CALIFORNIA ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR CALIFORNIA

2020 All Member Advocacy Meeting

The Sheraton Grand | 1230 J Street | Sacramento

2020 CAFP Participants' Handbook

MARCH 14-16, 2020

We've Got an App for That!

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

The free app will be available to download March 1. All AMAM registrants will receive an email invitation with a link to download the app.

You may also download it directly from iTunes or Google Play by searching for "CAFP Events."
The AMAM app lets you do more and get more value from the event – right from your mobile device:

- See the full AMAM schedule sorted by day, speaker, track and rate the sessions directly on the app.
- Connect and exchange contact details with other attendees.
- Share your event experiences on Facebook, Twitter and LinkedIn.
- Follow the events on Twitter at #amam2020.
- Find sessions and locations with maps of session rooms.
- Catch notifications about networking opportunities, contests and other breaking event news sent directly to your device.

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

If you have any questions, please contact Josh Lunsford at jlunsford@familydocs.org or 415-345-8667.

Table of Contents

1 AMAM App Information
4 Message from Your Speaker and Vice Speaker
5 Schedule of Events
8 Roster of Delegates and Alternates
10 Board Members and Officers of CAFP
11 Instructions to Delegates and Alternates
15 Knowledge-Based Decision Making Process
16 Parliamentary Procedure

Resolutions and Background Materials

17 List of Resolutions
18 A-01-20 – Advocacy for Closure of Detention Camps
24 A-02-20 – Patient Protection of Information from Adverse Childhood Experiences (ACEs) Screening
27 A-03-20 – Advocating for State-Level and National Policies Regarding Climate Change
31 A-04-20 – Resident Bill of Rights
34 A-05-20 – Improved Quality of Reproductive Healthcare for Incarcerated People
37 A-06-20 – Removing Routine Ultrasound in Medication Abortion Protocols
40 A-07-20 – Support Single-Payer Health Insurance
44 A-08-20 – Ensure Affordable Access to Medical Treatments Developed on University Campuses
49 A-09-20 – Promoting a Conflict-Free California Academy of Family Physicians
54 A-10-20 – Support Long-Term Care
59 A-11-20 – Increase Education in Substance Abuse Disorder for Residency Programs
63 A-12-20 – Tapering Regimens for Patients on Long Term Opioid Therapy
67 A-13-20 – Annual Influenza Vaccine Mandate Among Required Vaccinations for Schools
71 A-14-20 – X the X Waiver
74 A-15-20 – Creating a Buprenorphine Exemption from the Controlled Substances Act
77 A-16-20 – Working Toward Zero Waste
81 A-17-20 – Promote the Development of Hospital-Based Violence Mitigation Programs
85 A-18-20 – Develop Ergonomics Curriculum in the Workplace
88 A-19-20 – Opposition to Title X
93 A-20-20 – Hospital and Clinic Exemption from PG&E Public Safety Power Shut Off Events
95 A-21-20 – Eliminate the Use of Race-Based Medicine
985 Bylaws Change Proposal and Language

Elections

120 Report of the 2019 Nominating Committee/Election Slate
121 Candidates' Statements

Organizational Information

125 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

126 Dashboard on Actions of the 2019 CAFP Board on Proposals from the 2019 All Member Advocacy Meeting

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

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

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

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

1. AMAM is not a clinical education opportunity – CAFP's Family Medicine Clinical Forum (May 15-17, 2020, in Long Beach) is the CAFP's primary venue for excellent continuing professional development programming – the AMAM sticks to policy issues affecting the practice of medicine and care of patients, although from time-to-time, a CME opportunity may be piggybacked with the AMAM, as with this morning's Safe Prescribing program. We very much hope to see you in Long Beach.
2. AMAM is not a partisan debating society – we are here to help find solutions and make certain CAFP's policies serve our members and their patients well. Opinions differ, of course, but discussion and dialogue are respectful and civil.

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

So, fasten your seatbelts, it's going to be a terrific ride!

Shannon Connolly, MD, Speaker Lauren Simon, MD, MBA, Vice Speaker

Detailed Schedule of Events

Shannon Connolly, MD, Speaker and Lauren Simon, MD, MBA, Vice Speaker

Saturday, March 14, 2020, 10:00 am – 1:30 pm **Board of Directors Meeting , Carr Room**	
Saturday, March 14, 2020 | Opening Session | 2:00 – 5:00 pm **Magnolia Room**	
1:00 – 2:00 pm	**All Member Advocacy Meeting (AMAM) Registration**
2:00 – 2:10 pm	**Opening Session – Welcome and Setting Expectations** **What is the AMAM and What We Will Do Over the Next Three Days** *Shannon Connolly, MD, Speaker* - Certification of Delegates - Nominations for the Floor - Presentation of Election Slate and vote by acclimation if no contested elections - Lisa Folberg, MPP, CEO Introduction ** Secretary/Treasurer Elected by the Board of Directors only*
2:10 – 2:25 pm	**Welcome** *Walt Mills, MD, CAFP President*
2:25 – 3:15 pm	**Legislative Briefing on CAFP Priority Advocacy Issues** *Carla Kakutani, MD, CAFP Legislative Affairs Committee Chair* *Adam Francis, CAFP Director of Government Relations* *Bryce Docherty and Vanessa Cajina, CAFP Legislative Advocates*
3:15 – 3:30 pm	**FP-PAC Report** *Jay W. Lee, MD, MPH, FP-PAC Chair*
3:30-5:30 pm	**Review of CAFP Actions on 2019 Resolutions** **Resolutions Hearing – CAFP Board of Directors** *Shannon Connolly, MD, Speaker* • Delegates to the AMAM consider and vote on elections, bylaws changes, dues/special assessment changes and memorial resolutions. • Presentation of testimony to the Board of Directors concerning proposed policies developed by members and chapters, and submitted via resolution. All members are invited to speak.

	The CAFP Board hears all proposals, takes action on them over the course of the year and reports back to the members at the next AMAM.
5:00 pm	**RECESS**
6:15 pm	**Dine Around Dinners** **Meet in the Lobby at 6:15 pm for 6:30 reservations** Join your fellow delegates and alternates for Dutch treat dining at one of several Sacramento restaurants. Sign-ups are available in the Magnolia Room. Dining groups can be organized by region or practice type or issue area if desired. Chapter Presidents are invited to a dinner at Cafeteria 15L, hosted by CAFP. The students and residents are invited to a social at Tiger, hosted by the CAFP Foundation.

Sunday, March 15, 2020 | Closing Session | 7:30 am – 1:30 pm **Magnolia Room**	
7:30 – 8:15 am	**All Member Advocacy Meeting** **Registration and Continental Breakfast (Table Topics)**
8:15 am	**All Member Advocacy Meeting Reconvenes**
8:15 – 8:20 am	**Certification of Delegates/Instructions to Delegates**
8:20 – 8:25 am	**(If there are Contested Elections) Election of Officers, AAFP Delegates and Alternates for 2020-2021, Nominating Committee Members 2020-21** ** Secretary/Treasurer Elected by the Board of Directors only*
8:25 – 8:40 am	**Report of the CAFP Foundation** *Marianne McKennett, MD, CAFP Foundation President*
8:40 – 8:45 am	**FP-Pac Weekend Update** *Jay W. Lee, MD, MPH, FP-PAC Chair*
8:45 – 10:15 am	**Town Hall on Primary Care Payment** *Lauren Simon, MD, MPH, Vice Speaker* • Presentation #1 and Q&A: 8:45 am – 9:15 am *Ashby Wolfe, MD, MPP, MPH – Chief Medical Officer, Region IX, CMS* • Presentation #2 and Q&A: 9:15 am – 9:45 am *Lance Lang, MD – Chief Medical Officer, Covered California* • Presentation #3 and Q&A : 9:45 am – 10:15 am *Farzad Mostashari, MD, ScM – CEO, Aledade*
10:15 – 10:45 am	**Primary Care Payment Table Top Discussion and Report Out** *Lauren Simon, MD, MPH, Vice Speaker*
10:45 – 11:00 am	**BREAK**

11:00 – 11:40 am	**Susan Hogeland Fellows Project Presentation** *Marianne McKennett, MD – CAFP Foundation President* *Adia Scrubb, MD and Jessica Farmer, MD*
11:40 – 11:45 am	**Hero of Family Medicine Award Announcement** *Walt Mills, MD, CAFP President*
11:45 am – 12:30 pm	**Keynote Speaker and Lunch** *Introduction by David Bazzo, MD – CAFP President-Elect*
12:30 – 1:20 pm	**Advocacy Quiz Show – How Much Have YOU Learned?** *Adam Francis, CAFP Director of Government Relations*
1:20 – 1:30 pm	**BREAK**
1:30 – 5:00 pm	**Training Tracks**
Track 1 1:30 – 3:00 pm	**Crafting Your Message and Telling Your Story** *Mark Bernheimer – Founder and Principal, Medical Works Group*
3:15 – 3:30 pm	**BREAK**
Track 2 3:15 – 5:00 pm	**How to Meet with Your Legislator** *Adam Francis – CAFP Director of Government Relations*
5:00 – 7:00 pm	**Special FP-PAC Donor Reception – Glide Market (next to first floor bar)** Open to all 2020 FP-PAC contributors at no additional cost
7:00 pm	**Evening Free – Dine Around Sacramento** (

Monday, March 16, 2020 | Family Medicine Lobby Day Breakfast and Awards **8:00 am – 3:30 pm, 3rd Floor**	
8:00 – 9:30 am	**Breakfast and Legislative Issues Orientation** CAFP Director of Government Relations Adam Francis, and Legislative Advocate
9:30 – 10:30 am	**Legislative Meeting Prep in Groups**
10:30 – 11:00 am	**Champion of Family Medicine Presentation**
11:00 – 11:15 am	**Walk to the Capitol Building**
11:15 – 11:30 am	**Group Photo in front of the Capital (White Coats, please)**
11:30 am – 3:30 pm	**Legislative Visits at the Capitol**

Roster of 2020 Delegates and Alternates

County/Chapter	Delegates	Alternates
Alameda/Contra Costa (5)	Dr. Anastasia Coutinho Dr. Chrissy Chavez-Johnson Dr. C. Emily Lu Dr. Travis Bias Dr. Scott Loeliger	
Amador (1)		
Butte-Glenn-Tehama (1)		
Fresno-Kings-Madera (2)	Dr. Nidia Payan Dr. Jyothi Patri	Dr. Alex Sherriffs Dr. Robin Linscheid
Humboldt-Del Norte (1)		
Imperial (1)	Dr. Clara Padron Spence	
Inyo-Mono-Alpine (1)		
Kern (2)	Dr. Ndukwe Odeluga Dr. Jasmeet Bains Dr. Michelle Quiogue*	
Lassen-Plumas-Modoc-Sierra (1)		
Los Angeles (12)	Dr. Jerry Abraham Dr. Rebecca Bertin Dr. Monique George Dr. Nzinga Graham Dr. Emma Hiscocks Dr. Sam Huang Dr. Elisabeth Kalve Dr. Gregory Lewis Dr. Daniel Pio Dr. Felix Aguilar Dr. Mark Dressner Dr. Stacey Ludwig	Dr. Frank Aligagna Dr. Evan Bass Dr. Daniel Castor Dr. Francine Frater Dr. Katrina Miller Dr. Gil Solomon Dr. Michael Core Dr. Michelle Crespo Dr. Patrick Dowling Dr. Sirisha Mohan Dr. Divya Shenoy
Mendocino-Lake (1)		
Merced-Mariposa (2)		
Napa (1)	Dr. Tessa Stecker	Dr. Jessica Mitter Pardo
North Bay (3)	Dr. Elizabeth Shaw Dr. Francesca Manfredi Dr. Leigh Vall-Spinosa	Dr. Toni Rodriguez Dr. Panna Lossy Dr. Tara Scott
Orange (6)	Dr. Kim Yu Dr. William Woo Dr. Duy Nguyen Dr. Anupam Gupta Dr. Abbas Naqvi Dr. Christina Deckert	

County/Chapter	Delegates	Alternates
Placer-Nevada (2)	Dr. Karina Gookin	
Riverside-San Bernardino (7)	Dr. Shayne Poulin Dr. Prashanth Bhat Dr. Ecler Jacqua Dr. Moazzum Bajwa Dr. Scott Nass Dr. Nadia Khan Dr. Carrie Bacon	Dr. Elizabeth Dameff Dr. Paratou Farhadian Dr. Naz Khan Merfeld
Sacramento Valley (5)	Dr. Bill Eng Dr. Toussaint Mears-Clark Dr. Tonatzin Rodriguez Dr. Ava Asher Dr. Brea Bondi-Boyd	Dr. Kim Buss Dr. Erika Roshanravan Dr. Warren Brandle Dr. Carla Kakutani Dr. John (Andy) Brothers
San Diego (6)	Dr. Al Ray Dr. Joseph Leonard Dr. Merritt Mathews Dr. Lee Ralph Dr. Lance Fuchs Dr. Randy Swartz	Dr. Melissa Campos Dr. Patrick Yassini Dr. Anne Kaufhold Dr. Kristin Brownell Dr. Maria Carreido-Ceniceros Dr. Daniel Slater
San Francisco (2)	Dr. Clarissa Kripke Dr. Sunny Pak	
San Joaquin-Calavaras-Tuolomne (2)	Dr Elyas Parsa Dr Michelle Rowe	Dr. John Krpan Dr. Asma Jaffri
San Luis Obispo (2)		
San Mateo (2)	Dr. Steven Howard Dr. Alex Moldanado	
Santa Barbara (2)		
Santa Clara (4)	Dr. Diana Mokaya Dr. Iva Ilic Dr. Susan Wilturner Dr. Jen Tran	Dr. Jake Evans Dr. Rekha Reddy
Santa Cruz – Monterey (2)	Dr. Allen Bueno del Bosque Dr. Blaire Cushing	Dr. Eugene Santillano Dr. Jeannine Rodems
Shasta-Trinity (2)		
Siskiyou (1)		
Solano (2)	Dr. Matt Symkowick Dr. Rossan Chen	Dr. Robert Moore
Stanislaus (2)	Dr. Silvia Diego Dr. Nicole McLawrence	Dr. April Gunn Dr. Raeleigh Payanes
Tulare (2)		

Ventura (3)	Dr. Helen Petroff Dr. Leslie Lynn Pawson	
Yuba-Sutter-Colusa (1)		
Student and Resident Council (2 Students and 2 Residents)	Dr. Elizabeth Sophy (R) Dr. Anna Askari (R) * Michelle Do (S) * Susan Wang (S) *	Dr. Lulua Bahrainwala (R) * Dr. Rashma Ramachandran (R) * Hannah Dragomanovich (S) *

CAFP Officers and Board of Directors – 2019-2020	
Walter Mills, MD	President
David Bazzo, MD	President-Elect
Lisa Ward, MD, MScPH, MS	Immediate Past President
Shannon Connolly, MD	Speaker
Lauren Simon, MD	Vice Speaker
Raul Ayala, MD	Secretary-Treasurer
Carol Havens, MD	AAFP Delegate
Jeffrey Luther, MD	AAFP Delegate
Jay W. Lee, MD, MPH	AAFP Alternate Delegate**
Lee Ralph, MD	AAFP Alternate Delegate**
Marianne A. McKennett, MD	CAFP-F President
Anthony “Fatch” Chong, MD	District I
Jorge Galdamez, MD	District II
Kevin Rossi, MD	District III
Arthur Ohannessian, MD	District IV
Maisara Rahman, MD	District V
Raul Ayala, MD	District VI
Grace Chen Yu, MD	District VII
Jeremy Fish, MD	District VIII
Ron Labuguen, MD	District IX
Nate Hitzeman, MD	District X
Steven Harrison, MD	Rural Director
Alex Mroszczyk-McDonald, MD	Young Physician Director
Brent Sugimoto, MD, MPH	*CFP* Editor** and AAFP Board**
Robert Assibey, MD	Resident Co-Director***
Elizabeth Sophy, MD	Resident Co-Director***
Andrea Banuelos Mota	Student Co-Director***
Zachary Nicholas	Student Co-Director***

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

*** Non-voting member*

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

2020 Instructions to Delegates and Alternates
CAFP All Member Advocacy Meeting

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

Introduction:

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

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

Advance Preparation: In this Handbook, you will find the Report of Actions of the 2020 All Member Advocacy Meeting and how to access 2019 reports about the CAFP and the CAFP Foundation. Please read the Report of Actions carefully so you will be familiar with the previous actions of the AMAM, the policies considered.

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

What to Do on Site:

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

2. **Certification of Delegates:** CAFP bylaws require that Delegates to AMAM must be reported to the secretary/treasurer sixty (60) working days prior to AMAM (January 10, 2020). 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 2:30 pm, Saturday, March 14, 2020 following lunch and again on Sunday, March 15, 2018 at 8:30 am following breakfast at The Sheraton Grand Hotel, 1230 J Street, Sacramento, CA. The order of business will be as outlined in the Participants' Handbook and may be changed by the Speaker of the AMAM as necessary. Meeting rooms also are subject to change.

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

Submission of Resolutions: Resolutions to be submitted to the AMAM should have been submitted to the Academy or the Speaker of the AMAM at least sixty (60) working days prior to the meeting during which they are to be considered (January 10, 2020). 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 2020, the Delegates of the AMAM will meet first at 2:00 pm Saturday, March 14 to consider resolutions submitted to the AMAM.

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 CAFP Nominating Committee nominated candidates for the following positions, to be elected by the AMAM (The Committee's report is found on page 111):

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

The committee may also submit nominations for District Directors when nominations were not made by a District. In addition, it submits nominations to the Board of Directors for Secretary/Treasurer and Editor. These individuals are elected at the AMAM, but ONLY by members of the Board of Directors.* Nominating Committee members from the Board are elected by the Board of Directors at its first meeting following the Annual Meeting. Members of the Committee from the AMAM must be delegates and are elected by the AMAM and begin serving the same year (two-year terms).

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

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

Knowledge-Based Decision Making Process

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

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

This process poses four questions:

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

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

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

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

Parliamentary Procedure

Sturgis Standard Code of Parliamentary Procedure

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

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

Resolutions and Background Materials

A-01-20 – Advocacy for Closure of Detention Camps
A-02-20 – Patient Protection of Information from Adverse Childhood Experiences (ACEs) Screening
A-03-20 – Advocating for State-Level and National Policies Regarding Climate Change
A-04-20 – Resident Bill of Rights
A-05-20 – Improved Quality of Reproductive Healthcare for Incarcerated People
A-06-20 – Removing Routine Ultrasound in Medication Abortion Protocols
A-07-20 – Support Single-Payer Health Insurance
A-08-20 – Ensure Affordable Access to Medical Treatments Developed on University Campuses
A-09-20 – Promoting a Conflict-Free California Academy of Family Physicians
A-10-20 – Support Long-Term Care
A-11-20 – Increase Education in Substance Abuse Disorder for Residency Programs
A-12-20 – Tapering Regimens for Patients on Long Term Opioid Therapy
A-13-20 – Annual Influenza Vaccine Mandate Among Required Vaccinations for Schools
A-14-20 – X the X Waiver
A-15-20 – Creating a Buprenorphine Exemption from the Controlled Substances Act
A-16-20 – Working Toward Zero Waste
A-17-20 – Promote the Development of Hospital-Based Violence Mitigation Programs
A-18-20 – Develop Ergonomics Curriculum in the Workplace
A-19-20 – Opposition to Title X
A-20-20 – Hospital and Clinic Exemption from PG&E Public Safety Power Shut Off Events
A-21-20 – Eliminate the Use of Race-Based Medicine

Bylaws Change Proposal and Language

Res. A-01-20

TITLE: **Advocacy for Closure of Detention Camps**

Introduced by: Ian Kim MD, Esther Kang, Marisol Solis, Kim Tran, Marina Sebastiano, Matt Paranial, and Kevin Durgun MD

WHEREAS, the American Academy of Family Physicians (AAFP), California Academy of Family Physicians (CAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Psychiatric Association (APA), American College of Obstetricians and Gynecologists (ACOG), and the American College of Emergency Physicians (ACEP) have previously called for an end to family separation and a reinstatement of the Flores Settlement Agreement [1, 2, 3], and

WHEREAS, previously, AAFP has adopted policies at the 2018 and 2019 Congress of Delegates stating, "That the American Academy of Family Physicians support a progressive immigration policy that would recognize the human rights of migrants and immigrants and that would allow them access to health care" [4] and "any individuals in detention facilities with age appropriate food, water, personal hygiene, and health care" [5], and

WHEREAS, Doctors for Camp Closure (D4CC) is a nonpartisan organization of physicians that has recently called attention to medical neglect in U.S. detention centers of migrants seeking asylum, and

WHEREAS, D4CC has written a Position Statement calling for four things: (1) immediate end of the use of detention, to be replaced with well-established and effective alternatives to detention; (2) immediate end to separation of families; (3) immediate implementation of independent medical oversight of migrant detention centers to ensure standards of medical care are being met [6]; and (4) immediate cessation of dangerous deportations, in which individuals are deported to dangerous and deadly conditions in their countries of origin or are deported to settings in which they face life-threatening medical complications, and

WHEREAS, the American Academy of Pediatrics has stated, "The Department of Homeland Security facilities do not meet the basic standards for the care of children in residential settings," and, "From the moment children are in the custody of the United States, they deserve health care that meets guideline-based standards, treatment that mitigates harm or traumatization, and services that support their health and well-being" [7], and

WHEREAS, migrants held in U.S. detention centers are subjected to well-documented medical neglect -- including unreasonable delays in care, poor practitioner and nursing care, and botched emergency

responses -- that greatly increase their risks of trauma, mental and physical illnesses, and death [8, 9]. Substandard care in detention centers contributed to 8 of 15 deaths from 2015-2017 [8], and

WHEREAS, alternatives to detention -- such as community support and release on recognizance -- are well-established programs that are known to be far less expensive than detention, far less inhumane than detention, and highly effective. Alternative programs such as the Alternatives to Detention Program (a private prison company) have already been funded and overseen by the federal government. An alternative to detention program that paired people with social workers and connected them with housing and legal resources found that 99.6% percent of program enrollees attended court dates [10], and

WHEREAS, alternatives are widely used in the pre-trial criminal justice context. They are recommended as cost-savers by the American Jail Association, American Probation and Parole Association, American Bar Association, Association of Prosecuting Attorneys, Heritage Foundation, International Association of Chiefs of Police, National Conference of Chief Justices, National Sheriffs' Association, Pretrial Justice Institute, Texas Public Policy [8], and

WHEREAS, the cost of daily participation in the ICE program is $4.43 per day, compared to the daily costs of detention which are $129.64 for one adult and $295.94 for a member of a family unit. Compliance rate was 77 percent in 2018 [8], and

WHEREAS, there are numerous reported cases of migrants who, having survived trauma and escaped from dangerous conditions in their countries of origin, were killed shortly after being deported back to those conditions [11, 12]. Deportation is especially dangerous for people with chronic medical conditions [13], and

WHEREAS, UNHCR (the UN refugee agency), states that appropriate medical treatment must be provided where needed, including psychological counselling, in its Guidelines on the Applicable Criteria and Standards relating to the Detention of Asylum-Seekers and Alternatives to Detention [14], therefore be it

RESOLVED: That the CAFP issues an official statement calling for: (a) immediate end of the use of detention, to be replaced with well-established and effective alternatives to detention; (b) immediate end to separation of families (consistent with previous CAFP/AAFP positions); (c) immediate implementation of independent medical oversight of migrant detention centers to ensure standards of medical care are being met; and (d) immediate cessation of dangerous deportations, in which individuals are deported to life-threatening conditions in their countries of origin or are deported to settings in which they face life-threatening medical complications, and be it further

RESOLVED: that the CAFP forwards the above statement to the Congress of Delegates for National Action.

