute only by registering with the staff.

4. **Voting:** Each Delegate member of the AMAM shall have one vote when electing CAFP officers. Alternate delegates may not vote unless they are standing in for a Delegate from their chapter. Please refer to the Nominating Committee Report and Candidate Statements section of this handbook for information about this year's slate of candidates. Delegates will receive a card upon registration that will qualify them to vote on any resolution concerning dues, special assessments or referenda. Officer elections are conducted through acclamation or secret ballot.

Standing Rules of the All Member Advocacy Meeting:

When AMAM Convenes: The AMAM will convene at 1:00 pm, Saturday, March 9, 2019 following lunch and again on Sunday, March 10, 2019 at 8:15 am following breakfast at The Citizen Hotel, 926 J Street, Sacramento, CA. The order of business will be as outlined in the Participants' Handbook and may be changed by the Speaker of the AMAM as necessary. Meeting rooms also are subject to change.

Parliamentary Procedure: *Sturgis Standard Code of Parliamentary Procedure* governs the AMAM. A summary of the *Code* is included in the handbook.

Submission of Resolutions: Resolutions to be submitted to the AMAM should have been submitted to the Academy or the Speaker of the AMAM at least sixty (60) working days prior to the meeting during which they are to be considered (December 16, 2018). The Board of Directors will accept testimony on all resolutions except those regarding dues increases or special assessments; such resolutions will be considered by the voting Delegates of the AMAM under the direction of the Speaker or Vice Speaker.

Who May Speak or Testify? All CAFP members have the privilege of the floor. If you wish to speak during the AMAM and the Speaker has recognized you, go to the nearest microphone and identify yourself. Please state clearly your name and chapter for the record. No member may speak a second time during the discussion until all members have been given an opportunity to speak once. This will give every Academy member the opportunity to present his or her views.

Delegates and Alternate Delegates are also given the privilege of the floor to discuss matters pending on the floor, upon being recognized by the Speaker.

The Speaker may, with a simple majority vote of the AMAM, move to limit debate on the floor.

Voting: The Speaker and Vice Speaker may appoint a Tellers Committee of three from the alternate delegate roster of the AMAM and name one of the alternates to chair the Committee. The Tellers Committee is responsible for counting votes on the floor and for counting ballots in a contested election. Delegates vote on election of officers and resolutions concerning dues increases, special assessments and referenda to place before the membership.

Who May Speak at the Board of Directors Reference Committee Hearing? Any Academy member has the privilege of speaking at the reference committee hearing. Non-members may also be asked to provide additional information to clarify or present essential facts on an item during discussion. The amount of time individuals may speak may be limited at the discretion of the Speaker, Vice Speaker or President of the Academy.

When Does the Board Reference Committee Meet? The Board of Directors will convene at 10:30 am-Noon on Sunday, March 10, 2019 to hear commentary.

Report of the Board of Directors Acting as the Reference Committee: Delegates at the AMAM WILL NOT VOTE on any resolution unrelated to dues increases, special assessments or referenda to place before the membership. The Board of Directors will take all resolutions, testimony provided, responses during a question and answer period, etc. under advisement and make a determination about what action to take on each resolution during the course of the year. The Board will provide a report on its actions during the year and submit a final report at the next AMAM. The Board may decide to approve a resolution, approve as amended, or disapprove a resolution. It may determine that actions proposed by some resolutions are beyond the scope of the Academy.

Reaffirmation/Acclamation Calendars: Reaffirmation and/or acclamation also may be used by the Board when a resolution is determined to be either reaffirmation of CAFP policy or of an acclamation nature. These items will be noted in the Participants' Handbook.

Nominating Procedures: The Nominating Committee consists of two members selected by and from the Board of Directors, three members elected by and from the AMAM, and the immediate past president, who serves as chair. The 2018 Committee nominated candidates for the following positions, to be elected by the AMAM:

President-Elect	AAFP Delegate and Alternate
Speaker	New Physician Director
Vice Speaker	Nominating Committee Members (two AMAM positions)
Secretary-Treasurer *	Editor*

The committee may also submit nominations for District Directors when nominations were not made by a District. In addition, it submits nominations to the Board of Directors for Secretary/Treasurer and Editor. These individuals are elected at the AMAM, but ONLY by members of the Board of Directors.*

Nominating Committee members from the Board are elected by the Board of Directors at its first meeting following the Annual Meeting. Members of the Committee from the AMAM must be delegates and are elected by the AMAM and begin serving the same year (two-year terms).

Names of announced candidates for office are placed in nomination during the first session of AMAM. The floor is open for additional nominations. Should there be nominations from the floor or contested elections, nominating speeches of three minutes each will be given at the second session of the AMAM, prior to the election. A secret written ballot will be used in the case of contested elections. Ballots will be tallied by members of the Tellers Committee.

**Voted upon only by the CAFP Board of Directors; Secretary-Treasurer must be a sitting member of the Board for the duration of his/her one-year term. The Editor also is elected by the Board and is a non-voting member.*

Knowledge-Based Decision Making Process

The CAFP adopted the knowledge-based decision making at the Board of Directors and committee levels in 2000, and utilizes it at the AMAM by altering the way resolutions are presented. Resolutions are accompanied by information that will address the following issues in an effort to permit the reference committee and members of the AMAM to make decisions based on knowledge rather than opinion.

In this process, there are two segments to our discussion:

1. Dialogue – to understand; and
2. Deliberation – to decide (i.e., vote).

This process poses four questions:

1. What do we know about the needs, wants and preferences of our members, prospective members and customers relevant to this decision? = WHY?
2. What do we know about the current and evolving dynamics of our profession relevant to this decision? (Foresight) = WHY?
3. What do we know about the strategic position and internal capacity of our organization relevant to this decision? = HOW?
4. What are the ethical implications of our choices relevant to this decision? = RISKS

With regard to each decision the AMAM is asked to make, we must ask ourselves:

1. Do we know exactly what we are being asked to do?
2. What are the pros and cons of doing this?
3. What do we know about our members' environment that is relevant to this decision?
4. What do we know about our members' needs relevant to this decision?
5. What is our internal capacity for doing this?
6. What are the financial ramifications for doing this?
7. What are the risks and benefits of doing this?

By following this process, CAFP is certain to have even better outcomes based on CAFP's strategic plan and the surrounding environment.

Parliamentary Procedure

Sturgis Standard Code of Parliamentary Procedure

Order of Precedence	Requires Second?	Debatable?	Vote Required
Privileged Motions			
1. Adjourn	Yes	Yes	Majority
2. Recess	Yes	Yes	Majority
3. Question of Privilege	No	No	None
Subsidiary Motions			
4. Postpone Temporarily	Yes	No	Majority
5. Vote Immediately	Yes	No	2/3
6. Limit Debate	Yes	Yes	2/3
7. Postpone Definitely	Yes	Yes	Majority
8. Refer to Committee	Yes	Yes	Majority
9. Amend	Yes	Yes	Majority
10. Postpone Indefinitely	Yes	Yes	Majority
Main Motions			
11. a. The main motion	Yes	Yes	Majority
b. Specific main motions			
Reconsider	Yes	Yes	Majority
Rescind	Yes	Yes	Majority
Resume consideration	Yes	No	Majority

No Order of Precedence	Requires Second?	Debatable?	Vote Required
Incidental Motions			
a. Motions			
Appeal	Yes	Yes	Majority
Suspend rules	Yes	No	2/3
Object to consideration	Yes	No	2/3
b. Requests			
Point of order	No	No	None
Parliamentary inquiry	No	No	None
Withdraw a motion	No	No	None
Division of question	No	No	None
Division of assembly	No	No	None

Resolutions and Background Materials

Res. A-01-19 – Paid Parental Leave
Res. A-02-19 – Ensuring Quality and Safe Care
Res. A-03-19 – Increasing Family Centeredness at AAFP Meetings
Res. A-04-19 – Gender Pronouns Inclusion
Res. A-05-19 – Resident Well-Being and Burnout
Res. A-06-19 – Improve Access to Healthcare for Formerly Incarcerated Persons
Res. A-07-19 – Decriminalizing Abortion Provision
Res. A-08-19 – Mifepristone in EPL
Res. A-09-19 – Communicating with Patients with Terminal Illness and-or Existential Distress
Res. A-10-19 – Opioids

A-01-19

TITLE: **Paid Parental Leave Policy**

Introduced by: Rossan Chen, MD MSc; Tessa Stecker, MD
Endorsements: Napa-Solano Chapters

WHEREAS, the US Family and Medical Leave Act (FMLA), which guarantees 12 weeks of job-projected time off is unpaid and does not apply to about half of the American work force[1,2], and

WHEREAS, the first few months of a child's life is the most important time for bonding and development, and

WHEREAS, paid parental leave lowers rates of infant mortality and maternal depression, enhances rates of exclusive and overall breastfeeding, encourages preventive care such as immunizations and well checks,[3] and improves early childhood development[4], and

WHEREAS, paid maternity leave improves women's participation in the labor force, safeguards women's incomes and career advancement, and is associated with increased wages[5] and work hours[6], and

WHEREAS, paid paternity leave enhances bonding and promotes gender equality by encouraging new fathers to participate in child-rearing and household work, and by facilitating mothers' participation in or return to the labor market[7], and

[1] Han, W.-J. and Waldfogel, J. 2003. "Parental Leave: The Impact of Recent Legislation on Parents' Leave-Taking." *Demography*. 40(1):191–200

[2] Berger LM, Hill J, Waldfogel J. Maternity leave, early maternal employment and child health and development in the US. *Econ J (London)*. 2005;115(501):F29-F47.

[3] Nandi A, Jahagirdar D, Dimitris MC, et al. The Impact of Parental and Medical Leave Policies on Socioeconomic and Health Outcomes in OECD Countries: A Systematic Review of the Empirical Literature. Milbank Q. 2018 Sep;96(3):434-471

[4] Maternity and paternity at work. International Labour Organization. 2014.

[5] Nandi A, Jahagirdar D, Dimitris MC, et al. The Impact of Parental and Medical Leave Policies on Socioeconomic and Health Outcomes in OECD Countries: A Systematic Review of the Empirical Literature. Milbank Q. 2018 Sep;96(3):434-471.

[6] Bedard K and Rossin-Slater M. The economic and social impacts of paid family leave in California: Report for the California Employment Development Department. October 13, 2016.

[7] Nandi A, Jahagirdar D, Dimitris MC, et al. The Impact of Parental and Medical Leave Policies on Socioeconomic and Health Outcomes in OECD Countries: A Systematic Review of the Empirical Literature. Milbank Q. 2018 Sep;96(3):434-471

WHEREAS, paid parental leave prevents intimate partner violence and decreases the incidence of abusive head trauma by reducing financial stress, increasing egalitarian parenting practices, and promoting child/parent bonding[8], and

WHEREAS, currently among US employers, 35% offer paid maternity leave, 29% provide paid paternity leave, 28% offer paid adoption leave, 21% provide paid foster child leave, and 12% offer paid surrogacy leave because the policies promote wellness, recruitment, and retention[9], and

WHEREAS, the absence of a paid parental leave policy might bias employers against hiring women of childbearing age, which could concentrate women in lower-paying or part-time positions and contribute to gaps in wages and benefits compared to men and non-mothers[10], and

WHEREAS, unpaid leave provided through FMLA may increase disparities among low-income and minority parents because FMLA only benefits parents who can afford to take the time off[11,12], and

WHEREAS, five million prime-age workers in the US could be added to the labor force through policies like paid parental leave, which would boost economic growth[13], and

WHEREAS, there is little evidence that the duration of paid leave had negative employment or economic consequences; in fact, increasing the duration and benefit level provided by paid leave policies increased rates of women's labor force participation[14,15], and

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[8] D'Inverno AS, Reidy DE, Kearns MC. Preventing intimate partner violence through paid parental leave policies. Prev Med. 2018 Sep;114:18-23.

[9] Society for Human Resource Management

[10] Nandi A, Jahagirdar D, Dimitris MC, et al. The Impact of Parental and Medical Leave Policies on Socioeconomic and Health Outcomes in OECD Countries: A Systematic Review of the Empirical Literature. Milbank Q. 2018 Sep;96(3):434-471

[11] Rossin M. The effects of maternity leave on children's birth and infant health outcomes in the United States. *J Health Econ*. 2011;30(2):221-239.

[12] Nepomnyaschy L and Waldfogel J. Paternity leave and fathers' involvement with their young children. Community, Work & Family. 2007;10:4, 427-453.

[13] Daly MC, Pedtke JH, Petrosky-Nadeau N, and Schweinert A. Why aren't US workers working? Federal Reserve Bank of San Francisco. November 13, 2018.

[14] Nandi A, Jahagirdar D, Dimitris MC, et al. The Impact of Parental and Medical Leave Policies on Socioeconomic and Health Outcomes in OECD Countries: A Systematic Review of the Empirical Literature. Milbank Q. 2018 Sep;96(3):434-471.

[15] Bedard K and Rossin-Slater M. The economic and social impacts of paid family leave in California: Report for the California Employment Development Department. October 13, 2016.

