California Academy of Family Physicians

2017 All Member Advocacy Meeting

2017 AMAM Participants’ Handbook
We’ve Got an App for That!

California Academy of Family Physicians (CAFP) is excited to announce that its 2017 events will have a new App platform — live on February 21! Our mobile app brings the AMAM experience to a new level. Participants can see more, do more and get more value from the event — right from their mobile devices.

With the AMAM App, you can:

- See the full AMAM schedule sorted by day, speaker, track and have the ability to 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 #amam2017.
- Find sessions and locations with maps of session rooms.
- Catch notifications about networking opportunities, contests and other breaking event news pushed directly to your device.

Download and install the app https://crowd.cc/s/cpVq from your device.

Or download the app directly from iTunes or Google Play.

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, all of 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 Shannon Goecke at sgoecke@familydocs.org or 415-345-8667.
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AMAM Information

2016 All Member Advocacy Meeting Survey Results – on request to cafp@familydocs.org
**Detailed Schedule of Events**

Lisa Ward, MD, MScPH, MS, Speaker  
Walter Mills, MD, MBA, Vice-Speaker

### 2017 All Member Advocacy Meeting

**Saturday, March 4 – Sunday, March 5, 2017**  
**Family Medicine Lobby Day – Monday, March 6, 2017**  
**The Citizen Hotel – 926 J Street – Sacramento, CA 95814**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>11:45 am – 1:00 pm</td>
<td>All Member Advocacy Meeting (AMAM) Registration</td>
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</table>
| 12:30 – 12:45 pm | Opening Session of the All Member Advocacy Meeting  
                   - Certification of Delegates  
                   - Presentation of Election Slate  
                   - Nominations from the floor, if any |
| 12:45 – 1:00 pm | Address of the President  
                   Lee Ralph, MD |
| 1:00 – 1:10 pm  | Address of the President-elect  
                   Michelle Quiogue, MD |
| 1:10 – 1:12 pm  | Passing of the Gavel  
                   Dr. Lee presents Dr. Quiogue with her gavel. |
| 1:12 – 2:00 pm  | Legislative Briefing on Key CAFP Issues  
                   Carla Kakutani, MD, Adam Francis and Jodi Hicks  
                   CAFP Legislative Committee Chair, Staff and Legislative Advocate |
| 2:00 – 2:20 pm  | How One Family Physician Is Dealing with the Election Results and How CAFP Helped  
                   Shannon Connolly, MD, New Physician Director |
| 2:20 – 3:20 pm  | Town Hall Meeting  
                   20-minute presentations followed by 10 minutes of Q & A |
| 2:20 – 2:50 pm  | Value-Based Payment/MACRA  
                   Ashby Wolfe, MD, MPH, MPA and Leah Newkirk, JD, LSN Consulting |
| 2:50 – 3:20 pm  | Workforce Development Progress  
                   Conrad Amenta, CAFP Director of Health Policy |
| 3:20 – 3:35 pm  | BREAK                                                               |
| 3:35 – 4:25 pm  | Legislative Staffers Tell It Like It Is  
                   Assembly and Senate staffers talk about what it’s like to be on the receiving end of your letters, calls and visits, and how to strengthen your case |
| 4:25 – 5:00 pm  | Table Discussion                                                   |
Discuss how you can adapt what you just learned for your lobbying visits on Monday, or with legislators in your district in the future.

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<tr>
<th>Time</th>
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<tbody>
<tr>
<td>5:00 pm</td>
<td><strong>Recess</strong></td>
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<tr>
<td>6:15 pm</td>
<td><strong>Dine Around Dinners</strong>**</td>
</tr>
<tr>
<td></td>
<td>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 and be organized by region, practice type or issue area if you wish. The North Bay chapter invites to dinner any chapters interested in promoting member engagement.</td>
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</tbody>
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### Sunday, March 5, 2017 ● Closing Session — Metropolitan Terrace

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>7:15 – 8:00 am</td>
<td>All Member Advocacy Meeting</td>
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<tr>
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<td>Registration and Continental Breakfast</td>
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<tr>
<td>8:00 am</td>
<td>All Member Advocacy Meeting Reconvenes</td>
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<tr>
<td>8:05 am</td>
<td>Certification of Delegates/Instructions to Delegates</td>
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<tr>
<td>8:10 am</td>
<td>Candidate Speeches (if any)</td>
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<tr>
<td>8:20 am</td>
<td>Voting Instructions (if necessary)</td>
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<tr>
<td></td>
<td>Election of Officers, AAFP Delegates and Alternates for 2017-18, Rural Director 2017-2020, Nominating Committee Members 2017-18 Election of Secretary/Treasurer* *Elected by the Board of Directors only</td>
</tr>
<tr>
<td>8:30 – 9:30 am</td>
<td>Keynote Address and Q &amp; A</td>
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<tr>
<td></td>
<td>Wanda Filer, MD, Chair of the Board, American Academy of Family Physicians</td>
</tr>
<tr>
<td>9:30 – 9:40 am</td>
<td>FP PAC Report</td>
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<tr>
<td></td>
<td>Carla Kakutani, MD, FP-PAC Chair</td>
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<tr>
<td>9:40 – 9:50 am</td>
<td>Hero of Family Medicine Award Presentation</td>
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<td></td>
<td>Presentation by Lee Ralph, MD, President</td>
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<tr>
<td>9:50 – 10:00 am</td>
<td>Report of the CAFP Foundation</td>
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<tr>
<td></td>
<td>Anthony “Fatch” Chong, MD, CAFP Foundation President</td>
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<tr>
<td>10:00 – 10:10 am</td>
<td>Review of CAFP Board 2016-17 Policies and Actions on Resolutions</td>
</tr>
<tr>
<td>10:10 – 10:55 am</td>
<td>Resolutions Hearing – CAFP Board of Directors</td>
</tr>
<tr>
<td></td>
<td>Presentation of testimony to the Board of Directors concerning proposed policy changes or additions developed by members and chapters. Elections, bylaws changes (if any), dues changes (if any) 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 is available here: <a href="http://www.familydocs.org/f/2017ResolutionForm.pdf">http://www.familydocs.org/f/2017ResolutionForm.pdf</a></td>
</tr>
<tr>
<td>10:55 am – 11:15 am</td>
<td>Student and Resident Leaders’ Presentation</td>
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<tr>
<td>Time</td>
<td>Event</td>
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<tr>
<td>11:15 am</td>
<td>Announcement of Election Results (if necessary)</td>
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<tr>
<td>11:15 – 11:25 am</td>
<td>Family Medicine for America’s Health Update</td>
</tr>
<tr>
<td>11:30 am</td>
<td>Adjournment</td>
</tr>
<tr>
<td>11:45 am</td>
<td>LUNCH presentation of the Champion of Family Medicine Award</td>
</tr>
<tr>
<td>1:15 – 5:30 pm</td>
<td>Training Tracks</td>
</tr>
<tr>
<td>Track 1</td>
<td>Successful Advocacy through Telling Your Story – Metropolitan Terrace</td>
</tr>
<tr>
<td>1:15 – 3:15 pm</td>
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<tr>
<td>3:15 – 3:30 pm</td>
<td>BREAK – Beverages and Snacks</td>
</tr>
<tr>
<td>Track 2</td>
<td>Advocacy – How to Meet with Your Legislator – Metropolitan Terrace</td>
</tr>
<tr>
<td>3:30 – 5:30 pm</td>
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<tr>
<td>5:45 – 6:45 pm</td>
<td>Special FP-PAC Donor Reception</td>
</tr>
<tr>
<td>6:45 pm</td>
<td>Evening Free – Dine Around Sacramento (Meet in the lobby)</td>
</tr>
</tbody>
</table>
Monday, March 6, 2017 • Family Medicine Lobby Day Breakfast and Briefing – Quorum Room

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>7:30 – 9:00 am</td>
<td><strong>Breakfast and Legislative Issues Orientation</strong>&lt;br&gt;C AFP Director of Government Relations Adam Francis, Director of Health Policy (TBD) and Legislative Advocate Jodi Hicks of DiMare, Brown, Hicks and Kessler.</td>
</tr>
<tr>
<td>8:45 am</td>
<td><strong>Group Photo</strong></td>
</tr>
<tr>
<td>9:00 am – 12:00 pm</td>
<td><strong>Legislative Visits at the Capitol</strong></td>
</tr>
<tr>
<td>12:00 pm</td>
<td><strong>Debrief and Adjournment</strong></td>
</tr>
</tbody>
</table>
**Roster of 2017 Delegates and Alternates [2.3.17]**

*Asterisked Delegates and Alternates indicate those whose names were submitted after the deadline. They must be approved by a 2/3 vote of the Congress.*