References:

1. American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, and American Psychiatric Association. Joint Statement of America's Frontline Physicians Opposing Final Rule Rolling Back Protections in Flores Settlement Agreement. Apr 2019.
2. Linton, J. M., & Green, A. (2019). Providing Care for Children in Immigrant Families. Pediatrics, 144(3). doi: 10.1542/peds.2019-2077
3. American College of Emergency Physicians. ACEP Opposes Current DHS Practices of Family Separation. June 2018.
4. AAFP Resolution No. 513 Immigration Policy - Congress of Delegates 2018. Proposed by New Mexico Chapter. 2018.
5. AAFP Resolution No. 407 Family Separation - Congress of Delegates 2019. Proposed by New Mexico Chapter. 2019.
6. Doctors for Camp Closure. Doctors for Camp Closure Official Position Statement. Oct 2019.
7. Julie M. Linton, Marsha Griffin, Alan J. Shapiro, Council on Community Pediatrics. Pediatrics May 2017, 139 (5) e20170483; doi: 10.1542/peds.2017-0483
8. American Civil Liberties Union. Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention. 2018. Retrieved from www.aclu.org/report/code-red-fatal-consequences-dangerously-substandard-medical-care-immigration-detention
9. von Werthern, M., Robjant, K., Chui, Z. et al. The impact of immigration detention on mental health: a systematic review. BMC Psychiatry 18, 382 (2018) doi:10.1186/s12888-018-1945
10. American Civil Union Liberties. Alternatives to Immigration Detention: Less Costly and More Humane than Federal Lock-Up. Retrieved from www.aclu.org/other/aclu-fact-sheet-alternatives-immigration-detention-atd
11. Tsou, P. Y. (2018). A Pediatrician's Day in Immigration Court. Pediatrics, 141(1), e20170921.
12. Stillman, S. (2019, July 9). When Deportation Is a Death Sentence. Retrieved from www.newyorker.com/magazine/2018/01/15/when-deportation-is-a-death-sentence
13. Rubin, A. J., & Bogel-burroughs, N. (2019, August 8). ICE Deported Him to a Country He'd Never Seen. He Died 2 Months Later. Retrieved from www.nytimes.com/2019/08/08/us/iraq-jimmy-aldaoud-deport.html
14. UNHCR. Guidelines on the Applicable Criteria and Standards relating to the Detention of Asylum-Seekers and Alternatives to Detention. Retrieved from www.unhcr.org/en-us/publications/legal/505b10ee9/unhcr-detention-guidelines.html

Speaker's Note:
Policy and materials developed by CAFP support the issuance of the statement in opposition to camps. Our materials assert:

- Migrants seeking asylum have not committed crimes. The inhumane detention of asylum seekers criminalizes a process that is a human right and that is recognized and protected by both U.S. and international law. According to U.S. and international law, migrants in detention have rights to basic standards of medical care [8]
- People held in immigration detention have constitutional protection under the Fifth Amendment, which prohibits the imposition of punishment upon any person in the custody of the United States without due process of law. [8]
- The U.S. is party to the International Covenant on Civil and Political Rights (ICCPR), Article 9 of which states "Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention," and which furthermore states that governments should provide "adequate medical care during detention." [8]
- The U.S. is party to the Convention Against Torture (CAT), the monitoring body of which has found that failure to provide adequate medical care can violate the CAT's prohibition of cruel, inhumane or degrading treatment. [8]
- While held in U.S. detention centers, migrants--over 50% of whom are composed of families and unaccompanied children--are subjected to well-documented medical neglect, including unreasonable delays in care, poor practitioner and nursing care, botched emergency responses, the withholding of basic preventive health measures such as vaccinations, and the withholding of basic hygiene supplies, that greatly increase their risks of trauma, mental and physical illnesses, and death. [6, 8, 9]
- The subject of this resolution does not relate to the objectives described in the CAFP 2019-2021 Strategic Plan.

Fiscal Note:
There would be minimal cost for drafting a letter and releasing a statement.
There would be no significant cost as a result of referring for national action.

PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this re solution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?
This resolution seeks to advocate for the closure of detention camps and the end to inhumane treatment of migrants and asylees at the borders of the United States. Numerous studies have documented the medical neglect and trauma that detainees are subjected to in detention camps. In addition, in the past few years, new federal policies--such as those supporting stricter caps on

immigration, family separation, and "remain in Mexico" protocols--have made it increasingly difficult for migrants and asylees to seek refuge and help at our borders [1-6].

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

Family physicians across California and the United States are on the clinical front lines providing care to immigrant families and communities most directly impacted by federal immigration policy. Family physicians at the southern borders are particularly affected by immigration policies; roughly a third of the nation's 44.4 million immigrants live in California (24%) and Texas (11%). There are roughly 44.4 million immigrants in the United States, with an estimated 1 million individuals immigrating or seeking refuge in the U.S. each year [10].

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

Doctors for Camp Closure (D4CC; www.d4cc.nationbuilder.com) is a nonpartisan organization comprised of physicians and medical students who have recently called to attention the inhumane treatment of migrants and asylum seekers who are coming to the borders of the United States. D4CC has written a comprehensive position statement calling for three things: (1) immediate end of the use of detention, to be replaced with well-established and effective Alternatives to Detention; (2) immediate end to separation of families; (3) immediate implementation of independent medical oversight of migrant detention centers to ensure standards of medical care are being met, (4) immediate cessation of dangerous deportations, in which individuals are deported to dangerous and deadly conditions in their countries of origin or are deported to settings in which they face life-threatening medical complications [1].

Our proposed resolutions:

1. CAFP issues an official statement calling for: (a) immediate end of the use of detention, to be replaced with well-established and effective alternatives to detention; (b) immediate end to separation of families (consistent with previous CAFP/AAFP positions); (c) immediate implementation of independent medical oversight of migrant detention centers to ensure standards of medical care are being met; and (d) immediate cessation of dangerous deportations, in which individuals are deported to life-threatening conditions in their countries of origin or are deported to settings in which they face life-threatening medical complications; and

2. CAFP forwards the above statement to the Congress of Delegates for National Action.

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

While held in U.S. detention centers, migrants--over 50% of whom are composed of families and unaccompanied children--are subjected to well-documented medical neglect, including unreasonable delays in care, poor practitioner and nursing care, botched emergency responses, the withholding of basic preventive health measures such as vaccinations, and the withholding of basic hygiene supplies, that greatly increase their risks of trauma, mental and physical illnesses, and death. For example, substandard care contributed to 8 of 15 deaths from 2015-2017 in detention camps. Recently, in 2019, multiple migrant children died of influenza while in custody at detention camps. Finally, multiple studies have shown the longstanding adverse effects of immigration detention camps on mental health [9].

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

1. Doctors for Camp Closure. Doctors for Camp Closure Official Position Statement. Oct 2019.
2. Davis, Julie; Shear, Michael. How Trump Came to Enforce a Practice of Separating Migrant Families. The New York Times. Retrieved June 19, 2018.
3. Scherer, Michael; Dawsey, Josh. "Trump cites as a negotiating tool his policy of separating immigrant children from their parents". The Washington Post. Retrieved June 17, 2018.
4. Rucker, Philip; Dawsey, Josh; Kim, Seung Min (June 18, 2018). Trump defiant as crisis grows over family separation at the border. The Washington Post. Retrieved June 19, 2018.
5. UN says Trump separation of migrant children from parents 'may amount to torture'. The Independent. June 22, 2018.
6. Michael D. Shear, Julie Hirschfeld Davis, Thomas Kaplan & Robert Pear, Federal Judge in California Issues Injunction Halting Government From Separating Families, The New York Times (June 26, 2018).
7. American Civil Liberties Union. Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention. 2018.
8. American Civil Union Liberties. Alternatives to Immigration Detention: Less Costly and More Humane than Federal Lock-Up. <www.aclu.org/other/aclu-fact-sheet-alternatives-immigration-detention-atd>
9. von Werthern, M., Robjant, K., Chui, Z. et al. The impact of immigration detention on mental health: a systematic review. BMC Psychiatry 18, 382 (2018) doi:10.1186/s12888-018-1945
10. Radford, J. Key findings about U.S. immigrants. Pew Research Center. Retrieved Jan 2, 2019.

Res. A-02-20

TITLE: **Patient Protection of Information from Adverse Childhood Experiences (ACEs) Screening**

Introduced by: Adia Scrubb, MD and Yasmin Bains, MS, OMSIV

Endorsements: Napa-Solano and East Bay Chapters

WHEREAS, Adverse Childhood Experiences (ACEs), traumatic events experienced in childhood, as determined by the landmark CDC-Kaiser Adverse Childhood Experiences Study, have been associated with increased risk of chronic health conditions, mental illness, and substance misuse in adulthood[1,2], and

WHEREAS, as of January 1, 2020, California Medi-Cal providers will be reimbursed for ACEs screening as part of the pediatric and adult (under age 65) well exam[3], and

WHEREAS, the clinical response to identification of ACEs includes trauma-informed care, identification and treatment of ACE-associated health conditions, validation of protective factors, referral to resources and follow-up as needed[4], and

WHEREAS, the sensitive nature of the ACEs screening, ACEs-associated health-conditions[5], limited time allocation in primary care office visits, limited provider training and a cap on Medi-Cal payment for screening may lead to overdiagnosis, overtreatment, over-referring and the risk of the ACEs screening score being misinterpreted as a diagnostic score by patients, providers and insurance companies, and

WHEREAS, billing and coding are based upon the patient's total ACEs score, with a score of 4 or greater to indicate high risk and a score of 0 to 3 to indicate lower risk[6]. Misinterpretation of the ACEs score may be used by insurance companies to screen for risk, and

[1] https://www.cdc.gov/vitalsigns/aces/pdf/vs-1105-aces-H.pdf
[2] https://www.ajpmonline.org/article/S0749-3797(98)00017-8/fulltext
[3] http://centerforyouthwellness.org/wp-content/uploads/2019/12/CYW_Impact_Annual-Report_2019.pdf
[4] https://www.acesaware.org/treat/clinical-assessment-treatment-planning/
[5] https://www.acesaware.org/wp-content/uploads/2019/12/ACEs-Clinical-Algorithms-Workflows-and-ACEs- Associated-Health-Conditions.pdf
[6] https://www.acesaware.org/about-aces-aware/faq/

WHEREAS, effective as of 2019, the 2017 Tax Reconciliation Act repealed the Affordable Care Act's individual shared responsibility penalty. Healthy and/or young individuals can elect to not have insurance which can potentially distort the risk pool and lead to adverse selection, and

WHEREAS, 51 to 75% of populations surveyed have at least one ACEs score. An ACEs score of 4 or more is associated with increased risk of chronic disease, high risk behavior, disability, mental health issues, smoking, diabetes, and alcohol abuse. Increased ACEs screening can potentially identify a new "high risk" pool to practitioners and administrative bodies[7], and

WHEREAS, SB 78 signed into law by Governor Newsom in June 2019 requires Minimal Essential Coverage in the state of CA with exemptions for hardship and religion[8], and

WHEREAS, insurance companies experiencing adverse selection may leave the marketplace or screen for risk, and

WHEREAS, the ACEs survey collects historical patient information associated and high ACEs scores may potentially serve as a surrogate marker of high risk, in place of pre-existing conditions, among insurance companies, and

WHEREAS, the collection of data on ACEs is a not a benign intervention which may cause further stigmatization and affect quality and access to health care for vulnerable populations, therefore be it

RESOLVED: That the CAFP support the collection of information from the ACEs screening be subject to pre-existing conditions protections for health insurance, and be it further

RESOLVED: That CAFP support the ACEs score as a tool for screening purposes only, and not diagnostic of the implied risk condition, and be it further

RESOLVED: That CAFP refer to AAFP for national action.

[7] Campbell JA, Walker RJ, Egede LE. Associations Between Adverse Childhood Experiences, High-Risk Behaviors, and Morbidity in Adulthood. Am J Prev Med. 2016 Mar

[8] https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB78

Speaker's Note:

- CAFP is engaged with state-level ACEs efforts, including as a member of the Trauma Informed Care Implementation Planning Committee and in producing education on integrating the use of ACE's screening into primary care practices.
- Support for the assessment of early childhood trauma is well-established in AAFP policy:

  Adverse childhood experiences (ACEs) are traumatic events or chronic stressors that are uncontrollable to a child. It is estimated that 64% of Americans have experienced at least one ACE and 13% have experienced four or more. ACEs incorporate a variety of events and stressors including, but not limited to: child abuse and neglect, sexual abuse, domestic violence, substance abuse, mental illness, crime, extreme economic adversity, bullying and school or community violence, sudden loss of a loved one, sudden and frequent relocation, serious accidents or life-threatening childhood illness, natural disasters, kidnapping, and war. Experiencing ACEs without supportive adults can lead to toxic stress, or an extensive activation of the stress response system. This can lead to an increased allostatic load, or "wear and tear" on the body and brain. ACEs have been linked with maladaptive health behaviors including, but not limited to physical inactivity, alcohol, substance and tobacco misuse and negative health outcomes, including but not limited to heart disease, cancer, chronic lung disease, skeletal fractures, liver disease, suicide, depression, obesity and poor self-rated health throughout the lifespan.

  Due to the dramatic impact ACEs have on behavior and health outcomes, the American Academy of Family Physicians (AAFP) encourages physicians to learn about ACEs and to recognize the impact ACEs may have on their patients' health. In addition, the AAFP supports programs that aim to: (1) prevent the occurrence of ACEs; (2) reduce the severity of the acute consequences of ACEs; and (3) treat long-term consequences of ACEs. Examples of these types of programs include but are not limited to (1) parental education, (2) parent-child interaction and psychotherapy, (3) dual substance abuse treatment and parenting interventions, and (4) trauma-informed care. Additionally, the AAFP supports research on the effectiveness of ACEs screening and mitigation strategies to improve health outcomes, and advocates for public policies and legislation to support these initiatives. (2019 COD)

- ACE's is explicitly supported in the 2019-2021 CAFP Strategic Plan.

Fiscal Note:

There would be no significant cost for supporting the proposed ACEs policy as it would fall within established procedures for updating and taking positions on proposed legislation and policy.

There would be no significant cost as a result of referring for national action.

Res. A-03-20

TITLE: **Advocating for state-level and national policies regarding climate change**

Introduced by: Rossan Chen, MD, MSc, Kaiser Napa Solano Family Medicine Residency Program; Anastasia Coutinho, MD MHS, La Clinica Monument; Hannah Dragomanovich, OMS-3, Touro University College of Osteopathic Medicine; Panna Lossy MD, Sutter Santa Rosa Family Medicine Residency Program; Sara Martin, MD MSc, Sutter Santa Rosa Family Medicine Residency Program

Endorsements: Napa-Solano, East Bay, and North Bay Chapters

WHEREAS, the United Nations' Intergovernmental Panel on Climate Change (IPCC) has published its fifth report concluding that the overwhelming cause of climate change is the anthropogenic burning of fossil fuels[9], and

WHEREAS, the CAFP and the AAFP are recognized leaders in advocating for the health of all Americans, especially the vulnerable and underserved, who are most likely to be the first harmed by a changing climate, and

WHEREAS, physicians have committed to protecting public and community health and, thus, share an obligation to influence medical institutions and policy makers to do the same, and

WHEREAS, climate change causes numerous harmful public health effects across multiple domains, including increases in respiratory, cardiovascular and allergic disease, heat-related illness, changes in the prevalence and geographical distribution of food- and water-borne illnesses and other infectious diseases, food insecurity, increasing natural disasters and their effects, injuries and premature deaths related to these extreme weather events, and threats to mental health[10], and

WHEREAS, California has had unprecedented wildfires that have led to disruptive power outages, both of which have wrought havoc on local medical centers and medical training systems, impacting the health of patients as well as the ability to provide high quality care and train high quality physicians, and

[9] IPCC, 2014: *Climate Change 2014: Synthesis Report. Contribution of Working Groups I, II and III to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change* [Core Writing Team, R.K. Pachauri and L.A. Meyer (eds.)]. IPCC, Geneva, Switzerland, 151 pp.
[10] Luber G, Knowlton K, et al. . "Human Health." *National Climate Assessment*. Accessed on January 2, 2020. Accessed on: nca2014.globalchange.gov/report/sectors/human-health.

WHEREAS, the other leading primary care societies including the American Academy of Pediatrics (AAP) and the American College of Physicians (ACP) have taken the lead in creating position papers and policies that more thoroughly address climate change and health[11], therefore be it

RESOLVED: That the CAFP support legislation that addresses climate change and decreases the impact of the healthcare system on carbon emissions and waste, and be it further

RESOLVED: That the CAFP lobby for physician representation in government agencies working on climate change and environmental issues, and be it further

RESOLVED: That the CAFP establish a climate change committee to partner with other state and national medical organizations to (1) mitigate the health effects of climate change on our patients and institutions and (2) support health care organizations decreasing their impact on the environment, and be it further

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

Speaker's Note:

- AAFP has adopted policy supporting the notion that climate change can and does influence population health:

  In recognition of the numerous and serious adverse health consequences resulting from pollution, greenhouse gas emissions from human activities, climate change and ozone layer depletion, the American Academy of Family Physicians (AAFP) recommends strong action on the part of all public and private institutions to reduce pollution of our land, atmosphere, and water. Pollution, human greenhouse gas emissions, and ozone depletion lead to numerous severe consequences, including climate change and poor health outcomes. Those consequences more often affect vulnerable populations.

  The AAFP opposes any federal or state government actions to reduce public access to environmental health research data. The AAFP also opposes any actions taken by local, state, or national governments that weaken existing stream and air protections.

  The AAFP will continue to work with other health care organizations to inform the public and policymakers about the harmful health effects of climate change. The AAFP will also highlight the

[11] Crowley RA et al. Climate Change and Health: A Position Paper of the American College of Physicians. *Annals Int Med. 2016; 164(9):608-610.*

immediate and long-term health benefits associated with decreased greenhouse gas emissions and clean air and water.

The AAFP recognizes that toxins and chemicals are the proximate cause of certain diseases, and pollution in water and air aggregates in human bodies through a variety of channels, including dermal contact, ingestion, inhalation, and bioaccumulation. The AAFP supports policies to research and manage toxic environmental exposures, particularly those that can cause irreversible damage to health, especially the health of members of vulnerable populations. (1969) (2019 COD)

- Climate change is not in the 2019-2021 CAFP Strategic Plan, although existing policy allows CAFP to support legislative proposals to reduce the existence and impact of climate change.

Fiscal Note:
There would be no significant cost for supporting legislation as it would fall within established procedures for updating and taking positions on proposed legislation and policy.

There may be significant cost to advocate for physician representation in government agencies working on climate change and environmental issues as it would require significant staff time and minimal travel costs. It could also potentially require hiring advocates as this is outside the parameters of our current lobbying contract.

Establishing a new CAFP Committee distinct from those already staffed and funded in the CAFP budget would be significant. Assuming at least one in-person meeting, costs would likely exceed $10,000.

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 address the growing threat of climate change and the need for family physicians to be involved in fighting against the damaging effects that occur as a result of climate change as well as preventing further long lasting effects.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?
All CAFP members and patients are affected by climate change. There are over 39 million Californians and everyone is impacted by the effects of climate change regardless of socioeconomic status.

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

We wish that CAFP establish a committee of attending physicians, residents, and students in order to address the growing threat of climate change, educate lawmakers about the importance of doing everything in our power to protect our planet, and take action to address the health concerns that exist as a result of climate change. We would also like CAFP lobbyists to advocate for bills they come across that address climate change so that CAFP and family physicians in general are involved in the solution fighting against climate change.

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

There is a plethora of evidence that proves that climate change is not only real, but an imminent threat to our community on a local, national, and international scale. As physicians, it is our duty to advocate for the wellbeing of our patients, and climate change is a threat to everyone's well being. See footnotes on resolution for references.

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

See footnotes on resolution for references.

Res. A-04-20

TITLE: Resident Bill of Rights

Introduced by: Dr. Allen Bueno del Bosque and Dr. Blair Cushing

WHEREAS, successful completion of residency training is a requirement to obtain a fully license to practice medicine in the state of California, and

WHEREAS, residency is well known to be particularly mentally and emotionally taxing on physicians in training for a variety of reasons, and

WHEREAS, rates of burnout and physician suicides are at all-time highs and physicians in training are at particularly high risk given their vulnerable position, and

WHEREAS, the types of support offered through physician wellness programs serve more as a bandage or temporary reprieve rather than as solutions to address the root cause of these complex problems, and

WHEREAS, even the best program directors and faculty can unintentionally perpetuate historical hierarchical patterns of abuse towards physicians in training by emulating the power dynamics that they themselves had to experience, and

WHEREAS, additional attention needs to be paid to ways in which our own programs may act unjustly or fail to allow for due process when decisions are made about academic progress or disciplinary matters towards residents, therefore be it

RESOLVED: That the California Academy of Family Physicians in collaboration with the CAFP Resident Council develop a universal Resident's Bill of Rights which could be applicable across training sites; and be it further resolved

RESOLVED: That the California Academy of Family Physicians will strongly encourage all family medicine residency programs in the state to implement an endorsed Resident Bill of Rights in order to better ensure equal protections and improved working conditions for all family physicians in training.

Speaker's Note:

- Neither CAFP nor AAFP have policy supporting the creation of a Resident Bill of Rights, and it is not represented in the 2019-2021 CAFP Strategic Plan.
- Residents Bills of Rights have been produced by student and residency advocacy groups, many in petition form, and have been signed by significant numbers of CAFP and AAFP members.

Fiscal Note:
The resource implications for CAFP are moderate based on the amount of staff time required. Staff would be required to identify existing resources and assess for appropriateness, then develop and finalize the bill of rights. A communications strategy would also be required to ensure uptake by residency program directors and faculty.

PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this re solution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?
All resident physicians are part of a uniquely vulnerable population serving as both students and employees. Successful completion of training is a requirement to practice independently in the future – the final payoff of many years of dedicated study. Oftentimes program directors or faculty groups are acting as both judge and jury in disciplinary matters, justifying their actions by claiming that residents are a type of "student" in an educational program. Rights that would otherwise be afforded to an employee under state and federal labor laws are often disregarded or residents are not informed about their ability to contest such decisions or request a formal process with human resources as any other employee.

Working conditions that would be considered unconscionable for those in any other line of work are considered the norm in residency training. Despite these intense pressures, residents are held to high standards of performance that are also high stakes for their future career aspirations. They are often left with little recourse and inadequate support in instances where they may fail to perform at the expected standard for whatever reason.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?
All current and future Family Medicine Residents in California are potentially affected by this issue. Adoption of a universal Resident's Bill of Rights endorsed by the CAFP would go a long way towards improving the wellness of generations of future physicians.

WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY, i.e., what action do you wish CAFP to take?
While other groups, specifically unionized residents, have already attempted to achieve something similar elsewhere it has thus far been institution-specific. A universally adopted Bill of Rights would respect residents as the vital employees that they are within healthcare systems who deserve equal

representation as such. Currently, most programs have set their bar for work conditions as that which would satisfy ACGME requirements rather than what is truly in the best interest of residents and the patients they are caring for. Working conditions that would be considered substandard or even abhorrent in other fields are currently tolerated as "the culture of medicine" and CAFP has an opportunity to lead the way in demanding better for our fellow family physicians and creating a new set of standards for what we consider acceptable for training programs across the board.

De-coupling clinical progression through residency with personal/professional /employee matters is an essential component, such as ensuring that residents are made aware of their ability to seek recourse or formal process with the employer's Human Resources Department for personnel matters. Too many young physicians have had their careers harmed by interpersonal conflict that would likely never have such an impact on other professionals. A Bill of Rights can help to promote professional/employee and inter-personal matters to be handled under the hospital or clinic Human Resources Department where national standards are applied and already in place.

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

Currently, residency programs control both clinical education as well as the employee/resident de-facto managerial position. The residency program unfortunately then acts as prosecutor, jury and judge in any matters that are professional/political in nature. The already vulnerable resident is placed in an even worse position when their ability to advance professionally is threatened, potentially as a result of factors outside of their individual control.

As far more family medicine residents lack rather than are represented by labor unions, a common Bill of Rights would help to ensure a more level playing field for resident physicians who do find themselves in abusive workplace situations without adequate protections.

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

CIR Announces 2017 Campaign to Address the Unhealthy Culture of Residency. Available at: https://www.cirseiu.org/cir-announces-2017-campaign-to-address-the-unhealthy-culture-of-residency/
Doctor suicides linked to institutional bullying? 17 May 2018. Available at: http://www.pamelawible.com/doctor-suicides-linked-to-institutional-bullying/
National Physician Burnout, Depression, and Suicide Report 2019. 16 Jan 2019. Medscape. Available at: https://www.medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056?faf=1#1
The Resident and Fellow Bill of Rights. 24 Oct 2019. KevinMD. Available at: https://www.kevinmd.com/blog/2019/10/the-resident-and-fellow-bill-of-rights.html
When Doctors Struggle with Suicide, Their Profession Often Fails Them. 31 July 2018. Available at: https://www.npr.org/sections/health-shots/2018/07/31/634217947/to-prevent-doctor-suicides-medical-industry-rethinks-how-doctors-work

Res. A-05-20

TITLE: Improved Quality of Reproductive Health Care for Incarcerated People

Introduced by: Anya Desai MD, Talia Eisenstein MD, Emily Guh MD

WHEREAS, the AAFP published a position paper entitled "Incarceration and Health: A Family Medicine Perspective," advocating for evidence-based prenatal care, contraception, sexually transmitted infection treatment and prevention, and substance use disorder treatment without mentioning options counseling or access to abortion, and

WHEREAS, the first systematic review of pregnancy frequency and outcomes was published in May 2019 titled *Pregnancy Outcomes in US Prisons, 2016-2017*, finding that during 2016-2017, 1% of pregnancies in incarcerated people ended in abortion, compared to 18% of pregnancies ending in abortion nationally, and

WHEREAS, literature has documented wide discrepancies in the care of incarcerated patients including: pregnancy testing and management, methods of shackling people in the peripartum period, and access to opiate use disorder treatment, and

WHEREAS, in California, current discrepancies for incarcerated people include coerced pregnancy testing, lack of timely access to routine and emergent prenatal care, poor compliance with the 2012 *No More Shackles* law, and inconsistent data collection of contraception use and pregnancy outcomes, and

WHEREAS, in some California jails and prisons, there are coercive practices in pregnancy options counseling, as well as barriers to timely abortion care, including requiring court-ordered transport, proof of pre-pay ability, and restricting abortion at varying gestational age limits not always consistent with state law, and

WHEREAS, AB-732, the Reproductive Dignity for Incarcerated People Act, which would codify regulations for California state prisons and extend protections for pregnant people incarcerated in county jails, was introduced to the California legislature in 2019 and will be up for a vote in 2020, therefore be it

RESOLVED: that the CAFP will lobby and advocate for legislative efforts to improve access to quality reproductive health care for incarcerated people in California, both in jails and prisons, including AB-732, and be it further

RESOLVED: that the CAFP will advocate for legislative efforts for incarcerated people in California that aim to improve access to timely but non-coercive abortion and that additionally address the accountability of correctional facilities in complying with existing reproductive health legislation, and be it further

RESOLVED: that the CAFP will instruct its delegates to submit a resolution to the AAFP COD to update the position paper entitled "Incarceration and Health: A Family Medicine Perspective" to add more specific reproductive health data in incarcerated populations referencing data from *Pregnancy Outcomes in US Prisons, 2016-2017,* and be it further

RESOLVED*:* that the CAFP will instruct its delegates to submit a resolution to the AAFP COD to advocate for national policy that helps to improve reproductive healthcare for incarcerated patients, including non-directive options counseling and access to timely abortion if desired.