WHEREAS, all Organization for Economic Co-operation and Development (OECD) countries other than the United States offers some form of national paid parental leave policy[16], usually financed through social security or public funds[17], and

WHEREAS, there has been a global shift towards the International Labour Organization's recommendation of at least 14 weeks of paid leave and a wage replacement of at least two-thirds of previous wages[18], and

WHEREAS, nine US states/territories have passed legislation mandating paid family leave; California (2004), New Jersey (2009), Rhode Island (2014), Washington (2017), Washington, DC (2017), New York (2018), Massachusetts (2018), Hawaii, and Puerto Rico[19], and three more US states are preparing similar legislation (Oregon, Colorado, and Connecticut)[20], and

WHEREAS, in competitive races in the 2018 midterm elections, nearly 30% of candidates for Congress and governor included paid leave in their platforms[21], and

WHEREAS, around 80% of Americans support paid parental leave[22], and be it further

RESOLVED: That CAFP support a requirement on employers to provide at least 12 weeks of paid parental leave with job protection and wage replacement of at least two-thirds of previous earnings, up to a cap, for each new infant born or adopted, financed through an insurance-based pool, and that the paid leave may be taken by any family member caring for the child at any time in the first year of a child's birth or adoption in parts or as a block; and be it further

RESOLVED: That CAFP refer this to AAFP for national action.

Speaker's Note:

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[16] Nandi A, Jahagirdar D, Dimitris MC, et al. The Impact of Parental and Medical Leave Policies on Socioeconomic and Health Outcomes in OECD Countries: A Systematic Review of the Empirical Literature. Milbank Q. 2018 Sep;96(3):434-471.
[17] Maternity and paternity at work. International Labour Organization. 2014.
[18] Maternity and paternity at work. International Labour Organization. 2014.
[19] Nandi A, Jahagirdar D, Dimitris MC, et al. The Impact of Parental and Medical Leave Policies on Socioeconomic and Health Outcomes in OECD Countries: A Systematic Review of the Empirical Literature. Milbank Q. 2018 Sep;96(3):434-471.
[20] Miller CC and Tankersley J. A California dream for paid leave has an old problem: How to pay for it. New York Times. January 6, 2019. https://nyti.ms/2GZRIMO (accessed January 6, 2019).
[21] Shabo V. 2018 Midterm elections saw candidates in competitive races embrace equal pay, paid leave, and related issues in record numbers – and win. National Partnership for Women & Families. November 16, 2018.
[22] Horowitz JM, Parker K, Graf N, and Livingston G. Americans widely support paid family and medical leave, but differ over specific policies. Pew Research Center. March 23, 2017.

This resolution addresses a gap in existing CAFP and AAFP policy. It is complementary and enhances existing policy. This resolution may have a financial effect on CAFP members who own and run clinical practices or other businesses.

Fiscal Note:
The resource implications of this resolution becoming CAFP policy are minimal, as is the referral to AAFP for national action. The requirements set out by this resolution are covered by CAFP and AAFP operations related to legislative advocacy.

PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this resolution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?
The United States is the only developed nation to lack a paid parental leave policy. This has led to significantly less time that parents can afford to spend bonding with their newborn or newly adopted child. The lack of a parental leave policy also unfairly penalizes families financially for having a child or adopting a child. A paid parental leave policy allows employees to take full advantage of job-protected leave through FMLA, reducing disparities among low income and minority parents who might not be able to afford to take the entire 12 weeks off.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?
All CAFP members and members' patients who deliver or adopt a child are affected by this proposed policy.

WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY, i.e., what action do you wish CAFP to take?
We propose that CAFP encourage the AAFP to advocate for a national policy for paid parental leave with job protection for all part-time and full-time employees in this country that rivals other developed nations. Unlike FMLA, this policy should apply to all workers regardless of their company's size. There should be a cap to the payments, which have ranged from 50-90% of regular wages in the state-run programs. Workers would need to pay a small percentage (approximately 1% in California) payroll tax that funds an insurance-based pool run through a federal agency. When workers need paid parental leave, they can apply to the federal agency for wage replacement.

WHAT EVIDENCE EXISTS TO: 1) INDICATE THAT A PROBLEM EXISTS; OR 2) THAT THERE IS NEED FOR A NEW OR REVISED POLICY?
Infant mortality rates are on the rise. One in nine women suffer from symptoms of postpartum depression. Also, labor force participation among US men and women ages 25-54 has been declining over the past 20 years. A key factor is the lack of support for paid parental leave and subsidized child care.

Res. A-02-19

TITLE: Ensuring Quality and Safe Care by All Primary Care Providers

Introduced by: Brent Sugimoto, MD, MPH, FAAFP
Endorsements: East Bay Chapter of the CAFP

WHEREAS, Family Physicians are uniquely qualified to influence the discussion on the shape and place of primary care in our health care system, and

WHEREAS, the shortage of primary care physicians, expected to reach 50,000 by 2030, is a growing concern for the health of our nation, and

WHEREAS, the position of the American Academy of Family Physicians (AAFP) is "that the nurse practitioner should only function in an integrated practice arrangement under the direction and responsible supervision of a practicing, licensed physician," and

WHEREAS, the Federal Trade Commission views nurse practitioner scope of practice laws as limiting the supply of primary care, and as such, is already promoting reform of scope of practice laws to allow independent practice of nurse practitioners, and

WHEREAS, nurse practitioners may already practice independently in 22 states, the District of Columbia, and the Veterans' Affairs Health System, despite undergoing just 1,500 hours of training, compared to the 16,000 hours required of Family Physicians, and

WHEREAS, the number of states allowing independent scope of practice of nurse practitioners is likely to increase regardless of AAFP opposition, and

WHEREAS, Family Physicians can provide critical input and legislative advocacy on adequate training of all primary care providers—including nurse practitioners—for the health and safety of the public, and

WHEREAS, the AAFP's current policy on nurse practitioner scope of practice stymies the Academy's participation in discussions of safe and adequate training of the increasingly independent nurse practitioner workforce, therefore be it further

RESOLVED: That the AAFP policy on nurse practitioners supports independent practice when nurse practitioners are trained under a standard that allows the demonstration of the competencies necessary for the safe delivery of quality primary care.

Speaker's Note:
AAFP policy on independent practice of NPs (https://www.aafp.org/about/policies/all/nurse-practitioners.html) currently reads:

The nurse practitioner should not function as an independent health practitioner. The AAFP position is that the nurse practitioner should only function in an integrated practice arrangement under the direction and responsible supervision of a practicing, licensed physician. In no instance may duties be delegated to a nurse practitioner for which the supervising physician does not have the appropriate training, experience and demonstrated competence.

The AAFP position is that the training programs preparing nurse practitioners, like the training for all other health care providers, should be constantly monitored to assure the quality of training provided and that the number of graduates reflects demonstrated needs.
AAFP policy on team-based practice (https://www.aafp.org/about/policies/all/teambased-care.html) currently reads:

- The AAFP encourages health professionals to work together as multidisciplinary, integrated teams in the best interest of patients. Patients are best served when their care is provided by an integrated practice care team led by a physician.
- The medical home represents an example of an integrated practice arrangement in which a licensed physician (MD/DO) works with other health care personnel to manage the care of an individual patient and a population of patients using a multidisciplinary, collaborative approach to health care. The arrangement should support an interdependent, team-based approach to comprehensive care delivery. It should address patient needs for high-value, accessible health care and be supported by enhanced communication and processes that empower non-physician staff to effectively utilize the skills, training and abilities of each team member to the full extent of their professional capacity.
- The central goal of team-based care is to provide the most effective, efficient, and accessible evidence-based care to the patient. Patient-oriented outcome measures and patient experience should be central in assessing the quality of care delivered by the team. (1996 COD) (2017 COD)
- CAFP policy on independent practice reads:

CAFP recognizes nurse practitioners, certified nurse midwives and physician assistants as health care providers. NPs, CNMs and PAs work collaboratively with, and under the supervision of, physicians in providing quality health care. CAFP opposes independent practice of NPs, CNMs and PAs. 5/93 BoD

Therefore, passing this resolution as currently worded requires CAFP to update its policy on the independent practice of NPs in a way that contrasts with the national standard set out by AAFP. Furthermore, it requires CAFP to advocate for a significant change in AAFP policy pertaining to both independent practice of NPs and team-based care.

Fiscal Note:
The resource implications of passage of this resolution could be considerable, potential resulting in significant staff costs. These costs include but are not limited to:

- Researching and developing new policy in favor of independent practice of NPs under specific conditions, including a review of legislation as it exists in other states.
- Referring for consideration by CAFP Committees, including the Legislative Affairs Committee and Medical Practice Affairs Committee, new draft CAFP policy in support of independent practice.
- Putting forward resolutions to the AAFP to amend its policies on independent practice of NPs and team-based care.
- Leveraging these new policies, if passed, to develop and communicate positions on quality requirements for NPs.

PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this resolution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?
This resolution would allow the AAFP/CAFP to engage in discussions and debate of the conditions under which nurse practitioners can practice independently, which is prohibited under a policy that opposes independent scope of practice for nurse practitioners.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?
All members and all patients

WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY, i.e., what action do you wish CAFP to take?
For the CAFP to move from a defensive to a proactive stance on scope of practice for Advance Practice Registered Nurses (APRN) such as nurse practitioners.

WHAT EVIDENCE EXISTS TO: 1) INDICATE THAT A PROBLEM EXISTS; OR 2) THAT THERE IS NEED FOR A NEW OR REVISED POLICY?
Advance Practice Registered Nurses such as NP's are becoming increasingly successful in gaining independent practice in primary care with a goal of nationwide independent scope, yet training is inadequate to the develop the competencies needed for safe and quality primary care. As CAFP and AAFP oppose independent practice, they cannot influence a discussion that unchecked, will dilute the value of primary care to the American public.

PLEASE PROVIDE CITATIONS to support the existence of the problem and your proposed solution.
References:

1. Federal Trade Commission (2014). Competition and the Regulation of Advanced Practice Nurses.
2. "State Practice Environment". American Association of Nurse Practitioners. https://www.aanp.org/advocacy/state/state-practice-environment. Accessed December 15, 2018.

3. Institute of Medicine. (2010). The future of nursing: Leading change, advancing health. Education and Training: Family Physicians versus Nurse Practitioners. AAFP. https://www.aafp.org/dam/AAFP/documents/advocacy/workforce/scope/FPvsNP.pdf. Accessed

Res. A-03-19

TITLE: Increasing Family-Centeredness at AAFP Meetings

Introduced by: Tenessa MacKenzie MD; Alison Block MD
Endorsements: CAFP North Bay Chapter

WHEREAS, the mission of the American Academy of Family Physicians (AAFP) is to improve the health of patients, families, and communities by serving the needs of members with professionalism and creativity[1], and

WHEREAS, the AAFP encourages all physicians, including women, to participate actively in all AAFP programs and activities and at all levels of leadership[2], and

WHEREAS, meetings such as AAFP FMX and Congress of Delegates (COD) provide important opportunities for career development, education, and networking[3], and

WHEREAS, women's careers are disproportionately affected by the lack of childcare services and facilities[4,5,6], and

WHEREAS, the American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG) annual meetings offer on-site child care services [7,8], and

WHEREAS, the AAFP advocates for the removal of barriers to breastfeeding including encouraging breastfeeding-friendly workplaces and protecting the right to breastfeed in public[9], now, therefore be it

RESOLVED, that AAFP adjusts its recommendations regarding children at AAFP meetings from "Out of consideration for others, please do not bring children to CME events" to "AAFP supports families. Please use your best judgment regarding bringing children to CME events;" and be it further

RESOLVED, that the CAFP ask the AAFP to provide an on-site play area for children and their caregivers at AAFP FMX and COD; and be it further

RESOLVED, that the CAFP ask the AAFP to enhance efforts to accommodate breastfeeding parents at AAFP FMX and COD by providing a lactation lounge with basic services including privacy, running water, refrigerated milk storage, and opportunities to donate excess breast milk.

Speaker's Notes:
This resolution does not represent an amendment or addition to existing CAFP or AAFP policy, in that it is not connected to legislative or policy efforts.

Fiscal Note:
The resource implications of this resolution are minimal, consisting of communication between CAFP and AAFP staff.

PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this resolution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?
This resolution aims to make AAFP conferences and meetings, with particular emphasis on AAFP FMX and COD, more accommodating to participants with families. By decreasing barriers to childcare and breastfeeding, there may be improved interest and attendance at AAFP FMX and COD, especially among NCCL constituencies including women, LGBT physicians and allies, and new physicians with young families.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?
This issue affects all CAFP/AAFP members with families, especially those for whom finding childcare is a barrier to attending conferences and those who are currently breastfeeding.

WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY, i.e., what action do you wish CAFP to take?
We propose that CAFP uses its position to urge the AAFP to increase family-centeredness at its annual AAFP FMX and COD meetings by committing to the above four "resolved" clauses.

WHAT EVIDENCE EXISTS TO: 1) INDICATE THAT A PROBLEM EXISTS; OR 2) THAT THERE IS NEED FOR A NEW OR REVISED POLICY?
Please see "whereas" section and problem statement.