<table>
<thead>
<tr>
<th>County/Chapter</th>
<th>Delegates</th>
<th>Alternates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda/Contra Costa (5)</td>
<td>Brea Bondi-Boyd</td>
<td>Jeremy Fish, MD</td>
</tr>
<tr>
<td></td>
<td>Christina Chavez-Johnson</td>
<td>Suzan Goodman, MD</td>
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<tr>
<td></td>
<td>Deborah Greer, MD</td>
<td>Samantha Malm, MD</td>
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<tr>
<td></td>
<td>Shani Muhammad, MD</td>
<td>Sarah McNeil, MD</td>
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<tr>
<td></td>
<td></td>
<td>Vicky Valderde-Salas, MD</td>
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<tr>
<td>Amador (1)</td>
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<tr>
<td>Butte-Glenn-Tehama (1)</td>
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<tr>
<td>Fresno-Kings-Madera (2)</td>
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<tr>
<td>Humboldt-Del Norte (1)</td>
<td>Hal Grotke, MD</td>
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<tr>
<td>Imperial (1)</td>
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<tr>
<td>Inyo-Mono-Alpine (1)</td>
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<tr>
<td>Kern (2)</td>
<td>Shweta Argarwal, MD</td>
<td>Shakti Srivastava, MD</td>
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<td></td>
<td>Frank Lang, Jr.</td>
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<tr>
<td>Lassen-Plumas-Modoc-Sierra (1)</td>
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<tr>
<td>Los Angeles (12)</td>
<td>Rebecca Bertin, MD</td>
<td>Felix Aguilar, MD</td>
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<tr>
<td></td>
<td>Monique George, MD</td>
<td>Sandra Avila, MD</td>
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<tr>
<td></td>
<td>Nzinga Graham, MD</td>
<td>Karen Boston, MD</td>
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<td></td>
<td>Julie Howard, MD</td>
<td>Lawrence Dardick, MD</td>
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<td></td>
<td>Po-Yin Samuel Huang</td>
<td>Mark Dressner, MD</td>
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<tr>
<td></td>
<td>Kelly Jones, MD</td>
<td>Judy Kim, MD</td>
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<td></td>
<td>Nazmeen Khan, MD</td>
<td>Jon Malachowski, MD</td>
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<tr>
<td></td>
<td>Katrina Miller, MD</td>
<td>Shabana Tariq, MD</td>
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<td></td>
<td>Gerardo Moreno, MD</td>
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<td></td>
<td>Theresa Nevarez, MD</td>
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<td></td>
<td>Daniel Pio, MD</td>
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<td>Monica Plesa, MD</td>
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<td>Mendocino-Lake (1)</td>
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<td>Merced-Mariposa (1)</td>
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<td>Monterey (2)</td>
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<tr>
<td>Napa (1)</td>
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<tr>
<td>North Bay (3)*</td>
<td>* Toni Ramirez, MD</td>
<td>* Panna Lossy, MD</td>
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<tr>
<td></td>
<td>* Tara Scott, MD</td>
<td>* Francesca Manfredi, MD</td>
</tr>
<tr>
<td></td>
<td>Melanie Southard, MD</td>
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<tr>
<td>County/Chapter</td>
<td>Delegates</td>
<td>Alternates</td>
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<tr>
<td>Orange (6)</td>
<td>William Kurt Armstrong, MD</td>
<td>Sofia Meraz, MD</td>
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<td>Christina Deckert, MD</td>
<td>Gina Nguyen, MD</td>
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<td>Jorge Galdamez, MD</td>
<td>Angel Yap, MD</td>
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<td>Ana Karina Melgar, MD</td>
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<td></td>
<td>Timothy Munzing, MD</td>
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<td></td>
<td>Jenny Tan, MD</td>
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<tr>
<td>Placer-Nevada (2)</td>
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<tr>
<td>Riverside-San Bernardino (5)</td>
<td>* Hobart Lee, MD</td>
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<td>* Scott Nass, MD</td>
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<td></td>
<td>* Michael Nduati, MD, MBA, MPH</td>
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<td></td>
<td>* Van Nguyen, MD</td>
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<tr>
<td>Sacramento-El Dorado (4)</td>
<td>Bill Eng, MD</td>
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<td></td>
<td>Carol Havens, MD</td>
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<tr>
<td>San Diego (6)</td>
<td>Anthony “Fatch” Chong, MD</td>
<td>Steven Green, MD</td>
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<td>Lance Fuchs, MD</td>
<td>Cecilia Gutierrez, MD</td>
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<td>Joseph Leonard, MD</td>
<td>Randy Schwartz, MD</td>
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<td></td>
<td>Albert Ray, MD</td>
<td>Brad Stiles, MD</td>
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<td>Patrick Yassini, MD</td>
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<tr>
<td>San Francisco (2)</td>
<td>Clarissa Kripke, MD</td>
<td>Ronald Labuguen, MD</td>
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<td>Sunny Pak, MD</td>
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<tr>
<td>San Joaquin-Calaveras-Tuolomne (2)</td>
<td>R. Sharif Latif, MD</td>
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<td>San Luis Obispo (2)</td>
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<tr>
<td>San Mateo (2)</td>
<td>Steven Howard, MD</td>
<td>Karen Jackson, MD</td>
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<td>Alex Maldonado, MD</td>
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<tr>
<td>Santa Barbara (2)</td>
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<tr>
<td>Santa Clara (3)</td>
<td>* Catherine Forest, MD</td>
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<td>Santa Cruz (2)</td>
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<td>Shasta-Trinity (2)</td>
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<td>Stanislaus (2)</td>
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<td>Tulare (1)</td>
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<td>Ventura (2)</td>
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<td>Yolo (2)</td>
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<tr>
<td>Yuba-Sutter-Colusa (1)</td>
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### County/Chapter

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<thead>
<tr>
<th>County/Chapter</th>
<th>Delegates</th>
<th>Alternates</th>
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<tbody>
<tr>
<td>Residents (2)</td>
<td>Amina Moheyuddin, MD</td>
<td></td>
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<tr>
<td></td>
<td>Tonantzin Rodriguez, MD</td>
<td></td>
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<tr>
<td>Students (2)</td>
<td></td>
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*Asterisked Delegates and Alternates indicate those whose names were submitted after the deadline.*

### CAFP Officers and Board of Directors – 2016-2017

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Lee Ralph, MD</td>
<td>President</td>
</tr>
<tr>
<td>Michelle Quiogue, MD</td>
<td>President-Elect</td>
</tr>
<tr>
<td>Jay W. Lee, MD, MPH</td>
<td>Immediate Past President</td>
</tr>
<tr>
<td>Lisa Ward, MD, MScPH, MS</td>
<td>Speaker</td>
</tr>
<tr>
<td>Walter Mills, MD</td>
<td>Vice Speaker</td>
</tr>
<tr>
<td>David Bazzo, MD</td>
<td>Secretary-Treasurer</td>
</tr>
<tr>
<td>Carla Kakutani, MD</td>
<td>AAFP Delegate</td>
</tr>
<tr>
<td>Jeffrey Luther, MD</td>
<td>AAFP Delegate</td>
</tr>
<tr>
<td>Carol Havens, MD</td>
<td>AAFP Alternate Delegate**</td>
</tr>
<tr>
<td>Jay W. Lee, MD, MPH</td>
<td>AAFP Alternate Delegate**</td>
</tr>
<tr>
<td>Anthony “Fatch” Chong, MD</td>
<td>CAFP-F President</td>
</tr>
<tr>
<td>David E. J. Bazzo, MD</td>
<td>District I</td>
</tr>
<tr>
<td>William Woo, MD</td>
<td>District II</td>
</tr>
<tr>
<td>Elisabeth Kalve Levitt, MD</td>
<td>District III</td>
</tr>
<tr>
<td>Daniel Castro, MD</td>
<td>District IV</td>
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<tr>
<td>Lauren Simon, MD</td>
<td>District V</td>
</tr>
<tr>
<td>Raul Ayala, MD</td>
<td>District VI</td>
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<tr>
<td>Jeannine Rodems, MD</td>
<td>District VII</td>
</tr>
<tr>
<td>Taejoon Ahn, MD, MPH</td>
<td>District VIII</td>
</tr>
<tr>
<td>Ashby Wolfe, MD, MPH, MPP</td>
<td>District IX</td>
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<tr>
<td>Pat Moore-Pickett, MD</td>
<td>District X</td>
</tr>
<tr>
<td>Walter Mills, MD</td>
<td>Rural Director</td>
</tr>
<tr>
<td>Shannon Connolly, MD</td>
<td>Young Physician Director</td>
</tr>
<tr>
<td>Nate Hitzeman, MD</td>
<td>CFP Editor**</td>
</tr>
<tr>
<td>Laura Doan, MD</td>
<td>Resident Co-Director***</td>
</tr>
<tr>
<td>Matthew Varallo, DO</td>
<td>Resident Co-Director***</td>
</tr>
<tr>
<td>Ridwa Abdi</td>
<td>Student Co-Director***</td>
</tr>
<tr>
<td>Michelle Yim</td>
<td>Student Co-Director***</td>
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**Non-voting member**

***One resident and one student Co-Director serve as Delegates at the AMAM.***
2017 Instructions to Delegates and Alternates

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 2016 All Member Advocacy Meeting and how to access 2016 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 Susan Hogeland, CAE, Executive Vice President, 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 9, 2016). 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 12:30 pm, Saturday, March 4, 2017 and again on Sunday, March 5, 2017 at 8:00 am at The Citizen Hotel, 926 J Street, Sacramento, CA. The order of business will be as outlined in this 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 this 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 9, 2016). 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?** In 2017, the Board of Directors will convene at 10:10 am and conclude at 10:55 am on Sunday, March 5.