Speaker's Note:

- CAFP policy supports the inclusion of incarcerated people in universal principles of access to and quality of care, but has not developed California-specific policy.
- CAFP and AAFP policy on access to reproductive health services and medications is extensive, but does not address specifically incarcerated populations.
- AAFP, has developed policy on Incarceration and Health.
- CAFP is in Support of AB 732, the bill referenced in this resolution.

Fiscal Note:
CAFP would not incur significant costs to support legislation referenced in this resolution, however, moderate costs may be incurred for advocacy depending on CAFP's level of legislative engagement.

No significant cost would be incurred to refer for national action.

References:

[1] Davis, Dawn M., Jennifer K. Bello, and Fred Rottnek. "Care of Incarcerated Patients." American family physician 98.10 (2018).
[2] Sufrin, Carolyn, et al. "Pregnancy Outcomes in US Prisons, 2016–2017." American journal of public health 109.5 (2019): 799-805.
[3] Kelsey, C. M., et al. "An examination of care practices of pregnant women incarcerated in jail facilities in the United States." Maternal and child health journal 21.6 (2017): 1260-1266.
[4] Bronson, Jennifer, and Carolyn Sufrin. "Pregnant women in prison and jail don't count: data gaps on maternal health and incarceration." Public Health Reports 134.1_suppl (2019): 57S-62S.
[5] Goodman, Melissa, Ruth Dawson, and Phyllida Burlingame. Reproductive Health Behind Bars. ACLU of California; 2016. https://www.aclunc.org/publications/reproductive-health-behind-bars-california, accessed 1/3/19

[6] Mothers Behind Bars. Washington, DC: National Women's Law Center / The Rebecca Project for Human Rights; 2010. http://www.rebeccaprojectjustice.org/images/stories/files/mothersbehindbarsreport-2010.pdf, accessed 1/3/19

[7] Assem. Bill 732, 2019-2020 Reg. sess. (cal.2019) (a bill to improve the quality of reproductive health care for pregnant people in county jails and state prisons). Available at (https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB732). Accessed 1/3/19

Res. A-06-20

TITLE: **Removing Routine Ultrasound in Medication Abortion Protocols**

Introduced by: Maryana Boulos, MD, Danielle Fincher, MD, MPH, Montida Fleming, MD, and Suzan Goodman, MD, MPH

WHEREAS, abortion rates have declined in the last decade[1], but patients choosing medication abortion over other methods have increased from 5% to 39% from 2001 to 2017[2,] and

WHEREAS, de-medicalized protocols for medication abortion have been increasingly accepted in the US, and may especially improve access in primary care settings, and

WHEREAS, clinical dating by last menstrual period (LMP) plus exam has been shown to be an acceptable alternative to pre-treatment ultrasound[3, 4, 5] with rare underestimation in early pregnancy[3], and

WHEREAS, using protocols with ultrasound-as-needed has similar outcomes to routine ultrasound for medication abortion[4], and

WHEREAS, a standardized symptom assessment by phone combined with serial serum hCG tests is an acceptable alternative to post-abortion ultrasound[6], and

WHEREAS, ultrasounds are costly for patients and clinics, and require additional training that not all family medicine physicians possess, and

WHEREAS, requiring pre- and post-treatment ultrasound creates additional barriers to abortion access[7] and to its provision by family physicians, and

WHEREAS, Medicaid reimbursement is currently bundled in many states, including California, requiring both pre-and post-abortion ultrasounds despite above-cited evidence, therefore be it

RESOLVED: that the CAFP support de-medicalization of early medication abortion by eliminating requirements for routine ultrasound in medication abortion provision, and be it further

RESOLVED: that CAFP lobby for the unbundling of pre- and post- abortion ultrasound in the Medi-Cal reimbursement requirements for medication abortion, and be it further

RESOLVED: that the CAFP support this resolution at the AAFP and work to unbundle ultrasound in medication abortion protocols for Medicaid reimbursement in all states.

Speaker's Note:

- CAFP has reliably supported legislation increasing access to medical abortions.
- CAFP does not have policy, however, specific to the de-medicalization of early medication abortion, nor the use of ultrasounds in the provision of medication abortion.

Fiscal Note:
CAFP would not incur significant costs to support legislation referenced in this resolution, however, moderate costs may be incurred for advocacy depending on CAFP's level of legislative engagement. Dedicated lobbying related to changes in reimbursement requirements in Medi-Cal would incur significant costs, however, and to duplicate those efforts across states by bringing this action to AAFP and building support among state delegations would involve significant costs of staff time and lobbyist time.

Citations:
1. Jatlaoui TC, Ewing A, Mandel MG, et al. Abortion Surveillance - United States, 2013. MMWR Surveill Summ 2016;65(No. SS-12):1–44. DOI: http://dx.doi.org/10.15585/mmwr.ss6512a1
2. JonesRK, WitwerE, Jerman J. Abortion Incidence and Service Availability in the United States, 2017. New York: Guttmacher Institute, 2019.
https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017
3. Bracken H, Clark W, Lichtenberg E, Schweikert S, Tanenhaus J, Barajas A, Alpert L, Winikoff B. Alternatives to routine ultrasound for eligibility assessment prior to early termination of pregnancy with mifepristone–misoprostol. BJOG 2011;118:17–23.
DOI: https://doi.org/10.1111/j.1471-0528.2010.02753.x
4. Clark W, Panton T, Hann L, GoldM. Medication Abortion Employing Routine Sequential Measurements of Serum hCG and Sonography Only When Indicated. Contraception, 2007;75(2):131-135. DOI: https://doi.org/10.1016/j.contraception.2006.08.001
5. Schonberg D, Wang LF, Bennett AH, Gold M, Jackson E. The Accuracy of Using Last Menstrual Period to Determine Gestational Age for First Trimester Medication Abortion: A Systematic Review. Contraception. 2014;90(5):480–48.
DOI: https://doi.org/10.1016/j.contraception.2014.07.004
6. Grossman D, Grindlay K. Alternatives to Ultrasound for Follow-up After Medication Abortion: A Systemic Review. Contraception. 2011; 83(6):504–510.
DOI: https://doi.org/10.1016/j.contraception.2010.08.023

7. State Laws and Policies: Requirements for Ultrasound. New York: Guttmacher Institute, 2020. https://www.guttmacher.org/state-policy/explore/requirements-ultrasound.

Res. A-07-20

TITLE: **Support Single-Payer Health Insurance**

Introduced by: Helen Petroff MD, Leslie-Lynn Pawson MD, Josephine Soliz MD, John Ford MD, Kristi Schoeld MD, Neil Jorgensen MD

WHEREAS, California Governor Gavin Newsom recently appointed the Healthy California for All Commission to develop a plan for achieving a health care delivery system for California that provides coverage and access through a unified financing system, including, but not limited to a single payer financing system, and

WHEREAS, The Commission will prepare an initial report to the Governor and Legislature by July 2020 with a final report in February 2021.

WHEREAS, 28.5 million Americans and 2.8 million Californians lacked health insurance in 2017 (1), and

WHEREAS, compared to ten other high-income countries, the U.S. ranks last in health care affordability, and has the highest rate of infant mortality and mortality amenable to health care (2), and

WHEREAS, employer-sponsored health plans are increasingly unaffordable for workers since 85% of these plans include an annual deductible and the average deductible was $1,573 for single coverage in 2018 (3), and

WHEREAS, in 2017 the U.S. spent $3.7 trillion on health care, or 17.9% of GDP (4), twice as much per capita on health care as the average of wealthy nations that provide universal coverage (5), and

WHEREAS, illness and medical bills contribute to 66.5% of all bankruptcies, a figure that is virtually unchanged since before the passage of the Affordable Care Act (ACA), and 530,000 families suffer bankruptcies each year that are linked to illness or medical bills (6), and

WHEREAS, overhead consumes 12.2% of private insurance premiums (7), while the overhead of fee-for-service Medicare is less than 2% (8), and

WHEREAS, providers are forced to spend tens of billions more dealing with insurers' billing and documentation requirements (9), bringing total administrative costs to 31% of U.S. health spending, compared to 16.7% in Canada (10), and

WHEREAS, the U.S. could save over $500 billion annually on administrative costs with a single-payer system (11), and

WHEREAS, billing-driven documentation that contributes to physician burnout would be greatly reduced under a single-payer reform (12), and

WHEREAS, the savings from slashing bureaucracy would be enough to cover all of the uninsured and eliminate cost sharing for everyone else (13), and

WHEREAS, a single-payer system could control costs through proven-effective mechanisms such as global budgets for hospitals and negotiated drug prices (14), thereby making health care financing sustainable, and

WHEREAS, a single-payer reform will reduce malpractice lawsuits and insurance costs because injured patients won't have to sue for coverage of future medical expenses, and

WHEREAS, a single-payer system would facilitate health planning, directing capital funds to build and expand health facilities where they are needed, rather than being driven by the dictates of the market, and

WHEREAS, a single-payer reform will dramatically reduce, although not eliminate, health disparities. The passage of Medicare in 1965 led to the rapid desegregation of 99.6% of U.S. hospitals (15), and

WHEREAS, a single-payer system will allow patients to freely choose their doctors, gives physicians a choice of practice setting, and protect the doctor patient relationship, and

WHEREAS, there is single-payer legislation in both houses of Congress, H.R. 1384 and S. 1129, and

WHEREAS, the New York State Academy of Family Physicians supports a single payer health insurance system in New York and nationally (16), therefore be it

RESOLVED: that CAFP express its support for universal access to comprehensive, affordable, high-quality health care through a single-payer national health program, starting with single-payer health insurance at the state level in California.

Speaker's Note:

- Neither CAFP nor AAFP have policy explicitly supporting single-payer as the preferred approach to delivering and/or financing health care.

- In response to resolutions on this topic received at previous AMAM meetings, CAFP developed Principles of Health System Reform, which outline the five dimensions any health system reform proposal must address before CAFP can consider supporting it. (Universal, comprehensive, high-quality, timely, and financially sustainable.) The CAFP Board adopted these principles at their 7.15.17 meeting.
- AAFP has produced 1) extensive policy and discussion papers in response to resolutions submitted at Congress of Delegates related to adopting support for single payer, and 2) a paper outlining the different kinds of single-payer systems that exist in other countries.

Fiscal Note:
Adoption of this resolution would not result in significant cost to CAFP as it would fall within established procedures for updating policy and taking positions on proposed legislation.

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?
To replace our current health insurance system, which does not cover everyone, is unaffordable for those it does cover, limits patients' choice of providers, exacerbates socioeconomic inequity and causes physician burnout, with something (a lot) better.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?
39.5 Million Californians, 327 Million Americans

WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY, i.e., what action do you wish CAFP to take?
Include language supporting single payer health insurance for California and the nation in its policy documents, website, and official communications with state government.

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

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

1. "Health Insurance Coverage in the United States: 2017," U.S. Census Bureau, September 2018.
2. Schneider, et al., "Mirror, Mirror 2017: International comparison reflects flaws and opportunities for better U.S. health care," Commonwealth Fund, July 17, 2017.
3. Claxton, et al., "Health benefits in 2018: Modest growth in premiums, higher worker contributions at firms with more low-wageworkers," Health Affairs, October 2018.

4. "National Health Expenditures Fact Sheet 2017," U.S. Centers for Medicare & Medicaid Services, December 2018.
5. Sawyer and Cox, "How does health spending in the U.S. compare to other countries?" Kaiser Family Foundation, December 7, 2018.
6. Himmelstein, et al., "Medical bankruptcy: Still common despite the Affordable Care Act," American Journal of Public Health, March 1, 2019.
7. National Health Expenditure Accounts, U.S. Centers for Medicare & Medicaid Services, December 2018.
8. 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, June 2018
9. Morra, et al., "U.S. physician practices versus Canadians: spending nearly four times as much money interacting with payers," Health Affairs, August 2011.
10. Woolhandler, et al., "Costs of health administration in the U.S. and Canada," NEJM, Sept. 21, 2003.
11. Woolhandler and Himmelstein, "Single-payer reform: The only way to fulfill the President's pledge of more coverage, better benefits, and lower costs," Annals of Internal Medicine, April 2017.
12. Downing, et al., "Physician burnout in the electronic health record era: Are we ignoring the real cause?" Annals of Internal Medicine, July 3, 2018.
13. Pollin, et al., "Economic analysis of Medicare for All," Political Economy Research Institute, University of Massachusetts -Amherst, November 30, 2018.
14. Marmor and Oberlander, "From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy," Journal of General Internal Medicine, March 13, 2012.
15. Himmelstein and Woolhandler, "Medicare's rollout vs. Obamacare's glitches brew," Health Affairs blog, Jan. 2, 2014.
16. NEW YORK STATE ACADEMY OF FAMILY PHYSICIANS POLICY MANUAL ON KEY HEALTH ISSUES, www.nysafp.org/

Res. A-08-20

TITLE: **Ensure Affordable Access to Medical Treatments Developed on University Campuses**

Introduced by: Reshma Ramachandran, MD MPP, Kaiser Permanente Los Angeles Medical Center

Endorsements: Vikas Jayadeva MD, Med, Kaiser Permanente Los Angeles Medical Center; Ramsey Salem MD, MPH, Kaiser Permanente Los Angeles Medical Center

WHEREAS, one-fourth to one-third of all medicines originate in a university lab, and

WHEREAS, the National Institutes of Health contributed funding in some capacity to all 210 new drugs approved by the Food and Drug Administration between 2010 and 2016, and

WHEREAS, 1 in 4 Americans report difficulty affording medications prescribed to them and 1 in 3 Americans didn't fill at least one of their prescriptions over the past year due to drug prices, and

WHEREAS, the Final Rule of the FDA Amendments Act (FDAAA) requires that all universities post the results of their clinical trials onto the public registry Clinicaltrials.gov within 12 months of their primary completion date, and

WHEREAS, many of our most critical medicines, diagnostics, vaccines, and medical devices are invented, discovered, or developed at universities and academic medical centers and their accessibility around the world, including to our own patients depends critically on how universities manage their intellectual property, and

WHEREAS, the prostate cancer drug, Xtandi (enzalutamide) was discovered and developed with public funding from the National Institutes of Health and Department of Defense at the University of California Los Angeles before being licensed to Pfizer and Astellas without protections for affordability and now is priced at $150,000 per patient per year in the United States, and

WHEREAS, family physicians are at the frontlines in witnessing patients' struggles to afford the medications prescribed to them to allow them to have healthy, productive lives, therefore be it

RESOLVED: the CAFP work to its partners to develop continuing medical education and other educational materials so that all future and current CAFP members receive independent, evidence-based education on the drug development and approval processes, and be it further

RESOLVED: that the CAFP explore with its partners various ways from advocacy to legislation to ensure that universities make the medical treatments discovered or developed on their campuses, especially those developed with public funding, affordable and accessible to all patients, and be it further

RESOLVED: the CAFP urge universities and academic medical centers to employ provisions in their licensing agreements with industry to allow for a non-exclusive license on medical treatments in low- and middle-income countries to ensure generic competition and therefore, affordable access to treatments, and be it further

RESOLVED: the CAFP request universities commit to full sharing of all data and research findings to promote further research and scientific progress, including publishing all clinical trials, and be it further

RESOLVED: the CAFP support policies that would ensure fair return on public investment including those that would tie affordability provisions to public funding for drug discovery and development through the National Institutes of Health and other government agencies.

Speaker's Note:
CAFP has been active through legislation and regulatory efforts to address the large financial burden placed on patients and the health care system by exorbitant prescription drug costs. These efforts have focused on improving purchaser negotiating power, removal of gag clauses, increased access to affordable generics, and transparency in drug pricing decisions and processes. CAFP does not have policy related to university and academic medical center involvement in the drug development process, but has related policy on prescription drug cost containment and price transparency.
Existing CAFP Policy reads:

<u>Prescription Drug Cost Containment and Price Transparency Policy</u>

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. *BoD 7.16.16*

Pharmaceuticals-HMO Kickbacks for Drugs: CAFP favors 1) Full disclosure of "kickback" arrangements between health plans and pharmaceutical organizations; and 2) Making sure that discount arrangements are reflected in actuarially sound premiums and capitation rates such that neither patients nor physicians are adversely affected by the use of "kickbacks." *10/97 BoD*

Fiscal Note:
The costs of adopting this resolution would be moderate to significant, potentially constituting a new major organizational effort.
The costs of developing new CME and educational material is significant, including; partner engagement, research, staff time for developing content, potentially engaging a consultant, travel, and CME placement.

The costs of working with partners and Universities to influence University policy and procedures would be moderate to significant, as it would include significant staff time, research, and potentially outside expertise.

The final resolved, to support new policies would not be a significant expense as it would fall within established procedures for updating and taking positions on proposed legislation and policy.

PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this re solution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?

This resolution aims to advance CAFP's work ensuring access to affordable medicines through the lens of universities and academic medical centers where many of its members work. Universities and academic medical centers serve as critical hubs of innovation for new medical treatments often with support from taxpayer dollars through federal funding from the National Institutes of Health (NIH) and Department of Defense (DoD) as well as state funding through direct contributions of the state budget to public universities as well as tax rebates. This resolution aims to ensure that Californians and all patients should not have to pay twice or thrice (first, through their taxes; second, through their insurance premiums; and finally, through their co-payments) for life-saving medical treatments. The University of California system is one of the largest recipients of funding from the NIH for the development of novel medical treatments, but too often, license these drugs to major pharmaceutical companies without protections to ensure affordability and accessibility. In fact, University of California, Los Angeles (UCLA) has come under public pressure in the case of Xtandi (enzalutamide), a life-saving prostate cancer drug that was discovered with the support of NIH and DoD funding but licensed to Pfizer and Astellas Pharmaceuticals for a $1.1 billion-dollar buyout. No protections were included in this license to ensure affordability and accessibility and patients today face a $150,000 price tag for this medication each year. Even after insurance, many patients are unable to afford this medication. Additionally, UCLA has also filed a patent claim in India that would bar generic production of this drug in India, where prostate cancer is among the top 10 cancers by prevalence. This patent would additionally delay introduction of a generic here in the United States. UCLA students have been urging the University of California system to rethink its licensing practice since 2016, but the institution has been reticent to do so. CAFP in representing family physicians who all too often see patients forgoing taking their medicines due to price can make a difference by calling for universities to do the right thing and also supporting state initiatives to provide oversight over such licensing practices.

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

Every single member and their patients are affected by this problem.

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

See the RESOLVED clauses above.

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

https://www.lamag.com/citythinkblog/ucla-xtandi-india/
https://www.statnews.com/2018/03/30/students-ucla-xtandi-patent/
https://thewire.in/health/us-students-urge-ucla-to-drop-proxy-patent-battle-for-cancer-drug-in-india
https://www.chronicle.com/article/Higher-Ed-Inc/244704?key=40t1HyvNc9fWSmBHhIazDg6rIvOiCXG57Jxvydebi-QXbgEWnXraofcUeMOtl2YqVjI5WVlWUmRic29pNkVLR09qZGZGd2l5YVAyZ0ZUdGxPdjZNQ2FuYzV0Yw

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

https://www.ncbi.nlm.nih.gov/pubmed/21031002
https://www.pnas.org/content/115/10/2329
https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/
https://www.goodrx.com/blog/health-insurance-aside-americans-still-struggle-to-pay-for-their-medications/

Res. A-09-20

TITLE: Promoting a Conflict-Free California Academy of Family Physicians

Introduced by: Reshma Ramachandran, MD MPP, Kaiser Permanente Los Angeles Medical Center

WHEREAS, the CAFP's mission states that the organization "empowers, educates, and connects current and future family physicians to improve the health of all Californians", and

WHEREAS, the CAFP utilizes advocacy and education towards "expand[ing] access to high quality and cost-effective patient care for California", and

WHEREAS, the CAFP like other professional medical associations is tasked with representing the professional and financial interests of its members, often engaging in activities such as policy lobbying to influence and shape health care policy making it critical that the organization "maintain a high degree of academic independence and scientific integrity by avoiding inappropriate influence from commercial interests", and

WHEREAS, the CAFP receives contributions industry partners such as pharmaceutical companies for educational and other programmatic activities, and

WHEREAS, the CAFP has adopted a policy on Conflict of Interest as well as CME Conflict of Interest (COI) Resolution Procedure in accordance to the ACCME Standards for Commercial Support and the Council of Medical Specialty Societies (CMSS) "Code for Interactions with Companies", and

WHEREAS, it has long been established in the medical literature that various types of remuneration, financial or otherwise, from various healthcare industries including pharmaceutical and medical device companies have had undue influence on medical education and practice including prescribing behavior, therefore be it

RESOLVED: that the CAFP works toward a complete ban on health care industry funding, particularly from pharmaceutical and medical device companies with possible exceptions being income from journal advertising, and be it further

RESOLVED: that the CAFP provides educational programming around conflict of interest and its impact on medical education and health care advocacy for its membership, and be it further

RESOLVED: that the CAFP ensures that any funds from health care industry contributors are truly unrestricted and not allocated towards any advocacy activities including programmatic events that might preclude the organization's ability to act on certain issues or relay a perceived conflict of interest, and be it further

RESOLVED: that the CAFP establishes safeguards to ensure all conference programming including Continuing Medical Education activities are free from conflict-of-interest including through establishing a CME committee comprised of members without any industry to distribute unrestricted, educational grants from industry or seek other funding from independent foundations or pubic grants, and be it further

RESOLVED: that the CAFP prohibits gifts and promotional materials including those intended for educational purposes from pharmaceutical and medical device companies to be distributed to its membership, and be it further

RESOLVED: that the CAFP establishes clear conflict-of-interest guidelines for all speakers at all its events, regardless of CME eligibility or not, including a mandatory public disclosure of any financial or non-financial relationships with health care industries at the start of any presentation or talk, and be it further

RESOLVED: that the CAFP examines best practices of other state and national professional medical associations in managing real and perceived conflicts of interests and provide a report to be presented to the CAFP Board of Directors and publicly available on its website.

Speaker's Note:
CAFP has policy on disclosure of conflict of interest, industry support and bias in education. Board members, committee members, and staff members complete a conflict of interest disclosure annually. The disclosures are reviewed, and conflicts are managed by the Board.

In addition, the Committee on Continuing Professional Development has adopted and follows a disclosure of interest process for any individual who has the potential to influence educational content, including planners, staff, reviewers, and faculty members. All COI forms are reviewed, and any reported conflict is managed and resolved prior to the activity. CAFP has just received its 3rd consecutive six-year accreditation with commendation (in November 2019), by the Accreditation Council for Continuing Medical Education (ACCME), which sets and enforces standards in physician continuing education within the United States. ACCME acts as the overseeing body for institutions and organizations providing continuing medical education activities and accomplishing accreditation with commendation is no small feat. Accreditation in the ACCME System seeks to assure the medical community and the public that

CAFP delivers education that is relevant to clinicians' needs, evidence-based, evaluated for its effectiveness, and independent of commercial influence. CAFP must adhere to the ACCME's Standards for Commercial Support which dictate relationships with commercial supporters and provide complete documentation on this support.

RESOLVEDS 4, 5, and 6 are already CAFP policy and in place.

All said, while we are confident in our policies and processes to address conflict of interest, more can always be done to educate members on our processes, improve our methods of handling commercial support, and ensure transparency of our work.