References:
1. AAFP Mission Statement (2004) (2014 COD)
https://www.aafp.org/about/policies/all/mission.html
2. AAFP Policy Equal Representation of Women in Family Medicine (B1983) (2015 COD)
https://www.aafp.org/about/policies/all/women-family-medicine.html
3. About AAFP FMX
https://www.aafp.org/events/fmx/about.html
4. AMWA Position Paper on Dependent Care (1989) (Revised 2000)
https://www.amwa-doc.org/wp-content/uploads/2018/05/Dependent-Care.pdf
5. Angela L. Bos, Jennie Sweet-Cushman & Monica C. Schneider (2017) Family-friendly academic conferences: a missing link to fix the "leaky pipeline"?, Politics, Groups, and Identities, DOI: 10.1080/21565503.2017.1403936
6. Rachel S. Harris (2015) Child Care Shouldn't Be An Issue, Inside Higher Ed.

https://www.insidehighered.com/views/2015/09/16/essay-says-child-care-shouldnt-still-be-issue-scholarly-meetings

7. AAP Experience National Conference and Exhibition Family Resources
https://aapexperience.org/family-resources/

8. ACOG Annual Clinical and Scientific Meeting Family & Fun
https://annualmeeting.acog.org/family-and-fun/

9. AAFP Breastfeeding, Family Physicians Supporting (Position Paper)
https://www.aafp.org/about/policies/all/breastfeeding-support.html

Res. A-04-19

TITLE: **Requiring Gender Pronouns on Nametags at all AAFP Events**

Introduced by: Montida Fleming, MD and Anjana Sharma, MD, MAS

WHEREAS, transgender and gender non-conforming individuals are more likely to experience both explicit and implicit discrimination and abuse resulting in severe psychological stress and worse health outcomes due to their gender identity[1], and

WHEREAS, medical students, residents, and physicians who identify along the gender spectrum identify family medicine as one of the most inclusive specialties[2], and

WHEREAS, individuals who identify as transgender, gender non-conforming, or non-binary may have specific pronoun(s) to be used upon referencing their person that may or may not be readily assumed or known on presentation, and

WHEREAS, we as family physicians should strive to create a safe space for learning and collaboration among our community of diverse family doctors across the country without gender diverse individuals being subjected to marginalizing language, and

WHEREAS, having transgender and gender non-conforming individuals be the only participants to include their preferred pronoun is marginalizing, and

WHEREAS, in 2018, policy was created to ensure that at the National Conference of Constituency Leaders, the American Academy of Family Physicians (AAFP) will begin including preferred pronouns upon badges starting in 2019, and

WHEREAS, a resolution to allow registrants for all AAFP-sponsored events and conferences to select their own preferred pronouns of address to be visible on registrant badges appears to be an optional selection and therefore risks singling out trans or gender non-conforming individuals; therefore, be it

RESOLVED: That CAFP propose to the AAFP that they require all individuals to identify their preferred pronouns upon event registration to be printed on name badges at all AAFP-sponsored events and conferences starting in 2020.

Speaker's Notes:
This resolution does not represent an amendment or addition to existing CAFP or AAFP policy, in that it is not connected to legislative or policy efforts.

Fiscal Note:

The resource implications of this resolution are minimal, consisting of communication between CAFP and AAFP staff.

Citations:

1. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. The report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality, 2016.
2. Sitkin NA, Pachankis JE. Specialty choice among sexual and gender minorities in medicine: the role of specialty prestige, perceived inclusion, and medical school climate. LGBT Health. 2016;3(6):451–460.

No additional information provided by author.

Res. A-05-19

TITLE: **Statement of Commitment from California Family Medicine Residency Programs to Improve Resident Well-Being and Reduce Burnout**

Introduced by: Yasmin Bains, MSc, MS3, Touro University College of Osteopathic Medicine – California
Endorsements: Napa and Solano Chapters

WHEREAS, physician burnout increased significantly from 45.5% to 54.4% between 2011 and 2014.[1] This increase has been attributed to various factors such as; loss of autonomy in practice, loss of doctor-patient relationship, decreased continuity of care, mandated electronic health records, and student loan burden[1], and

WHEREAS, family physicians experience the highest rates of depression and burnout among all medical specialties[2], and

WHEREAS, the prevalence of burnout is greater among residents and fellows than among medical students, physicians, or college graduates of similar age[3,4], and

WHEREAS, American Academy of Family Physicians (AAFP) is addressing the issue of clinician burnout through its partnership with the National Academy of Medicine (NAM) by providing resources for physicians to develop resiliency while concurrently taking a systems-based approach[5], and

WHEREAS, AAFP alongside over 150 organizations, has formally committed to addressing burnout and promoting physician well-being through its "Statement on Commitment to Clinician Well-being and Resilience"[6], now, therefore be it

RESOLVED, that the California Academy of Family Physicians (CAFP), in conjunction with AAFP and NAM will urge family medicine residency programs to provide a statement of commitment, addressing plans of action to promote resident well-being and reducing burn-out in clinical training. Provisions in their plans of action should include but not be limited to:

1. Promote the resources already in place through the Physician Health First portal to help residents and their mentors identify each resident's goals, assess their well-being, plan and track progress (https://www.aafp.org/membership/benefits/physician-health-first/planner/get-started.mem.html)
2. Establish a wellness committee at each residency to engage all parties involved on the drivers of burnout specific to the program and workplace/personal strategies to promote well-being[7]
3. Improve access to and encourage residents to utilize mental health resources through residency training[8]
4. Encourage training and support through CAFP, AAFP, and NAM for Family Medicine Residency Program leadership on identifying and addressing resident burnout (ex. online workshops, conferences, and on-site consultations).

References:

1. Alexander, AG et al. Work–Life Balance, Burnout, and the Electronic Health Record. *The American Journal of Medicine*, 2018;131(8): 857-858
2. Medscape National Physician Burnout & Depression Report 2018
3. Dyrbye LN, West CP, Satele D, et al. Burnout among US medical students, residents, and early career physicians relative to the general US population. *Acad Med*. 2014;89(3):443–45
4. Hull, S.K., DiLalla, L.F. & Dorsey, J.K. Prevalence of Health-Related Behaviors Among Physicians and Medical Trainees *Acad Psychiatry*, 2008; 32: 31.
5. National Academy of Medicine. Action Collaborative of Clinician Well-Being and Resilience. https://nam.edu/initiatives/clinician-resilience-and-well-being/. Accessed January 6, 2019
6. National Academy of Medicine. AAFP on Commitment to Physician Well-Being and Resilience. https://nam.edu/wp-content/uploads/2017/10/American-Academy-of-Family-Physicians-Commitment-Statement.pdf. Accessed January 6, 2019
7. Shanafelt, Tait D. et al. Executive Leadership and Physician Well-being. *Mayo Clinic Proceedings*. 2017; 92 (1): 129 – 146
8. Maneesh, B. et al. Improving Resident Use of Mental Health Resources: It's Time for an Opt-Out Strategy to Address Physician Burnout and Depression. *Journal of Graduate Medical Education*. 2018; 10(1): 67-69

Speaker's Notes:
Existing CAFP and AAFP policy on family physician burnout, well-being and professional satisfaction is extensive and supports the passage of this resolution.

Fiscal Note:
The resource implications of this resolution are minimal for CAFP, consisting primarily of communication to family medicine residency programs via existing networks, such as the CAFP Residency Network (CRN) and CAFP communications. The resolution does not set out accountability or tracking of efforts by residency programs by CAFP, limiting CAFP action to 'urging' programs to create and implement plans.

The resource implications for family medicine residency programs, however, are more significant, especially establishing and supporting a wellness committee at each residency program. It is possible that the additional resource implications for residency programs will result in requests for support from CAFP.

PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this resolution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?
While systemic challenges contribute to the increasing rates of burnout in physicians, studies show that burnout starts in medical school and is prevalent throughout residency. Moreover, medical students who burnout in medical school are less likely to enter primary care and more likely to choose specialties which offer better work-life balance and flexible schedules. The AAFP has taken significant steps to address physician burnout through its collaboration with NAM and the initiative "Physician Health First". But, additional steps are necessary to engage Family Medicine Residency Programs to prioritize resident wellness and to address this issue which affects all levels of medical training.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?
All CAFP members, their patients, colleagues and families are affected by this proposed policy.

WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY, i.e., what action do you wish CAFP to take?
CAFP should advocate for physician-in-training wellness initiatives in place by AAFP and NAM, and support California residency programs to help navigate their unique challenges (individual, organizational, and work-place) with addressing resident burnout.

WHAT EVIDENCE EXISTS TO: 1) INDICATE THAT A PROBLEM EXISTS; OR 2) THAT THERE IS NEED FOR A NEW OR REVISED POLICY?
Please see above resolution statements and references for explanation.

Res. A-06-19

TITLE: **Improve access to healthcare for formerly incarcerated persons**

Introduced by: Hannah Dragomanovich, OMS-2; Touro University California College of Osteopathic Medicine, Alia McKean, OMS-2; Touro University California College of Osteopathic Medicine

Endorsements: Napa-Solano chapters

WHEREAS, in 2016 there were 2,131,000 incarcerated persons in the United States, of which 202,700 were in California[23]; and

WHEREAS, the prevalence of disease is extremely high among incarcerated persons; about 40% of inmates in American prisons and jails suffer from at least one chronic medical condition[24]; and

WHEREAS, a significant number of incarcerated persons are affected by mental illness, with 14.8% of federal inmates and 25.5% of state inmates having at least one mental health condition[2]; and

WHEREAS, annually, 626,000 incarcerated persons are released from state and federal correctional facilities, of which 36,000 persons are released in California[25]; and

WHEREAS, in the first two weeks after release, the risk of death among formerly incarcerated Americans is nearly 13 times higher than in the general population, with the leading causes of death being drug overdose, cardiovascular disease, homicide, and suicide[26]; and

WHEREAS, about 1 in 70 former inmates are hospitalized due to an acute condition within 7 days of release, and 1 in 12 are hospitalized within 90 days of release, which is significantly higher than in the general population[27]; and

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[23] Kaeble D, Cowhig M. Correctional Populations in the United States, 2016. US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. https://www.bjs.gov/content/pub/pdf/cpus16.pdf. Accessed Jan 3, 2019.

[24] Wilper AP, Woolhandler S, Boyd JW, et al. The health and health care of US prisoners: results of a nationwide survey. *Am J Public Health*. 2009;99(4):666-72.

[25] Carson, A. Prisoners in 2016. US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics https://www.bjs.gov/content/pub/pdf/p16.pdf. Accessed Jan 3, 2019.

[26] Binswanger IA, Stern MF, Deyo RA, et al. Release from prison--a high risk of death for former inmates. *N Engl J Med*. 2007;356(2):157-65.

[27] Wang EA, Wang Y, Krumholz HM. A high risk of hospitalization following release from correctional facilities in Medicare beneficiaries: a retrospective matched cohort study, 2002 to 2010. *JAMA Intern Med*. 2013;173(17):1621-8.

WHEREAS, formerly incarcerated persons face difficulties in maintaining continuity of care upon leaving prison or jail; in one study, only 32% of participants were released with a supply of their daily medications, and a mere 15% were released with their medical records[6]; and

WHEREAS, upon reentry to society, formerly incarcerated persons primarily rely on emergency medical services rather than primary care, though they require chronic care management for their complex health needs[28]; and

WHEREAS, the Transitions Clinic program presents a possible solution to this health disparity by offering patient-centered primary care to recently-released persons; community health workers with a personal history of incarceration perform case management for these patients and work with other organizations that also help address the social challenges surrounding reentry[29]; and

WHEREAS, a randomized controlled trial conducted at the Southeast Health Center, a Transitions Clinic in San Francisco, demonstrated a 14% reduction in emergency department use over 12 months, an average cost savings of $912 per patient[30]; and

WHEREAS, currently only 11 states have Transitions Clinic programs (CA, TX, WA, AR, AL, NC, MD, NY, MA, CT, RI); in California, there are only 8 clinics, most of which are centered around the Bay Area and Los Angeles, although the Transitions Clinic Network and the California Healthcare Foundation are implementing new programs throughout California[31]; and

WHEREAS, while Transitions Clinics exist in the Bay Area and Los Angeles, higher rates of Californians are being sent to prison from inland counties such as in the Central Valley and Northern Sacramento Valley[32]; and now, therefore be it

RESOLVED: That CAFP improve access to healthcare for formerly incarcerated persons following release by advocating for the creation of an agency that helps patients enroll in health insurance and establish care with a primary care provider prior to their release, and be it further

RESOLVED: That CAFP work with the California legislature to advocate for increased funding for the Transitions Clinic Program to further increase the number of clinics throughout the state, particularly in inland counties, and be it further

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[28] Wang EA, Hong CS, Shavit S, Sanders R, Kessell E, Kushel MB. Engaging individuals recently released from prison into primary care: a randomized trial. *Am J Public Health*. 2012;102(9):e22-9.

[29] California Health Policy Strategies. Reentry Health Policy Project: Meeting the Serious Health and Behavioral Needs of Prison and Jail Inmates Returning to the Community. http://calhps.com/reports/FINAL-REPORT-Revised-January-2018.pdf. Updated Jan 2018. Accessed Jan 3, 2019.

[30] Transitions Clinic Program. http://transitionsclinic.org/transitions-clinic-program/. Accessed Jan 3, 2019.

[31] Transitions Clinic Network Partners. http://transitionsclinic.org/locations/. Accessed Jan 3, 2019.

[32] Goss J, Hayes, J. California's changing prison population: Just the Facts (February 2018). *Public Policy Institute of California.* www.ppic.org/main/publication_show.asp. Accessed Jan 3, 2019.

RESOLVED: That CAFP refer this to AAFP for national action.

Speaker's Note:
AAFP has produced a position paper titled "Incarceration and Health: a Family Physician Perspective" (https://www.aafp.org/about/policies/all/incarcerationandhealth.html) containing considerations for care for the incarcerated. This paper does not focus on transitions in care for the formerly incarcerated.

Neither AAFP nor CAFP have specific policy on incarcerated prisoners or transitions in care for the formerly incarcerated. As a result, passage of this resolution would complement and enhance existing policy.

There are provisions within the resolution, specifically the provision calling for "creation of an agency that helps patients enroll in health insurance and establish care with a primary care provider prior to their release" that are potential duplicative of the role played by the state insurance exchange, Covered California, and the California Department of Health Care Services.