**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 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 Delegates 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 2016 Committee nominated candidates for the following positions, to be elected by the AMAM:

- President-Elect
- Speaker
- Vice Speaker
- Secretary-Treasurer *

- AAFP Delegates and Alternate
- Rural Director
- Nominating Committee Members (one AMAM position)
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 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.
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”

<table>
<thead>
<tr>
<th>Order of Precedence</th>
<th>Requires Second?</th>
<th>Debatable?</th>
<th>Vote Required</th>
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<tbody>
<tr>
<td><strong>Privileged Motions</strong></td>
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<tr>
<td>1. Adjourn</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>2. Recess</td>
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<td>3. Question of Privilege</td>
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<td>4. Postpone Temporarily</td>
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<td>5. Vote Immediately</td>
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<td>6. Limit Debate</td>
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<td>7. Postpone Definitely</td>
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<td>8. Refer to Committee</td>
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<tr>
<td>9. Amend</td>
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<td>b. Specific main motions</td>
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<td>Reconsider</td>
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<td>Rescind</td>
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<td>Resume consideration</td>
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<td><strong>Incidental Motions</strong></td>
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<td>Appeal</td>
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<td>Suspend rules</td>
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<td>Object to consideration</td>
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<td>b. Requests</td>
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<td>Point of order</td>
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<td>Division of assembly</td>
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Resolutions and Background Materials

A-01-17 – Repeal the Hyde Amendment
A-02-17 – Call for a Physical Activity Vital Sign in Clinical Practice
A-03-17 – Endorse Restriction of Antibiotic Use in Food Animals
A-04-17 – Acknowledge the Negative Health Impacts of Artificial Food Colors and Endorse Their Elimination from the American Food System
A-05-17 – Protect the Integrity of the Affordable Care Act
A-06-17 – New Search Options for Specific Residency Characteristics in the Residency Directory on the AAFP Website
Res. A-01-17

November 14, 2016

TITLE: Repeal the Hyde Amendment

Introduced by: Nicole Cory Baltrushes-Hughes, MD, Alison D. Block, MD

WHEREAS, the AAFP has confirmed a woman’s legal right to make her own reproductive choices, and supports women’s access to reproductive health services without non-evidence-based restrictions; and

WHEREAS, the landmark Supreme Court case Roe v. Wade recognized a woman’s constitutional right to decide, in consultation with her physician, whether to terminate a pregnancy; and

WHEREAS, the adoption of the Hyde Amendment in 1976 cut off federal funding for abortions excepting those performed in cases of rape, incest and endangerment of the patient’s life, thereby prohibiting funding of abortions paid for with federal Medicaid or for women on native American reservations, military personnel and their dependents, federal employees and their dependents, teenagers participating in State Children’s Health Insurance Program, low-income residents of the District of Columbia, members of the Peace Corps, and federal prison inmates, among others; and

WHEREAS, the Hyde Amendment disproportionately affects underserved, low income, and minority patients as 75 percent of women seeking abortion in 2014 were poor or low income, and women who are unable to access desired abortion are more likely to live in poverty; and

WHEREAS, the AAFP is against discrimination of any kind and continues to affirm its commitment to the underserved; and

WHEREAS, it takes poor women up to three weeks longer to obtain a desired abortion and women often have to divert funds that would otherwise be used for rent, utility bills, or food to cover the cost of an abortion; and

WHEREAS, the costs and risks of an abortion procedure increase with gestational age such that delays in accessing care are of particular importance; and

WHEREAS, providing funding for abortion does not compel morally-opposed women to have abortions or morally-opposed providers to participate, but limiting funding does inhibit a woman's reproductive autonomy; now, therefore be it

RESOLVED, that the California Academy of Family Physicians (CAFP) endorse the principle that women receiving health care paid for through health plans funded by state or federal governments who have coverage for continuing a pregnancy also should have coverage for ending a pregnancy; and be it further

RESOLVED, that the CAFP urge the AAFP to engage in advocacy and lobbying efforts to overturn the Hyde Amendment, which bans federal funding for abortions; and be it further
RESOLVED, that the CAFP submit a resolution to the 2017 American Academy of Family Physicians (AAFP) Congress of Delegates calling on AAFP to endorse the principle that women receiving health care paid for through health plans funded by state or federal governments and who have coverage for continuing a pregnancy also should have coverage for ending a pregnancy; and be it further

RESOLVED, that the CAFP submit a resolution to the 2017 American Academy of Family Physicians (AAFP) Congress of Delegates calling on AAFP to engage in advocacy and lobbying efforts to overturn the Hyde Amendment, which bans federal funding for abortions.

Speaker’s Note:

Fiscal Note:

REFERENCES:

Res. A-02-17

Date: December 2, 2016

Title: Call for a Physical Activity Vital Sign in Clinical Practice

Introduced by: Alex Mroszczyk-McDonal, MD Kaiser Permanente Fontana, CA

Endorsed by:

WHEREAS, physical inactivity increases the relative risk of coronary artery disease, stroke, hypertension, and osteoporosis by 45 percent, 60 percent, 30 percent and 59 percent, respectively, and

WHEREAS, physical inactivity is associated with an increased risk of 25 chronic diseases, and

WHEREAS, US Physical Activity Guidelines recommend at least 150 minutes per week of moderate-intensity activity (e.g., brisk walking), and

WHEREAS, 90 percent of American adults do not meet current physical activity guidelines, and

WHEREAS, deaths attributable to physical inactivity may soon exceed those attributed to cigarette smoking, and

WHEREAS, physical activity is reflected in improved cardiorespiratory fitness, expressed as metabolic equivalents, which in turn correlates with a reduced risk of cardiovascular disease, and

WHEREAS, in persons with and without heart disease, each single Metabolic Equivalent increase in cardiorespiratory fitness is associated with an approximately 15 percent reduction in mortality, and

WHEREAS, individuals with low cardiorespiratory fitness have higher annual healthcare costs, and

WHEREAS, the American Heart Association recently emphasized that physical inactivity represents a leading cause of death worldwide, and

WHEREAS, the beneficial effects of regular exercise are often underestimated by many clinicians who then miss opportunities to endorse proven behavioral interventions, and

WHEREAS, the 19th Surgeon General of the United States Vivek Murthy, MD, has endorsed physical activity as a priority in clinical settings, and

WHEREAS, vital signs inform clinicians about the likelihood of future disease and the presence and severity of acute and chronic illness, and

WHEREAS, asking a patient about exercise habits may have greater impact than asking questions about smoking or diet, which are routinely asked, and has significant implications regarding preventative care, and
WHEREAS, current AAFP policy endorses promotion of fitness as an integral component of preventive care, risk reduction and disease management and family physicians are uniquely positioned to promote fitness among their patients and encouraged to open a dialogue with their patients about fitness during patient visits, and

WHEREAS, a physical activity vital sign is successfully being used in several large health care systems, including Kaiser Permanente, Intermountain Healthcare (Utah), and the Greenville Health System (South Carolina), now, therefore be it

RESOLVED, that California Academy of Family Physicians’ (CAFP) policy reflect and formally endorse the World Health Organization policy that adults aged 18–64 should do at least 150 minutes of moderate-intensity aerobic physical activity throughout the week or do at least 75 minutes of vigorous-intensity aerobic physical activity throughout the week or an equivalent combination of moderate- and vigorous-intensity activity, and be it further

RESOLVED, that the CAFP develop policy endorsing the routine, standardized and widespread practice of measuring patients’ habitual physical activity, and consider physical activity a “vital sign,” be to assessed at every clinical visit to engage patients in conversation and preventative counseling to ensure they are aware of and understand the proven connection between regular physical activity and optimal health, and be it further

RESOLVED, that the CAFP partner with like-minded organizations, such as American Society of Sports Medicine, American College of Sports Medicine, and/or Exercise is Medicine to provide tools, references and resources to allow physicians to better and more accurately assess patients’ physical activity and counsel and connect patients to resources in the community accordingly.