Fiscal Note:
CAFP receives a significant amount of non-dues revenue from unrestricted educational grants, from the pharmaceutical industry, state and national government, and foundations. We do not receive advertising revenue for *California Family Physician* magazine. The complete elimination of commercial support would cost the CAFP more than $800,000 annually, requiring significant cuts to services and staff.

There would be moderate expense associated with the research and writing of a report on real and perceived conflicts of interests, including staff time.

PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this re solution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?
This resolution aims to curb any real and perceived conflicts of interest of the CAFP with health care industry partners, particularly pharmaceutical and medical device companies. While the CAFP has adopted strong policies to help mitigate these conflicts, there are opportunities to ensure that CAFP becomes an exemplar in handling such conflicts among professional medical societies. CAFP does currently solicit and accept funding from the pharmaceutical and medical device industry. Such relationships and funding of advocacy activities may hinder CAFP's integrity and independence on truly advocating on the behalf of family physicians and their patients. For instance, a number of proposals have been introduced both within the state legislature as well as through Governor Gavin Newsom's office to curb high drug prices, but CAFP has been relatively silent on these issues. This might be construed to be due to CAFP's ties with the pharmaceutical industry. Additionally, as CAFP is a professional medical association speaking on the behalf of family physicians to policymakers at various levels, it is critical for the organization to maintain its integrity in doing so. Accepting funds from the pharmaceutical and medical device industries threatens this integrity as well as its independence in providing education to its members. It has been long established in medical literature that without safeguards, financial relationships with these industries lead to undue influence on medical education

and practice, including prescribing behavior. CAFP in representing the front-line of primary care should reflect best practice in the profession by curbing these conflicts of interest and also providing education to their members on these relationships as well as their impacts.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?
All engaged members including those who receive educational materials from CAFP as well as their patients.

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

WHAT EVIDENCE EXISTS TO: 1) INDICATE THAT A PROBLEM EXISTS; OR 2) THAT THERE IS NEED FOR A NEW OR REVISED POLICY?
It has been noted by a number of non-profit organizations engaged in efforts around drug pricing that Horizon Pharmaceuticals had contributed towards an event around Susan Hogeland Advocacy Fellowship. While the funding has not gone towards the fellowship itself, this contribution has raised questions about the organization's engagement on issues around drug pricing and whether which has been noted to be contributing to significant price hikes of combinations of already existing drugs making them out of reach for millions: https://www.propublica.org/article/horizon-pharma-vimovo-common-medication-455-million-specialty-pill

Additionally, drugs manufactured by Horizon Pharmaceuticals have been noted to be among the most expensive in the United States by list price: https://www.goodrx.com/blog/20-most-expensive-drugs-in-the-usa/ Amidst growing debates around drug pricing, CAFP should look closely at who they receive contributions from and if such relationships are preventing CAFP from having a stronger voice on issues affecting our patients on a daily basis.

Moreover, it was also noted that the CAFP has received funding from a pharmaceutical company regarding a project detailing how physicians learn. While this is not a direct promotional activity, it has been well documented in the literature including through the Congressional Budget Office (http://www.cbo.gov/ftpdocs/105xx/doc10522/12-02-DrugPromo_Brief.pd) that pharmaceutical marketing and promotional budgets towards academic detailing or education targeted towards health care providers has considerably risen over the past 30 years whereas spending for other forms of promotional activity such as journal advertisements, direct-to-consumer advertising, and meetings and events have largely stagnated. While this project might have some educational benefit to CAFP, it is concerning that the results of such work will be harnessed by pharmaceutical companies to continue to influence the practice of medicine through educational activity. By adopting this resolution, we have an

opportunity to continue to improve on CAFP's strong policies and procedures and also raise awareness about why CAFP had adopted these.

PLEASE PROVIDE CITATIONS to support the existence of the problem and your proposed solution.
Other resources for proposals for managing professional medical association relationships with industry:
https://jamanetwork.com/journals/jama/fullarticle/2623622
https://jamanetwork.com/journals/jama/fullarticle/183670
https://www.communitycatalyst.org/doc-store/publications/CME_toolkit.pdf

Res. A-10-20

Title: **Support for Long-Term Care**

Introduced by: Rebecca Howe, MD and Sky Lee, MD

Endorsements: Sacramento Valley Chapter of the California Academy of Family Physicians

WHEREAS, demographic trends (aging Baby Boomers) are driving increased health spending and 73.5 million are expected to be enrolled in Medicare by 2027, up from 57.2 million in 2017,[12] and

WHEREAS, Medi-Cal long-term care costs are expected to nearly double from $6.6 billion to $12.4 billion by 2023,[13] and

WHEREAS, nursing home care can cost more than $7000 per month and home care more than $4000 per month,[14] and

WHEREAS, patients with Medicare often need to spend down their savings in order to be eligible for Medi-Cal long-term care coverage, and

WHEREAS, family caregivers are providing upwards of $470 billion of unpaid services to family members,[15] with on average 24 hours of care per week,[16] and

WHEREAS, 2/3 of workers age 45-74 are caring for an aging parent, spouse, or relative,[17] and

WHEREAS, businesses lose an estimated $33.6 billion nationally each year due to lost productivity from family caregivers' reduced paid working hours,[18] and, home care worker hourly wage has been stagnant: $10.21 in 2005 to $10.11 in 2015,[19] and

[12] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected
[13] https://www.rureadyca.org/will%20boomers%20bust%20the%20budget
[14] https://www.genworth.com/about-us/industry-expertise/cost-of-care.html
[15] http://www.aarp.org/ppi/info-2015/valuing-the-invaluable-2015-update.html
[16] http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Final-Report-June-4_WEB.pdf
[17] http://www.aarp.org/content/dam/aarp/ppi/2014-10/family-caregivers-workplace-fact-sheet-aarp.pdf
[18] https://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf
[19] http://phinational.org/home-care-workers-key-facts

WHEREAS, limited benefits and challenging scheduling and working conditions cause high turnover rates among home care workers,[20] and

WHEREAS, when San Francisco enacted a living wage requirement for home care workers, worker turnover dropped by 57%,[21] and

WHEREAS, the AAFP Long-Term Care Policy (1988, COD 2018) states that "the Academy supports the development of a federal policy for long-term care, including respite care, nursing home care and home health care," and "should include a provision addressing spousal impoverishment,"[22] but does not discuss home care worker or family caregiver support, therefore be it

RESOLVED: That CAFP create a task force to review existing policies and proposals to support long-term care and provide a recommendation for future efforts to support long-term care back to the CAFP, and be it further

RESOLVED: That this resolution be sent to the AAFP Congress of Delegates to be discussed on a national level in order to consider updating the AAFP Long-Term Care Policy to address the need for home care worker and family caregiver support.

Speaker's Note:
CAFP policy supports inclusion of long-term care in its Principles of Health System Reform (Adopted BoD 7.15.17):

- Every individual's coverage should include guaranteed access to evidence-based essential benefits that include, but are not limited to:
    - Access to comprehensive primary, preventative and wellness care services, including diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, **long-term care**, home care, day care, etc.).

AAFP policy supports the development of federal long-term care strategies:

> The Academy supports the development of a federal policy for long-term care, including respite care, nursing home care and home health care, which includes but is not limited to the following characteristics:

[20] http://phinational.org/sites/phinational.org/files/research-report/paying-the-price.pdf
[21] http://onlinelibrary.wiley.com/doi/10.1111/j.0019-8676.2004.00376.x/full
[22] https://www.aafp.org/about/policies/all/long-care.html

- The need for the care should be verified by a physician;
- The care should be under a case management system, with family physicians given the opportunity to coordinate or provide care;
- Peer Review Organizations or approved state utilization review organizations should review medical care for quality assurance;
- The evaluation of the patient should be physician directed;
- The measure providing expansion of benefits should include a provision addressing spousal impoverishment;
- Eligibility for the assistance should be based on a functional/cognitive capacity assessment rather than diagnosis;
- The policy should include both public and private financing; and
- Physician visits to residents in long-term care facilities should be paid based on the appropriateness of service rather than mandated federal guidelines.

(1988) (2018 COD)

Fiscal Note:
There would be no significant cost for forwarding to AAFP for national action.

The cost for establishing a new CAFP task force distinct from those already staffed and funded in the CAFP budget would be significant. Assuming at least one in-person meeting, costs would likely exceed $10,000.

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 calls attention to the lack of adequate and accessible long-term care for patients and the need for a broader AAFP policy on Long-Term Care that discusses support for home care workers and family caregivers.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?
The issue of limited long-term care options affects all CAFP members who have patients needing this support or services. This is a substantial and growing patient population.

WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY, i.e., what action do you wish CAFP to take?
This resolution proposes adding language to the existing AAFP Long-Term Care policy to address the need for home care worker and family caregiver support. It also calls for a review and consolidation of

current policies and proposals in support of long-term care and the development of recommendations for policies related to this topic that address the needs of patients, home care workers, and family caregivers.

Relevant proposals could include the following:

- **Patient support:** state or federal long-term care support and services benefit (refs: CLASS Act, WA Long-Term Care Trust Act, Long-Term Care America – Buttigieg, Kupuna Caregivers in HI)
- **Home care worker support:** $15/hour wage floor, benefits, regular hours, good working conditions, path to citizenship for undocumented caregivers (refs: Caring Across Generations, National Domestic Workers Alliance, Domestic Workers Bill of Rights Act – Kamal Harris, Pramila Jayapal)
- **Family caregiver support:** expand family medical leave, expand IHSS and PACE, provide respite options such as Lifespan Respite Care Program

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 above.

PLEASE PROVIDE CITATIONS to support the existence of the problem and your proposed solution.
See footnotes above. Below are references for the programs mentioned in the "specific solution" section above:

Patient support:

- CLASS Act: Caldwell, J and Bedlin, H. Beyond the CLASS Act: The Future of Long-Term Care Financing Reform. Public Policy & Aging Report, 2014, 24, 50-55.
- WA Long-Term Care Trust Act: https://responsiblefuture.org/the-ltc-trust-act/
- Long-Term Care America – Pete Buttigieg: https://www.forbes.com/sites/howardgleckman/2019/11/25/buttigieg-proposes-an-ambitious-and-much-needed--long-term-care-reform-plan/#5473260c7b01
- Kupuna Caregivers in HI: https://hawaiiadrc.org/Portals/_AgencySite/KCG%20Info%20sheet%20071117_FINAL.pdf

Home care worker support:

- $15/hour wage floor: https://www.nelp.org/publication/giving-caregivers-a-raise-the-impact-of-a-15-wage-floor-in-the-home-care-industry/
- Caring Across Generations: https://caringacross.org/policy-agenda/
- National Domestic Workers Alliance: https://www.domesticworkers.org/

- Domestic Workers Bill of Rights: https://www.harris.senate.gov/imo/media/doc/Domestic%20Workers%20Bill%20of%20Rights%20Summary.pdf

Family caregiver support:

- IHSS: https://www.cdss.ca.gov/in-home-supportive-services
- PACE: https://www.medicaid.gov/medicaid/ltss/pace/index.html and CalPACE: http://www.calpace.org/
- Lifespan Respite Care Program: https://acl.gov/programs/support-caregivers/lifespan-respite-care-program

Res. A-11-20

Title: **Increase Education in Substance Use Disorder for Residency Programs**

Author: Sky Lee MD

WHEREAS, Over 21 million people in the United States require substance use disorder treatment however less than 4 million people receive treatment.6 (SAMHSA), and

WHEREAS, over 47,000 overdose deaths in 2017 involved opioids, nearly 68% of all drug overdose deaths 3(CDC), and

WHEREAS, California had a statistically significant increase in drug overdose death rate from 2016 to 2017 1(CDC), and

WHEREAS, Buprenorphine significantly decreases all cause mortality for people with opioid use disorder 5 (Sordo), and

WHEREAS, AAFP called on health and human services to require comprehensive coverage for medications for addiction treatment.4 https://www.aafp.org/dam/AAFP/documents/advocacy/coverage/aca/LT-HHS-NoticeBenefitPaymentParameters2020-021919.pdf, and

WHEREAS, AAFP's position on chronic pain management and opioid misuse encourages the expansion of x-waiver training courses, including residency programs and having faculty members who are waivered at each site. And "align residency program training to deliver evidence-based information on best practices in the management of chronic pain and opioid dependence." https://www.aafp.org/about/policies/all/pain-management-opioid.html, and

WHEREAS, in 2019 CAFP and CAFP Foundation jointly awarded 2 million dollars in grant funding for California primary care residency programs to increase substance use disorder education, and

WHEREAS, Only 23% of internal medicine, family medicine and psychiatry residency programs dedicate 12 or more hours of training to addiction medicine (Tesema), and

WHEREAS, only 10% of early career family physicians felt prepared to prescribe buprenorphine and only 7% are currently prescribing buprenorphine for opioid use disorder (Tong), therefore be it

RESOLVED: that CAFP seek additional grant funding and use funding from the CAFP budget if necessary to support the integration of addiction training into Family Medicine residency program curriculum through the California Primary Care Residency Program Collaborative, and be it further

RESOLVED: that CAFP/AAFP write a letter to the Accreditation Council on Graduate Medical Education (ACGME) encouraging increased training in substance use disorder treatment for residency, and be it further

RESOLVED: that CAFP offer x-waiver trainings (as long as a data 2000 waiver continues to be required to treat opioid use disorder) at major conference events such as the All Member Advocacy Meeting, Family Medicine Clinical Forum and Student +FM Resident Summit, and be it further

RESOLVED: that the California Academy of Family Physicians delegation to the American Academy of Family Physicians submit a resolution to the AAFP Congress of delegates requesting the AAFP to write a letter to the Accreditation Council on Graduate Medical Education (ACGME) encouraging increased training in substance use disorder treatment for residency, and be it further

RESOLVED: that the California Academy of Family Physicians delegation to the American Academy of Family Physicians submit a resolution to the AAFP Congress of delegates requesting the AAFP to offer x-waiver trainings (as long as a data 2000 waiver continues to be required to treat opioid use disorder) at major conference events such as the FMX Experience, and National Conference for Family Medicine Residents and Medical Students.

Speaker's Note:
The current CA Primary Care Residency Program Collaborative, with its 30 programs (OB, IM and FM), continues it work through September 2020. The project is supported by a one-year grant from the CA Department of Health Care Services, via SAMSHA. While we will continue to seek support for activities like the Collaborative, we cannot be assured of additional state funding.

CAFP has offered X-waiver workshops at past Family Medicine Clinical Forums, and based on needs assessment with members, could offer these workshops again, and at other meetings. The 8-hour course would require coordination with either CSAM or ASAM.

Fiscal Note:
Adoption of this resolution may result in significant expense for CAFP. Seeking grant funding would require staff time to research and write the proposal and meet with funders and potential partners. Likewise, continuation of the program without grant funding would result in expense exceeding $1 million. The current program includes $1.5 million in grant funds to participating programs.
There would be minimal expense to draft a letter to ACCME.

There would be moderate cost to develop and place X-waiver workshops and training. However, these costs may be offset by registration fees.

There would not be significant cost to refer for national action.

PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this resolution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?

The resolution aims to increase education in substance use disorder for family medicine physicians. Increase in education would ideally decrease the extraordinary treatment gap for substance use disorder and increase access to care for patients.

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

This policy will benefit all CAFP members and their patients as substance use disorder as a chronic medical condition is present in all clinical settings. Family Medicine physicians are well equipped to address the epidemic as it affects a wide age range from adolescents to the elderly.

Family Medicine physicians are well positioned to eliminate the treatment gap for substance use disorders (SUD) due to our mission for community building and our broad spectrum of care (we make up approximately 17% of the hospitalist work force and file a significant number of emergency department claims). In order to meet needs of care, physicians must reduce biases and develop easy to implement practices with SUD treatment, particularly for buprenorphine. Buprenorphine significantly decreases all cause mortality for people with opioid use disorder (OUD). Only 10% of early career family physicians felt prepared to prescribe buprenorphine and only 7% are currently prescribing buprenorphine for OUD. These numbers reflect our need to increase our efforts in addiction education in our residency programs especially as only 23% of internal medicine, family medicine and psychiatry residency programs dedicate 12 or more hours of training to addiction medicine. This session will educate all family medicine attendees on how to implement a medication first model specifically for OUD and how to engage with community partners to maintain sustainability.

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

The resolution proposes that CAFP offer x-waiver trainings at its major annual conference events, thus increasing the number of x-waivered providers in the community and increasing access to care. The resolution also proposes that CAFP continue to offer grant funding to encourage residency programs to increase training in addiction and substance use disorder treatment.

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

SAMHSA's recent report "Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health" highlights the scope of the problem of the lack of treatment for substance use disorders for people who need it. Numerous studies have shown the

benefits of buprenorphine and methadone for opioid use disorder including decrease in all-cause mortality, decrease in neonatal abstinence syndrome, increased functioning and decrease in substance use.

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

1. 2016-2019 Drug Overdose Death Rate Increases. Centers for Disease Control. https://www.cdc.gov/drugoverdose/data/statedeaths/drug-overdose-death-rate-increase-2016-2017.html Last reviewed: 07/01/2019. Accessed 12/09/2019.
2. American Academy of Family Physicians. Chronic pain management and opioid misuse: A public health concern (position paper). https://www.aafp.org/about/policies/all/pain-management-opioid.html . Accessed 12/09/2019.
3. Drug Overdose Deaths. Centers for Disease Control. https://www.cdc.gov/drugoverdose/data/statedeaths.html last reviewed: 6/27/2019. Accessed 12/09/2019.
4. Munger, M. Letter to CMS Secretary Alex Azar in response to 'HHS notice of Benefit and Payment Parameters for 2020'. 02/19/2019. https://www.aafp.org/dam/AAFP/documents/advocacy/coverage/aca/LT-HHS-NoticeBenefitPaymentParameters2020-021919.pdf Accessed 12/09/2019
5. Sordo L, Barrio G et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ. 2017;357:j1550.
6. Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.
7. Tesema L, Marshall J et al. Training in office-based opioid treatment with buprenorphine in US residency programs: A national survey of residency program directors. Substance Abuse. 2018;39:4,434-440
8. Tong ST, Hochheim CJ, et al. Buprenorphine provision by early career family physicians. Ann Fam Med. 2018;16(5):443-446

Res. A-12-20

TITLE: **Tapering Regimens for Patients on Long Term Opioid Therapy**

Introduced by: Rosemary Cotter MD, Sky Lee MD

WHEREAS, there are millions of patients on long term opioid therapy for non-cancer pain in the United States (1), many of whom receive care from a family physician, and

WHEREAS, the AAFP's Chronic Pain Management and Opioid Misuse position statement advocates for evidence-based recommendations to inform the care of patients who use opioid medications for chronic pain (2), and

WHEREAS, the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain supports slow tapers for patient on long term opioid therapy and recommends collaboration with patient to determine concerns and goals regarding tapering (3), and

WHEREAS, a published consensus panel report highlights that providers commonly misapply the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain by initiating rapid tapers of patients' opioid dose to below the daily MME threshold recommended in the guideline without adequate attention to the needs of established or inherited patients on long term opioid therapy (4), and

WHEREAS, the FDA recently issued a safety announcement to alert health care professionals to avoid rapid tapering for patients physically dependent on opioids because of the risk for patient harms including serious withdrawal symptoms, uncontrolled pain, psychological distress, and suicide (5), and

WHEREAS, opioid tapering for patients on long term opioid therapy has been shown to be associated with subsequent termination of care, placing patients at risk for opioid misuse or illicit opioid use (6), and

WHEREAS, patient-centered, voluntary, and slower tapering plans have been shown to be successful at reducing opioid usage in the outpatient setting (7), and

WHEREAS, in special consideration for prenatal patients, opioid withdrawal during pregnancy has been associated with spontaneous abortion and premature labor (3), and

WHEREAS, the 2019 HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics describes risks of rapid opioid tapers, recommends careful consideration

of the risks versus benefit of a taper, and recommend shared decision making with patients to create individualized taper plans (8), therefore be it

RESOLVED: that the CAFP create policy that adopts the recommendations and language of the HHS opioid tapering guidelines in order to support creation of tapering plans 1) only after weighing risks and benefits of opioid therapy, 2) via shared decision making with patients to create an individualized tapering plan, and 3) without misapplication of the current CDC Guideline in ways that cause inappropriately rapid opioid tapering, and be it further

RESOLVED: that this resolution be sent to the COD to be discussed on a national level in order to consider including the language of the HHS guidelines in AAFP's position paper "Chronic Pain Management and Opioid Misuse: A Public Health Concern" (which currently does not include recommendations regarding opioid tapering) in line with the resolution as above.

Speaker's Note:
The CAFP has policy affirming "that no entity should use MME (morphine milligram equivalents) thresholds as anything more than guidance" and that "CAFP will advocate against misapplication of the CDC Guideline by pharmacists, health insurers, pharmacy benefit managers, legislatures, and governmental and private regulatory bodies in ways that prevent or limit patients' medical access to opioid analgesia" (BOD 7.13.19). The above resolutions regarding appropriate tapering are in line with this theme of limiting harm to patients on chronic opioids.

Additionally, the AAFP's Chronic Pain Management and Opioid Misuse position paper includes the following recommendations:

- Deliver patient-centered, compassionate care to patients struggling with chronic pain and/or opioid dependence
- Critically appraise currently available evidence and guidelines on the treatment of chronic pain and opioid dependence
- Align residency program training to deliver evidence-based information on best practices in the management of chronic pain and opioid dependence (2)

However, it does not include any reference to, recommendations for, or acknowledgement of issues regarding opioid tapers.

The above resolution advocates for the creation of CAFP policy to discuss safe and effective strategies regarding decisions surrounding opioid tapers using the language in the HHS guidelines, and additionally calls for bringing this discussion to the national level for consideration of the addition of tapering recommendations to AAFP's policy paper.

Fiscal Note:
There would be no significant unbudgeted cost for adopting the proposed policy as it would fall within established procedures for updating and taking positions on proposed legislation and policy.

There would be no significant cost as a result of referring for national action.

PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this resolution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?
This resolution seeks to create policy that advocates for improved management of and decision-making surrounding tapering opioid dosages of patients on long-term opioid therapy for chronic non-cancer pain. This resolution calls for creation of CAFP policy regarding opioid tapering, and also for addition of recommendations regarding opioid tapers to AAFP's current opioid position paper.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?
As many family physicians care for patients currently on long-term opioid therapy, I would expect this to affect most physicians in the CAFP and many of their patients.

WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY, i.e., what action do you wish CAFP to take?
This resolution calls for the CAFP to create policy regarding opioid tapering in line with the recent HHS opioid tapering guidelines. It also asks that this resolution be brought to the national level to discuss the addition of the recommendations in the HHS guidelines to the AAFP's opioid policy paper, as this policy paper currently does not address opioid tapering at all.

WHAT EVIDENCE EXISTS TO: 1) INDICATE THAT A PROBLEM EXISTS; OR 2) THAT THERE IS NEED FOR A NEW OR REVISED POLICY?
As noted in the resolution, there are studies showing that rapid tapering of opioids is associated with subsequent loss to follow up (6) and risks including serious withdrawal symptoms, uncontrolled pain, psychological distress and suicide (5). Additionally, patient-centered tapering has been shown to decrease opioid usage in the outpatient setting (7). Both the CDC guideline for opioid prescribing (3) and the recent HHS guidelines (8) support shared decision making with patients regarding tapering plans.

PLEASE PROVIDE CITATIONS to support the existence of the problem and your proposed solution.
1. "Opioid Overdose: U.S. Prescribing Rate Maps". Centers for Disease Control and Prevention. October 3, 2018. 2018 Oct 3. https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html

2. Hauk L. “Management of chronic pain and opioid misuse: A position paper from the AAFP. *Am Fam Physician.* 2017 Apr 1;95(7):458-459. https://www.aafp.org/about/policies/all/pain-management-opioid.html

3. Dowell, D, Haegerich TM, and Chou R. “CDC guideline for prescribing opioids for chronic pain”. *MMWR.* 2016 Mar 18;65(1):1-49. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm

4. Kroenke K, et al. “Challenges with implementing the centers for disease control and prevention opioid guideline: A consensus panel report”. *Pain Med*. 2019 Apr 1;20(4):724-735. https://www.ncbi.nlm.nih.gov/pubmed/30690556

5. US Food and Drug Administration. “FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering. https://www.fda.gov/Drugs/DrugSafety/ucm635038.htm.