Fiscal Note:
The resource implications of this resolution may be significant and could exceed $30,000 in staff time. Cost would largely be incurred through advocating for the creation of a new state agency or function within an agency, and advocating for an increase in funding for the Transitions Clinic Program. Both advocacy efforts would require research, consultation with CAFP committees, and lobbying. The first of the provisions is complex, requiring comparison between the operational responsibilities and capacity of existing agencies. The second provision, because it involves increasing funding for an existing program as opposed to creation of a new program, has smaller resource implications. Minimal expense would be incurred as the result of referring to AAFP for national action.

PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this resolution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?
Formerly incarcerated persons represent a vulnerable population whose needs have yet to be addressed nationwide. These individuals experience a higher prevalence of chronic medical conditions and mental illness than the general population. However, formerly incarcerated persons lack appropriate case management upon release from correctional facilities, and are ultimately forced to seek medical care from the emergency department for acute conditions. By establishing a smoother transition into health care upon reentry to the community, we could improve their overall wellbeing and prevent exacerbations of chronic conditions, and help them integrate into society more seamlessly. Additionally, Transition Clinic programs provide culturally competent and integrated care, combining the efforts of

primary care physicians and case managers who are better equipped to manage complex cases. However, such clinics are in high demand and are lacking in areas that need them most.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?

There are 36,000 people released from California prisons and jails every year. These people need adequate medical care and would greatly benefit from a smoother transition upon release. Family physicians often take care of formerly incarcerated patients and could benefit from the care coordination and wrap-around services provided by Transitions Clinic Programs.

WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY, i.e., what action do you wish CAFP to take?

The CAFP should encourage state prisons and local jails to work with primary care providers to ensure that incarcerated persons are enrolled in a healthcare plan and are connected with a primary care provider or Transitions Clinic program prior to being released, thus ensuring continuity of care. Additionally, CAFP should work with legislators to increase funding for more Transition Clinic programs to be established in areas of need throughout California, particularly rural and inland counties. Finally, CAFP should encourage AAFP to adopt similar policies nationwide.

WHAT EVIDENCE EXISTS TO: 1) INDICATE THAT A PROBLEM EXISTS; OR 2) THAT THERE IS NEED FOR A NEW OR REVISED POLICY

Please see resolution statistics and statements for explanation of the problem.

PLEASE PROVIDE CITATIONS to support the existence of the problem and your proposed solution.

Please see footnotes.

Res. A-07-19

TITLE: Decriminalization of Abortion Provision

Introduced by: Ariel Franks, MD and Alison Block, MD

WHEREAS, the American Academy of Family Physicians (AAFP) supports efforts to protect physician autonomy and the patient physician relationship without unnecessary interference by legislative authorities[1], and

WHEREAS, one in four women in the United States will have an abortion by the age of 45[2], and

WHEREAS, several studies internationally show that access to safe abortion significantly decreases maternal morbidity and mortality[3], and

WHEREAS, the AAFP has resolved that it supports a woman's access to reproductive health services and opposes nonevidence-based restrictions on medical care and the provision of such services[4], and

WHEREAS, first trimester abortions have a very low rate of complications requiring hospitalization, approximately 0.5% or less[5], making them one of the safest office procedures physicians perform, and

WHEREAS, targeted regulation of abortion providers (TRAP) bills severely limit abortion providers, with provisions including but not limited to: requiring facilities providing abortion care meet the same standards as ambulatory surgical center[6], and prohibiting physicians from providing abortions if they do not have direct admitting privileges to or affiliation with a hospital[7], and

WHEREAS, studies have shown that there is no difference in the complication rates between procedures performed in outpatient clinics versus in ambulatory surgical centers[8], indicating these limitations are medically unnecessary, and

WHEREAS, physicians should act in the best interest of the patient using evidence-based practices, and this ethical practice should not be criminalized[9]; therefore be it further

RESOLVED: That the CAFP propose to the AAFP that they endorse all ACOG statements that oppose legislation that targets family doctors who provide abortion services, and

RESOLVED: That the CAFP propose that the AAFP issue a position paper against the practice of criminalizing physicians for providing abortion care.

Speaker's Note: While CAFP has not formally endorsed the American College of Obstetrics/Gynecology's statements, CAFP has extensive policy on reproductive health issues, including the policies below that refer to pregnancy and termination of pregnancy. Adoption of this resolution would not be in opposition to current policy.

Determination by the Board on the methods of "propose that the AAFP …" would be required.

TERMINATION OF PREGNANCY

The CAFP believes physicians should seek, through extensive education and patient counseling, to decrease the number of unwanted pregnancies. However, should a woman become pregnant, it is her legal right to make reproductive decisions, including the decision to carry the pregnancy to term or to have a safe, legal abortion.

The CAFP endorses the concept that abortion should be performed only by a duly licensed physician in conformance with standards of good medical practice as determined by the laws and regulations governing the practice of medicine in that locale.

No physician shall be compelled to perform any act which violates his/her good judgment or personally held moral standards. In these circumstances, the physician may withdraw from the case so long as the withdrawal is consistent with good medical practice.

The woman considering an elective abortion should be informed adequately of the potential health risks of both abortion and continued pregnancy. The physician should also provide to the pregnant patient either:

Information regarding: financial and other assistance available to her; financial and other assistance available to the child; and the availability of licensed and/or regulated adoption agencies; or

Resources where such information can be obtained. *COD 2/93*

TERMINATION OF PREGNANCY – EDUCATION

Support and recommend that programs offer training of medical students, residents and new physicians in the basic skills of termination of pregnancy, and encourage medical training institutions to provide such training.

Support the education of medical students, residents and new physicians regarding the need for physician providers of termination of pregnancy, and the medical and public health importance of access to safe termination of pregnancy.

Support the concept that no physician or other health professional shall be required to perform any act violative of personally held moral principles. *B-12-95, 1/95 CoD*

Recommend Family Medicine Residency Programs provide residents with annual up-to-date lectures in all evidence-based contraception and pregnancy options counseling. *B-7-05, 4/05 CoD*

Recommend Family Medicine Residencies consider adopting an “opt out” policy on abortion training, in which medication and aspiration abortion would be included in residency curriculum, but residents may choose not to participate if they are opposed to performing abortions. *B-7-05, 4/05 CoD*

CAFP endorses the principle that women receiving healthcare paid for through health plans funded by state or federal governments should be provided with access to the full range of reproductive options when facing an unintended pregnancy.

CAFP urges the AAFP to engage in advocacy efforts to overturn the Hyde Amendment that bans federal funding for abortions. *ER-02-08 CoD 3.8.08*

TERMINATION OF PREGNANCY – Access to Mifepristone**.** Joined a lawsuit by the American Civil Liberties Union against the Food and Drug Administration (*Graham T. Chelius, MD on behalf of himself and his patients; Society of Family Planning, on behalf of its members and their patients; California Academy of Family Physicians, on behalf of its members and their patients; and Pharmacists Planning Services Inc., on behalf of its members and their patients v. Don J. Wright, MD, MPH, in his official capacity as Acting Secretary, United States Department of Health and Human Services, et al)* to discontinue the REMS on mifepristone. *4/17 BoD*

*REMS / MIFSPRISTEONE***.** The California Academy of Family Physicians (CAFP) endorses the principle that the REMS classification on mifepristone is not based on scientific evidence and limits access to abortion care. *BoD 4.12-13.18*

Fiscal Note: These actions would have minimal fiscal requirements.

Citations:

1. American Academy of Family Physicians. Infringement on Patient Physician Relationship. https://www.aafp.org/about/policies/all/infringement-relationship.html
2. Jones RK, Jerman J. Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014. Am J Public Health. 2017;107(12):1904-1909.
3. Haddad LB, Nour NM. Unsafe abortion: unnecessary maternal mortality. Rev Obstet Gynecol. 2009;2(2):122-6.
4. American Academy of Family Physicians. Congress of Delegates. Resolution No. 504: Support the Women's Health Protection Act. https://www.aafp.org/about/governance/congress-delegates/previous/2014/resolutions/newyork-c.mem.html
5. White K, Carroll E, Grossman D. Complications from first-trimester aspiration abortion: a systematic review of the literature. Contraception. 2015;92(5):422-38.
6. Guttmacher Institute. Targeted Regulation of Abortion. January 2019. ***Guttmacher Institute*** (https://www.guttmacher.org; https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers)
7. see endnote 5.
8. Roberts SCM, Upadhyay UD, Liu G, et al. Association of Facility Type With Procedural-Related Morbidities and Adverse Events Among Patients Undergoing Induced Abortions. JAMA. 2018;319(24):2497-2506.
9. American Academy of Family Physicians. Criminalization of the Medical Practice. https://www.aafp.org/about/policies/all/criminalization.html

No Additional Information Provided by the Author

Res. A-08-19

TITLE: Mifepristone Use in Early Pregnancy Loss Management

Introduced by: Jennifer Sneden, MD; Danielle Wisniewski, MD; Emily Guh, MD; Lauren Wondolowski, MD

WHEREAS, the American Academy of Family Physicians (AAFP) supports a woman's access to reproductive and maternity health services and opposes nonevidence-based restrictions on medical care and the provision of such services (2014 COD); and

WHEREAS, early pregnancy loss is the most common complication of early pregnancy, affecting 10-20 percent of all clinically recognized pregnancies, with most occurring before 12 weeks gestation[1-2] ; and

WHEREAS, patients consider many factors when choosing between miscarriage management options, and they report higher levels of satisfaction of their care when treated according to their preferences [3]; and

WHEREAS, a recent high quality randomized-controlled trial demonstrated that a single dose of mifepristone prior to misoprostol is superior to misoprostol alone for medical management of early pregnancy loss without increasing the rate of serious adverse events,[4]; and

WHEREAS, women receiving mifepristone had lower rates of uterine aspiration required for treatment failure than women receiving misoprostol alone and completion of their medication abortion was therefore more timely and cost-effective, [5-6]; and

WHEREAS, the American College of Obstetricians and Gynecologists updated its protocol for medical management of early pregnancy loss in November of 2018 to recommend that "a dose of mifepristone (200mg orally) before misoprostol administration should be considered when mifepristone is available" as the standard of care for medical management of EPL and supports improving access to mifepristone for reproductive health indications, including for medical management of early pregnancy loss [7]; and

WHEREAS, the current US Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategy (REMS) and Elements to Assure Safe Use (ETASU) requirements of mifepristone limit access to mifepristone by making it difficult for providers to purchase and prescribe the medication for office-based treatments; and

WHEREAS, in 2018 AAFP resolved to endorse the principle that the REMS classification on mifepristone is not evidence-based and resolved to engage in advocacy and lobbying efforts to overturn the REMS classification on mifepristone to improve access to reproductive health care [8]; and

WHEREAS, the *American Family Physician* current guidelines and education on management of early pregnancy loss do not include the use of mifepristone for medical management [9]; therefore be it further

RESOLVED: The California Academy of Family Physicians (CAFP) instruct its AAFP delegates to submit a resolution to the 2019 AAFP Congress of Delegates to support the safety and efficacy of mifepristone as the most evidence-based care for medical management of EPL; and

RESOLVED: That the CAFP instruct its AAFP delegates to submit a resolution to the 2019 AAFP Congress of Delegates to reaffirm its efforts to overturn restrictions on the prescribing of Mifepristone, especially in light of data supporting its use in early pregnancy loss; and

RESOLVED: That the CAFP instruct its AAFP delegates to submit a resolution to the 2019 AAFP Congress of Delegates to recommend that early pregnancy loss management be included in the Family Medicine Experience (FMX) and *American Family Physician* topics on a rotational basis.

Speaker's Note: CAFP has policy on the use of mifepristone as follows:
The California Academy of Family Physicians (CAFP) endorses the principle that the REMS classification on mifepristone is not based on scientific evidence and limits access to abortion care. *BoD 4.12-13.18*
This resolution is an extension of current policy and is supported by evidence-based studies and practice.

Your CAFP delegation, and other state chapters introduced a resolution to the AAFP Congress of Delegates in 2018 calling for the removal of the REMS for mifepristone. The resolution was adopted.

TERMINATION OF PREGNANCY – Access to Mifepristone
Joined a lawsuit by the American Civil Liberties Union against the Food and Drug Administration (*Graham T. Chelius, MD on behalf of himself and his patients; Society of Family Planning, on behalf of its members and their patients; California Academy of Family Physicians, on behalf of its members and their patients; and Pharmacists Planning Services Inc., on behalf of its members and their patients v. Don J. Wright, MD, MPH, in his official capacity as Acting Secretary, United States Department of Health and Human Services, et al)* to discontinue the REMS on mifepristone. *4/17 BoD*

Fiscal Note: Adoption of this resolution would have minimal fiscal requirements for staff time to related to submitting an AAFP resolution.

SUBMITTED BY THE AUTHOR

Citations:

1. Wilcox AJ, Weinberg CR, O'Connor JF, Baird DD, Schlatterer JP, Canfield RE, et al. Incidence of early loss of pregnancy. *N Engl J Med* 1988;319:189–94.
2. Wang X, Chen C, Wang L, Chen D, Guang W, French J. Conception, early pregnancy loss, and time to clinical pregnancy: a population-based prospective study. *Fertil Steril* 2003;79:577–84.