Speaker’s Note:

Fiscal Note:

CITATIONS


Res. A-03-17

Date: December 6, 2016

Title: Endorse Restriction of Antibiotic Use in Food Animals

Introduced by: Kimberly Clinite, MD, Dwiju Kumar, MD MPH, Kendall Madden, MD MS, Guillermo Padilla, MD MPH, Jessica Rhodes, MD, MPH, Tara Scott, MD, Laura Vega, MD

Endorsed by: Northbay CAFP Chapter

WHEREAS, antibiotic resistance in the US is an urgent and increasing threat to public health\(^1\), and

WHEREAS, every year in the US there are two million antibiotic resistant infections causing 23,000 human deaths\(^2\), and

WHEREAS, in the medical community, there is large consensus that the judicious stewardship of antibiotics is critical to reducing antibiotic resistance\(^3\), and

WHEREAS, in 2014, 70 percent of all antibiotics in the US were used on food animals\(^4\), therefore any campaign to address antibiotic stewardship is incomplete without addressing use of antibiotics in food animal production\(^5\) and

WHEREAS, the Food and Drug Administration (FDA), United States Department of Agriculture (USDA), and Centers for Disease Control (CDC) all have agreed strong scientific evidence links antibiotic use in food animals to the development of antibiotic resistant infections in humans\(^6\), and

WHEREAS, antibiotic resistant organisms are transferred to humans through consumption of contaminated meat, direct contact with infected food animals, AND consumption of produce grown with contaminated fertilizer or water, and

WHEREAS, using chronic low dose antibiotics, widely practiced in food animal production, creates resistant pathogens, including those resistant to all known antibiotics,\(^7\) and

WHEREAS, recent legislation (SB 27) in California, as well as newer FDA and USDA guidelines, do not sufficiently address the health risks posed by use of antibiotics in food animals\(^8-9\), and

WHEREAS, the American Medical Association, Infectious Diseases Society of America, American Public Health Association, and World Health Organization all support the termination or phasing out of non-therapeutic use of antimicrobials in food animals\(^9-10-11-12-13\) now, therefore be it

RESOLVED, that the California Academy of Family Physicians support legislation restricting the use of antibiotics in food animal production to the treatment of animals with active disease, equivalent to the use in humans, and be it further
**RESOLVED,** that the California Academy of Family Physicians ask the American Academy of Family Physicians to urge the Food and Drug Administration and the United States Department of Agriculture to restrict use of antibiotics in food animal production to the treatment of animals with active disease, equivalent to the use in humans, and be it further

**RESOLVED,** that the California Academy of Family Physicians ask the American Academy of Family Physicians to create educational content for family physicians, in the form of journal reviews, continuing professional education programs or educational materials, that focus on comprehensive antibiotic stewardship AND specifically include education about the role of the food animal production system in the development of antibiotic resistance in humans.

**Speaker’s Note:** CAFP currently has no policy on this topic; AAFP’s policy on non-therapeutic antibiotic use is [here](#) - it advocates for 'restrictions,' but its key is restriction to "treatment of established disease," and that the industry is expected to demonstrate efficacy (as opposed to total restrictions). AB-49 (2014) declared the intent of the CA legislature to enact new legislation related to overuse of non-therapeutic use of antibiotics in livestock, in response to FDA inaction, but the legislation died. Several other legislative attempts to regulate antibiotics have been made but have failed, including possible requirements that physicians develop their own antibiotics reduction plans and post them in their medical offices.

**Fiscal Note:** Minimal so long as CAFP is not asked to author legislation.

**CITATIONS**

2. ibid

Supporting Evidence

1) 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 seeks to harness the medical expertise of the CAFP to engage lawmakers in limiting non-judicious use of antibiotics in livestock production in order to stem the tide of increasing antibiotic resistant infections in humans.

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

All CAFP members and their patients are affected by increasing antibiotic resistance and are at risk for infection from direct exposure through occupational contact, direct exposure from consumption of common foods or through human-to-human transmission.

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

We request that the CAFP work with state lawmakers to increase understanding around the importance of antibiotic resistance and its direct link to the livestock industry and support legislation that will support judicious use of antibiotics in livestock, as defined above. We also request that the CAFP push this important issue up to the national level, urging the AAFP to engage the FDA and the USDA to increase restrictions on non-judicious use of antibiotics.

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

The CDC reports that every year in the US there are two million antibiotic resistant infections causing 23,000 human deaths. The FDA, USDA, and CDC have all agreed there is strong scientific evidence linking antibiotic use in food animals to the development of antibiotic resistant infections in humans. Currently, non-judicious antibiotic use in the livestock industry is allowed under the FDA’s “Guidance for the industry” which is a set of non-binding guidelines which pharmaceutical and livestock companies are recommended, by not required, to follow. The scientific evidence and the regulation of antibiotic use in the livestock industry are out of step and in need of leadership to align regulations to protect humans from life-threatening illness.
5) PLEASE PROVIDE CITATIONS to support the existence of the problem and your proposed solution.

See Citations.
Res. A-04-16

**Date:** December 6, 2016

**Title:** Acknowledge the Negative Health Impacts of Artificial Food Colors and Endorse Their Elimination from the American Food System

**Authors:** Jacqueline Abdalla, MD, Anastasia Coutinho, MD, Kayla Flores Tindall, MD, MPH, Afsoon Fooorohar, DO, Tara Scott, MD, Stacie Vilendrer, MD, Maya Zwerdling, MD

**Endorsements:** North Bay Chapter, CAFP

**Whereas,** artificial food colors (AFCs) are made of petroleum and coal tar\(^1\), and

**Whereas,** AFCs initially were intended for small-scale use and there has been a fivefold increase in the use of AFCs between 1995 and 2009\(^2\), and

**Whereas,** AFCs are routinely used in food and beverage products, more than 90 percent of child-oriented food products contain AFCs\(^3\), and a single serving of many common foods exceeds the Food and Drug Administration’s (FDA) recommended daily limit of AFCs\(^4^-^5\) and

**Whereas,** AFCs are associated with hyperactivity and hypersensitivity in susceptible populations, have been inadequately tested for safety in humans\(^6^-^9\) and all nine FDA-approved AFCs have been associated with carcinogenicity in animal studies\(^10\), and

**Whereas,** natural alternatives to artificial food dyes are available and European products produced with natural dyes are almost indistinguishable from products produced in the United States\(^11\), and

**Whereas,** due to the above health risks, the United Kingdom banned six AFCs still used in the United State\(^12\) now, therefore be it

**RESOLVED,** that the California Academy of Family Physicians (CAFP) acknowledge the health risks posed by Artificial Food Colors (AFCs) and ask the American Academy of Family Physicians to write to the Food and Drug Administration urging the elimination of AFCs from products marketed to children, and be it further

**RESOLVED,** that the California Academy of Family Physicians (CAFP) urge the American Academy of Family Physicians to create education for family physicians and their patients on the potentially harmful health effects of artificial food colors in the form of journal reviews, continuing professional education and patient education materials.

**Speaker’s Note:** Neither CAFP nor AAFP has policy on this issue. The FDA has a 2003 article about its regulatory process [here](#). The Federal Food, Drug and Cosmetic Act governing artificial coloring use is [here](#). And the list of permitted artificial colors is [here](#).
Fiscal Note: Minimal.

CITATIONS

2. Ibid.
6. Ibid.

1) 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?

Family physicians see a wide array of chronic health and behavioral problems in the office. We suggest that traditional medical education does not provide physicians with adequate information on the health and safety of many food additives in the American food system, including but not limited to artificial food colorants (AFCs). There is scientific evidence that AFCs may lead to adverse health effects such as allergy, asthma, hypersensitivity reactions, hyperactivity and cancer. We believe that those adverse health effects are not widely known or understood by the majority of family physicians and the CAFP should use its position to increase physician awareness of these issues.

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

All family physicians are consultants for their patients when it comes to making recommendations for healthy food choices. Physicians and their patients may be under-informed about the potential health risks posed by AFCs, which are ubiquitous in the American food supply, especially in foods marketed to
children. All consumers of processed foods are affected by the presence of AFCs and therefore this topic is relevant to all family physicians and their patients. (see references in Resolution)

3) 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 the CAFP use its position to urge the AAFP to increase awareness among patients and physicians about the potentials risks of food dyes by providing evidence-based review of the science on AFCs to members. We also propose that the CAFP urge the AAFP to write to the FDA to eliminate AFCs in foods marketed to children since they add no nutritional benefit to foods.

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

The Center for Science in the Public Interest investigated food colorants and concluded that the nine artificial dyes approved in the United States are likely carcinogenic, cause hypersensitivity reactions and behavioral problems, and are inadequately tested. All nine FDA-approved artificial food dyes have been associated with carcinogenicity or genotoxicity in animal studies¹.

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

See Citations

¹ Ibid.
WHEREAS, the Patient Protection and Affordable Care Act of 2010 has expanded health insurance coverage to more than 20 million Americans by expanding Medicaid, creating the health exchanges, preventing insurance companies from denying coverage based on pre-existing conditions, and allowing youth to stay on their parents’ plans until age 26, and lowering the uninsured rate by 43 percent, from 16 percent in 2010 to 9.1 percent in 2015; and

WHEREAS, the Affordable Care Act has increased health insurance quality by requiring a basic package of essential health benefits as defined by the Department of Health and Human Services, and

WHEREAS, the Affordable Care Act has increased health insurance affordability for individuals by capping annual and lifetime limits and providing insurance exchange subsidies, and has been shown to decrease personal debt due to unpaid medical bills; and

WHEREAS, the individual mandate is crucial for the financial stability of health insurance markets through cross-subsidies from the healthy to the sick, the young to the old, and the wealthy to the poor, and

WHEREAS, a regular source of health care has been shown to decrease preventable illnesses and premature deaths, diminish health disparities, reduce health care costs, utilize specialty care prudently, and improve quality of clinical care; and

WHEREAS, eliminating the Medicaid expansion and federal financial assistance for coverage through the health exchanges, as Congress has attempted to do through the budget reconciliation process, will double the number of uninsured people from 28.9 million to 58.7 million by 2019, disproportionately affecting working families and adults without college degrees, and shift the cost of uncompensated care to state and local governments by an additional $1.1 trillion between 2019-2028, and

WHEREAS, abolishing the individual and employer mandates would cause $3 billion in losses to insurance companies as people stop paying premiums and would result in most, if not all, insurers leaving the health exchanges by 2018, and

WHEREAS, repealing the Affordable Care Act would result in higher uninsured rates compared to prior to enactment of the ACA due to disruptions to the non-group insurance market, now, therefore be it

RESOLVED: That the California Academy of Family Physicians advocate for the AAFP to work with Congressional leaders to reinforce the importance of the Patient Protection and Affordable Care Act, maintain the key components of the legislation with regard to coverage, quality and affordability in
order to keep Americans healthy and reduce health care costs, and work to improve the law rather than repeal and replace it.