6. Perez HR, et al. “Opioid Taper is associated with subsequent termination of care: a retrospective cohort study”. *J Gen Intern Med*. 2019 Aug 19. Epub ahead of print. https://www.ncbi.nlm.nih.gov/pubmed/31428983

7. Darnall BD, et al. “Patient-centered prescription opioid tapering in community outpatients with chronic pain”. *JAMA Intern Med*. 2018 May 1;178(5):707-708. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2672574

8. US Department of Health and Human Services Working Group on Patient-Centered Reduction or Discontinuation of Long-Term Opioid Analgesics. “HHS guide for clinicians on the appropriate dosage reduction or discontinuation of long-term opioid analgesics”. 2019 Oct. https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf

Res. A-13-20

TITLE: **Annual Influenza Vaccine Mandate Among Required Vaccinations for School**

Introduced by: Rossan Chen, MD MSc

Endorsements: Napa-Solano Chapter

WHEREAS, influenza affected an estimated 45 million people, resulted in 810,000 hospitalizations and 21 million outpatient visits, and caused 61,000 deaths in the United States in 2017-2018, including 186 pediatric deaths (80% of whom were not vaccinated against influenza), [23] [24] and

WHEREAS, CDC estimates that so far this season there have been at least 6.4 million flu illnesses, 55,000 hospitalizations and 2,900 deaths from the flu in the United States (as of 1/9/20)[25], and

WHEREAS, influenza is estimated to result in a total average annual economic cost of over $11 billion, with direct medical costs estimated to be over $3 billion annually in the United States,[26] and

WHEREAS, influenza causes US employees to miss approximately 17 million workdays, which costs an estimated $7 billion a year in sick days and lost productivity,[27] and

WHEREAS, the attack rates during the annual outbreaks of influenza are highest in children, with an average of 20–30% of children affected, and

WHEREAS, most cases of influenza this year have been strain B, which affects children more than adults, [28] and

WHEREAS, all children aged 6-59 months, and children with chronic pulmonary conditions such as asthma, are at increased risk for severe illness and complications from influenza and for influenza-related outpatient, emergency department, or hospital visits, and

---

[23] https://www.cdc.gov/flu/about/burden/index.html
[24] https://www.cdc.gov/flu/about/season/flu-season-2017-2018.htm
[25] https://www.cdc.gov/flu/weekly/index.htm
[26] Putri WC, Muscatello DJ, Stockwell MS, Newall AT (June 2018). "Economic burden of seasonal influenza in the United States". *Vaccine*. **36** (27): 3960–66.
[27] https://www.healthline.com/health/influenza/facts-and-statistics#5
[28] https://www.nytimes.com/2020/01/08/health/flu-season-severity.html

WHEREAS, in healthy children over the age of two years, the vaccine reduces the chances of getting influenza by approximately two-thirds,[29] and

WHEREAS, the influenza vaccine has been found to be cost-effective among children, [30] and

WHEREAS, serious adverse reactions from the influenza vaccine are rare, particularly with the inactivated influenza vaccines,[31] and

WHEREAS, while influenza vaccine effectiveness could be improved, the vaccine is estimated to have prevented 7.1 million illnesses, 3.7 million medical visits, 109,000 hospitalizations, and 8,000 deaths, despite an overall estimated vaccine effectiveness of 38% during the recent severe 2017–18 influenza season,[32] and

WHEREAS, California eliminated personal belief exemptions for vaccines (SB 277), which caused the proportion of kindergarten students who received all of the required vaccines to rise from 92.8 % in the 2015-2016 school year (the academic year before S.B. 277 took effect) to 95.1 % in the 2017-2018 school year,[33] therefore be it

RESOLVED: The CAFP work with state senator Dr. Richard Pan and other state legislators to add the annual influenza vaccine to the list of required immunizations in order to attend public and private elementary and secondary schools, child care centers, family day care homes, nursery schools, day nurseries, and developmental centers (pre-kindergarten facilities) according to the California Health and Safety Code, Sections 120325-120375.

Students who decline the annual influenza vaccine must be required to wear a mask at school from October 1 to April 30. Exceptions to the requirement include medical contraindications to the influenza vaccine such as a documented severe allergic reaction to any component of the vaccine or to a previous dose of any influenza vaccine.

---

[29] Jefferson T, Rivetti A, Di Pietrantonj C, Demicheli V (2018). "Vaccines for preventing influenza in healthy children". *The Cochrane Database of Systematic Reviews*. **2**: CD004879

[30] Newall AT, Jit M, Beutels P (August 2012). "Economic evaluations of childhood influenza vaccination: a critical review". *PharmacoEconomics*. **30** (8): 647–60.

[31] Jefferson T, Rivetti A, Di Pietrantonj C, Demicheli V. Vaccines for preventing influenza in healthy children. Cochrane Database of Systematic Reviews 2018, Issue 2.

[32] Rolfes MA, Flannery B, Chung J, et al. US Flu VE Network, the Influenza Hospitalization Surveillance Network (FluSurv-NET), and the Assessment Branch, Immunization Services Division, CDC. Effects of Influenza Vaccination in the United States during the 2017–2018 Influenza Season. Clin Infect Dis 2019

[33] https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Immunization/2017-2018KindergartenSummaryReport.pdf

Speaker's Note:
While supportive of vaccine mandates and increased access to immunizations, CAFP policy is not specific to the flu vaccine. Four states currently require the flu vaccine, almost exclusively for childcare enrollment (i.e., children younger than 59 months). The flu vaccine has not been included in California vaccine mandates, often under the reasoning that the school year begins before the vaccine is available.
Existing CAFP Policy:

Immunization Policies: Encourage plans to: (1) Clearly specify immunization policies in writing for patients and providers by immunization name and time frame for covered services; and (2) Specify that additional immunizations outside of the contractual series are non-covered services. Educate its members about contractual language in agreements that clearly explain covered and non-covered immunization practices. *C-7-96, 2/96 CoD*

Personal and Religious Belief Exemptions to Immunizations**:** Support legislation to eliminate the personal and religious belief exemptions for school-aged children as contained in 2015's SB 277 (Pan-D). *BoD 4/24/15*

Preferential Supply of Influenza Vaccine: Manufacturers should preferentially supply influenza vaccine to physicians in time of shortage or public need. *2/01 CoD* Support legislation providing physicians priority access to the first available seasonal influenza vaccine. *A-05-10 03/10 CoD*

Immunization: Support the completion of the immunization registry state hub and encourages members' participation in such registries. *03/09 CoD*

Vaccines/Immunizations Policy:

- When medical practices incur a cost for vaccines, physicians should be adequately paid for the vaccine itself and all associated overhead costs (i.e., acquisition, storage, inventory, insurance, spoilage/wastage, etc.) of all immunizations and their administration with no patient cost-sharing.
- All children and adults, regardless of economic and insurance status, should have access to all immunizations recommended by the AAFP.
- Vaccine manufacturers and distributors should have payment policies that minimize physicians' financial risk involved in maintaining a vaccine inventory.
- Government programs (e.g., Vaccines for Children (VFC), 317 Immunization Grants, or state "universal purchasing") that subsidize the costs of vaccines at no cost to medical practices should be adequately funded by the federal and state government.

- Patients should receive all immunizations in their medical home; when recommended vaccines are provided outside of the medical home, all pertinent vaccine related information should be provided to the patient's medical home.
- The government should allow physicians to intermingle storage of VFC and other vaccine supplies, with appropriate documentation and cost accounting, due to the burdensome and unnecessary administrative hassle of doing otherwise.

BoD 5.03.13

Health Care System Principles:

Every individual's coverage should include guaranteed access to evidence-based essential benefits that include, but are not limited to:

- 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. *Adopted BoD 7.15.17*

Fiscal Note:

There would be significant cost to sponsor legislation. Given the history of recent vaccine battles in the Legislature, a fight against the anti-vaccination movement would be resource intensive.

Res. A-14-20

TITLE: X the X Waiver

Introduced by: Sheila Attaie, DO, Mary Kathryn Orsulak, MD, MPH, Sky Lee, MD

Endorsements: Sacramento Valley Chapter of the California Academy of Family Physicians

WHEREAS, in 2018, more than 2 million people had opioid use disorder, 10.3 million people misused prescription opioids, and over 130 people died every day from opioid-related drug overdoses[5], and

WHEREAS, as family medicine physicians and lifelong learners, it is our duty to continue medical education both as a requirement for licensing and to best serve the needs of our patient populations, including those with opioid use disorder, and

WHEREAS, there is overwhelming evidence demonstrating Medications for Opioid Use Disorder (MOUD) reduce drug use, disease rates, overdose, death, healthcare expenditure, and crime[6], and

WHEREAS, deregulation of MOUD in France in 1995 resulted in a 79% decrease in overdose deaths and a 95% increase in the use of MOUD in just four years. Only 137 Buprenorphine-related deaths were reported between 1996 and 2000[2], and

WHEREAS, despite such compelling evidence, 90% of patients with opioid use disorder in the United States do not have access to treatment[6], and

WHEREAS, only 23% of publicly funded treatment programs offer FDA approved MOUD, and less than 50% of private-sector treatment programs offer FDA approved MOUD[6], and

WHEREAS, one of the most critical barriers to access and availability of MOUD is the Buprenorphine X waiver and associated regulations in prescribing MOUD, and

WHEREAS, in the United States, current FDA and DEA regulations require physicians to complete an 8-hour training (in person or online), followed by a Buprenorphine X waiver application. Nurse Practitioners and Physician Assistants must complete a 24-hour training followed by an X waiver application. After obtaining a X waiver, prescribers are limited to only 30 patients in the first year[1], and

WHEREAS, the American Academy of Family Physicians (AAFP) policy recognizes the importance of MOUD in the treatment of opioid use disorder, as well as encourages collaboration with state and

federal licensing boards to destigmatize MOUD, particularly in the setting of the community providers, and

WHEREAS, current AAFP policy encourages family physicians to obtain their Buprenorphine X waiver but also advocates for the removal of barriers in accessing MOUD, therefore be it

RESOLVED: that the CAFP write a policy paper recommending the deregulation of Buprenorphine administration by replacing the X waiver with Continued Medical Education requirements, and be it further

RESOLVED: that the CAFP under Tools and Resources of their educational webpage include a database of online, local, and live training sessions for MOUD, and be it further

RESOLVED: that the CAFP bring this resolution to the National Congress of Delegates for consideration and support on a national level.

Speaker's Note:
CAFP has no existing policy on Buprenorphine.

Existing CAFP Policy:
Expanded Use of Naloxone: Prevention of Drug Overdose-related Deaths:

1. Support the implementation of programs that allow first responders and non-medical personnel to possess and administer naloxone in emergency situations;
2. Support the implementation of policies that allow licensed providers to prescribe naloxone auto-injectors to patients using opioids or other individuals in close contact with those patients; and
3. Support the implementation of legislation that protects any individuals who administer naloxone from prosecution for practicing medicine without a license. *4.15 BoD*

Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis: That the California Academy of Family Physicians (CAFP) support the creation of facilities that provide a supervised framework and enhanced aseptic conditions for the injection of self-provided illegal substances with medical monitoring, with legal and liability protections for persons working or volunteering in such facilities and without risk of criminal penalties for recipients of such services. *7/18 BoD*
AAFP Policy:

Multiple avenues of treatment are available for opioid use disorders, including medication assisted treatment (MAT) and behavioral counseling. The Food and Drug Administration has approved three

drugs for the treatment of opioid use disorder: buprenorphine, methadone, and naltrexone. The AAFP encourages the training of family physicians regarding the proper assessment, treatment, and referral for treatment of opioid use disorder, including obtaining the MAT waiver to prescribe MAT in their practice. The AAFP advocates for removal of barriers to the access of MAT. The AAFP recognizes that the need for continuing MAT should be individualized and some patients may require indefinite or lifelong treatment. The AAFP opposes regulation that places lifetime limits on MAT treatment. (2003) (2019 COD)

Fiscal Note:
CAFP would incur moderate cost, depending on the level of legislative involvement at the state level. Dedicated lobbying to amend regulations would incur significant costs.

There would be no significant cost as a result of referring for national action.

Citations:

1. "Apply for a Practitioner Waiver." *SAMHSA*, 12 Dec. 2019, www.samhsa.gov/medication-assisted-treatment/training-materials-resources/apply-for-practitioner-waiver.
2. Auriacombe, Marc, et al. "French Field Experience with Buprenorphine." *The American Journal on Addictions*, U.S. National Library of Medicine, 2004, www.ncbi.nlm.nih.gov/pubmed/15204673.
3. "Opioid Overdose." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 18 Oct. 2019, www.cdc.gov/drugoverdose/index.html.
4. Public Affairs. "What Is the U.S. Opioid Epidemic?" *HHS.gov*, Https://Plus.google.com/+HHS, www.hhs.gov/opioids/about-the-epidemic/index.html
5. Salisbury-Afshar, Elizabeth. "Treating Opioid Use Disorder as a Family Physician: Taking the Next Step." *American Family Physician*, 1 Mar. 2018, www.aafp.org/afp/2018/0301/p302.html#afp20180301p302-b8.
6. "The AMA and AAFP Urge Removing All Barriers to Treatment for Substance Use Disorder ." *AAFP*, www.aafp.org/dam/AAFP/documents/advocacy/prevention/risk/BKG-AMA-AAFP-MAT.pdf.

Res. A-15-20

TITLE: Creating a Buprenorphine exemption from the Controlled Substances Act

Introduced by: Dylan Hanami, MD

WHEREAS, The X-waiver requirement for buprenorphine prescription creates unnecessary barriers for patients to access treatment for opioid use disorder, and

WHEREAS, We are in a national crisis where opioid overdose is the leading cause of injury-related death in the US, and

WHEREAS, Less than 4% of licensed physicians in the US are approved to prescribe buprenorphine for opioid use disorder, and nearly 50% of counties in the US lack a prescriber, and

WHEREAS, The prescription of buprenorphine for the treatment of opiate use disorder (OUD) is contingent upon physician completion of the X-waiver 8-hour training, and

WHEREAS, The X-waiver requirement stems from the Controlled Substances Act of 1970, where opiate agonists were regulated when used for the treatment of OUD due to the concern of diversion and misuse, and

WHEREAS, As a partial agonist, published data shows buprenorphine is safer than other full agonist opioids, does not create a euphoric state, and quells symptoms of withdrawal, and WHEREAS, Other full-agonist opioids (hydrocodone, hydromorphone) are not under the REMS classification, and subsequently, do not require 8 hour X waiver training, now, therefore be it, RESOLVED, That CAFP engage in advocacy efforts for (1) the exemption of buprenorphine from the Controlled Substances Act, and in turn, (2) remove the mandatory 8-hour X-waiver training, as it prohibits access to safe, effective and evidence-based treatment for opioid use disorder during a national crisis, therefore be it

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

Speaker's Note:
CAFP has no existing policy on Buprenorphine.

Existing CAFP Policy:
Expanded Use of Naloxone: Prevention of Drug Overdose-related Deaths:

- Support the implementation of programs that allow first responders and non-medical personnel to possess and administer naloxone in emergency situations;
- Support the implementation of policies that allow licensed providers to prescribe naloxone auto-injectors to patients using opioids or other individuals in close contact with those patients; and
- Support the implementation of legislation that protects any individuals who administer naloxone from prosecution for practicing medicine without a license. 4.15 BoD

Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis: That the California Academy of Family Physicians (CAFP) support the creation of facilities that provide a supervised framework and enhanced aseptic conditions for the injection of self-provided illegal substances with medical monitoring, with legal and liability protections for persons working or volunteering in such facilities and without risk of criminal penalties for recipients of such services. 7/18 BoD

AAFP Policy:
Multiple avenues of treatment are available for opioid use disorders, including medication assisted treatment (MAT) and behavioral counseling. The Food and Drug Administration has approved three drugs for the treatment of opioid use disorder: buprenorphine, methadone, and naltrexone. The AAFP encourages the training of family physicians regarding the proper assessment, treatment, and referral for treatment of opioid use disorder, including obtaining the MAT waiver to prescribe MAT in their practice.
The AAFP advocates for removal of barriers to the access of MAT. The AAFP recognizes that the need for continuing MAT should be individualized and some patients may require indefinite or lifelong treatment. The AAFP opposes regulation that places lifetime limits on MAT treatment. (2003) (2019 COD)

Fiscal Note:
CAFP would incur moderate cost, depending on the level of legislative involvement at the state level. Dedicated lobbying to amend regulations would incur significant costs.

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 practice problem this resolution seeks to solve is inadequate access to treatment for OUD. The REMS classification creates barriers for licensed physicians to prescribed evidence-based medications for opioid use disorder during a national crisis. It stigmatizes these patients, and stigmatizes safe treatment. Ironically, we prescribe opioids which have abuse potential, can be misused and diverted and are not required to complete 8-hours of extra training. Anecdotally, physicians are more wary of prescribing

suboxone than percocet. If the REMS classification was dissolved, patients would have more access to treatment for OuD.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?
In 2017, there were nearly 50,000 opioid related deaths in the US according to the CDC. Around 2000 of those deaths were in California. With appropriate treatment, some of these deaths may have been prevented.

WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY, i.e., what action do you wish CAFP to take?
I would like CAFP to increase advocacy efforts towards (1) the exemption of buprenorphine from the controlled substances act and (2) remove 8 hour X-waiver training would no longer be required, and any licensed physician would be able to prescribe buprenorphine.

WHAT EVIDENCE EXISTS TO: 1) INDICATE THAT A PROBLEM EXISTS; OR 2) THAT THERE IS NEED FOR A NEW OR REVISED POLICY?
As stated above, there are many deaths in the US related to opioid use disorder. We are in a national crisis. From current estimates, 50% of counties in the US lack a provider licensed to prescribed buprenorphine. According to Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment, creating an exemption from the Controlled substances act for buprenorphine may help increase access to appropriate treatment for OUD. Furthermore, by removing the 8 hour X-waiver training, more providers will be able to prescribe buprenorphine. Buprenorphine is safe, effective and evidence based treatment for opioid use disorder. It is a partial agonist, and does not create a euphoric state. It helps to manage withdrawal symptoms. Furthermore, in a recent study in France, buprenorphine prescribing regulations were removed, and there was a 79% decrease in opioid related death in 3 years.

5) PLEASE PROVIDE CITATIONS to support the existence of the problem and your proposed solution.
h ttps://www.cdc.gov/opioids/index.html
h ttps://jamanetwork.com/journals/jamapsychiatry/fullarticle/2719455 h ttps://www.ncbi.nlm.nih.gov/pubmed/29779547
h ttps://www.ncbi.nlm.nih.gov/pubmed/17915074 h ttps://www.ncbi.nlm.nih.gov/pubmed/15204673

Res. A-16-20

TITLE: **Working Toward Zero Waste**

Introduced by: Ava Asher, MD

Endorsements: CAFP Sacramento Valley Chapter

WHEREAS, environmental and occupational factors contribute to more than 25% of all global disease, and toxic agents ranked fifth in underlying causes of U.S. deaths in 2000[34], and

WHEREAS, single-use plastics (including cups with polyurethane lining, plastic food wraps, plastic cutlery, and food sachets as a few of the many products in question), are a burden to the environment, and

WHEREAS, recycling is not available at all conference locations, nor has recycling been shown to effectively resolve the plastic pollution problem[35], and

WHEREAS, "The American Academy of Family Physicians (AAFP) has long recognized the environment's impact on health. Environmental factors have short- and long-term impacts on health and well-being. The AAFP is committed to providing strategies to help family physicians understand and recognize the impact of the environment on patient health, and improve the health of patients affected by poor environmental conditions,"[36] and

WHEREAS, we in primary care are well aware, prevention is best – reducing the origination of single-use plastics is better than trying to figure out where to store waste, and finding out later it is being discarded into our local water-ways and oceans; that we do not know where our waste goes imparts on us a responsibility to prevent waste in the first place, and

[34] US Department of Health and Human Services, Agency for Toxic Substances and Disease Registry. Taking an Exposure History: What Role Do Primary Health Care Providers Have in Detecting, Treating, and Preventing Disease Resulting from Toxic Exposures? June 5, 2015

[35] CNN Business Daniel; Weiner-Bronner. Starbucks cups are not easily recycled. Here's why that's a problem. February 27, 2019

[36] AAFP Environmental Health and Climate Change, https://www.aafp.org/patient-care/social-determinants-of-health/environment.html

WHEREAS, the answer to our environmental health emergency must involve collective action[37], and the CAFP is a collective of medical professionals dedicated to the health of our individual patients and communities, therefore be it

RESOLVED: The CAFP recognize the opportunity to make a statement in support of improving the environmental health of our patients and our planet by requesting all future conference and meeting sites make every attempt to reduce waste by avoiding waste, and be it further

RESOLVED: Alert CAFP members that future events will make increasing efforts to be Zero-Waste or "Green," and encourage participants to bring their own water bottles, travel coffee mugs, utensils (reusable "sporks," and/or food containers (("Tupperware"), and be it further

RESOLVED: Request conference host sites not use disposable silverware, cups, napkins, beverage containers, etc., and be it further

RESOLVED: Consider a site's ability or willingness to avoid waste-generation when contracting for meetings and conferences, and be it further

RESOLVED: Rather than boxed lunches with individually plastic wrapped internals, request creative solutions like 2-3 room buffets or table buffets, and be it further

RESOLVED: If CAFP "swag" is considered necessary, consider reusable (water bottles, coffee mugs, utensils) or biodegradable items for future "swag" rather than items that are highly likely to be disposed of at home, and be it further

RESOLVED: The CAFP will carry out an audit of its carbon footprint – from its energy emissions and transport to the staff canteen, and consider committing to reducing its carbon emissions, moving to net zero.[38], and be it further

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

[37] The Guardian, Sandra Laville. One year to save the planet: a simple, surprising guide to fighting the climate crisis in 2020. January 7, 2020

[38] The Guardian, Sandra Laville. One year to save the planet: a simple, surprising guide to fighting the climate crisis in 2020. January 7, 2020

Speaker's Note:

CAFP has made efforts to reduce waste at its meetings and office whenever possible, including using e-Board agendas, electronic handouts at Clinical Forum, and this year providing a "family style" luncheon instead of a boxed lunch at Clinical Forum.

The decision about where to have Clinical Forum and other events is largely guided by cost, availability and amenities, sometimes leaving CAFP with few practical choices.

Fiscal Note:

CAFP is contracted for space through 2021 with the Long Beach Hilton. Breaking that contract would carry significant costs.

- Hotels pass any additional costs of "going green" on to the consumer so we may see higher costs associated with our request to reduce waste. For example, the hotel has to pay additional labor costs when serving a "family style" luncheon instead of boxed lunches.
- There would be no significant cost associated with asking event attendees to bring water bottles and taking other measures to reduce their environmental footprint or utilizing eco-friendly promotional products.
- There would be undetermined but potentially significant costs to carry out an audit of our carbon footprint, including hiring a consultant.
- There would not be significant cost to refer for national action

PROBLEM STATEMENT: This resolution seeks to improve environmental health in a few ways: by bringing it to the attention of primary care physicians as an issue to discuss with patients, as advised in the recent AAFP magazine article and as a stated commitment by the AAFP, and to physically reduce the CAFP waste impact at conference sites and therefore on the planet as a whole.

PROBLEM UNIVERSE: this proposal would affect all CAFP members who attend conferences and, if well received, would be promoted as a reasonable request for all CAFP members to ask of their other affiliations.

WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY: this proposal is for the CAFP to set an example for other professional organizations that also have large conferences with unnecessary waste with far reaching, although not obviously visible, impact.

WHAT EVIDENCE EXISTS TO: 1) INDICATE THAT A PROBLEM EXISTS; OR 2) THAT THERE IS NEED FOR A NEW OR REVISED POLICY? Please see footnotes 1, 2, 3, 4.

PLEASE PROVIDE CITATIONS to support the existence of the problem and your proposed solution:
Please see footnotes 1, 2, 3, 4.

Res. A-17-20

TITLE: Promote the Development of Hospital-Based Violence Mitigation Programs

Introduced by: Julia Marino, PGY-1; UCSF Fresno Family & Community Medicine

Endorsements: Fresno Chapter

WHEREAS, there has long been an association between exposure to violence and/or abuse and adverse health outcomes1, and

WHEREAS, approximately one third of an average family physicians' patients are affected by family violence 1, and

WHEREAS, in 2017, out of a population of approximately 900,000 children in California, CPS received over 400,000 total referrals for child abuse and neglect, over half of which were referred for investigation 2, and

WHEREAS, more than 50/100,000 African Americans 20/100,000 Latinos die from homicide each year in the US 3, and

WHEREAS, homicide is the second leading cause of death for adolescents and young adults (ages 10-24) 4, and

WHEREAS, an average of 20 people are victims of intimate partner violence every minute in the United states, totaling to more than 10 million victims each year 5, and

WHEREAS, victims of family violence interact with health care systems approximately twice as often as non-victims 1, and

WHEREAS, injury recidivism rates are currently upwards of 35% 3, and

WHEREAS, analysis demonstrates a 50% reduction in the violent reinjury rate for participants in hospital-based violence intervention programs over a 10-year period6, therefore be it

RESOLVED: That CAFP support the development of comprehensive violence mitigation programs across the state, and be it further

RESOLVED: That such programs be modeled after the San Francisco Wraparound Project to provide evidence-based, resilience training and trauma-informed care for victims of violence in vulnerable populations across the state, and be it further

RESOLVED: That CAFP work with the California legislature to advocate for funding for the San Francisco Wraparound Project and the development of new hospital-based violence mitigation programs throughout the state.