3. Wieringa-De Waard M, Hartman EE, Ankum WM, Reitsma JB, Bindels PJ, Bonsel GJ. Expectant management versus surgical evacuation in first trimester miscarriage: health-related quality of life in randomized and non-randomized patients. *Hum Reprod* 2002;17:1638–42.
4. Schreiber, C. A. *et al.* Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss. *N. Engl. J. Med.* **378**, 2161–2170 (2018).
5. Westhoff, C. L. A Better Medical Regimen for the Management of Miscarriage. *N. Engl. J. Med.* **378**, 2232–2233 (2018).
6. Strand, E. A. Increasing the management options for early pregnancy loss: the economics of miscarriage. *Am. J. Obstet. Gynecol.* **212**, 125–126 (2015).
7. ACOG Practice Bulletin No. 200: Early Pregnancy Loss. *Obstet Gynecol* (2018).
8. AAFP Resolution No. 505. Removing REMS Categorization on Mifepristone. AAFP Congress of Delegates (2017).
9. Prine, L. & Macnaughton, H. Office Management of Early Pregnancy Loss. *American Family Physician*. Vol 84 No 1. (2011)

Res. A-09-19

Title: **Clear Communication and Upholding the Social Contract When Responding to Patients with Terminal Illness and/or Existential Distress**

Introduced by: Clarissa Kripke, MD, FAAFP

WHEREAS, California is a majority-minority state with high rates of racial, ethnic, cultural, linguistic, educational and religious diversity, and

WHEREAS, misunderstanding of prescriptions and other information and instructions given by physicians is extremely common, and

WHEREAS, there is evidence that explicit information leads to better comprehension, and,

WHEREAS, using a euphemism such as "medical-aid-in-dying" is subject to misinterpretation, and

WHEREAS, California Academy of Family Physicians (CAFP) members treat many people for whom English is a second language or who require translators, and

WHEREAS, California's End of Life Option Act (EOLOA) requires medical translators to assess a patient's understanding, a requirement which is outside their scope of practice and which violates their ethical commitments, and

WHEREAS, CAFP members treat many people from cultures which de-emphasize individual self-determination in medical decision-making and who are deferential to the opinions and needs of authority figures, physicians, or family members, and

WHEREAS, regardless of prognosis, prescribing drugs with the intention of hastening a patient's death violates long-standing, medical ethical principles and is illegal in most states, and

WHEREAS, the recent change in California's law authorizing physicians to prescribe lethal drugs to terminally ill patients does not represent a change in best practice or ethics, and

WHEREAS, the prohibition against harming or intentionally hastening the death of a patient is a key boundary which supports the trust required for an effective doctor-patient relationship, and

WHEREAS, a patient doesn't have to request or receive a lethal prescription to have their care negatively affected by physicians or physician organizations exposing the belief that some people are better off dead, and

WHEREAS, prescribing lethal drugs is neither best practice nor consistent with long standing medical ethics as a response to patients who express existential distress, now, therefore be it

RESOLVED: that CAFP rescind policy A-07-17, and be it further

RESOLVED: that CAFP reaffirm and recommit to implement CAFP's existing policy on End-of-Life Care which describes appropriate responses to patients who express existential distress, and be it further

RESOLVED: that CAFP include representatives of vulnerable populations when developing and delivering CME on End-of-Life Care.

Speaker's Notes: Pursuant to CAFP bylaws, resolution A-07-17 was submitted to the Board for review in July 2017. The resolution called for the American Academy of Family Physicians (AAFP) to reject the term "assisted suicide" to describe the process whereby terminally ill patients of sound mind ask for and receive prescription medication they may self-administer to hasten death should their suffering become unbearable. It acknowledged that use of medical aid in dying is an ethical, personal end-of-life decision that should be made in the context of the doctor patient relationship, and asked AAFP to submit a resolution to the House of Delegates of the American Medical Association that calls on that organization to: 1) reject use of the term "assisted suicide" when referring to the practice of medical aid-in-dying; and 2) modify its current policy with language that recognizes medical aid-in-dying as an ethical end-of-life option when practiced where authorized and according to prescribed law.

The CAFP Board considered and passed the resolution at the July 2017 Board meeting and reported on the resolution at the CAFP All Member Advocacy Meeting in March 2018.

The CAFP AAFP delegation took action on the policy as called for in the resolution by submitting to the AAFP: Resolutions 403: Medical Aid in Dying Is an Ethical End of Life Option and 405: Reject "Assisted Suicide" Terminology in Aid in Dying to the 2018 Congress of Delegates. Both resolutions were adopted with substitute language. AAFP's new policies are:

> That the American Academy of Family Physicians acknowledge that use of medical aid-in-dying is an ethical, personal end-of-life decision that should be made in the context of the doctor-patient relationship.
>
> That the American Academy of Family Physicians seek to modify the current American Medical Association (AMA) policy on end-of-life care with language that recognizes medical aid-in-dying as an ethical end-of-life option when practiced where authorized and according to prescribed law.
>
> That the American Academy of Family Physicians reject the term "assisted suicide" to describe the process whereby terminally ill patients of sound mind ask for and receive prescription medication they may self-administer to hasten death should their suffering become unbearable.
>
> That the American Academy of Family Physicians urge the American Medical Association (AMA) and its CEJA to reject use of the term "assisted suicide" when referring to the practice of medical aid-in-dying.

In response to submission of a subsequent resolution to the CAFP Board on communicating Board actions to the membership, the Board reviewed the process by which A-07-17 was reviewed and passed, and concluded it had acted in accordance with CAFP Bylaws.

Also of note, CAFP's Committee on Continuing Professional Development (CCPD) has been actively engaged in the development and implementation of EOL educational activities, including, but not limited to, the EOLOA, palliative care for primary care and documenting advanced directives and advance care planning. The CCPD would welcome engagement from representatives of vulnerable populations for review of current resources and development of new ones.

Fiscal Note:
The resource implications of rescinding policy, reaffirming existing policy and seeking input from representatives of vulnerable populations are likely to be minimal. If the CAFP Board determines that passage of this resolution also requires advocating against previously passed policy at AAFP, more significant staff costs may be incurred.

SUBMITTED BY THE AUTHOR

PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this resolution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?
A therapeutic doctor-patient relationship requires trust and clear communication. Trust requires boundaries. Physicians are human and subject to unconscious biases, just like everybody else. Our personal beliefs and experiences impact the care we provide. They inform the words and frameworks we use to counsel patients. Patients also internalize negative messages from family and friends, media, and trusted authority figures. When people make life and death decisions about their health care, they are influenced by the opinions of their doctors and the policies of professional organizations. There is an inherent power differential in the doctor-patient relationship. Managing that power differential requires extraordinary care. The most important boundaries are to do no harm, seek informed consent, and avoid intentionally hastening a person's death. CAFP policy A-07-17 commits CAFP to change these core ethical principles, and to obscure that fact by using misleading language to talk about it.

Timeline and context:

In March of 2015 Resolution A-07-15, "Death with Dignity and End of Life Options for People with Terminal Illnesses" was submitted. The authors of the California End of Life Option Act legislation were invited to present at the All Member Advocacy meeting to seek CAFP's support for the legislation. Significant concerns about the resolution were raised. No members, aside from the authors of the resolution, testified in favor. The CAFP board declined to adopt it, and instead adopted a new policy on end-of-life care.

In June 2016, the End of Life Option Act was passed in California in a special session on health care funding. It was passed without full debate. It's legal status has been challenged both on the basis of the process by which it was passed, and the substance of the law. It is making its way slowly through the courts and its future is uncertain.

In 2017, the same author who submitted A-07-15, submitted a new resolution, entitled, "Medical Aid-in-Dying Is not 'Assisted Suicide'". The resolution was received by the board after the 2017 All Member Advocacy Meeting. Without notification or input from the membership, the CAFP board adopted it as Resolution A-07-17. The policy:

1. requires CAFP to use a confusing and misleading euphemism when discussing prescriptions of lethal drugs to terminally ill patients

2. directs the Academy to declare physician assisted suicide, "ethical"

3. requires CAFP to represent physician assisted suicide as a personal, private matter, instead of a societal issue which impacts social policy and vulnerable populations

4. changes the social contract between CAFP physicians and the public

3. directs CAFP to disseminate these ideas and values to the national AAFP organization

The risks of this policy change, especially for vulnerable populations, deserves to be discussed by the full membership, in an open forum. Because CAFP members represent a privileged group who may not be fully aware of the concerns and experiences of less privileged populations, before considering such an important policy change, members must have the opportunity to educate themselves about the ethical and practical concerns that impact the people they serve.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?

All CAFP members treat diverse populations including vulnerable populations. Proponents of physician-assisted suicide emphasize that the numbers of people who request lethal prescriptions are small, and few requests come from members of vulnerable populations. It is true that the potential *benefit* of CAFP's current policy is limited to a small number of relatively, educated, privileged people. However, the potential *harm* is much broader. Once physicians and the public accepts the premise that some people's lives are so burdensome, tragic, full of suffering, meaningless, hopeless, and undignified that they would be better off dead, the logical corollary is that ending their lives can be considered an act of mercy. This opens the door to a variety of abuses:

- proposing suicide as a solution to people who are experiencing existential distress or who are in untenable social or economic situations
- secondary gain
- premature withdrawal of life saving care for people with disabilities based on false assumptions about quality of life
- explicit or implicit messages that people have a responsibility to die to relieve family, insurance providers, health care providers, or taxpayers
- expansion to people who have existential distress but no terminal illness
- expansion to active euthanasia of adults and children with and without consent

WHAT SPECIFIC SOLUTIONS ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY:
Prior to adopting A-07-17, CAFP's board implemented sound policy on end-of-life consistent with medical ethics and values. I propose that the board could simply rescind A-07-17 and reaffirm its commitment to that policy. (The text of the relevant CAFP policies are listed at the end of the resolution.)

WHAT EVIDENCE EXISTS TO 1) 1) INDICATE THAT A PROBLEM EXISTS; OR 2) THAT THERE IS NEED FOR A NEW OR REVISED POLICY?
Efforts to normalize assisted suicide and the ethical justifications are of particular concern to the disability community. Proponents of the practice frequently cite fear of being disabled as the primary reason that they feel that life is not valuable. This is obviously a threat to people with disabilities who value their own lives and whose opportunities and access to care is limited by false assumptions about their quality of life. Belief that living with disability means poor quality of life, easily becomes a self-fulfilling prophesy. For example, one early adopter of the end of life option act reported that he prescribed a patient a lethal prescription because she was despondent due to being "bed bound." A more appropriate response would have been to provide her a Hoyer lift, wheelchair, aide and transportation.

Instead of lethal prescriptions, people with loss of function due to chronic disease and terminal illness need:

- services and supports
- home modifications
- transportation
- personal assistance
- person-centered planning
- support for decision-making that allows them to continue to direct their lives to the extent possible
- help maintaining their circle of support
- friends
- inclusion
- support to participate in family and community

What they are typically offered is primarily medical treatments to cure disease or manage symptoms. This is important, but not sufficient. There is consensus that people shouldn't be coerced into ending their lives because of lack of access to the support and care they need. We are a long way from providing it, even to people with significant social capital and financial resources.

More information about the concerns of the disability community can be found at:

- Disability Rights and Education Fund: Assisted Suicide Laws: https://dredf.org/public-policy/assisted-suicide/
- Euthanasia Blues: https://www.youtube.com/watch?v=8Mwj8TUrbWg

- Facts about disability and quality of Life: https://www.independentliving.org/docs3/gill99.html
- Not Dead Yet: https://notdeadyet.org/not-dead-yets-articles
- Panel on Societal Issues and the End of Life Option Act https://www.youtube.com/watch?v=FHIdQLo_8QA&list=PLPdSQGGMt89eDiKtQtbZmgGmWA8aWMU4Z&index=5&t=0s

PLEASE PROVIDE CITATIONS:

1. Carr, L. Legalising assisted dying is dangerous for disabled people. Not compassionate. Sept. 9, 2016. The Guardian. https://www.theguardian.com/commentisfree/2016/sep/09/legalising-assisted-dying-dangerous-for-disabled-not-compassionate
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3. Davis, T. C., Federman, A. D., Bass, P. F., 3rd, Jackson, R. H., Middlebrooks, M., Parker, R. M., & Wolf, M. S. (2009). Improving patient understanding of prescription drug label instructions. *J Gen Intern Med, 24*(1), 57-62. doi:10.1007/s11606-008-0833-4
4. Kheriaty, A. The dangerously contagious effect of assisted-suicide laws. Washington Post. Nov 20 2015. https://www.washingtonpost.com/opinions/the-dangerously-contagious-effect-of-assisted-suicide-laws/2015/11/20/6e53b7c0-83fb-11e5-a7ca-6ab6ec20f839_story.html?noredirect=on&utm_term=.8b0d94026b4f
5. Kripke, C. Patients with Disabilities. Avoiding Unconscious bias when discussing Goals of Care. 2017. American Family Physician. https://www.aafp.org/afp/2017/0801/p192.pdf
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7. Tolle, S., Tilden, V.P., Drach, L.L. Characteristic and Proportion of Dying Oregonians who Personally Consider Physician-Assisted Suicide. J of Clin. Ethics. 2004.15(2): 111-2.
8. US Census Quick Facts, California: https://www.census.gov/quickfacts/fact/table/ca/PST045217

Res. A-07-17 – Medical Aid-in-Dying Is Not "Assisted Suicide"
RESOLVED, That the American Academy of Family Physicians reject the term "assisted suicide" to describe the process whereby terminally ill patients of sound mind ask for and receive prescription medication they may self-administer to hasten death should their suffering become unbearable, and be it further

RESOLVED, That the American Academy of Family Physicians acknowledge that use of medical aid in dying is an ethical, personal end-of-life decision that should be made in the context of the doctor patient relationship, and be it further

RESOLVED, that the American Academy of Family Physicians submit a resolution to the House of Delegates of the American Medical Association that calls on that organization to: 1) reject use of the term "assisted suicide" when referring to the practice of medical aid-in-dying; and 2) modify its current

policy with language that recognizes medical aid-in-dying as an ethical end-of-life option when practiced where authorized and according to prescribed law. *BOD 11.4.17*

End-of-Life Care EXT
CAFP recognizes the need for appropriate end-of-life care, which may include:
Appropriate treatment of physical pain, recognizing that in some cases such treatment may hasten the end of life; Compassionate care which is interpersonal, existential or spiritual, and may include working together with social workers, hospice, clergy, family and friends; and Eliciting and addressing a patient's reasons for considering physician aid-in-dying. Only through dialogue can family physicians, their patients and society as a whole continue to explore what is reasonable and morally appropriate. The highest-quality health care is an outgrowth of a partnership between the patient, the family and the health professional or professional team.