**Speaker’s Note:** Existing CAFP policy supports both the ACA and the principles on which it’s based. The CAFP Board reviewed the ACA at its 2.1.17 meeting and prioritized its provisions and adopted an overarching statement about health policy that is included in the policy section of this handbook.

**Fiscal Note:** Anywhere from minimal to $150,000 or more.

**CITATIONS**

1. Ibid.

1. **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 Patient Protection and Affordable Care Act (2010) is under attack by the new administration to repeal and replace it. Eliminating the individual mandate will threaten the financial stability of the health insurance pools by leaving only the sickest and most expensive patients to insure. Researchers from the RAND Corp. analyzed President-elect Trump’s health care reform principals and determined that his plan would increase the number of uninsured by 16-25 million, with the biggest impact on people with multiple chronic medical conditions who would face higher out of pocket costs.

2. **PROBLEM UNIVERSE:** Approximately how many CAFP members or members’ patients are affected by this problem or proposed policy?

All CAFP members and members’ patients are potentially affected by the dismantling of the Affordable Care Act, whether directly through loss of their health insurance coverage or indirectly through reduction in health care quality, skyrocketing health care costs, and untreated communicable diseases.

3. **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 advocate for the AAFP to work with Congressional leaders to reinforce the importance of the Patient Protection and Affordable Care Act, maintain the key components of the legislation with regard to coverage, quality, and affordability in order to keep Americans healthy and reduce health care costs, and work to improve the law rather than repeal and replace it.

If the Affordable Care Act is repealed, Congress is unlikely to come together on a replacement health plan that would provide “great health care at lower costs” as President-elect Trump has promised, because this new plan would require the government to raise new taxes, substantially cut spending in other areas such as defense, and/or increase the national deficit.

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

Statements by President-elect Trump, House Speaker Paul Ryan, and the incoming administration to repeal and replace the Affordable Care Act. There have been proposals to create special insurance plans called “high risk pools” for people whom insurance companies will not cover. These high risk pools were trialed at the state level in the past, and did not work well because of weaker coverage at higher prices, and soaring costs that fell on state governments to cover.

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

See Citations
Res. A-06-17

Date: December 9, 2017

Title: New Search Options for Specific Residency Characteristics in the Residency Directory on the AAFP Website

Introduced by: Drs. Emilia De Marchis, Emily Guh, Nicole Person-Rennell, Lealah Pollock, Sarah McNeil

Endorsed by*:

*Endorsement not required

WHEREAS, the scope of family medicine is broad and the Member Interest Groups offer a unique window into the many different practice styles and therefore the breadth of training that many medical students seek out when looking for a residency program, and

WHEREAS, family medicine includes women’s reproductive health (family planning, contraception counseling, pregnancy options counseling, abortion, prenatal care, miscarriage care and deliveries),¹⁻⁵ and

WHEREAS, the AAFP supports provision of opportunities for residents to have access to supervised, expert training in management techniques and procedures pertaining to reproductive health and decisions commensurate with the scope of their anticipated future practices,² and

WHEREAS, there is a shortage of family medicine physicians who place long-acting reversible contraception (LARC)³ and who perform medication or surgical abortions,⁶⁻⁷ and

WHEREAS, RHEDI (The Center for Reproductive Health Education in Family Medicine) identifies residency programs that have integrated abortion training into their curriculum and are interested in attracting residents who seek training that includes abortion care,⁸ now, therefore be it

RESOLVED, that the California Academy of Family Physicians instruct its delegates to present a resolution to the American Academy of Family Physicians (AAFP) calling on the AAFP to get input from each Member Interest Group about at least one searchable feature to add to “Find Residency Programs” on the AAFP website, and be it

RESOLVED, that the California Academy of Family Physicians advocate to the AAFP to include abortion training as a searchable term in “Find Residency Programs” to emphasize the role of reproductive care within the scope of family medicine for those interested in providing these services.

Specifically:

1. On the AAFP website “Find Family Medicine Residency Programs” (http://www.aafp.org/medical-school-residency/residency/find-programs.html)⁹, prospective residents will be able to search for “abortion,” “abortion training,” and “RHEDI” (http://www.rhedi.org/)⁸
2. To consult with all of the Member Interest Groups about which other searchable fields to add, such as other procedures (colonoscopy, primary c-section), buprenorphine provision, hospitalist training, point of care ultrasound, global health opportunities, high volume maternity care, etc.

Speaker’s Notes:

Fiscal Note:

1) 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 AAFP is committed to access to comprehensive health care for all patients, however access to full spectrum women’s reproductive health services in the US remains inadequate for those with the greatest need, in part because there is a shortage of providers and clinics currently offering comprehensive reproductive health services. The AAFP has affirmed that full spectrum reproductive health services are well within the scope of Family Medicine physicians, however recruiting material on the AAFP website does not help medical students identify programs that emphasize training in this area. Under the section “Medical School and Residency,” designed for prospective medical students and residents interested in Family Medicine, a method to search specifically for programs with curricula strong in women’s reproductive health or other curricular interests is unavailable. Emphasizing the full scope of our practice and empowering future providers to obtain the training that they desire is incredibly important for the pipeline.

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

Given that approximately one in three women will have an abortion in her lifetime and that the vast majority of women will access a family physician for reproductive healthcare needs, reinforcing the importance of comprehensive reproductive healthcare in residency training is critical to all of our patients. Furthermore, this resolution addresses the pipeline, so has the potential to widely impact all CAFP members and their patients.

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

Advocate to the AAFP to include full spectrum family planning training (including abortion) as searchable items in “Find Residency Programs” on the AAFP website to emphasize the role of reproductive care within the scope of family medicine for those interested in providing these services.

Specifically:

1. On the AAFP website “Find Family Medicine Residency Programs” (http://www.aafp.org/medical-school-residency/residency/find-programs.html), prospective residents will be able to search for “abortion,” “abortion training,” and “RHEDI” (http://www.rhedi.org/).
3. To consult with all of the Member Interest Groups about which other searchable fields to add, such as other procedures (colonoscopy, primary c-section), buprenorphine provision, hospitalist training, point of care ultrasound, global health opportunities, high volume maternity care, etc.

4) 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

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


Elections

MINUTES
CAFP NOMINATING COMMITTEE
November 7, 2016

PRESENT: Drs. Jay W. Lee, MD, MPH, Chair, Shannon Connolly, Kelly Jones, Jeannine Rodems; Susan Hogeland, CAFP Staff.
ABSENT: Drs. Maria Greaves and Asma Jafri.

1. Call to Order

2. Proposed 2017 Slate of Nominees

1) President-elect – Lisa Ward, MD
2) Speaker 2017-18 – Walter Mills, MD
3) Vice Speaker 2017-18 – David Bazzo, MD
4) AAFP Delegate 2017 (one-year term to fill vacancy created by resignation of Carla Kakutani, elected to serve 2016-2017) – Carol Havens, MD
5) AAFP Delegate 2017-2018 – Jeffrey Luther, MD (incumbent)
6) AAFP Alternate Delegate 2017 (one-year term to fill vacancy created by potential election of Carol Havens to delegate for 2017) – Lee Ralph, MD
7) One Nominating Committee member for 2017-18 from the AMAM (two-year term) – Tonatzin Rodriguez, MD
8) Secretary/Treasurer 2017-18 (one-year term) – recommendation only to the CAFP Board of Directors – Shannon Connolly, MD (Dr. Connolly recused herself from the discussion and vote.)
9) Rural Director, CAFP Board – 2017-2020 – Steve Harrison, MD

3. Adjournment
Candidates’ Statements

For the Office of President-elect – Lisa Ward, MD, MScPH, MS
I am so honored to be nominated for the position of C AFP President-elect. As your future President, it is my aim to represent the core values of the C AFP on behalf of our patients, our practices, and our colleagues. In the year to come, our organization’s voice will be critical in its support of access to care for millions of Californians, to strategically grow the primary care workforce, and to serve as stewards of our healthcare delivery system. As your President-elect, I aim to represent our organization as it navigates the opportunities and tradeoffs that will surely confront health policy and healthcare in California. It would be my great privilege to serve as your Academy’s President-elect, particularly in this time, when it feels like our organization has so much to contribute when so much is at stake. Our advocacy is ever important to the people we serve and I add my voice to yours as your C AFP President-elect.