---

1. "Violence (Position Paper)." AAFP Home, 19 Mar. 2019, www.aafp.org/about/policies/all/violence.html
2. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2019). Child Maltreatment 2017: Reports from the States to the National Child Abuse and Neglect Data System: Table 2-1: Screened-In and Screened-Out Referrals, 2016.
3. "Where Do We Go From Here? Interim Analysis to Forge Ahead... : Journal of Trauma and Acute Care Surgery." LWW, journals.lww.com/jtrauma/Abstract/2009/12000/Where_Do_We_Go_From_Here Interim_Analysis_to.7.aspx.
4. Injury prevention & control: data & statistics. Web-based Injury Statistics Query and Reporting System (WISQARS). National Center for Injury Prevention and Control, Centers for Disease Contorl and Prevention; 2007. http://www.cdc.gov/injury/wisqars/index.html
5. Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens MR. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2011.
6. Juillard et al. "A decade of hospital-based violence intervention; Benefits and shortcomings". Journal of Trauma and Acute Care Surgery: December 2016 - Volume 81 - Issue 6 - p 1156–1161

Speaker's Note:
CAFP has several policy statements regarding violence, violence prevention and funding violence prevention programs. In supporting the programs below, it is taken that CAFP would advocate for the creation of like programs within hospitals.

Taxes on Alcohol: The California Academy of Family Physicians encourages and supports legislation which will increase the excise tax on alcoholic beverages with the moneys used to help fund educational programs on violence prevention and treatment of alcoholism and related illnesses; and, the CAFP

delegation to the AAFP Congress of Delegates introduce a resolution asking the AAFP to recognize the above. *2/94 CoD*

Educate FPs/Public on Firearms and Risk of Injury and Death: The California Academy of Family Physicians should continue to develop programs to educate family physicians, their patients and the public on the issue of ownership of firearms and the concurrent risk of injury and death, domestic and family violence, alcohol and other drug abuse and the concurrent risk of violent injury and death, the relationship of increasing violence in the media and increasing violence in our society, the preventable nature of violence, and the importance of addressing the root causes of violence as part of a comprehensive violence prevention approach; and, the CAFP delegation to the AAFP Congress of Delegates introduce a resolution asking the AAFP to recognize the above. 2/94 CoD

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. 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. 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 towards and victimization of these groups. *BoD 2-1-2017*

Fiscal Note:
There would be no significant cost for supporting hospital-based violence mitigation programs as it would fall within established procedures for updating and taking positions on proposed legislation and policy. There may be significant cost to advocate for development of statewide comprehensive violence mitigation programs depending on the level of legislative involvement

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?
Violence is a public health crisis and there are currently very few evidence-based solutions for violence mitigation. The San Francisco Wraparound Project has over 10 years of data demonstrating reduced violent injury recidivism.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?
As noted in resolution statistics and statements, family violence alone affects approximately one third the average family pphysician's patient population. Community and gang-related violence would significant;y increase that number.

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 work with the state legislature to advocate for funding and local chapters should work with county hospitals to implement violence-mitigation programs modeled after the evidence-based successes of the San Francisco Wraparound Project.

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

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

Res. A-18-20

TITLE: Develop Ergonomics Curriculum for the Workplace

Introduced by: Julian Nguyen DO, PGY-1; UCSF-Fresno, Jonathan Campbell DO, PGY-1; UCSF-Fresno, Sireesha Mudunuri DO, PGY-1; UCSF-Fresno

Endorsements: Fresno Kings Madera Chapter

WHEREAS, in 2018, 2.8million nonfatal workplace injuries were reported 1, of which 466,000 were in California 2, of those over 65,000 were in office and administrative settings 2, and

WHEREAS, over 900,000 of these cases resulted in days away from work (DAFW), and 37% of these required a visit to a medical facility 1, and

WHEREAS, the median DAFW was 8 days in the private industries 1, and

WHEREAS, cost compensation of musculoskeletal disorders (MSDs) as a result of workplace injury total over $20billion in worker's compensation3 and over 5 times that in indirect costs, and

WHERAS, MSDs are the most frequently reported cause of lost work time and accounted for 1/3 of all worker injury cases 4, and

WHEREAS, productivity loss secondary to absenteeism related to workplace injury and illness cost U.S. employers over $225billion 5, and

WHEREAS, a 2002 study assessing the effectiveness of an ergonomics training program showed an increase in injury reports, but considerably lowered total cost 6, therefore be it

RESOLVED: That the CAFP work in conjunction with employers develop an ergonomics curriculum in workplaces to prevent workplace injury and lower workplace cost, and be it further

RESOLVED: That the CAFP advocate for more data reporting regarding workplace injuries, compensation, ergonomics programs and their efficacy, and be it further

RESOLVED: That CAFP refer this to AAFP and advocate for national action through collaboration with OSHA, BLS, CDC, and national agencies to develop curriculums & studies given the limited resources available currently.

References:

1 Employer-Reported Workplace Injury and Illness, 2018. U.S. Bureau of Labor Statistics. https://www.bls.gov/news.release/osh.nr0.htm. Accessed 1/9/2020

2 Nguyen, Jessica, Numbers of nonfatal occupational injuries and illnesses by industry and case types, California, 2018 (thousands). U.S. Bureau of Labor Statistics. https://www.bls.gov/iif/oshwc/osh/os/18summ2_06.xlsx. Accessed 1/9/2020

3 1218-AB58 - 2014. PREVENTION OF WORK-RELATED MUSCULOSKELETAL DISORDERS | Occupational Safety
and Health Administration,
https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=4481&p_table=UNIFIED_AGENDA, Accessed 1/9/2020

4 Safety and Health Topics | Ergonomics | Occupational Safety and Health Administration, https://www.osha.gov/SLTC/ergonomics/, Accessed 1/9/2020

5 Stinson, Claire, Worker Illness and Injury Costs U.S. Employers $225.8 Billion Annually | CDC Foundation, https://www.cdcfoundation.org/pr/2015/worker-illness-and-injury-costs-us-employers-225-billion-annually, Accessed 1/9/2020

6 Lewis, R. Jeffrey, Krawiec, Marianne, Confer, Ellen, Agopsowicz, Daniel, Crandall, Eileen, Musculoskeletal disorder worker compensation costs and injuries before and after an office ergonomics program ScienceDirect, https://doi.org/10.1016/S0169-8141(01)00054-3, Accessed 1/9/2020

Speaker's Note:

CAFP does not have existing policy on the development of an ergonomics curriculum in medical or graduate medical education. AAFP, however, has policy related to recognizing occupational health and safety and mitigation of illnesses and injury in the workplace, as well as common occupational disorders and workplace injuries of which family physicians should be aware. Together, these policies represent a curriculum for family physicians to treat workplace illness and injuries. They are not aimed at employers, however.

This is not a priority outlined in the CAFP 2019-2021 Strategic Plan.

Fiscal Note:

Costs of developing this curriculum are estimated by the authors as over $15,000, requiring collaboration with other organizations, data collection, interpretation, and formulating the curriculum. The required staff time would be significant.

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?

By addressing workplace injuries due to poor ergonomics, the most common MSDs regarding back, shoulder, and knee can be significantly impacted through preventative care. This allows patient autonomy in this regard of their health, and can have significant implications in pain medication use, tolerance, and possibly crisis. Through the contribution of CAFP in developing this curriculum, a decrease in worker's compensation cost, group insurance cost, and taxpayer cost can also be measured.

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

Over 400,000 workplace injury cases are reported annually in California.

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

To work in collaboration with statewide labor agencies (e.g. BLS & OSHA) to develop curriculums for ergonomics in the workplace, and to increase data collection in the impacts of workplace injuries and its presence in healthcare cases and costs.

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

Please see footnotes on Page 2.

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

Please see footnotes on page 2.

Res. A-19-20

TITLE: Provide CME and Continue to Oppose Title X Regulation Prohibiting Funding Eecipients from Referring Patients for Abortion Care

Introduced by: Sheila Attaie DO, Linh Vo MD, and Lauren Wondolowski MD

WHEREAS, Title X is a nearly 50-year-old federal program ensuring access to affordable reproductive and preventive health care[1], and

WHEREAS, in 2018, over $286 million in Title X funding was distributed amongst non-profit local, state, school-based, faith-based, and community health centers to subsidize care for 3.9 million patients, 65% of whom live at or below the poverty line[1,7], and

WHEREAS, in 2019 the Trump administration restricted Title X recipients from providing abortion referrals, regardless of a patient's need or personal request[2,11], and

WHEREAS, starting in March 2020, Title X recipients will also be mandated to "establish and maintain physical separation" from the provision of abortion[2], and

WHEREAS, as a result of this restrictive regulation, many major organizations like Planned Parenthood and state health departments are withdrawing from Title X funding[3], and

WHEREAS, more than 25% of clinics across the nation have been defunded, which has detrimental implications for reproductive health access[8], and

WHEREAS, AAFP endorses the principle that women receiving healthcare paid for through health plans funded by state or federal governments should be provided with access to the full range of reproductive options (2017 COD), and

WHEREAS, the AAFP supports a woman's access to reproductive health services and opposes non evidence-based restrictions on medical care (2018 COD), and

WHEREAS, the AAFP opposes legislation that infringes upon the patient-physician relationship (2016 COD), and

WHEREAS, the AAFP and other leading professional medical organizations have explicitly addressed the need for comprehensive counseling and referral for all pregnancy options including abortion[13,4] and have issued statements opposing the Title X changes[14, 15], therefore be it

RESOLVED: the CAFP include a session at a future Family Medicine Clinical Forum about the Title X regulations and how clinics receiving Title X funding can navigate providing services, and be it further

RESOLVED: the CAFP continue to support physician voices speaking out against the regulations by publishing a blog post or article on the topic.

Speaker's Note:
CME content is based on a number of elements, from learner expressed needs to new laws and regulations, from changes in practice guidelines to new treatment options. The Committee on Continuing Professional Development takes these elements into consideration as it developed the Forum program and other CME activities and initiatives. The Forum, and other venues, such at the California Residency Network meetings, could be considered for this topic. CAFP has included these topics in its educational program, and is currently in Year 3 of a CAFP Foundation funded Reproductive Health Care initiative.

Fiscal Note:
There would be minimal cost associated with placing this CME content at the Clinical Forum as well as drafting a blog or article and placing it.

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?
Title X is a federal program for affordable reproductive and preventative health care. This program's success is considered largely responsible for improvements in people's health over the nearly 50 years since its inception, including the historically low unintended and teen pregnancy rates currently in the United States. The program has served approximately 4 million people per year with a dedication to providing access to medically-underserved patients. Detrimental changes to this critical program will disproportionately affect under-resourced communities, including people of color who already face significant health disparities due to systemic inequities. The February 2019 Title X regulations put forth by the Department of Health and Human Services removed the requirement for nondirective pregnancy counseling and prohibit referrals for abortion. Title X has never permitted funds to be used to pay for abortions. These changes not only affect patients' access to comprehensive reproductive health care, but they also intrude on the patient-doctor relationship.

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

Title X funding provided family planning services for almost 4 million patients in 2018, 25% of whom were in California. Thus, nearly 1 million California patients are affected by this change in policy to Title X funding. As of December 2019, in California alone, there was a 40% decrease in clinics receiving Title X funding as many clinics have withdrawn from the program due to the new restrictions.

Abortion is incredibly common in the United States, approximately 1 in 4 women will have an abortion by the age of 45 and 18% of pregnancies in 2017 ended in abortion. Nearly half of pregnancies are unintended and almost 5% of reproductive-age women have an unintended pregnancy each year. As such, family physicians will invariably encounter patients in their practices that have had or will have an abortion, and many patients will seek care with their primary care providers for counseling surrounding an unintended pregnancy.

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

Many organizations have expressed their opposition to the 2019 Title X regulations put forth by HHS. Given that family physicians provide more than 25% of ambulatory care in the United States, it is important for the CAFP and AAFP to take leadership roles in advocating for health policies that reflect the needs of our clinic populations. Specifically, the state of California alone receives a quarter of the national Title X funding, and therefore provides precedent for the implications of losing Title X funding on a large scale.

The new Title X regulations not only impact reproductive health care for patients, but they also impact the patient-physician relationship. Supporting informed decision-making by patients is a basic tenet of medical ethics and practice, and appropriately included in detail in the AMA Code of Medical Ethics and the AAFP Curriculum Guidelines for Family Medicine Residents for Medical Ethics. This informed decision-making process between physicians and patients requires that patients understand the risks and alternatives to the prescribed care or treatment in order to make decisions about their health. The regulations imposed on Title X grantees directly interfere in this relationship by prohibiting referral for abortion, even if requested by a patient, and not requiring nondirective options counseling.

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

Given that the Title X revised regulations were published in February 2019 and are still undergoing various legal challenges, it is important for family physicians to remain abreast of the changes and the effects on practice. There are many prior policies from the AAFP that are directly violated by the changes to Title X funding regulations and warrant action from the CAFP and AAFP. These changes not only interfere in patient-physician relationships, but they impact patients' access to necessary reproductive health care in the US. In this changing landscape, the CAFP can take a role to help its members remain informed and publicly continue to speak out against the regulations. To this end, the

authors of this resolution are happy to collaborate on CME and/or a piece for publication through the CAFP.

PLEASE PROVIDE CITATIONS to support the existence of the problem and your proposed solutions:

1. Affairs, Office of Population. "Title X Family Planning Annual Report Summary." *HHS.gov*, US Department of Health and Human Services, 29 Aug. 2019, www.hhs.gov/opa/title-x-family-planning/fp-annual-report/fpar-infographic/index.html
2. "Compliance With Statutory Program Integrity Requirements." *Federal Register*, Office of the Assistant Secretary for Health, Office of the Secretary, HHS, 4 Mar. 2019, www.federalregister.gov/documents/2019/03/04/2019-03461/compliance-with-statutory-program-integrity-requirements
3. Frederiksen, Brittni, et al. "Data Note: Impact of New Title X Regulations on Network Participation." *The Henry J. Kaiser Family Foundation*, 23 Sept. 2019, www.kff.org/womens-health-policy/issue-brief/data-note-impact-of-new-title-x-regulations-on-network-participation/
4. "Induced Abortion in the United States." *Guttmacher Institute*, 18 Sept. 2019, www.guttmacher.org/fact-sheet/induced-abortion-united-states.
5. Hornberger, Laurie L. "Options Counseling for the Pregnant Adolescent Patient." *Pediatrics*, vol. 140, no. 3, 2017, doi:10.1542/peds.2017-2274.
6. "Publicly Supported Family Planning Services in the United States." *Guttmacher Institute*, 31 Oct. 2019, www.guttmacher.org/fact-sheet/publicly-supported-FP-services-US.
7. Ranji, Usha, et al. "Financing Family Planning Services for Low-Income Women: The Role of Public Programs." *The Henry J. Kaiser Family Foundation*, 29 Oct. 2019, www.kff.org/womens-health-policy/issue-brief/financing-family-planning-services-for-low-income-women-the-role-of-public-programs/.
8. "The Status of Participation in the Title X Federal Family Planning Program." *The Henry J. Kaiser Family Foundation*, Kaiser Family Foundation, 20 Dec. 2019, www.kff.org/interactive/the-status-of-participation-in-the-title-x-federal-family-planning-program/.
9. U.S. Department of Health and Human Services. "Fact Sheet: Final Title X Rule Detailing Family Planning Grant Program." *HHS.gov*, US Department of Health and Human Services, 22 Feb. 2019, www.hhs.gov/about/news/2019/02/22/fact-sheet-final-title-x-rule-detailing-family-planning-grant-program.html.
10. U.S Department of Health and Human Services. "Title X Family Planning Annual Report." *HHS.gov*, US Department of Health and Human Services, August 2019, https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2018-national-summary.pdf
11. "Unintended Pregnancy in the United States." *Guttmacher Institute*, 9 Jan. 2019, www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.
12. "Visits to Primary Care Delivery Sites: United States, 2008." *Center for Disease Control*, 2010, www.cdc.gov/nchs/data/databriefs/db47.pdf.

13. "Women's Health Care Physicians." *The American College of Obstetricians and Gynecologists* , Ethics in Obstetrics and Gynecology, Aug. 2009, www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Informed-Consent.
14. "The Final Title X Regulation Disregards Expert Opinion and Evidence-Based Practices." *The American College of Obstetricians and Gynecologists*, 26 Feb. 2019, https://www.acog.org/About-ACOG/News-Room/Statements/2019/Final-Title-X-Regulation-Disregards-Expert-Opinion-and-Evidence-Based-Practices.
15. "Joint Letter to Senate Committee on Appropriations on FY20 Title X." *American Academy of Family Physicians,* 3 July 2019,
16. https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/women/LT-SenAppropriationsSub-FY20TitleX-070319.pdf.

Res. A-20-20

TITLE: **Hospital and Clinic Exemption from PG&E Public Safety Power Shut Off Events**

Introduced by: Rossan Chen, MD, Adia Scrubb, MD, Anastasia Coutinho, MD

Endorsements: Napa-Solano Chapter, East Bay Chapter

WHEREAS, in October 2019, PG&E began Public Safety Power Shutoffs throughout Northern California during high fire conditions with a maximum of up to 48 hours of prior notice with no clear anticipated length of duration, and

WHEREAS, hospitals require PG&E services to provide adequate clinical care to patients, including urgent and emergent surgeries, ventilator capabilities, emergency imaging services, elevators for patient transport, and lighting to avoid falls, and

WHEREAS, clinic settings require PG&E services also provide adequate clinical care to patients, including keeping their doors open for acute and chronic care management, storage of vaccinations and medications, nebulizer and dialysis services, and communication with patients, and

WHEREAS, electronic medical record access and patient communication depend on electricity, and

WHEREAS, generators and emergency power sources may have a lag time before working; sudden outages can trigger a long reboot, which may compromise patient care; and generators have a finite power supply in the face of power shut-offs of unknown duration, and

WHEREAS, many community clinics do not have generators or redundant power systems, nor the resources to purchase such equipment, and the process of moving medications and vaccines to other facilities, rescheduling appointments, and communicating with patients is very time consuming, and

WHEREAS, the California Public Utilities Commission exempted hospitals with over 100 beds from statewide rolling blackouts in 2001[39], and

WHEREAS, the California Hospital Association has been advocating for an exemption from the planned PG&E power shut offs in 2018[40], therefore be it

[39] https://www.sfgate.com/health/article/Hospitals-Spared-From-Blackouts-State-PUC-2938682.php
[40]https://www.calhospital.org/cha-news-article/hospitals-may-experience-power-outages-fire-precautions

RESOLVED: That CAFP develop and advocate for legislation in which hospitals and clinics be exempt from PG&E power outages in order to continue to provide needed patient care, and be it further

RESOLVED: That CAFP publicize to clinic settings that may not have generator infrastructure resources for funding sources to pay for such equipment, and be it further

RESOLVED: That CAFP support legislation that prioritize limiting the duration of PG&E outages in hospital and clinic settings.

Speaker's Note:
CAFP does not have policy on this issue and this issue is not represented in the 2019-2021 CAFP Strategic Plan.

Fiscal Note:
This could result in significant expense if CAFP were to sponsor legislation. Supporting legislation would be a minimal expense depending on the level of legislative involvement.

CAFP would incur moderate expense to gather clinic information and push out notifications.

Res. A-21-20

TITLE: Eliminate the use of race-based medicine

Introduced by: Juliana E. Morris, Monica Hahn, Stephen Richmond

WHEREAS, Race is a social construct and there is no underlying genetic or biological factor that unites people within the same racial category, and

WHEREAS, race is poorly defined, changing over time and dependent on country (for example, an individual can be classified as both white in Brazil and Black in the United States of America), and

WHEREAS, while genetic ancestry can be used to assess genetic predisposition for disease, people who belong to the same racial category do not share the same genetic ancestry, and

WHEREAS, unlike genetic ancestry, racial categories are too broad, poorly-defined, and not scientific, and

WHEREAS, as race is a social category, when race is used as a risk factor for disease, that risk is a reflection of how society treats people of different races, not of any underlying genetic predisposition, and

WHEREAS, as race is not biological, there is no value in ascribing racial health disparities to innate biological difference, but there is value in understanding how racism and systemic oppression result in racial health disparities, and

WHEREAS, medical calculations that use race as a variable are fundamentally flawed, as the only characteristic shared by people of the same race is the lived experience of being treated as a member of that racial category, and

WHEREAS, the race coefficient used in estimating glomerular filtration rate may underestimate CKD in black patients, which in turn may systematically cause high-risk black patients to miss time-sensitive interventions, and

WHEREAS, one of the American Academy of Family Physicians key strategic objectives is to “take a leadership role in addressing diversity and social determinants of health as they impact individuals, families, and communities across the lifespan and to strive for health equity”, therefore be it

RESOLVED: That the California Academy of Family Physicians end the practice of using race as a proxy for biology or genetics in their educational events and literature, and require race be explicitly characterized as a social construct when describing risk factors for disease, and be it further

RESOLVED: That the California Academy of Family Physicians advocate for estimated glomerular filtration rate to be reported without regard to race at health care institutions and laboratories within California.

Speaker's Note:
CAFP does not have policy on race-based medicine, nor does the Committee on Continuing Professional Development use race-based medicine as an educational marker. The CCDP does follow the state requirements to include, where appropriate, information on cultural and linguistic proficiency in clinical education activities. The CCDP will also be reviewing new legislation requiring health care disparities to be addressed in CME activities.

Fiscal Note:
There would be low to moderate cost depending on the level of legislative and regulatory agency engagement.

PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this re solution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?
Race-based medicine has its roots in racism and eugenics; however, race continues to be used throughout many areas of medicine. While many family physicians today understand that race is a social construct, we are still taught to implicitly accept that there are race-based differences in kidney function, lung disease, cardiovascular risk, bone health, hypertension treatment standards, and other domains. In implicitly accepting these notions, the incorrect concept that there are biological differences based on race is perpetuated, and the true causes of race-based health disparities, e.g. racism, are obscured. This is different than recognizing the specific diseases that are based on ancestral geographic origin (i.e. sickle cell disease), given that geographic origin is not synonymous with race. The routine utilization of race-based medicine can create inequitable health care and exacerbate health disparities for patients and communities. In eliminating the use of race-based medicine, physicians are prompted to examine the true underlying reasons for differences in health outcomes, and provide more equitable and individualized care.

PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?
All CAFP members who practice clinical medicine, engage in research, engage in policy/advocacy, and engage in medical education and teaching of trainees, are affected by this problem.

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

We propose that CAFP eliminate race-based medicine concepts from its educational materials and literature. We also encourage the CAFP to publicly support efforts by its members to eliminate race-based reporting of kidney function (i.e. eGFR) at their health care institutions.

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

There has been extensive research in the social sciences about the problematic nature of utilizing race-based medicine. There has been a dearth of medical research examining specifically the dangers of utilizing race-based medicine; however, this area is gaining more attention in the medical community in recent years. Several prominent medical centers (Beth Israel Deaconess Hospital in Boston and San Francisco General Hospital) have eliminated race-based reporting of estimated glomerular filtration rate (eGFR). These changes were made based on the mounting evidence that differential criteria used in clinical settings based on the race-adjusted eGFR calculation causes African-American patients to receive inadequate interventions, including delayed time to referral to specialty care for advanced chronic kidney disease and delayed qualification for and referral to kidney transplant. There is currently a study being undertaken at Brigham and Women's hospital that examines the impact of race-based eGFR reporting, and we expect in the near future that many more studies will bolster the existing evidence characterizing the problem further.

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

1. Braun, Lundy. *Breathing Race into the Machine: The Surprising Career of the Spirometer from Plantation to Genetics*. University of Minnesota Press, 2014. *JSTOR*, www.jstor.org/stable/10.5749/j.ctt5vkbdf. Accessed 8 Jan. 2020.
2. Eneanya ND, Yang W, Reese PP. Reconsidering the Consequences of Using Race to Estimate Kidney Function. *JAMA.* 2019;322(2):113–114.
3. Roberts D. The Problem With Race Based Medicine. Ted Talk. 2015.
4. AAFP Minnesota Resolution to Denounce Race-Based Medicine 2019: https://www.aafp.org/about/governance/congress-delegates/2019/resolutions2/minnesota-c.mem.html
5. AAFP New York Resolution to Denounce Race-Based Medicine 2019: https://www.aafp.org/about/governance/congress-delegates/2019/resolutions2/newyork-n.mem.html

CAFP Proposed Bylaws Amendments

2019 CAFP Proposed Bylaws Update - Summary of Substantial Changes

Throughout the document:

- Replaced male pronouns with “they/them/their”
- Replaced EVP with CEO
- Replaced “chartered and unchartered county units” with “county chapters”
- Made consistent any references to the dates by which the AMAM must be announced and removed stipulation that it be announced by the Board, thereby updating to current practice.