Within the context of this continuing relationship, family physicians must seek the underlying causes of suffering at the end of life, and then aggressively implement measures to correct them. Appropriate education in palliative care and medical management, advanced communication skills to discover the patient's wishes and value choices, and appropriate sharing of decision-making with the patient and the patient's family can go a long way toward alleviating suffering and improving care at the end of life. Family physicians should continue to provide assistance in dealing with dying patients' symptoms, needs and fears.

NOTE: This policy was adopted by the CAFP Board of Directors 4.24.15 as part of the Legislative Affairs Committee Report and replaces policies under the topic of TERMINAL ILLNESS including Compassionate Care RC-1-00, 2/00 Cod, Physician-Assisted Suicide RC-1-00, 2/00 CoD, Statement on Terminal Illness Care 5/93 BoD and Terminal Illness and Physician-Assisted Death A-10-96 CoD. CAFP took a neutral position on pending legislation to enact the End of Life Options Act in 2015.

B-13-18 Open, Member-Driven Process for Policy Development for CAFP

RESOLVED: That a process for obtaining member comments and input on resolutions received between meetings of the All Member Advocacy Meeting be developed; and be it further

RESOLVED: That CAFP members have an opportunity to comment on and provide input into the proposed new process for soliciting member input on resolutions received between meetings of the All Member Advocacy Meeting for consideration by the Board of Directors before such a policy is adopted;

Res. A-10-19

TITLE: **Inappropriate Use of CDC Guidelines for Prescribing Opioids**

Introduced by: Romero Santiago, MD, MPH
Endorsements: CAFP Student and Resident Councils

WHEREAS, in response to the epidemic of opioid diversion, misuse, addiction, overdoses, and overdose deaths, the National Centers for Disease Control and Prevention issued the CDC Guidelines on Opioid Prescribing; and

WHEREAS, this document was intended as a guide to improved medical practice and to serve as a tool for prevention, and was specifically designed to address opioid prescribing outside of cancer care or end-of-life care; and

WHEREAS, there is concern that while the CDC Guidelines can assist in reducing excessive prescribing of opioids for persons not already on opioids, there is not clear guidance regarding the management of patients who are already on high-dose opioid therapy for chronic non-malignant pain who may be passed on from one practitioner to another; and

WHEREAS, the CDC Guidelines appropriately suggest non-opioid alternatives to be utilized before the initiation of opioid therapy and also mention levels of opioid prescribing such as Morphine Milligram Equivalents (MMEs) which there is a demonstrated correlation with adverse clinical scenarios; and

WHEREAS, some licensure boards have taken the approach that a licensed health professional with prescribing privileges is practicing below the community standard for quality care if they prescribe opioids in excess of the MME levels mentioned in the CDC Guidelines; and

WHEREAS, some legislatures have taken actions to criminalize certain medical practices to the extent that a physician may be liable for criminal prosecution if he/she were to prescribe opioids in amounts that exceed the MME levels mentioned in the CDC Guidelines; and

WHEREAS, upon discovering that any physician who prescribes methadone or buprenorphine products for the treatment of addiction involving opioid use are going to be prescribing MMEs that exceed the threshold levels mentioned in the CDC Guidelines, the American Society of Addiction Medicine crafted a Public Policy Statement stating that buprenorphine and methadone doses for the maintenance treatment of addiction should not be “counted” as a “violation” of the MME equivalents of the CDC Guidelines or of other practice edicts or state statutes; and

WHEREAS, some national pharmacy chains have recently generated letters to physicians informing them that they plan to scrutinize incoming prescriptions and at times will not fill a prescription that calls for an opioid dosage that exceeds the CDC Guidelines threshold; and

WHEREAS, such decisions by pharmacies or pharmacists can interfere with the practice of medicine and interfere with good quality patient care by numerous types of physicians ranging from family physicians to oncology and palliative care physicians, when the pharmacy refuses to fill a legally written prescription; and

WHEREAS, the CDC Guidelines should be utilized as informational and should not be misused as standards of care, especially given that we as family physicians are the primary managers of chronic pain patients longitudinally; therefore be it

RESOLVED: That our California Academy of Family Physicians (CAFP) applaud the Centers for Disease Control and Prevention (CDC) for its efforts to prevent the incidence of new cases of opioid misuse, addiction, and overdose deaths, and be it further

RESOLVED: That our CAFP affirms that no entity should use MME (morphine milligram equivalents) thresholds as anything more than guidance, and physicians should not be subject to professional discipline, loss of board certification, loss of clinical privileges, criminal prosecution, civil liability, or other penalties or practice limitations solely for prescribing opioids at a quantitative level that prescribing the MME thresholds found in the CDC Guideline, and be it further

RESOLVED: That our CAFP affirms that some patients with acute or chronic pain can benefit from taking doses of opioid pain medications at doses greater than generally recommended in the CDC Guideline for Prescribing Opioids for Chronic Pain and that such care may be medically necessary and appropriate, and be it further

RESOLVED: That our CAFP advocate against misapplication of the CDC Guideline by pharmacists, health insurers, pharmacy benefit managers, legislatures, and governmental and private regulatory bodies in ways that prevent or limit patients' medical access to opioid analgesia, and be it further

RESOLVED: That our CAFP collaborate with the AAFP and other medical societies such as the AMA to communicate with the nation's largest pharmacy chains to recommend that they stop writing threatening letters to physicians including family physicians and stop presenting policies, procedures and directives to retail pharmacists that encourage denial of prescriptions for opioids that exceed certain numerical thresholds without taking into account the diagnosis and previous response to treatment for a patient and any clinical nuances that would support such prescribing as falling within standards of good quality patient care

Speaker's Note: While CAFP does not have specific policy addressing the Centers for Disease Control's Guidelines for Prescribing Opioids, the CAFP, as a founding partner of the Collaborative for Risk Evaluation and Mitigation Strategies (REMS) Education (CO*RE), has been actively engaged in physician and clinician education on prescribing opioids, including, not limited to education that meets the Food and Drug Administration's Blueprint for REMS. The CO*RE curriculum has been adapted to include the CDC guidelines, and several CAFP leaders are members of the master faculty.

The call for affirmation of policy related to prescribing and professional discipline require additional definition. It is not clear if the resolution calls for a simple affirmation of CAFP policy or affirmation outside of CAFP.

Fiscal Note:
The resource implications of passage of this resolution could be considerable, potential resulting in significant staff costs. These costs include but are not limited to:

- Staff time and potential contractor time for advocating against misapplication of the CDC Guideline by private and public entities.
- Staff time, travel, and other expenses associated with collaborating with the AAFP and other medical societies to communicate with the nation's largest pharmacy chains.
- Potentially researching and developing policy.

There would be minimal fiscal implication for adopting the first resolved related to praising the CDC's efforts.

SUBMITTED BY THE AUTHOR

References:

1) https://www.cdc.gov/drugoverdose/prescribing/guideline.html
2) https://www.statnews.com/2018/12/06/overzealous-use-cdc-opioid-prescribing-guideline/
3) https://www.fightcancer.org/releases/final-cdc-opioid-prescribing-guideline-could-have-unintended-consequences-cancer-survivors

Elections

CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

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PRESENT: Michelle Quiogue, MD, Chair; Drs. Asma Jafri, Monique Thompson, Steven Harrison, and Anthony Chong; Ms. Lisa Folberg, CAFP Staff

NOT PRESENT: Tonatzin Rodriguez, MD

1. Call to Order
2. CAFP Open 2019-2020 Positions
    a. President-elect 2019-20
    b. Speaker 2019-20
    c. Vice Speaker 2019-20
    d. AAFP Delegate 2019-20
    e. AAFP Alternate Delegate 2019-20
    f. One Nominating Committee member for 2019-20 from the AMAM (two-year terms)
    g. Secretary/Treasurer 2019-20 (one-year term) – recommendation only to the CAFP Board of Directors
3. Nominations: Committee unanimously agreed to recommend the following:

Office	Incumbent	Nominee
Elected by Delegates at the All Member Advocacy Meeting		
President-elect	Walter Mills, MD, MBA (ineligible)	David Bazzo, MD
Speaker	David Bazzo (eligible)	Shannon Connolly, MD
Vice-Speaker	Shannon Connolly, MD (eligible)	Lauren Simon, MD
AAFP Delegate (2019-20)	Jeffrey Luther, MD (eligible)	Jeffrey Luther, MD
AAFP Alt. Delegate (2019-20)	Jay Lee, MD (eligible)	Jay Lee, MD
Nominating Committee (2019-20)*	Tonatzin Rodriguez, MD	Tonatzin Rodriguez, MD
Elected by and from the Board		
Secretary-Treasurer (2019-20)	Lauren Simon, MD (ineligible)	Raul Ayala, MD

4. *The All Member Advocacy Meeting (AMAM) now nominates and elects a total of three members of the Nominating Committee from the AMAM Delegates (additional member added at 1996 Congress of Delegates and bylaws change approved at 1997 Congress); two are elected for two-year terms in one year, and one is elected for a two-year term the next. Nominations may be made from the floor, although there is no written prohibition on recommendations from the Nominating Committee, and traditionally, such recommendations have been made. A list of the 2017 Delegates and Alternates is attached; we have not yet compiled the 2018 list because the deadline for submission of names of Delegates and Alternates is December 18.

5. **Adjournment**

Candidates' Statements

For the Office of President-elect – David Bazzo, MD

I came to you last year asking for the privilege to represent you as Speaker for Californian Academy of Family Physicians (CAFP) and you placed your trust in me. I am asking you to do so again. CAFP is second to none when it comes to representing the needs and interests of family physicians in advocating to optimize our ability to help our patients. The politics of our State and Nation have enormous impact on our capacity to keep our patients healthy. And, as with any process, unless you have a seat at the table, your opinion is not heard. Well, through the work of your CAFP, your voices are heard – Your interests are represented. The members of the board do have influence and work on your behalf to ensure that physicians have a say on the future practice of medicine. I am proud of my membership and position on the board and view it an honor to volunteer to help our organization. I ask that you continue to place your trust in me to serve our organization by supporting my election. Thank you.

For the Office of Speaker – Shannon Connolly, MD

As a member of CAFP since I was a medical student, I have "grown up" within this organization and learned from my colleagues and my own experiences that family medicine is both the most difficult and most rewarding job in the world. Our daily work is as varied and diverse as the patients that we serve, but we are connected by our love of medicine and our commitment to ensuring our patients receive high quality compassionate care. I truly believe family doctors have a perspective on the communities they serve that is invaluable in shaping modern health care delivery. It would be my honor to serve as your Speaker where I will work to ensure that that perspective is heard as I advocate for you and your patients.

For the Office of Vice Speaker – Lauren Simon, MD, MPH

I am honored by your nomination for the office of CAFP Vice -Speaker. In the past two decades I have been actively involved in CAFP and have developed a keen awareness about issues that affect us as family physicians, our patients, our communities and our medical learners.

Within CAFP I have focused on the areas of advocacy, pipeline and medical education. In those areas I have served/currently serve on the CAFP Board of Directors (2006-2012 and 2015 to present) and currently serve as CAFP Secretary-Treasurer (2018-19) and Co-chairperson the Inland Empire Region of the CAFP California Residency Network (CRN), 2014-present. I am familiar with the duties of the Vice-Speaker through my work on the CAFP Board and from my attendance at the CAFP All Member Advocacy Meeting (AMAM)where I have served as Delegate or Alternate Delegate, from 2000-present. Additionally, I served as CAFP Alternate Delegate to the California Medical Association House of Delegates in 2016.

I have enjoyed participating in lifelong learning for current and future family physicians through serving on the CAFP Foundation Board of Trustees; developing the clinical research poster competition; presenting lectures and producing written and electronic continuing medical education (CME) for CAFP CME offerings. These activities have only added to the joy I feel as a Family Physician and increased the opportunities to work with others who share my love for our specialty and the compassionate care we provide for the people in our communities.

For the Office of AAFP Delegate 2019-2020 – Jeffrey Luther, MD

I am honored to be nominated to the position of Delegate to the AAFP for 2019-20. My first experiences in organized medicine took place at our own Congress of Delegates starting back in the mid-nineties. While serving as a CAFP Delegate or Alternate Delegate over the intervening years I developed a deep appreciation for the potential of such policy-making bodies to understand and address issues that affect us, as family physicians, our patients and our communities.

Building on this, serving as AAFP Alternate Delegate for five years and then as Delegate for the last five has given me the opportunity to learn from my colleagues (from California and elsewhere) and has given me an even greater appreciation for what can and needs be done at the national level. From health care reform to reproductive rights, medical education to Academy leadership, there are many, at times divergent, perspectives even within our specialty, and that of California needs to be presented clearly and effectively. My time in the AAFP Congress has also enabled me to forge relationships with colleagues from other state chapters and with national leaders, relationships that are critical in representing our priorities to the national academy. I look forward to continuing this work as your AAFP Delegate, and I thank you for the opportunity.