Lisa Ward, MD

For the Office of Speaker – Walter Mills, MD, MMM, FACPE
I firmly believe that Family Medicine is crucial to having a moral, effective health care system. The C AFP champions this cause for each FP and the communities we serve so passionately. As Speaker, I will dedicate myself to supporting our amazing organization’s work, especially in advocacy and leadership. My experience in clinical and academic leadership roles has prepared me well to be a C AFP servant leader, and it is with a commitment to paying it forward, that I seek this office.

Walt Mills, MD

For the Office of Vice Speaker – David Bazzo, MD
I’ve had the privilege to serve on the California Academy of Family Physicians Board of Directors since 2013. During this time, I’ve seen what advocacy through organized medicine can accomplish. C AFP is second to none when it comes to representing the needs and interests of 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, safe, and to keep cost controlled. Additionally, now more than any other time in history will it be important to represent family physicians and more importantly our patients at the highest level of the political arena.

I have had other opportunity to work with C AFP in a number of capacities, most recently as your Secretary/Treasurer. Additionally, I’ve been privileged to serve our members as past chair and current member of the Committee on Continuing Professional Development. Service to our members and patients is what I view as most important for our Board to accomplish. I take this commitment with the utmost respect and consider it the highest honor to serve and represent the Family Physicians of California.
The members of the board do have influence and work on your behalf to insure 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 as Vice Speaker. Thank you.

David Bazzo, MD

For the Office of AAFP Delegate 2017 – Carol S. Havens, MD

These are challenging and interesting times for AAFP and the house of medicine in general. From issues of professional responsibilities such as maintenance of certification, to funding and support for Family Medicine training programs, to public health issues including the future of health care in the U.S., divisions and disagreements are everywhere. The AAFP will need to be visible, forceful and effective in protecting Family Physicians and our patients. The CAFP has been an active participant in the AAFP, and has taken strong stands for the future of our specialty. I want to continue to be part of that voice as one of our delegates to the AAFP. I humbly ask for your vote. Thank you.

Carol S. Havens, MD

For the Office of AAFP Delegate 2017-2018 – Jeffrey Luther, MD

I am honored to be nominated to the position of Delegate to the AAFP for 2017-18. My first experiences in organized medicine took place at our own Congress of Delegates starting back in the mid-nineties. While serving as a Delegate or Alternate Delegate over the intervening years, I developed a deep appreciation for the potential of such policy-making bodies to push forward issues that affect us, as family physicians, and our patients.

Building on this, serving as AAFP Alternate Delegate for five years and as Delegate for the last three 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.

Jeffrey Luther, MD

For the Office of AAFP Alternate Delegates 2017 – Lee P. Ralph, MD

I greatly appreciate the nomination to serve as one of the CAFP Alternative Delegates to the AAFP for the upcoming year. I am honored to be asked to further serve the CAFP at the national level. I have been an active AAFP member for more than 25 years now, serving principally at the local and state levels. Two years ago, I was asked to step in as an Alternate Delegate to the AAFP Congress of Delegates in Denver, CO and this past year, while serving as CAFP President, attended the Congress of Delegates in
Orlando, FL. These were both wonderful experiences that have inspired me to desire to remain active as a family physician advocate at the national level.

The current changes in healthcare demand active participation at all levels to ensure the needs of family physicians are being addressed. Affordable healthcare for all Americans, reduced administrative burdens on physicians, improved payment for services rendered and prevention of physician burnout all are issues demanding advocacy on our part. I would greatly appreciate your support in allowing me to continue my “engagement” with and on behalf of the CAFP and to continue to fight for issues of critical importance to all family physicians. Thank you for your support.

Lee P. Ralph, MD

For the Office of Nominating Committee Member 2017-2018 – Tonatzin Rodriguez, MD, MPH

Thank you for the nomination. As a new medical student, CAFP played an important role in my path toward family medicine. While in medical school at UC Davis, both the CAFP summer preceptorship program and the CAFP research grant introduced me to the field of family medicine, connected me with outstanding mentors and fostered my interest in prevention. My funded research project focused on health literacy in cancer prevention, which went on be published in a peer-reviewed journal and was presented at an AAFP conference. A few of my leadership roles include involvement in the CAFP Medical Student & Resident Council and serving as the California delegate for AAFP Medical Student and Resident Assemblies. In the community, I volunteer at the local free clinic, teach medical students, and mentor pre-health students. My advocacy interests include medical education, debt reduction, mentorship, women’s health, the undocumented population and increasing access to primary care.

This year, I serve as Chief Resident at the Sutter Health Family Medicine Program in Sacramento and participate in the year-long AAFP Chief Resident Leadership Development program. After graduation, I will join the Marshall Sierra Primary Medicine in Placerville and continue my involvement with CAFP. I am supported by my amazing husband (Mauricio) and our 6-year-old daughter (Citlali). Serving as a member of the CAFP Nominating Committee would be an honor – to advocate for the goals of CAFP, and to work with our fellow amazing family medicine champions. Thank you very much for the nomination and your consideration.

Tonatzin Rodriguez, MD, MPH

For the Office of Rural Director 2017-2020 – Steve Harrison, MD

I feel passionately that rural practice is an afterthought in most medical circles, in the same way that the area between coasts is considered "flyover" and therefore less relevant. I would be honored to bring those issues germane to rural physicians forward with the conviction that only comes with experience.

You can consider me the exception that proves the rule. I was born in New York City and lived in Norristown Pennsylvania, Florence Italy, City, Old Saybrook Connecticut, Albuquerque New Mexico
and then San Diego California when I was 13. I then lived in San Francisco, Dallas, Texas and Baltimore, Maryland before settling in King City in 1989.

I always dreamed of a full spectrum rural practice and was able to satisfy that dream for 20 years, until the social contract changed and I could no longer keep the doors open. I still live in King City. I believe in small town practice in the same way that I believe with small town life.

Respectfully,

Steve Harrison, MD

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

I am honored to be under consideration to serve as the CAFP Board Secretary-Treasurer. For the last two years, I have been the New Physician Board Member for the CAFP, where I represent the interests of physicians in their first seven years of practice. I am eager to deepen my involvement in an organization that has made such a difference in my professional life. I attended medical school at USC Keck School of Medicine and residency at UCLA and am currently the Associate Medical Director and Director of Primary Care at Melody Women's Health, a nonprofit that provides comprehensive primary care services to low-income women. I enjoy combining my interests in the patient-centered medical home model, practice redesign and evidence-based practices in family planning. I have a strong interest in advocacy, and have been a delegate at the AAFP National Conference of Constituency Leaders for five years. I currently am President of the Los Angeles Chapter of the CAFP, and I completed the CAFP CME Leaders Institute several years ago. I look forward to continuing my work with the CAFP by advocating for family doctors and their patients and striving daily to promote joy in the practice of medicine.

Shannon Connolly, MD
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 2016 AMAM

1) RES. A-01-16 – Dispensing of “Medical Marijuana” by Licensed Pharmacists

**RESOLVED:** That California Academy of Family Physicians support legislation to require any and all dispensing of “Medical Marijuana” be supervised by licensed pharmacists.

**Action:** Referred to the Legislative Affairs Committee (LAC); CAFP Board of Directors approved a “do not adopt” recommendation because the subsequently adopted state ballot initiative would address this issue. CAFP Board asked the LAC to develop CAFP policy on this issue if legislation proposing that pharmacists dispense medical marijuana is introduced. 4.15.16

2) RES. A-02-16 – Support Mandatory Immunizations for Vaccine-Preventable Diseases and Elimination of Personal Belief Exemptions Prior to a Child’s Entry into School

**Proposed Actions:** RESOLVED, that the California Academy of Family Physicians ask the American Academy of Family Physicians to support a policy that requires mandatory immunization of children entering any elementary school, nursery school, day care center, or development center against multiple vaccine-preventable diseases, and be it further

RESOLVED, that the California Academy of Family Physicians ask the American Academy of Family Physicians to support a policy that eliminates vaccine personal belief exemptions and only accepts medical exemptions per the discretion of a medical health professional, and be it further

RESOLVED, that California Academy of Family Physicians ask the American Academy of Family Physicians to support the “consistent enforcement, ease of obtaining vaccinations relative to that of obtaining non-medical exemptions, and adequacy of financial, logistical, and community support for implementation” of policy requiring mandatory immunization of children entering any elementary school, nursery school, day care center, or developmental center against multiple vaccine-preventable diseases and policy that eliminates vaccine personal belief exemptions and only accepts medical exemptions per the discretion of a medical health professional.

**Action:** Accept Res. A-02-16 – Support of Mandatory Immunizations for information (it reflects current CAFP policy). 4.15.16

3) RES. A-03-16 – Endorse Access without Age Restriction to Over-the-Counter Oral Contraceptive

**Proposed Actions:** RESOLVED, that the California Academy of Family Physicians endorse the policy that there be no age restriction to oral contraceptive pill availability over-the-counter, and be it further

RESOLVED, that the CAFP ask the American Academy of Family Physicians to write to the U.S. Food and
Drug Administration (FDA) to urge that all adolescents be included in the over-the-counter (OTC) oral contraceptives studies required by the FDA (e.g., label comprehension study, actual use study) to determine whether OTC access is appropriate for this population.