Article I: Name and Affiliation: Added language clarifying that CAFP policy **may** be different from AAFP policy, to represent the needs of CA family physicians and their patients.

Article III: Section 1. Mission: Inserted the new, Board approved, CAFP mission.

Article V: Section 2. Dues and Assessments: Added language to reflect the current practice for setting **county** dues, and included a threshold amount of $20 to allow chapters flexibility to raise dues by a small amount without the hassle of board approval and protect CAFP against unreasonable increases.

Article V: Section 3. Membership Application: Updated the membership application process to reflect current practice, which is executed by AAFP.

Article VII: All Member Advocacy Meeting: Section 5. Resident and Student Delegates and Section 6. Terms: deleted the requirement that delegate terms be for two years, as this is not current practice.

Article VII: Section 10: Resolutions: Added language to reflect the deadline currently used for submission of resolutions, as well as a stipulation for the hearing of emergency resolutions that includes some barrier to prevent members from waiting until the last minute to submit all resolutions. Also updated language to reflect current policy of reporting back as to the disposition of resolutions after each quarterly Board meeting.

Article VIII: Board of Directors: Section 2. Composition: Clarifies that members who sit on the AAFP Board are ex-officio, as required by AAFP Bylaws.

Article VIII: Section 8. Resident and Student Directors: updated terms to reflect current practice.

Article IX: Elected and Appointed Officers: Section 3. Executive Committee: Included language allowing EC **or** Board to appoint committees. Keeping either/or language allows us the flexibility in an urgent situation to convene a committee without having to go through the much more administratively time consuming and slower process of getting Board approval. This is unlikely, however, we may need to be nimble if for example and initiative is filed and we need to put a committee together for a quick response.

Article IX: Section 4. President: In order to be consistent with Article IX above and Article XI: Committees and Board Appointments, which states that the Board or EC can appoint Committees, deleted the reference to the President being able to appoint Committees and task forces.

Article IX: Section 6(b). Secretary/Treasurer: Election and Term of Office: Expand this position to multiple years **if desired** (this has been done intermittently in the past), with a limit of three years, which would make it consistent with a Board term. The case could be made that it could be valuable to have a Secretary/Treasurer in a role for more than one year. Requires that their Board term not expire during their term of service.

Article IX: Section 7. Editor: moved this section to Article XI: Committees and Board Appointments, as the Editor is not an officer of the Board. Including them in this section could cause some confusion.

Article X: County Chapters. Section 1. Requirements for Granting Charters: Added language stating county chapters wishing to merge shall follow the same protocol as those wishing to form a chapter.

Article XI: Committees and Board Appointments: Section 1. Appointment of Committees: Made the language consistent that the EC **or** Board is responsible for approving committee charters and membership. Added the new Finance Committee as a standing Committee and merged Nominating Committee and Bylaws Committee into a "Governance Committee." Removed reference to the president being able to remove committee members with approval from the EC, since we captured that elsewhere as an EC or Board function. Also removed the reference that implied committee members are on for one year.

Article XI: Section 2. Governance Committee: changed "Nominating Committee" to "Governance Committee" and added language tasking them with periodically reviewing the Bylaws for necessary edits or policy changes.

Article XII: Revoking Member Status: Updated to reflect the current practice, pursuant to AAFP bylaws.

Article XIII: Miscellaneous: Section 2. Amendments: Inserted language providing the Governance Committee a role in periodically reviewing the Bylaws for necessary edits or policy changes.

BYLAWS

California Academy of Family Physicians

These bylaws were last amended by the Congress of Delegates in March 2013

PREAMBLE: Any family physician who is either appointed or elected to represent the California Academy of Family Physicians (CAFP) in capacities including: officer, director, editor, alternate director, committee chair or member, AAFP delegate or alternate delegate, delegate or alternate delegate to the CMA, chapter officer, delegate or alternate delegate to CAFP All Member Advocacy Meeting or other election or appointment, must be a member in good standing in the American and California Academies of Family Physicians.

ARTICLE I
NAME AND AFFILIATION

The name of this organization shall be the California Academy of Family Physicians, a chapter of the American Academy of Family Physicians. The policies adopted by this organization shall represent the needs of California family physicians and their patients, while maintaining alliance as a state constituent chapter of the American Academy of Family Physicians. State policies may or may not be consistent with the policies of the American Academy of Family Physicians.

ARTICLE II
DEFINITION AND USE OF TERMS

Terms in parenthesis may be used to stand for words indicated: California Academy of Family Physicians (Academy); American Academy of Family Physicians (AAFP); Board of Directors of the California Academy of Family Physicians (Board); All Member Advocacy Meeting of the California Academy of Family Physicians (AMAM); member of the California Academy of Family Physicians (member). Ex-officio means an individual member is entitled to vote unless it is specifically stated that they are ex-officio without the right to vote.

ARTICLE III
MISSION AND IMPLEMENTATION

Section 1. Mission

The mission of ~~the~~ California Academy of Family Physicians is:

CAFP empowers, educates, and connects current and future family physicians to improve the health of all Californians.

- ~~Advance the personal and professional development of family physicians;~~
- ~~Assist members throughout their careers with resources and support;~~
- ~~Analyze and distribute trends and information to assist family physicians in their practices; and~~
- ~~Advocate for positions that promote the health of Californians and enhance the role and practice of family physicians individually and collectively.~~

Section 2. Implementation

To assist in accomplishing ~~these objectives~~, the mission the Academy may grant charters to county and regional chapters and shall have the power to acquire, own, and convey real and personal property; to promote and support research; to grant honorary degrees in recognition of achievement in the science and practice of medicine and surgery; to issue publications; to establish, conduct, and maintain schools,

courses, museums, libraries, and other institutions for graduate study in medicine and surgery. The Academy shall have no capital stock and is not conducted for pecuniary profit and does not contemplate pecuniary gain or profit to the members.

ARTICLE IV
PERMISSIBLE ELECTRONIC TRANSMISSION METHODS OF VOTING

Communications between the Academy and members, delegates and directors may be made by means of electronic transmission as hereinafter provided.

"Electronic transmission by the Academy" means (a) a communication delivered by (1) electronic mail when directed to the electronic mail address for that recipient on record with the Academy, (2) posting on an electronic message board or network which the Academy has designated for those communications, together with a separate notice to the recipient of the posting, which transmission shall be validly delivered upon the later of the posting or delivery of the separate notice thereof, or (3) other means of electronic communication, (b) to a recipient who has provided an unrevoked consent to the use of those means of transmission for communications under this provision, and (c) that creates a record that is capable of retention, retrieval, and review, and that may thereafter be rendered into clearly legible tangible form.

"Electronic transmission to the Academy" means a communication (a) delivered by (1) electronic mail when directed to the electronic mail address which the Academy has provided from time to time to members, delegates and directors for sending communications to the Academy, (2) posting on an electronic message board or network which the Academy has designated for those communications, and which transmission shall be validly delivered upon the posting, or (3) other means of electronic communication, (b) as to which the Academy has placed in effect reasonable measures to verify that the sender is the member (in person or by proxy) or director purporting to send the transmission, and (c) that creates a record that is capable of retention, retrieval, and review, and that may thereafter be rendered into clearly legible tangible form.

ARTICLE V
QUALIFICATIONS AND CONDITIONS OF MEMBERSHIP
Section 1. Membership

The qualifications, classes and conditions of membership shall be the same as provided in the Bylaws of the AAFP. All active members of this organization shall be members of the AAFP and their county chapters. Any ~~A~~active member in good standing shall be eligible to vote and hold office.

Acceptance of membership in the Academy shall constitute an agreement to comply with the Bylaws of the Academy and the Bylaws of the AAFP. Subject to the right of appeal to the AAFP, a member shall recognize the Board as the sole and only judge of their right to be or remain a member. All rights, title and interest, both legal and equitable, of a member in and to the property of this organization shall cease in the event of any or either of the following: (a) expulsion of such member; (b) removal of their name from the roll of members; (c) their death or resignation. Any member who changes their occupation or status in such a manner as to render them ineligible for membership in the Academy may be removed from the membership roll by action of the Board.

Section 2. Dues and Assessments
The annual state dues and/or assessments for members shall be recommended by the Board subject to the approval of a majority of the delegates at the AMAM. Dues shall be payable at the times specified by the American Academy of Family Physicians. Annual county dues shall be set by the county chapter leadership and subject to Board approval when an increase exceeds $20.

Section 3. Application
Application for membership ~~shall be submitted to the Secretary/Treasurer of the Academy, in such form as the Academy shall prescribe~~ is received and executed by the AAFP, subject to AAFP Bylaws. ~~In the event that the application is incomplete, the Secretary/Treasurer may request further information, and may initiate such investigation as the Secretary/Treasurer deems appropriate.~~

ARTICLE VI
ANNUAL MEETING
Unless otherwise ordered by the Board, there shall be an annual meeting of the Academy and an annual convening of the All Member Advocacy Meeting together with such meetings of the Board, Executive Committee, and other committees as may be fixed by the Board. The time and place of the annual meeting shall be ~~designated by the Board and~~ announced at least sixty (60) days before the date.

ARTICLE VII
ALL MEMBER ADVOCACY MEETING
Section 1. Function
The AMAM shall convene at least annually to review Academy policy and direction implemented by the Board, Executive Committee, and committees of the Board. There ~~shall~~ may be presented at the AMAM annual activity reports from appropriate committees. The delegates to the AMAM may, at any time by majority vote, approve a referendum for submission to the members of the Academy on questions affecting the policy or recommendations of the Academy. The time and place of the AMAM shall be ~~designated by the Board and~~ announced at least 60 (sixty) days before the date.

Section 2. Composition
The delegates to the AMAM shall include the following: (1) Delegates from ~~chartered and unchartered county units~~ Academy county chapters as provided in this Article, (2) Members of the Board of Directors, and (3) Two resident and two student delegates to be chosen as provided in this article, Section 5. A Parliamentarian and Sergeant at Arms may be selected at the option of the Speaker and shall serve without vote unless they are otherwise delegates at the AMAM. General members in good standing with the Academy may attend the AMAM without a vote.

Section 3. Delegates from county chapters
Each county chapter shall be entitled to one (1) delegate and one (1) alternate for 1-49 Active members, and two (2) delegates and two (2) alternates for 50-99 Active members. For each additional 100 Active members, each chapter shall be entitled to one (1) additional delegate and alternate. The actual number of delegates and alternates allowed shall be based on the official membership rolls for the Academy as of July 1st of each year.

Section 4. Appointment or election of delegates

Where the county chapter has been issued a charter, it will elect its own delegates. Where no active chapter exists, the district director shall arrange for an election of delegates by the members of the Academy or shall appoint such delegates within the county unit ~~chapter~~ and transmit the results to the secretary/treasurer sixty (60) ~~working~~ days prior to the annual meeting.

Section 5. Resident and student delegates

Two resident and two student delegates, and two resident and two student alternates shall be chosen by the respective resident and student state organizations and submitted to the Academy no less than sixty (60) days prior to the meeting. ~~The length of the position shall be two (2) years.~~ Should the status of the resident or student change during their term, a new person will be chosen to complete the term.

Section 6. Terms

Terms of office of the delegates shall be determined by their respective county chapters. ~~but shall be for a minimum of two (2) years.~~

Section 7. Certification

To be seated, a delegate must be in good standing in the Academy. In the event that no certified delegate or alternate is present at the convening of the AMAM, a member or members of that county ~~unit~~ chapter present may be seated upon recommendation of the district director and with a two-thirds (2/3) affirmative vote of delegates at the AMAM.

Section 8. Convenings of the All Member Advocacy Meeting

The AMAM shall convene at least annually. Special convenings of the AMAM may be called by a two-thirds (2/3) affirmative vote of the entire Board, and shall be called by the president upon the written request of twenty-five (25) or more of the delegates to the AMAM. The Academy shall give notice of the convening date and place to the delegates to the AMAM and members of the Academy personally, by electronic transmission or by first class mail at least thirty (30) days prior to the date set for such convening. Business to be considered at a special convening shall be confined to the business for which the convening was called.

Section 9. Quorum

A majority of the total number of elected or appointed delegates to the AMAM shall constitute a quorum at any convening. The AMAM may adopt such rules of procedure for the transaction of its business as it deems desirable.

Section 10. Submitting of resolutions

Any chapter or member of the Academy may submit a resolution in writing to the AMAM, no fewer than sixty (60) days prior to the annual meeting ~~,in advance or on-site,~~ for consideration by the Board of Directors during a special session for that purpose. Emergency resolutions may be submitted on-site and heard subject to approval by the Speaker. The members of the Board shall hear testimony and report back as to the disposition of each resolution ~~at the next AMAM after each quarterly meeting of the Board~~.

Section 11. Referendum

The AMAM may at any time by a majority vote of delegates refer and submit to the members questions affecting the policy or recommendations of the Academy. The result of the referendum shall control the acts of the Academy and of its officers, committees, agents, and employees.

Section 12. Voting in the All Member Advocacy Meeting

Each delegate to the AMAM shall have one vote. At the request of a delegate at the AMAM and with an affirmative vote by the AMAM, an Academy member in good standing shall have the privilege of the floor but shall have no right to vote.

ARTICLE VIII

BOARD OF DIRECTORS

Section 1. Function

The Board is responsible for implementing the policies and directives of the Academy through its own actions and its committee structure. The control and administration of the Academy shall be vested in the Board, subject to the review of the delegates at the AMAM. The Board shall be authorized to conduct the business and affairs of the Academy. All actions of the Board shall be binding until and unless the AMAM rescinds those actions by a majority vote of delegates at the next AMAM meeting.

Section 2. Composition

The Board shall be composed of district directors, officers, AAFP delegates, ~~speaker, vice-speaker~~, members elected to the AAFP board (ex-officio), one resident member, one student 1 member, immediate past-president of the Academy, and the president of the California Academy of Family Physicians Foundation, ~~ex-officio~~. The Foundation President shall have ~~no~~-voting privilege ~~unless~~ if they are a member of the Academy in good standing. An alternate AAFP delegate may attend meetings with a vote in the event an AAFP delegate is unable to attend.

Section 3. Meetings of the Board

The Board shall meet at the time of the annual meeting and at such other times as may be set by the Board or the president.

Section 4. Absence from Meetings

The office of any director who is absent from two (2) successive meetings without reasonable excuse shall be declared vacant by the Board.

Section 5. Election and Terms of Office

All newly-elected Board members, with the exceptions noted herein, will be seated as voting members at the first Board meeting following the annual meeting.

District directors shall be elected by plurality vote of eligible members within their district. They shall be elected for a three (3) year term, with the provision that no one director serve for more than two (2) consecutive terms, with the exception of a fraction of 1/2 year or less. A district director's term of office shall begin with the first Board meeting following the annual meeting.

In the event that a district director is unable to complete a term, their district, with the assistance of the Academy if necessary, will hold an election to fill the vacancy, and the new director will be seated as a

voting member at the next meeting of the Board. Their term will be considered to have begun at the time of the first Board meeting following the preceding annual meeting.

If a district director is elected to ~~service~~ serve on the Board in another capacity, other than Secretary/Treasurer, they will vacate their seat as district director, and the district will fill the vacancy as specified above.

Where a chapter is entitled to more than one director, the Board may adjust the terms of office so that not more than one director will come up for election in any given year.

Section 6. District Directors

The Academy shall be divided into ten (10) districts according to geographical sections and county units. Each district shall be allowed one director and one alternate who may attend the meetings with a vote in the event the director is unable to attend. There shall be two at-large director seats; these directors shall be elected by the delegates at AMAM, and may not be elected from the same district. One at-large director shall be a representative of a rural area of the state, and shall be subject to the same terms and term limits as the District Directors. One at-large director shall be a new physician who must be in practice fewer than seven (7) years at the time of election and shall be elected for one three-year term only.

The districts are as follow:

I. Imperial; San Diego
II. Orange
III. Metropolitan Los Angeles County
IV. Non-metropolitan Los Angeles County
V. Inyo-Mono-Alpine; Kern; Riverside-San Bernardino; Tulare
VI. Fresno-Kings-Madera; Merced-Mariposa; San Luis Obispo; Santa Barbara; Ventura
VII. Monterey; San Benito; San Mateo; Santa Clara; Santa Cruz
VIII. Alameda-Contra Costa; San Joaquin-Calaveras-Toulumne; Stanislaus
IX. Humbolt-Del Norte; Mendocino-Lake; Marin; Napa; San Francisco; Solano; Sonoma
X. Amador; Butte-Glenn-Tehama; Lassen-Plumas-Modoc-Sierra; Placer-Nevada; Sacramento-El Dorado; Shasta-Trinity; Siskiyou; Yolo; Yuba-Sutter-Colusa

Section 7. Responsibilities of District Directors

Each district director, in addition to attending Board meetings and serving on such committees as they may be appointed to, shall select delegates and alternates to the Academy AMAM if no has been properly elected. The director shall be responsible for communication among the Board and the district boards, chapters, and the district membership, as well as recommending members from their district for committee assignments. They should meet with their delegates prior to the AMAM to discuss the submission of resolutions and other appropriate matters which are expected to come before the AMAM. The district director shall be required to give a report on the activities of their district to the Board at least annually.

Section 8. Resident and Student Directors

Resident and student directors of the Board shall keep the Board apprised of the viewpoint of the family medicine residents and students. Family medicine resident and student directors shall be recommended by their respective state organizations and approved by the Board. The length of their terms shall be: ~~two~~ one (~~1~~2) years for the resident director and one (1) year for the student director, with re-election for an additional year permitted. Alternate resident and student directors may be elected and attend meetings with a vote in the event their respective director is unable to attend.

Should the status of the resident or student change during their terms, other nominees will be chosen to complete the terms. No student or resident shall serve beyond one year after completion of medical school or residency respectively.

ARTICLE IX
ELECTED AND APPOINTED OFFICERS 8
Section 1. Officers
Officers shall consist of a president, a president-elect, a secretary/treasurer, a speaker, a vice speaker, and ~~an executive vice president~~ CEO. These officers, the immediate past president, and the Foundation president form the Executive Committee. As a portion of their responsibilities, elected officers will attend local chapter meetings as representatives of the California Academy.

Section 2. Elections
The president-elect, speaker, vice speaker and at-large directors shall be elected by the delegates at the AMAM from a slate consisting of names submitted by the ~~Nominating~~ Governance Committee and the names of additional candidates who are nominated and seconded from the floor by the delegates to the AMAM.

Section 3. Executive Committee
The Executive Committee or Board are responsible for appointing committees of the Board and the Executive Committee oversees the finances of the Academy. It shall be composed of the president, president-elect, secretary/treasurer, speaker, vice speaker, immediate past president, Foundation president, and ~~executive vice president~~ CEO, ex officio without vote. It shall be as representative as possible from all areas of the state. The Executive Committee shall have full authority to act for and on behalf of the Board whenever the business of the Academy demands prompt action in the interim between meetings of the Board or when it is impractical or impossible to convene the entire membership of the Board. A telephone conference call shall be considered proper in lieu of an actual meeting. The Executive Committee shall be authorized to act in matters of an emergency nature or on recurring matters that must be disposed of promptly. All other actions of this Committee shall be subject to ratification by the Board as its first order of business at its next meeting. These other actions shall be binding until ratification by the Board, however.

Section 4. President
(a) Function: The president shall be chair of the Board and of the Executive Committee, and ex-officio member of all other committees. ~~He may appoint any special committees or task forces and their~~

~~members, subject to the approval of the Executive Committee.~~ They shall report the activities of the Board at the AMAM at its annual meeting.

(b) Election and Term of Office: The president succeeds from the office of president-elect. Their term runs from the conclusion of one annual meeting until the conclusion of the next annual meeting or when their successor is seated.

Section 5. President-Elect

(a) Function: In the absence of the president, the president-elect shall assume all of their duties.

(b) Election and Term of Office: They shall be elected by the delegates at the AMAM. They shall succeed to the office of the president at the completion of the president's term.

Section 6. Secretary/Treasurer

(a) Function: The secretary/treasurer shall cause to be kept an accurate record of the minutes and transactions of the AMAM and the Board and serve as secretary of these bodies. The secretary/treasurer shall keep or cause to be kept adequate and proper accounts of the properties and funds of the Academy. They shall submit an annual budget to the Board for approval. They shall render to the Board, whenever requested, an account of all their transactions as the secretary/treasurer, and of the financial condition of the Academy. They shall have other powers and perform such other duties as may be prescribed by the Board. The secretary/treasurer shall give a surety bond in an amount to be determined by the Board, the premium to be paid by the Academy. Any of the duties of the secretary/treasurer may be assigned to the ~~executive vice president~~ CEO.

(b) Election and Term of Office: The secretary/treasurer shall be elected of and by the Board of Directors ~~for a term of one year.~~ for up to three one-year terms, and their Board term must not expire during the term of service.

~~**Section 7. Editor**~~

~~(a) Function: The editor shall be editor of the official publication. The Board may appoint associate editors to assist him with his duties.~~

~~(b) Appointment and Term of Office: He shall be appointed by the Board for a term of three years, with a maximum of two terms.~~

Section ~~7~~8. AAFP Delegates and Alternates

(a) Function: They shall represent the views of the CAFP at the AAFP meeting, report AAFP affairs to the CAFP, and prepare resolutions for presentation at the AAFP meeting.

(b) Election and Term of Office: AAFP delegates shall be elected by the delegates at the AMAM to serve staggered two-year terms and shall serve no more than three terms as delegates unless elected to an additional term by two-thirds (2/3) vote of the delegates at the AMAM. Alternate delegates shall be elected by the delegates to the AMAM to serve staggered two-year terms and shall serve no more than three terms as alternates unless elected to an additional term by two-thirds (2/3) vote of the delegates to the AMAM. Alternates may succeed to delegate positions.

Section ~~8~~9. Speaker and Vice Speaker of the All Member Advocacy Meeting
(a) Function: The speaker shall notify the delegates and alternates of the time and place of the meeting, prepare the agenda, and preside over meetings. The vice speaker shall assist the speaker with their duties.

(b) Election and Term of Office: The speaker and vice speaker shall be elected by the majority vote of the delegates at the AMAM for a one- year term.

Section ~~9~~10. ~~Executive Vice President~~ Chief Executive Officer (CEO)
(a) Function: The ~~executive vice president~~ CEO shall, under the direction of the Board, perform such duties as the title of the office ordinarily connotes and such duties of the officers as may be assigned to them by the Board. They shall supervise all other employees and agents of the Academy and have such other powers and duties as may be prescribed by the Board. They shall not be entitled to vote. They shall be bonded in an amount fixed by the Board, the premium to be paid by the Academy.

(b) Appointment and Term of Office: They shall be appointed by the Board for a term and stipend to be fixed by the Board.

Section 1~~0~~01. Vacancies in Office
If a vacancy occurs in the office of president, the president-elect shall automatically serve as president and their term as president will conclude at the expiration of the term for which they were originally elected. In the event a vacancy occurs in the office of the president-elect, it shall remain unfilled until the next meeting of the when the delegates to the AMAM shall elect a president. The Board shall fill any other vacancies in office by appointment until the next meeting of the AMAM. The delegates at the AMAM shall then fill the vacancy for the remainder of the unexpired term.

ARTICLE X
COUNTY CHAPTERS
Section 1. Requirements for Granting Charters
Upon the petition of any five (5) or more members of this Academy residing in any county in California, the Board may issue a charter for a county chapter, ~~provided that no more than one chapter shall be chartered in any county~~. Petitions shall be accompanied by the proposed Bylaws for the chapter. No charter shall be issued until such Bylaws are approved by the Board. County chapters petitioning to merge shall follow the same protocol.

Section 2. Membership in County Chapter
All members of the AAFP at the time the charter is issued shall automatically become members of the county chapter. No person may belong to the county chapter unless they are a member of the Academy and the AAFP.

Section 3. Transfers
Any member who transfers from one chapter to another shall automatically become a member of the county chapter to which they transfer.

Section 4. Revoking of Charters
The charter of any county chapter may be suspended or revoked by the delegates at the AMAM in the event of any action deemed to be in conflict with the letter or intent of these Bylaws or in the event of its failure to comply with all of the requirements of these Bylaws or with any lawful requirement of the AMAM, Board, or officers of the Academy. A member of the Academy may file written charges against any chapter with the secretary/treasurer of the Academy and shall state the acts of conduct complained of with reasonable particularity. The secretary/treasurer shall present the charges to the Board at its next meeting. The Board shall then, or at a time not more than thirty (30) days thereafter, consider the charges and shall either dismiss them or proceed in the same manner as set forth in the Bylaws of the AAFP for revoking of county charters.

Section 5. Branches
County chapters may issue charters to branches within their county upon approval of the Board.

Section 6. Election of County Chapter Officers
It is the responsibility of each local chapter to report the election of officers to CAFP within thirty (30) days of election.