For the Office of AAFP Alternate Delegate 2019-2020 – Jay Lee, MD

Representing the voice of Californians at the American Academy of Family Physicians Congress of Delegates (AAFP CoD) is more important than ever. There are many threats to and opportunities for delivering high-quality, patient-centered in our nation's broken health care system. As family physicians, we must use our collective voices to help shape the policy landscape upstream from the distal end of the delivery system where we see our patients and serve our communities. Otherwise, we risk losing our ability to impact lives. The AAFP CoD, as family medicine's policymaking body, is that platform for change.

I would be honored to continue serving as your California Alternate Delegate to the AAFP CoD. As a past president of the California Academy of Family Physicians and as a past convener of the AAFP National Conference of Constituency Leaders, I have the experience and have built the relationships to be an effective policymaking voice for our members and the patients we serve. And as a fellow family medicine revolutionary, I have the passion to move the policy vector towards justice. Thank you for the opportunity serve you in this capacity!

For the Office of Nominating Committee Member 2018-2019 – Tonatzin Rodriguez, MD

For the Office of Secretary-Treasurer (elected by and of the Board) – Raul Ayala, MD

The Importance of that "Yes" during a dinner invite with fellow CAFP colleagues was instrumental in shaping and refining the details of my career today. The conversations and that open dialogue of ideas carried throughout the event and continued during the AAFP conference, motivated me to want to be part of that transformation. I remember feeling and thinking to myself if possibly one day I would be able to be a fraction of what they were... To my amazing discovery those were the very people who would help me achieve and refine my voice, relationships and vision of health care for all. My vision is to help shape tomorrows leaders in health care by sharing my steps and stories. I am a firm believer that family doctors must rise and be the voice of our patients and colleagues. We must be the "Yes" of the future and be the change in health care our patients deserve.

It has been a pleasure to serve on the CAFP board for the last six years and various committees with CAFP and AAFP. I am honored and feel an exciting energy in continuing to serve and advance the Family Medicine Revolution!

Organizational Information

CAFP Annual Report – available on request to cafp@familydocs.org
CAFP Foundation Annual Report – available on request to cafp@familydocs.org
CAFP Year-end Financial Report – available on request to cafp@familydocs.org

Report on Actions by the CAFP Board of Directors on Policies Proposed at the 2018 AMAM and Submitted Directly to the CAFP Board

Policy on Communicating Board Action on Resolutions to CAFP Membership
Adopted by the Board of Directors 7.13.18

In response to requests received at the 2018 All Member Advocacy Meeting as well as policy adopted at the April 13, 2018 meeting of the CAFP Board of Directors, the following is proposed and adopted to ensure members are kept abreast of resolutions submitted to the Board of Directors between All Member Advocacy Meetings (AMAM) or after the deadline for submission of resolutions to the AMAM. This policy provides members an opportunity to comment on "interim" resolutions and be informed about Board actions taken subsequently on those resolutions:

1. All resolutions/policy proposals submitted to the Board of Directors after the deadline for receipt of resolutions at the AMAM and prior to the next meeting of the AMAM will be posted on the CAFP website and notification that they have been received and posted made to members in our *Academy in Action* electronic newsletter. The resolutions will remain on the website until the next quarterly Board meeting at which they will be considered, but no less than one month prior to the next meeting. If a resolution is received within less than one month of a Board meeting, it will be posted but consideration by the Board will be held off until the following meeting to allow adequate time for members to comment.

2. A chart reflecting actions taken by the Board on all resolutions will be posted on the website and updated after each quarterly meeting of the Board of Directors. Members will be notified about the updates via *Academy in Action* newsletter. Authors are and will continue to be notified of Board action taken on their resolutions.

3. A complete listing of the actions taken is included in the Participants' Handbook sent to all registrants at the AMAM. All policies adopted by the Board over the past year also are included in the Handbook for AMAM delegates' review. Time will be provided at the AMAM for the Speaker to review actions on resolutions more thoroughly.

4. Proposed policies may be submitted to CAFP at any time of the year by using the CAFP Policy Resolution form.

FP-PAC Dues: Political Resources to Help Family Physician Champions Win Elections

Resolution A-03-18: This resolution was introduced and endorsed by the CAFP Board of Directors and formally adopted during the 2018 All Member Advocacy Meeting.

RESOLVED, that Family Physicians Political Action Committee (FP-PAC) and the California Academy of Family Physicians (CAFP) pursue the inclusion of a $24 per Active member political contribution for FP-PAC in tandem with AAFP/CAFP/local chapter dues collection; and be it further

RESOLVED, that in the pursuit of inclusion of a $24 per member Family Physicians Political Action Committee contribution in tandem with AAFP/CAFP/local chapter dues collection, the following language should be included on the dues invoice:

"Of the total amount paid in dues, $24 will go to the Family Physicians Political Action Committee (FP-PAC) of the California Academy of Family Physicians (CAFP). Please contact CAFP (cafp@familydocs.org) if you do not wish this amount to be used for FP-PAC political purposes; that amount will instead go to CAFP's general fund. CAFP assumes that your dues are paid by you individually. If that is not the case, or if you have any questions or are not eligible to make a political contribution because you are not a US citizen or are an employee of an organization that may not allow political contributions, please contact CAFP at cafp@familydocs.org or call (415) 345-8667."

Communication with Members:

After adopting the resolution, CAFP undertook an extensive, multi-channel communications campaign, to apprise members of the dues increase and educate them about the benefits. Communications measures included:

- Feature articles in the August, September, October, November and December issues of Academy in Action, CAFP's Academy newsletter, emailed to all members.
- A dedicated CAFP dues increase webpage, posted to the CAFP website advocacy section.
- Feature article in the fall issue of FP-PAC eNews, emailed to all members.
- Two web flashes on the CAFP website homepage, in September and November.
- Dedicated emails sent directly to all Active members in September.
- Feature article in the October issue of CAFP's quarterly magazine, mailed to all members.
- Language included on all 2019 dues invoices sent from the AAFP via email and hard copy.

In addition, staff and Board members were prepped with information to answer questions and responded individually to all member inquiries.

Results:

From October 2018 – February 2018 we collected $93,134 in FP-PAC funds from 2019 member dues payments.

To date, only three members opted out of contributing to the FP-PAC and instead elected to have their dues redirected toward the CAFP general fund.

California Academy of Family Physicians

2018 Resolutions Submitted to the CAFP Board of Directors via the 2018 AMAM or Directly

Resolutions may be submitted to the CAFP Board of Directors at any time during the year. This DASHBOARD includes action on those heard at the 2018 All Member Advocacy Meeting and others submitted outside the AMAM timeframe as of 11.3.18.

Resolutions submitted to the Board at the AMAM are designated "A," as in Res. A-04-18 or ER for "emergency", i.e., submitted after the deadline.

Resolutions submitted too late for consideration by the Board at the current year's AMAM are designated "B," as in Res. B-12-18.

Resolutions will be tracked through the process and moved from Red to Green as final actions are determined.

The full resolutions are available for review on the CAFP website, www.familydocs.org. Resolutions must be posted on CAFP's website for at least one month prior to a Board meeting at which they will be considered to allow sufficient time for member comment.

GREEN -- Resolutions ADOPTED/AMENDED and ADOPTED by the CAFP Board of Directors	
Resolution#/Ttile/Date Submitted:	**A-02-18: Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis. (12.13.17)**
Orignial RESOLVEDs:	RESOLVED, that our CAFP work with state and local health departments to achieve the legalization and implementation of facilities that provide a supervised framework and enhanced aseptic conditions for the injection of self-provided illegal substances with medical monitoring, with legal and liability protections for persons working or volunteering in such facilities and without risk of criminal penalties for recipients of such services.
Recommended Actions and Progress Notes:	3.11.18: The resolution was presented and testimony was heard at the AMAM. 4.13.18 BOD: Refer to CAFP Legislative Affairs Committee and to Health of the Public Committee (if establishment is approved by the Board) for review and recommendation.
Final Action:	Referred Res. A-02-18 CAFP Legislative Affairs Committee and to Committee on Health of the Public for review and recommendation. ADOPTED an AMENDED Resolved at its July 14, 2018 meeting as follows: RESOLVED, that California Academy of Family Physicians (CAFP) support the creation of facilities that provide a supervised framework and enhanced aseptic conditions for the injection of self-provided illegal substances with medical monitoring, with legal and liability protections for persons working or volunteering in such facilities and without risk of criminal penalties for recipients of such services. The author was present at the July 14, 2018 Board meeting as a Student Co-Director; he abstained from voting.
Resolution#/Ttile/Date Submitted:	**A-03-18: FP-PAC Dues**
Original RESOLVEDs:	RESOLVED, that Family Physicians Political Action Committee (FP-PAC) and the California Academy of Family Physicians (CAFP) pursue the inclusion of a $24 per Active member political contribution for FPPAC in tandem with AAFP/CAFP/local chapter dues collection; and be it further RESOLVED, that in the pursuit of inclusion of a $24 per member Family Physicians Political Action Committee contribution in tandem with AAFP/CAFP/local chapter dues collection, the following language should be included on the dues invoice: *"Of the total amount paid in dues, $24 will go to the Family Physicians Political Action Committee (FPPAC) of the California Academy of Family Physicians (CAFP). Please contact CAFP (cafp@familydocs.org) if you do not wish this amount to be used for FP-PAC political purposes; that amount will instead go to CAFP's general fund. CAFP assumes that your dues are paid by you individually. If that is not the case, or if you have any questions or are not eligible to make a political contribution because you are not a US citizen or an employee of an organization that may not allow political contributions, please contact CAFP at*
Recommended Actions and Progress Notes:	3.11.18: ADOPTED by the 2018 All Member Advocacy Meeting -- No Board action required.
Final Action:	CAFP staff implemented a communications plan about the FP-PAC dues which were added to the 2019 dues billing.
Resolution#/Ttile/Date Submitted:	**A-03-18: Removing REMS Categorization on Mifepristione. (12.13.17)**

Orignial Resolveds:	RESOLVED, that the California Academy of Family Physicians (CAFP) endorse the principle that the REMS classification on mifepristone is not based on RESOLVED, that the CAFP engage in advocacy and lobbying efforts to overturn the REMS classification on mifepristone; and be it further RESOLVED, that the CAFP submit a resolution to the 2018 AAFP Congress of Delegates calling on the AAFP also to endorse the principle that the REMS classification on mifepristone is not based on scientific evidence and limits access to abortion care; and be it further RESOLVED, that the CAFP submit a resolution to the 2018 AAFP Congress of Delegates calling on the AAFP to engage in advocacy and lobbying efforts to overturn the REMS classification on mifepristone.
Recommended Action and Progress Notes:	3.11.18: The resolution was presented and testimony was heard at the AMAM. 4.13.18 BOD: ADOPT Resolveds 1, 3 and 4 and DO NOT ADOPT Resolved 2 (highlighted in red) of Res. A-04-18.
Final Action:	Board ADOPTED Resolveds 1, 3 and 4 and DID NOT ADOPT Resolved 2 of Res. A-04-18 CAFP already is engaged in a lawsuit to overturn the REMS on mifepristone and AAFP lobbies at the federal level. CAFP submitted a resolution to the 2018 AAFP Congress calling for the actions in Resolveds 3 and 4. Authors were notified 4.23.18
Resolution#/Ttile/Date Submitted:	**A-05-18: Increased Percentage of Women's Reproductive Health Topics at AAFP FMX and National Conference for Residents and Students. (12.7.17)**
Orignial Resolveds:	RESOLVED, That the California Academy of Family Physicians will advocate through the American Academy of Family Physicians to the Family Medicine Experience (FMX) Curriculum Advisory Panel (CAP) to increase the weight of women's reproductive health topics at future FMX events and remove the RESOLVED, That the California Academy of Family Physicians via its delegation will submit a resolution to the American Academy of Family Physicians (AAFP) calling on the AAFP to increase the representation of women's reproductive health topics among future AAFP CME events.
Recommended Action and Prograss Notes:	3.11.18: The resolution was presented and testimony was heard at the AMAM. 4.13.18 BOD: Refer to CAFP Committee on Continuing Professional Development for review and recommendation no later than the July Board meeting.
Final Action:	Refer Res. A-05-18 to CAFP Committee on Continuing Professional Development for review and recommendation no later than the July Board meeting. Resolution to AAFP approved by the CAFP Board of Directors on July 14, 2018 and forwarded to AAFP on July 17, 2018. Authors informed July 17, 2018 by email.
Resolution#/Ttile/Date Submitted:	**A-06-18: Reducing the Carbon Footprint of California Hospitals through New Renewable Energy Standards. (1.11.18)**
Orignial Resolveds:	RESOLVED, that California Academy of Family Physicians (CAFP) support stronger regulations regarding the sources of energy for California hospitals and standards for energy efficiency in new hospitals, such that all existing hospitals in California reach a minimum of 30 percent renewable energy by the year 2030 and 50 percent by 2050, and all new hospitals are required to use a minimum of 90 percent renewable energy starting in the year 2020; and be it further RESOLVED, that in order for hospitals to reach the goals of a minimum of 30 percent renewable energy by the year 2030 and 50 percent by 2050 and all new hospitals using a minimum of 90 percent renewable energy by the year 2020, hospitals should be encouraged to install rooftop solar panels, switch RESOLVED: That new and existing medical office buildings and other locations with physician offices be encouraged to undertake energy saving efforts to help them achieve a goal of 30 percent renewable energy by the year 2030 and 50 percent by 2050. (AMENDED RESOLVED)
Recommended Action and Propgress Notes:	3.11.18: The resolution was presented and testimony was health are the AMAM. 4.13.18 BOD: DO NOT ADOPT Res.A-06-18 or ADOPT AMENDED RESOLVED (in red):
Final Action:	Board ADOPTED Resolveds 1 and 2 of Res. A-06-18 and ADOPTED an AMENDED RESOLVED Author was contacted 4.23.18
Resolution#/Ttile/Date Submitted:	**A-07-18: Call for Physician Wellness as a Quality Indicator of Health Organizations (1.11.18)**