**Action:** This resolution was submitted to the AAFP’s 2016 Congress, and became Res. No. 501. A substitute resolution was adopted as follows and it was referred to the Commission on Governmental Advocacy, staff member Bob Hall rhall@aafp.org (chief lobbyist for AAFP):

RESOLVED, That the American Academy of Family Physicians write to the U.S. Food and Drug Administration (FDA) to encourage that adolescents, regardless of age, be included in the over-the-counter (OTC) oral contraceptives studies required by the FDA (e.g., label comprehension study, actual use study) to determine whether OTC access is appropriate for this population.

4) **RES. A-04-16 – Medical Student Debt Reform**

**Proposed Actions:** RESOLVED, that the CAFP use its legislative advocacy and lobbying efforts to support legislation that reduces the debt burden of past and current medical student borrowers, and be it further

RESOLVED, that the CAFP use its legislative advocacy and lobbying efforts to support legislation that reduces the interest rate of medical student loans, and be it further

RESOLVED, that the CAFP use its legislative advocacy and lobbying efforts to support legislation that removes the adjusted gross income cap to qualify for medical student loan interest payment tax deductions, and be it further

RESOLVED, that the CAFP represent its membership by writing a letter to AAFP leadership outlining its concerns regarding medical student debt reform.

**Action:** Refer Res. A-04-16 – Medical Student Debt Reform to the Medical Student and Resident Affairs Committee with a request that the committee examine various aspects of medical student debt and potential solutions to this pressing issue and examine whether debt correlates to choice of specialty and report back to the Board with a proposed set of policy recommendations; refer also to the Legislative Affairs Committee with a request that it monitor state and federal legislation that offers debt relief to medical students and consider support of such legislation if appropriate. Considered by the LAC 6.29.16. Board adopted recommendation that CAFP support legislation that encourages primary care specialization by reducing the debt burden of past and current medical student borrowers, reducing the interest rate of medical student loans and removing the adjusted gross income cap to qualify for medical student loan interest payment tax deductions; and CAFP to write a letter to AAFP on behalf of CAFP members detailing our solutions to improving/reforming medical school debt. **NOTE:** AAFP adopted OR CONSIDERED the following policies on this issue at its 2016 Congress:
Res. 605 Student Loan Repayment for Primary Care Faculty Physicians Substitute:  RESOLVED: That the AAFP work with organizations such as the Society of Teachers of Family Medicine to study the feasibility of pursuing legislation to allow family medicine faculty physicians, both volunteer and employed, to qualify for loan repayment programs.

Res. 606 Student Loan Forgiveness Post Teaching in a Residency Program: RESOLVED: That the AAFP through advocacy efforts, seek student loan forgiveness for family physicians who after completing residency enter into teach with a residency program in family medicine (NOT ADOPTED)

Res. 607 Student Loan Debt: RESOLVED: That the AAFP, through advocacy efforts, seek student loan forgiveness for family physicians who meet the following conditions: 1) work in a designated medically underserved setting, and 2) precept medical students and/or family medicine residents on a volunteer basis.

5)  RES. A-05-16 – Medicaid Coverage of Over-the-Counter Emergency Contraception (EC)

Proposed Actions: RESOLVED, That the California Academy of Family Physicians will advocate that over-the-counter emergency contraception be a covered benefit under Medi-Cal for all women of reproductive age, and be it further

RESOLVED, That the California Academy of Family Physicians will instruct its delegates to present a resolution to the American Academy of Family Physicians (AAFP) calling on the AAFP to advocate that emergency contraception, whether over-the-counter or by prescription, be a covered benefit under all Medicaid programs for all women of reproductive age.

Action: Adopt Res. A-05-16 – Medicaid Coverage of Over-the-Counter Emergency Contraception (EC) and submit to the AAFP Congress of Delegates. Added to CAFP Policy Manual; resolution submitted to the 2016 AAFP Congress of Delegates. AAFP adopted Res. 502-16 as follows: RESOLVED: That the AAFP advocate that emergency contraception, whether over-the-counter or by prescription, be a covered benefit under all Medicaid programs for all women of reproductive age.

Resolutions Adopted by 2016 All Member Advocacy Meeting – NONE

Policy Proposals Submitted in 2016 after the All Member Advocacy Meeting

6) RES. A-06-16 – Oppose the Legalization of Recreational Marijuana

Proposed Actions: RESOLVED, that the California Academy of Family physicians oppose the legal use of recreational marijuana, and be it further
RESOLVED, that the CAFP encourage further research on the adverse and beneficial effects of medical and recreational marijuana in adults and young individuals and to society in general prior to the legalization of marijuana, and be it further

RESOLVED, that the CAFP be actively involved in educating individual patients and the public in general as to the benefits and the adverse effects known to date from existing research.

**Action:** Refer Res. A-06-16 – Oppose Legalization of Recreational Marijuana – to the LAC for review and recommendation to the Board. Considered by the LAC 6.29.16. Board adopted recommendation to take a NEUTRAL position on the ballot proposition to Legalize the Adult Use of Marijuana and adopted a policy statement on the issue. (Policy is contained in section on policies adopted by CAFP Board over the past year.)

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**Policies Adopted by CAFP Board of Directors 2016-17 – see resolutions adopted above.**

**Policy on Legalization of Adult Use of Marijuana**
Approved by CAFP Board of Directors 7.16.16

*CAFP supports the decriminalization of the possession and personal use of marijuana, but lack of scientific data and peer-reviewed research prevents CAFP from endorsing its recreational use. CAFP supports the following measures to improve patient safety and expand the reliability and strength of marijuana research:*

1) The federal government should change pharmaceutical cannabinoids from a Schedule I to a Schedule II drug to facilitate research, and private manufacturing and distribution of marijuana should be permitted for research purposes.

2) In states in which marijuana is legalized, research should be conducted into the overall safety and health effects of the recreational use of marijuana, as well as the effects of legalization on patient and societal health.

3) The federal Food and Drug Administration, or a similar state agency, should thoroughly investigate recreational and medicinal marijuana for safety and efficacy, including monitoring for purity, standardization of strength and proper usage, as well as testing for harmful contaminants such as insecticides, herbicides or molds.

In addition, CAFP believes our society must recognize drug use and abuse as medical and social problems that must be treated with medical and social solutions. CAFP calls on the President and Congress to empower an objective commission to recommend revision of national drug laws to reduce the harm caused by current policies.
Prescription Drug Cost Containment and Price Transparency Policy

1) CAFP urges the elimination of the Medicare prohibition on drug price negotiation and encourages federal legislation to give the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.

2) CAFP supports an appropriate balance between incentives for innovation and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

3) CAFP opposes anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.

4) CAFP encourages the mitigation of restrictions that limit patient access to, and market competition for, prescription medication.

5) CAFP encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.

6) CAFP supports increased manufacturer rebates if the price of a generic drug rises faster than inflation.

7) CAFP supports shortening exclusivity time periods for biologics.

8) CAFP supports the freedom of family physicians to use the most effective pharmaceuticals when prescribing drugs for their patients and encourages family physicians to supplement medical judgment with cost considerations in making these choices;

9) CAFP encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

10) CAFP encourages family physicians to consider prescribing the least expensive FDA A-rated generic products, unless it is not available; and

11) CAFP encourages family physicians to become familiar with the prices in their communities of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

CAFP supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs incentivize research and development of clinically needed prescription drugs, while ensuring patients can reasonably afford their medications as long as clinically indicated.
The Future of Health Care Reform: Family Medicine’s Perspective
Adopted by the CAFP Board of Directors, February 1, 2017

Family physicians are on the frontline of health care each day, providing care to millions of men, women and children in communities large and small, rural and urban, wealthy and poor across the country and our state. One in five physician office visits takes place with a family physician. Individuals and their families turn to family physicians when they are sick and in need of guidance on life’s most complicated and challenging decisions. Family physicians witness each day the importance of health insurance coverage and the value of the patient-centered protections contained in the Affordable Care Act (ACA). Our health care system is not perfect and, clearly, some areas require additional reforms. Potential changes to current law must be patient-centered, focused on enhancing and improving our health care system for all, and acknowledge the important role of primary and preventive care. CAFP is committed to engaging in a dialogue and process that identify policies that strengthen our health care system and make health care more affordable for individuals and families at all income levels.

To assist in health care reform deliberations, CAFP offers the following recommendations:

1. **Ensure Coverage for All**
   - Individuals who already have health care coverage, including those insured through Medicaid expansion, should not lose that coverage as the result of any action or inaction on the part of the United States Congress, the Administration or the State of California. Expanding the number of individuals with health care coverage should be pursued in a manner that does not disrupt or destabilize the individual, small group or employer-based insurance markets. The significant reduction in the number of uninsured under the ACA must be protected. Premium assistance and cost-sharing reduction subsidies aimed at assisting qualifying individuals with the purchase of health care coverage and/or paying their deductibles and co-pays should be preserved; proposals to alter such subsidies should provide, at minimum, comparable assistance. Mandatory purchase of insurance may be required to ensure soundness of the risk pool.