Orignial RESOLVEDs:	RESOLVED: that the California Academy of Family Physicians advocate for the Triple Aim to be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of health care providers, and to make Physician Wellness a quality measure for healthcare systems and ask the American Academy of Family Physicians to do the same by working with Congressional leaders.
Recommended Action and Propgress Notes:	3.11.18: The resolution was presented and testimony was heard at the AMAM. 4.13.18 BOD: ADOPT Res. A-07-18.
Final Action:	The Board ADOPTED Res. A-07-18. A letter was written to AAFP asking it to work to make Physician Wellness a quality measure for health care systems and
Resolution#/Ttile/Date Submitted:	**A-09-18: One Cent Per Ounce Excise Tax on Suger-Sweetened Beverages * (1.14.18)**
Orignial RESOLVEDs:	RESOLVED, That the CAFP work with state legislators for a state-wide excise tax of one cent per ounce on sugar-sweetened beverages and advocate for the AAFP to work with Congressional leaders to implement a nation-wide excise tax of one cent per ounce on sugar-sweetened beverages, exempting beverages sweetened with artificial sweeteners, such as aspartame or saccharine given the current lack of strong scientific evidence that they are associated with deleterious health effects, but closely tracking studies to determine whether taxing might be justified in the future; and be it further RESOLVED: That the revenue generated from a state-wide and/or a nation-wide excise tax of one cent per ounce on sugar-sweetened beverages be earmarked to support childhood nutrition programs, obesity-prevention research, and subsidizing healthier foods and beverages.
Recommended Action and Propgress Notes:	3.11.18: The resolution was presented and testimony was heard at the AMAM. 4.13.18 BOD: Inform author of Res. A-09-18 that CAFP has existing policy supporting a sugar- sweetened beverage/soda tax; ADOPT AMENDED RESOLVEDS
Final Action:	Informed author of Res. A-09-18 that CAFP has existing policy supporting a sugar- sweetened beverage/soda tax; 4.13.18 BOD: ADOPTED AMENDED RESOLVEDS 1 and 2 as shown in red. RESOLVED: That the CAFP advocate for the AAFP to work with Congressional leaders to implement a nationwide excise tax on sugar- sweetened beverages; and be it further RESOLVED: That the revenue generated from a statewide and/or nationwide excise tax on sugar- sweetened beverages be earmarked to support health care programs, such as those related to childhood nutrition, obesity prevention and subsidizing healthier foods and beverages for those who need them. Resolution does not request CAFP submit a resolution to AAFP, only that we ask AAFP to work with Congressional leaders, etc. A letter so requesting was sent to AAFP on July 5 and receipt was acknowledged. Author contacted 4.23.18.
Resolution#/Ttile/Date Submitted:	**ER-01-18: A Call for Guidelines to Manage ICE Threats in Health Care Settings. (2.28.18)**
Orignial RESOLVEDs:	RESOLVED, that the CAFP create or endorse a policy that clarifies the legal rights of physicians, health care workers and patients relating to ICE raids in health care settings and that the CAFP distribute this policy among CAFP members, including but not limited to members practicing in Federally Qualified Health Centers; and be it further RESOLVED, that the CAFP create or endorse a toolkit and protocol, similar to Code Blue, with the scripts, roles, and algorithms for health care staff (legal observer, recorder, video recorder, etc.) to use when responding to an ICE raid in a health care setting; and be it RESOLVED, that the CAFP create or endorse a plan, including a script and templates for print, that healthcare organizations can use to communicate information with their communities following an ICE raid; and be it further RESOLVED, that the CAFP advocate for the addition of civils rights and immigration policy curricula to California residencies.
Recommended Action and Propgress Notes:	3.11.18: The resolution was presented and testimony was heard at the AMAM. 4.13.18 BOD: Refer to CAFP Medical Practice Affairs Committee for review and recommendation of Resolveds 1, 2 and 3. Ask the CA Residency Network for review and recommendation on Resolved 4.

	Comment from MPAC: MPAC recommended adoption of the resolution as amended in RESOLVED 1, adding "and obligations" after "the legal rights" on line 1. Comment from CRN: Response to the request for comment was limited, but indicated two issues of which to be aware: 1) residency programs are unlikely to include civil rights and immigration policy curricula unless it is fully-developed and presented to them as a module ready for adoption; and 2) residency program directors are obligated to adhere to existing organizational policy and curricula on these matters, which may in some cases preclude uptake of any CAFP-developed module. This leads staff to believe that the resources required to achieve this aspect of the resolution are significant and greater than the value it may yield to members in the long-term. Recommendation of CRN on Resolved 4: Do not adopt Resolved 4 of ER-01-18.
Final Action:	Referred ER-01-18 to CAFP Medical Practice Affairs Committee for review and recommendation of Resolveds 1, 2 and 3. Ask the CA Residency Network for review and recommendation on Resolved 4. Board ADOPTED Resolved 1 of ER-01-18, A Call for Guidelines to Manage ICE Threats in Health Care Settings; ADOPTED AN AMENDED Resolved 2 and DID NOT ADOPT Resolveds 3 and 4 at its meeting on July 14, 2018. RESOLVED, that the CAFP create or endorse a policy that clarifies the legal rights and obligations of physicians, health care workers and patients relating to ICE raids in health care settings and that the CAFP distribute this policy among CAFP members, including but not limited to members practicing in Federally Qualified Health Centers, and be it further RESOLVED, that CAFP investigate the existence of and evaluate a toolkit and protocol, similar to Code Blue, with the scripts, roles, and algorithms for health care staff (legal observer, recorder, video recorder, etc.) that family physicians might use when responding to an ICE raid in a health care setting and make their availability known to CAFP members. Authors advised 7.18.18 by email.
Resolution#/Ttile/Date Submitted:	**B-10-18: Two Percent Tax on Gun Sales to Fund Mental Health Support Services and Education at Public Schools. (3.16.18)**
Orignial RESOLVEDs:	RESOLVED: that the California Academy of Family Physicians (CAFP) advocate that the American Academy of Family Physicians (AAFP) encourage lawmakers to add a two per cent tax on gun and gun ammunition sales to fund mental health support services and education at public schools to: - Increase the availability of behavioral health therapists at schools; - Develop strategies for educators and administrators to identify at risk children; - Provide parenting support services and parenting classes; - Provide post-incident support services for students affected by any gun violence; and - Develop curriculum for life skills and stress management including conflict resolution, mindful meditation, and anger management that would be offered to all students.
Recommended Action and Propgress Notes:	4.13.18: B-10-18 asks for a resolution to be submitted to the AAFP/deadline 9.11.18. 4.13.18 BOD: Refer Res. B-10-18 to the Committee on Health of the Public (if establishment is approved by the Board) with a request to report back at the July Board meeting (resolved calls for submission of a resolution to the AAFP Congress). Request that the CAFP Committee on Health of the Public consider whether a tax on guns and ammunition might better be imposed on gun makers and retailers.
Final Action:	Referred Res. B-10-18 to the Committee on Health of the Public with a request to report back at the July Board meeting (resolved calls for submission of a resolution to the AAFP Congress). Request that the CAFP Committee on Health of the Public consider whether a tax on guns and ammunition might better be imposed on gun makers and retailers.

	The Board ADOPTED Resolved 1 and ADOPTED an additional Resolved 2 as shown in red on Res. B-10-8, Two Percent Tax on Gun Sales and Ammunition Sales to Fund Mental Health Support Services and Education at Public Schools: RESOLVED: that the California Academy of Family Physicians (CAFP) support a tax on gun and ammunition sales and that the revenue generated from such a tax be used to fund mental health support services, such as behavioral health therapists at schools, programs to identify at risk children, and post-incident support services for individuals affected by any gun violence; and be it further RESOLVED: That CAFP submit a resolution to the American Academy of Family Physicians (AAFP) to support a tax on gun and ammunition sales, and that the revenue generated from such a tax be used to fund mental health support services, such as behavioral health therapists at schools, programs to identify at risk children and post- incident support services for individuals affected by any gun violence. Resolution submitted to AAFP 7.17.18. Authors advised 7.17.18 by email.
Resolution#/Ttile/Date Submitted:	**B-12-18: Including 2017 AAFP Board Report F in Evidence-Based Academy Educational Programs. (3.11.18)**
Orignial RESOLVEDs:	RESOLVED, That the California Academy of Family Physicians ask the American Academy of Family Physicians (AAFP) to include the data and conclusions of 2017's Board Report F in evidence-based Academy educational programs, continuing professional development/education activities, and stage presentations at AAFP meetings in the areas of health care policy, health care economics and health care systems.
Recommended Action and Propgress Notes:	No testimony was presented at AMAM because the resolution was submitted too late. 4.13.18 BOD: ADOPT Res. B-12-18, Including 2017 AAFP Board Report F in Evidence-Based Academy Educational Programs. (CAFP is directed to "ask" AAFP to include this information, not submit a resolution to do so.):
Final Action:	The Board ADOPTED Res. B-12-18. A letter was sent to AAFP on July 5 asking that Board Report F data and conclusions be included in evidence-based Academy educational programs, continuing professional development/education activities, and stage presentations at AAFP meetings in the areas of health care policy, health care economics and health care systems. AAFP acknowledged receipt of the letter.
Resolution#/Ttile/Date Submitted:	**B-13-18: Open, Member-Driven Process for Policy Development for CAFP. (3.11.18)**
Original RESOLVEDs:	RESOLVED, That all policies passed between meetings of the All Member Advocacy Meeting without a process for member comments and input be rescinded immediately; and be it further RESOLVED: That a process for obtaining member comments and input on resolutions received between meetings of the All Member Advocacy Mmeeting be developed; and be it further RESOLVED: That CAFP members have an opportunity to comment on and provide input into the proposed new process for soliciting member input on resolutions received between meetings of the All Member Advocacy Meeting for consideration by the Board of Directors before such a policy is adopted; and be it further RESOLVED: That authors of policies rescinded by virtue of the fact that CAFP member input on them was not obtained by the Board of Directors before adoption be offered an opportunity to resubmit their resolutions to go through the new process that is developed for reconsideration.
Recommended Action and Propgress Notes:	No testimony was presenteda t the AMAM because the resolution was submitted too late.
Final Action:	The Board DID NOT ADOPT Resolved 1; the Board ADOPTED Resolveds 2 and 3; the Board DID NOT ADOPT Resolved 4 of Res. B-13-18. The Board encouraged the author to submit a new resolution that would seek to change any CAFP policy with which she disagrees; the Board determined it acted within the authority granted to it in the CAFP bylaws. A process for obtaining member comments and input on resolutions received between meetings of the AMAM was developed and approved at the July 14, 2018 meeting of the Board. Members have been advised via Academy in Action newsletter and on the CAFP website. A chart outlining all Board actions is updated after each quarterly meeting of the Board and new resolutions must be posted at least one month prior to their consideration by the Board, so members may comment on them. Author contacted 4.23.18.

Resolution#/Ttile/Date Submitted:	**A-01-18: Food Insecurity Screening in Healthcare Settings as higher Standards of Health Care. (12.18.17)**
Original RESOLVEDs:	RESOLVED, that the California Academy of Family Physicians (CAFP) supports and encourages clinicians to identify children and adults who are food-insecure to avoid detrimental development and co-morbidities by asking the following two screening tool questions: Are you worried that your food will run out before you get money to buy more? and Does the food you buy last and, if not, do you have money to get more? and, be it further RESOLVED, that the California Academy of Family Physicians (CAFP) support various ways for healthcare centers to connect families that are food insecure with short- and long-term food resources, by, for example, referring positively screened patients to local Calfresh representatives who may connect families with such resources.
Recommended Action and Propgress Notes:	3.11.18: The resolution was presented and testimony was heard at the AMAM. 4.13.18 BOD: Refer to CAFP Medical Practice Affairs Committee for review and recommendation and to Health of the Public Committee (if establishment is approved by the Board) for review and recommendation. MPAC recommends AMENDED resolveds: RESOLVED, that the California Academy of Family Physicians (CAFP) supports and encourages healthcare centers to screen for food insecurity if appropriate by using validated screening tool questions as a higher standard of health care, such as: 1. Are you worried that your food will run out before you get money to buy more? and 2. Does the food you buy last and, if not, do you have money to get more? 7.14.18 – The CAFP Board of Directors referred the resolution back to the Committee on Health of the Public with a request that the resolution be considered in the context of AAFP's work on the social determinants of health as well as in the context of social risk factors; ask for clarification of the term "health care center." Authors were informed on July 17; one author of A-01-18 was present at the July 14 Board meeting as a Resident Co-Director.
Final Action:	11.3.18 – The CHOP responded to the BOD referral and recommended the following language which was adopted by the BOD at its November meeting. RESOLVED, that the California Academy of Family Physicians (CAFP) supports and encourages family physicians and their practice teams to screen for food insecurity by using two validated screening tool questions as a higher standard of health care, such as: 1. Are you worried that your food will run out before you get money to buy more? and 2. Does the food you buy last and, if not, do you have money to get more? and be it further RESOLVED, that the California Academy of Family Physicians (CAFP) educate its membership about how to use and interpret the validated food insecurity screening tools and identify local resources to which to refer patients in need.
YELLOW– Resolutions REFERRED by the Board to CAFP Committees for Review and Recommendation	
Action has been taken on all resolutiosn referred to committees and the Board.	