2. **Maintain Insurance Reforms and Patient Protections**
   - The patient-centered protections in the ACA for individuals and families against discrimination in health insurance marketplaces are essential to ensure that everyone, regardless of age, race, gender or medical history, can obtain health insurance. CAFP urges the continuation of policies that provide the following protections:
     - Individuals should not be denied health care coverage, charged higher premiums or have their coverage canceled based upon a current or pre-existing health care condition, family history, disability, race, gender or income.
     - The prohibition on annual and lifetime caps on benefits should be retained and be applicable to all insurance products, public and private.
     - All health insurance products should be required to cover evidence-based essential benefits including coverage, with no out-of-pocket costs to insured persons, to those preventive care services and vaccines identified by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices, the Women’s
Preventive Services Initiative, Bright Futures and other designated evidence-based assessment entities. CAFP opposes changes in covered benefits that could undermine women’s access to care, including elimination of contraception and maternity care as covered essential benefits.

3. Protect the Safety-Net
CAFP and our members are committed to ensuring that all individuals, regardless of their socio-economic status, have access to health care coverage. This commitment is especially focused on those who do not have access to employer-based health insurance or are financially unable to secure health care coverage through the individual market. Those on Medicaid should not face discontinuation of that coverage; incentives to expand Medicaid and retain eligibility expansion must continue. While the approach to how benefits are extended to eligible populations is an important discussion, California's commitment to ensuring health security for our most vulnerable populations should not be in question.

4. Invest in Primary Care
The value of primary care to the health and well-being of individuals has long been documented, acknowledged and understood. Strengthening our investment in primary care is imperative to improving individual and population health outcomes and restraining health care spending growth. Primary care also is associated with enhanced access to health care services, better health outcomes and lower costs through changes in utilization such as lower rates of hospitalization and emergency department visits. Primary care is and must remain a critical and foundational component of any health care system by:

- Prohibiting the exclusion of primary care physicians from any network. Access to primary care physicians should be encouraged. Restrictive networks should be prohibited. Requiring that all primary care physicians be considered “in-network” for all insurance products encourages the establishment of a continuous relationship between patients and their primary care physician.
- Ensuring that all insurance products, public and private, guarantee access to, at minimum, four visits annually to a primary care physician for each enrollee, independent of cost-sharing.
- Requiring that all health insurance plans increase their overall investment in primary care functions to, at minimum, 12 percent of their total health care spending. Current spending on primary care represents approximately six percent of total spending on health care – a wholly inadequate percentage that does not support our state’s health care goals.
- Building on the successful Teaching Health Center (THC) program by reauthorizing the program and expanding it to a greater number of communities. The THC program, by all measures, has been a tremendous success and is a key to addressing our nation’s primary care physician workforce challenges. CAFP urges Congress to reauthorize, expand and appropriately fund this critical and highly successful program.
- All individuals should have access to a Patient Centered Medical Home through their primary care physicians.
Critical ACA Provisions to Add to State Law

While California has enacted many of the provisions of the ACA into state law, CAFP encourages the following provisions be replicated in our state:

• Plans must be prohibited from establishing lifetime or unreasonable annual limits on the dollar value of benefits.

• Premiums in the individual and small group markets must vary only by family structure, geography, the actuarial value of the benefit, age (in an actuarially sound ratio to ensure adequate risk pools) and tobacco use (in an actuarially sound ratio to ensure adequate risk pools).

• Each health insurance issuer must accept every employer and individual applying for coverage, permitting annual and special open enrollment periods for those with qualifying lifetime events.

• Consumers must be guaranteed coverage renewal regardless of health status, utilization of health services or any other related factor.

• Premium assistance (e.g., tax credits) should be provided for those who cannot afford a qualified health plan.

• Reasonable and standardized out-of-pocket maximum limits should be created based on an individual or families’ income in relation to the Federal Poverty Level.

• No employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions or other privileges of employment because the employee has received a health insurance premium tax credit or for other reasons.

• Insurers offering group or individual health coverage (including grandfathered plans) must provide an annual rebate to enrollees if their medical loss ratio is less than 85 percent for its large group business, or 80 percent for its small or individual group business.

• All individual health insurance and group plans offered to consumers must have uniform standards and requirements.

• Medicaid Eligibility – Non-elderly adults with income at or below 138 percent of the Federal Poverty Level should be eligible for Medicaid, using modified gross income for determination purposes. Income disregards and asset tests should not apply in Medicaid, except for long-term services and supports. Medicaid income eligibility levels should be no more stringent than they were on December 31, 2013 for all adults. This “maintenance of effort” (MOE) requirement should be included for all children currently covered in Medicaid or CHIP.

• Medicaid Benefits – Newly-eligible, non-elderly, non-pregnant individuals would receive benchmark or benchmark-equivalent coverage. Coverage must provide at least essential benefits. Prescription drug and mental health services must be covered at the actuarial equivalence of physical health services. Children who are enrolled in either Medicaid or CHIP may receive hospice services without foregoing curative treatment related to a terminal illness. Non-pregnant individuals with income up to the highest level applicable to pregnant women covered under Medicaid or CHIP must be eligible for family planning services and supplies, including related medical diagnostic and treatment services. Medicaid beneficiaries with disabilities who would otherwise require the level of care offered in a hospital, nursing facility, or intermediate care facility for the mentally disabled must be offered community-based attendant services and supports. Medicaid must provide diagnostic, screening, preventive and rehabilitation services, including: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) adult
immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration. These services shall not be subject to patient cost-sharing, but should receive an increased Federal medical assistance percentage (FMAP).

- States must have the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals, led by a physician, and would provide a comprehensive set of medical services, including care coordination. Community health teams should be established and funded to support the development of medical homes that increase access to comprehensive, community-based, coordinated care.

- Health insurers must report information on initiatives and programs that improve health outcomes through the use of care coordination and chronic disease management, prevent hospital readmissions and improve patient safety, and promote wellness and health.

- Hospital payment should be adjusted to encourage the reduction of readmissions based on each hospital’s percentage of potentially preventable Medicare readmissions.

- The primary care student loan program should be made more attractive to medical students by easing the criteria for schools and students to qualify for loans, shortening payback periods and loosening non-compliance provisions.

- Primary care physicians, as well as general surgeons practicing in health professional shortage areas, should receive 10 percent payment bonuses across payers (e.g., Medicare, Medicaid, private insurers, etc.).

- Financial support should be provided to create new or expanded primary care residency programs at teaching health centers, covering indirect and direct expenses related to training primary care residents in expanded or new programs.
General Statement on Health Policy
Adopted by the CAFP Board of Directors, February 1, 2017

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The role of the CAFP has always been to champion family medicine. The CAFP recognizes that the American political landscape is changing, and with these changes will come many new health policies. The statement below can serve as a guide for focusing our advocacy efforts for patients. The statement highlights marginalized groups that face uniquely challenging barriers to health care. They remain in the context of the broader social justice philosophy that all humans need good health care to flourish, however.

Based on a statement by the Cambridge Health Alliance and existing CAFP policy
https://medium.com/@socialjusticecoalition/a-letter-to-our-patients-in-the-trump-era-d99c9007f960#.w9im9sr9d

The CAFP affirms the following seven principles:

1) Health care is a human right.
   All people should have access to essential, effective health care regardless of their ability to pay. The CAFP supports measures that improve access and quality of care and will advocate for reforms that appropriately value primary and preventive care.

2) We believe in evidence-based medicine and public health policy.
   CAFP reaffirms its commitment to the principles of science. Medical research must be non-partisan, unbiased, and based on the scientific method. Public health policy must be evidence-based and free from political motivation. Social determinants of health and such things as a degraded environment that affects a community’s drinking water or its air quality also must be addressed.

3) Mental health services are a fundamental part of health care.
   CAFP supports parity for mental health care and treatment for substance use disorders. Efforts should be made to reduce stigma and remove barriers to mental health services. Addiction is a chronic and debilitating disease that requires compassion and treatment, not judgment and punishment.

4) Women’s health must be protected.
   CAFP rejects violence against women in all forms. CAFP supports women’s access to comprehensive health services without fear of intimidation or violence. This care must include safe and effective contraception and reproductive health services. CAFP supports every woman’s right to self-determination, without government interference in decisions that should be based solely on an individual woman’s values and safety in consultation with her physician.
CAFP opposes policies designed to restrict access to comprehensive reproductive health care by placing medically unnecessary regulatory burdens on physicians.

5) **CAFP believes patients deserve access to health care, regardless of immigration status.**
Family physicians treat immigrants and refugees every day. Many in these communities struggle to keep themselves and their families healthy with limited or nonexistent insurance coverage. CAFP believes communities are safer and healthier when all individuals, regardless of immigration status, have access to health care. CAFP rejects policy that requires physicians to report undocumented individuals as it is not consistent with our mission as health care providers.

6) **The neglect and mistreatment of marginalized communities affects health and must be opposed.**
CAFP believes that the experience of discrimination negatively affects health. Hate crimes and violence against religious, sexual, and racial minorities pose direct harm to patients. These problems are compounded by disparities in access to quality health care. CAFP opposes prejudice in all health care settings and communities.

7) **All people, regardless of their gender identity or sexual orientation, should be treated with dignity and respect.**
LGBTQ patients face challenges in accessing culturally competent, safe, and comprehensive health care. CAFP supports the equitable treatment of the LGBTQ population and stands against violence toward and victimization of these groups.