ARTICLE XI
COMMITTEES AND BOARD APPOINTMENTS
Section 1. Appointment of Committees
The Executive Committee or Board shall review committee ~~objectives~~ charters , assign duties, and appoint or remove committee members ~~for the following year.~~ ~~The president with the approval of the Executive Committee may at any time remove a committee chairman or member and make a new appointment in histheir place.~~ There shall be threewo~~three~~ standing committees of the Academy: the Executive Committee, the Finance Committee and the Governance ~~the Nominating~~ Committee. ~~, and the Bylaws Committee. The members of the Bylaws Committee shall be appointed by the Executive Committee. Other c~~Committees and task forces shall be appointed as deemed necessary by the Board or Executive Committee.

Section 2. ~~Nominating~~ Governance Committee
The ~~Nominating~~ Governance Committee shall consist of six (6) members, two (2) elected by and from the Board of Directors, three (3) elected by and from the delegates at the AMAM, and the immediate past-president, who shall serve as chair. The Governance Committee shall periodically review and propose amendments to the bylaws as necessary and nominate members for the following positions to be elected by the delegates at the AMAM.

1. President-Elect
2. Speaker
3. Vice Speaker
4. AAFP Delegates and Alternates
5. At-large Directors

In addition it shall submit nominations to the Board of Directors for the following positions:

1. Secretary/Treasurer
2. Editor

The terms of office for ~~Nominating~~ Governance Committee members, shall be as follow: Immediate Past President, one year; members from the Board, two (2) years, with terms to be adjusted so that one (1) member is elected each year; members from the delegates at the AMAM, two (2) years, with terms to be adjusted so that two (2) members are elected every other year and one (1) is elected in the intervening year.

The ~~Nominating~~ Governance Committee members from the Board shall be nominated by the Board and elected at the first Board meeting following the annual meeting. Members of the committee from among the AMAM shall be nominated and elected by the AMAM to begin 491 serving ~~the following~~ that year.

In considering any candidate, the committee shall seek views of chapter officers within the districts as well as individual members, consider previous offices held, ability to get along with other members of the profession, attitude toward family medicine, reputation for quality of medical care, service and performance on Academy committees, and potential for higher offices.

Section 3. Board Appointed Editor

(a) Function: The editor shall be editor of the official publication. The Board may appoint associate editors to assist them with their duties.

(b) Appointment and Term of Office: They shall be appointed by the Board for a term of three years, with a maximum of two terms.

ARTICLE XII

~~FAIR HEARING PROCEDURE~~ REVOKING MEMBER STATUS

~~Section 1. Notice of Objections or Proposed Action~~

In the event that ~~application for membership is denied, or in the event that charges are brought against any member, the applicant or member shall be given written notice, by certified mail with return receipt, which shall state:~~

~~1. That the proposed action, if adopted, may be reported pursuant to section 805 of the California Business & Professions Code.~~

~~2. The nature of the proposed adverse action.~~

~~3. That the applicant or member has the right to request a hearing.~~

~~4. That any request for hearing must be made in writing within 30 days following receipt of this notification.~~

a member is required to surrender their medical license, their membership shall be terminated, pursuant to AAFP bylaws. The AAFP will provide written notice to the chapter and member and oversee any fair hearing procedures.

~~Section 2. Hearing Panel~~

~~In the event that timely written request for a hearing is received, the President, with the advice of the Executive Committee, shall appoint a panel of unbiased individuals who shall gain no direct financial benefit from the outcome, who are not members of the local chapter wherein membership is sought, and who have not acted as an accuser, investigator, or a fact finder with respect to the application. Such~~

~~a panel shall consist of at least five members of the Academy, and the President shall designate the chairman. The Executive Committee may also appoint a hearing officer, who shall not act as a prosecuting officer or advocate, and who shall not be entitled to vote. The chairman shall, within 30 days following the appointment of the hearing panel, set a place, time, and date of the hearing, allowing sufficient time for at least 30 days prior notice to the concerned member or applicant.~~

~~**Section 3. Notice of Hearing**~~

~~The Secretary/Treasurer shall promptly give written notice of hearing to the applicant or member, specifying the reasons for the proposed action, including the acts or omissions charged, and including any statement of reasons for adverse recommendation on an application for a membership. At least 30 days prior written notice of hearing shall be provided to the applicant or member. Continuances may be granted only if the chairman determines there is good cause for continuance.~~

~~**Section 4. Conduct of Hearing**~~

~~The hearing shall be conducted in accordance with the provisions of section 809.2 and 809.3 of the California Business & Professions Code. An applicant or member shall have the right to be represented by an attorney at such person's own expense. The local chapter recommending against admission to membership or the persons bringing charges shall have the same right of representation. A hearing shall be commenced within 60 days after receipt of the request for hearing is received, unless good cause as specified in Section 809.2 exists. Upon the completion of the hearing, the hearing panel shall prepare a written decision, including findings of fact and a conclusion articulating the connection between evidence produced at the hearing and the decision reached. Such written decision, and an explanation of the procedure for appealing to the Board, shall be mailed promptly to the member or applicant and the Board.~~

~~**Section 5. Appeal**~~

~~An applicant or member may appeal the decision of the hearing panel by written request to the Board, made within 30 days after receipt of the hearing panel's decision. The Board, or a committee of the Board appointed for this purpose, shall afford the opportunity for the parties at the hearing to appear and respond, personally or by their attorneys. The Board, except for good cause determined in the Board's own discretion, shall not receive evidence or testimony, and shall act upon the record of the hearing and argument presented when the appeal is heard. The Board or its appointed committee shall prepare a written decision, which shall be final, unless appealed to the American Academy of Family Physicians. The Board may accept, reverse, or modify the decision of the hearing panel, or may require further hearing if a fair procedure has not been afforded.~~

ARTICLE XIII

MISCELLANEOUS 5

Section 1. Rules of Order

In the absence of any provision in the Bylaws all meetings of the Academy, the AMAM, the Board and committees shall be governed by the parliamentary rules and usages contained in the current edition of Sturgis Standard Code of Parliamentary Procedure.

Section 2. Amendments 574

The ~~BylawsGovernance~~ Committee, working with staff, shall meet as needed to review the Byl~~w~~aws for necessary edits or policy changes. In addition, ~~a~~Any twenty-five (25) or more members may propose amendments to these Bylaws by submitting the same in writing to the ~~executive vice president~~ CEO at least sixty (60) days prior to any regular convening of the AMAM. Notice of the proposed amendment(s) shall be given in writing by the ~~executive vice president~~ CEO to all delegates at the AMAM and the members of the Academy by official publication at least thirty (30) days before the convening at which the proposed amendments are to be voted upon. An affirmative vote of at least two-thirds (2/3) of the delegates present and voting shall constitute adoption.

Section 3. Indemnification

This Academy shall indemnify any of its agents against expenses, judgments, fines, settlements, and other amounts actually and reasonably incurred in connection with activities undertaken at the Academy's request if such a person acted in good faith and in a manner the person reasonably believed to be in the best interest of the Academy and to the extent such indemnification is permitted under California law.

For the purposes of this section, "agent" means any person who is or was a director, officer, employee, committee member, or other agent of the Academy who is or was serving at the request of the Academy; and "proceeding" means any threatened, pending, or completed action or proceeding, whether civil, criminal, administrative, or investigative.

Indemnification can be made only as to a specific case, upon a determination that indemnification is proper in the circumstances and must be authorized by a majority vote or a quorum consisting of directors who are not parties to the proceeding.

The Academy shall purchase and maintain insurance on behalf of any agents of the Academy against any liability asserted against or incurred by the agent in such capacity or arising out of the agent's status as such whether or not the Academy would have power to indemnify the agent against such liability under the provision of these Bylaws.

Section 4. Taking Effect of These Bylaws

These Bylaws and all future amendments become effective at the close of the AMAM convening 607 at which they are accepted unless otherwise stated.

Article XIV
EMERGENCY GOVERNANCE

Section 1. Emergency Condition.

The following Bylaws shall become operative upon any emergency resulting from an attack on the United States or on a locality in which the Academy conducts its business or holds its meetings, or upon any disaster, catastrophe or other similar emergency condition, as a result of which either of the following conditions occur:

a) All Member Advocacy Meeting. The quorum necessary for an AMAM convening cannot readily be convened.

b) Board of Directors. The regular quorum of a majority of directors necessary for a meeting cannot readily be convened.

Section 2. All Member Advocacy Meeting.
Regular convenings of the AMAM may be suspended by the Board of Directors during an emergency condition.

(a) Quorum. If a convening is not suspended, a majority of the delegates present at the commencement of the convening shall constitute a quorum.

(b) Elections. Any elections to be held at a meeting during an emergency condition shall be suspended.

(i) Office of the President. The President and President-Elect in office immediately prior to the commencement of the emergency condition shall remain in their respective offices until the first convening of the AMAM following the end of the emergency condition.

(ii) Continuation of Office. All other officers and elected Board members in office immediately prior to commencement of the emergency condition shall remain in their respective offices until the later of (i) the first convening of the AMAM following the end of the emergency condition, or ii) the end of their terms of office (in the absence of any emergency condition).

(iv) Extension of Tenure. Limitations on tenure of officers and directors shall not apply during an emergency condition.

Section 3. Board of Directors.
(a) Minimum Number of Directors. The Board of Directors shall be composed of a minimum of seven directors during an emergency condition.

(b) Designation of Emergency Directors. If fewer than seven Board members are available to meet, the chairs of the committees become Emergency Directors and shall serve on the Board of Directors (in addition to regular Board members who are available.) If there are still fewer than seven Board members available after taking into account the Emergency Directors and regular Board members, the available Board members shall appoint sufficient additional Emergency Directors to comprise the minimum.

(c) Duties and Privileges. Emergency Directors shall have all duties and privileges of directors, and shall serve as directors until the earlier of (i) the first convening of the AMAM following the end of the emergency condition, or (ii) at least seven regularly elected Board members (other than Emergency Directors) are available to meet.
(d) Authority. The primary duty of the Board of Directors during an emergency condition shall be the continuation and management of the Academy. The Board of Directors may, upon a two-thirds affirmative vote, adopt such other emergency bylaws as may be necessary for such continuation and management.

(e) Meetings. A meeting of the Board of Directors may be called by any director. Notice of any meeting shall be given to such directors as may be feasible to reach at the time and by such means as may be feasible at the time.

(f) Quorum. A majority of the members of the Board of Directors shall constitute a quorum.

(g) Effect of Action. Action taken in accordance with these emergency bylaws shall bind the Academy. No director acting in accordance with these emergency bylaws shall be liable for such action, except for willful misconduct.

Section 4. Duration.

To the extent not inconsistent with any emergency bylaws, the bylaws of the Academy shall remain in effect during the emergency condition. Upon the end of the emergency condition, as determined by the Board of Directors, the emergency bylaws shall cease to be operative.

Elections

The role of the CAFP Nominating Committee is to identify and nominate individuals for the positions shown below, to be elected by the Delegates and the Board of Directors at the 2020 All Member Advocacy Meeting (AMAM) and Board of Directors meeting. The 2019 committee members are Drs. Anthony Fatch Chong, Monique George, Steven Harrison, Asma Jafri and Tonatzin Rodriguez. Lisa Ward, immediate past president, chairs the committee. The nominating committee met in late October 2019 and presented this slate of officers, which was approved by the Board of Directors at its November 2019 meeting.

CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

1520 Pacific Avenue
San Francisco, CA 94109
TEL: 415.345.8667
FAX: 415.345.8668
EMAIL: cafp@familydocs.org
www.familydocs.org

Elected by Delegates at the All Member Advocacy Meeting

President-elect	Shannon Connolly	2020
Speaker	Lauren Simon	2020
Vice Speaker	Raul Ayala	2020
AAFP Delegate	Lee Ralph	2020-22
AAFP Alternate Delegate	Michelle Quiogue	2020-22
Nominating Committee * (from AMAM)	Monique George and Anjana Sharma	2020-21
Rural Director	Steven Harrison	2020-21

Elected by and from the Board

Nominating Committee * (from the BOD)	Arthur Ohannessian and Steven Harrison	2020-21
Secretary/Treasurer	Alex Mroszczyk-McDonald	2020

* The All Member Advocacy Meeting (AMAM) nominates and elects a total of three members of the Nominating Committee from the AMAM Delegates; two are elected for two-year terms in one year, and one is elected for a two-year term the next year. Nominations may be made from the floor as well. The Secretary/Treasurer position must be elected from among eligible Board members, e.g., those whose terms are not expiring during the proposed term of office (one year).

Adjournment

Candidates' Statements

For the Office of President-elect – Shannon Connolly, MD
I joined the CAFP as a first-year medical student with a hunch that family medicine might be the right job for the person who gets excited by every aspect of the human experience. At every stage of my career--from med school to residency to new physician to attending, the CAFP has nurtured my personal and professional growth. My colleagues here have taught me that family medicine is both the most difficult and most rewarding job in the world, and the people who practice it are my tribe. Our daily work is as varied and diverse as the patients that we serve, but we are connected by our love of medicine and our commitment to delivering high quality compassionate care. Family doctors have a perspective on the communities they serve that is invaluable in shaping modern health care delivery. It would be my honor to serve as your President-Elect, ensuring that that perspective is heard as I advocate for you and your patients. – *Shannon Connolly, MD*

For the Office of Speaker – Lauren Simon, MD, MPH
I am honored by your nomination for the office of CAFP Speaker**.** In the past two decades I have been actively involved in CAFP and have worked to address important issues that affect us as family physicians, our patients, our communities and our medical learners.

Within CAFP, I have focused on three key areas integral to our members: advocacy, pipeline and medical education. In those areas I have served on the CAFP Board of Directors from 2006-2012 and 2015 to present and currently serve as CAFP Vice-Speaker (2019-20) and Co-chairperson of the Inland Empire Region of the CAFP California Residency Network (2014-present.) I have enjoyed collaborating with CAFP members throughout the state and our dedicated CAFP staff while taking our issues to the legislators. I have served as Delegate, Alternate Delegate or Board member for the All Member Advocacy Meeting (AMAM) since 2000 and represented CAFP as Alternate Delegate to the California Medical Association House of Delegates in 2016.

It has been a pleasure to promote lifelong learning for current and future Family Physicians and support our Family Medicine Pipeline while serving on the CAFP Foundation Board of Trustees; developing the clinical research poster competition; and presenting lectures for CAFP continuing medical education (CME) offerings. These activities have only added to the joy I feel as a Family Physician and increased the opportunities to work with others who share my love for our specialty and the compassionate care we provide for the people in our communities. Working with colleagues and staff at CAFP has been one of the most valuable aspects of my career. I appreciate your nomination for position of CAFP Speaker and look forward to continuing to serve you on the CAFP Board. Thank you for your consideration. – *Lauren Simon, MD, MPH*

For the Office of Vice Speaker – Raul Ayala, MD

We are the voice of our patients. I am honored to receive the nomination for the next Vice Speaker of the California Academy of Family Physicians. I have served on the board for the last 8 years and have worked collaboratively to enhance continuing medical education, advocacy and improving our models of care. In the past year I have served as your CAFP Secretary-Treasurer and worked on our finance committee, internal review and audit committee. I also had the privilege of representing CAFP as a delegate to the California Medical Association where we joined as a state to focus on very important topics affecting our patients and communities. I am excited and want to continue my work as Vice Speaker and be that voice for you and your patients. I will strive to expand the importance of CAFP by collaborating with our local chapters and residency programs across the state and build relationships in the communities we serve. Thank you again for your nomination. – *Raul Ayala, MD*

For the Office of AAFP Delegate 2020-22 – Lee Ralph, MD

I am honored to be selected by the Nominating Committee to run for the office of AAFP Delegate for the CAFP. Our health care system and family medicine are at a crossroads during this election year. Access to care remains suboptimal while disparities in care continue to increase. Challenging reimbursement rates combined with ever-increasing administrative burden have led to an epidemic of physician burnout. Our combined voices as family physicians needs to be raised in a political fashion to help solve these divisive issues. I have been privileged to have attended numerous AAFP Congress of Delegates meetings representing CAFP and would like to continue the journey to help fight for those issues that are most relevant to you, the members of CAFP.

I have been a member of the AAFP for over 30 years dating back to my time in medical school at the University of Virginia and have been active in the San Diego AFP and CAFP ever since. I have previously served as a family medicine faculty member, pre-doctoral director and now in a medium-sized group private practice. Each of these positions has given me insight into the complexities of the problems that we face every day.

The CAFP has had tremendous leaders at the national level including Carol Havens, Jeff Luther, Carla Kakutani and Jay Lee. I have been fortunate enough to have been mentored by these experienced, politically active family physicians. As a Delegate I pledge to attempt to continue following in their successful legacies. I look forward to hearing from you as we continue to work on the important issues facing family physicians. Thank you for your consideration.

Respectfully submitted, *Lee P. Ralph, MD*

For the Office of AAFP Alternate Delegate 2020-22 – Michelle Quiogue, MD

I request your consideration to represent the CAFP as one of our Alternate Delegates to the AAFP Congress of Delegates.

As a result of over 10 years of experience at our own policy making meetings (previously COD and now AMAM), I have excellent knowledge of our policies. My years of service on the Board of Directors and as CAFP President gave me an appreciation of the broad diversity of values held by our membership. It would be my honor to bring all of this to the AAFP COD and work together with senior delegates towards advancing national policy towards more inclusive and compassionate health policy. – *Michelle Quiogue, MD*

For the Office of Nominating Committee Member 2020-22– Monique George, MD
I work at Kaiser Permanente Woodland Hills and enjoy providing both inpatient and outpatient care, minor surgical and women's health procedures and teaching as part of faculty with our Family Medicine Residency Program. I have been involved with the Los Angeles chapter of CAFP for the last 6 years, including the last 5 years as a member of the Executive Committee. My current role is as President-Elect. I would like to continue my involvement on the Nomination Committee for another term as I enjoy being an active participant in CAFP. I appreciate your consideration. – *Monique George, MD*

For the Office of Nominating Committee Member 2020-21 – Anjana Sharma, MD, MAS
I am grateful for the recommendation to serve in the CAFP nominating committee. I see the CAFP as the leading champion for change to improve health care access and strengthen primary care's voice in California, and am eager to grow my participation and service for the CAFP as well as build additional leadership skills.

I am Assistant Professor of Family & Community Medicine at University of California San Francisco (UCSF). I practice at the Zuckerberg San Francisco General Hospital's Family Health Center, teach as faculty at the UCSF Family and Community Medicine Residency, and also conduct research on patient safety in primary care. I have a strong interest in patient engagement and am the clinician lead for two patient advisory councils at our primary care clinic. We serve publicly insured, low income residents of SF county and I also provide clinical services for our refugee clinic. My interests include reproductive health, immigrant health, and patient engagement in quality improvement and safety - particularly for vulnerable populations.

I first became more involved in the CAFP through resolution-writing; my first experience was coauthoring and testifying for a resolution supporting increased women's health CME at AAFP conferences for the COD in 2018. I co-wrote a resolution supporting gender-affirming language at AAFP conferences for CAFP AMAM in 2019, and supplied language for addition to a resolution supporting healthcare access for detained immigrant families for COD 2019. I have also been honored with participating in the "Ready To Lead" women's leadership workshop for 2019-2020. I am a member of the CAFP Membership Engagement Committee. I look forward to participating in the upcoming NCCL as new physician's delegate and AMAM in the spring.

The CAFP has already made tremendous contributions to my leadership development and I look forward to extending my involvement. Participation in the Nominating Committee will be a tremendous learning and growth opportunity and a way to build more community across the CAFP membership. Thank you for the consideration for this important role. – *Anjana Sharma, MD MAS*

For the Office of Rural Physician/Board Member – 2020-2023 – Steve Harrison, MD
I have been the rural representative to the CAFP board for the last two terms. It has been an honor and a privilege and I am pleased to run for another term.

The position, from my perspective, is designed to remind the Board about those physicians in rural areas who are overwhelmed and too busy for the most part to give input themselves. As the numbers of Rural physicians continue to dwindle, supporting and promoting rural practice is crucial and more relevant today than ever. Input is always welcome.

If elected, this will be my last of three terms on the board. The opportunity to give input from a rural perspective and the opportunity to sit at the table with some of the foremost minds of our generation has been priceless and I would recommend it to anyone in our discipline.

Respectfully, *Steven W Harrison 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

California Academy of Family Physicians
2019 Resolutions Submitted to the CAFP Board of Directors

- Resolutions may be submitted to the CAFP Board of Directors (BOD) at any time during the year. This DASHBOARD includes action on those heard at the 2019 All Member Advocacy Meeting (AMAM) and others submitted outside the AMAM timeframe as of 3.28.19.
- Resolutions submitted to the Board at the AMAM are designated "A," as in Res. A-01-19 or ER for "emergency", i.e., submitted after the deadline.
- Resolutions submitted too late for consideration by the Board at the current year's AMAM are designated "B," as Board.
- Resolutions will be tracked through the process and moved from Yellow to Red or Green as final actions are determined.
- The full resolutions are available for review on CAFP's website, www.familydocs.org. Resolutions must be posted on CAFP's website for at least one month prior to a Board meeting at which they will be considered to allow sufficient time for member comment.

YELLOW: Resolutions Referred/Submitted the CAFP Board of Directors for Action 3/27-28/2019	
Resolution #/Title/Date Submitted	**A-02-19: Ensuring Quality and Safe Care by All Primary Care Providers (3-10-19)**
Original RESOLVEDS:	**RESOLVED:** That the CAFP policy on nurse practitioners supports independent practice when nurse practitioners are trained under a standard that allows the demonstration of the competencies necessary for the safe delivery of quality primary care.
Recommended Actions and Progress Notes:	BOD met on 3.27.19 and voted to form a working group to produce a set of principles to guide legislation and policy development. The BOD determined that these principles should include, but not be limited to: 1) Graduate education requirements 2) Regulation and liability 3) Payment 4) Bar on corporate practice BOD met on 7.13.19 and approved the formation of the new Committee on Scope of Practice and initial membership.
Final Action:	
Resolution #/Title/Date Submitted	**A-05-19: Statement of Commitment from California Family Medicine Residency Programs to Improve Resident Well-Being and Reduce Burnout**
Original RESOLVEDS:	**RESOLVED,** that CAFP, in conjunction with AAFP and NAM, will urge family medicine residency programs to provide a statement of commitment, addressing plans of action to promote resident well-being and reducing burn-out in clinical training. Provisions in their plans of action should include, but not be limited to: 1. Promote the resources already in place through the Physician Health First portal to help residents and their mentors identify each resident's goals, assess their well-being, plan and track progress (https://www.aafp.org/membership/benefits/physician-health-first/planner/get-started.mem.html)

	2. Establish a wellness committee at each residency to engage all parties involved on the drivers of burnout specific to the program and workplace/personal strategies to promote well-being[7] 3. Improve access to and encourage residents to utilize mental health resources through residency training[8] 4. Encourage training and support through CAFP, AAFP, and NAM for Family Medicine Residency Program leadership on identifying and addressing resident burnout (ex. online workshops, conferences, and on-site consultations)
Recommended Actions and Progress Notes:	BOD met on 3.27.19 and referred the Resolution to the California Residency Network for discussion for recommendation and report back to the Board.
Final Action:	
GREEN: Resolutions ADOPTED/AMENDED and ADOPTED by the CAFP Board of Directors	
Resolution #/Title/Date Submitted	**A-01-19: Paid Parental Leave Policy (3-10-19)**
Original RESOLVEDS:	**RESOLVED:** That CAFP support a requirement on employers to provide at least 12 weeks of paid parental leave with job protection and wage replacement of at least two-thirds of previous earnings, up to a cap, for each new infant born or adopted, financed through an insurance-based pool, and that the paid leave may be taken by any family member caring for the child at any time in the first year of a child's birth or adoption in parts or as a block; and be it further **RESOLVED:** That CAFP refer this to AAFP for national action.
Recommended Actions and Progress Notes:	BOD met on 3.27.19 and referred to the CAFP Medical Practice Affairs Committee, for recommendation, with report back to the July 2019 Board meeting.
Final Action:	BOD met on 7.13.19 to discuss the recommendation of the Medical Practice Affairs Committee. Adopted as amended below: **RESOLVED:** That CAFP support policies that provide employees with reasonable job security, wage replacement, and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should include: (1) medical leave for the employee, including pregnancy; (2) parental leave for the employee-parent, including leave for birth, adoption, or foster care leading to adoption; (3) leave if medically appropriate to care for a member of the employee's immediate family. Any legislative proposals will be reviewed through the Academy's normal legislative process for appropriateness, taking into consideration all elements therein. **RESOLVED:** That CAFP refer this to AAFP for national action. Authors informed. Resolution forwarded to the AAFP.

Resolution #/Title/Date Submitted	**A-03-19: Increasing Family-Centeredness at AAFP Meetings (3-10-19)**
Original RESOLVEDS:	**RESOLVED,** that AAFP adjusts its recommendations regarding children at AAFP meetings from "Out of consideration for others, please do not bring children to CME events" to "AAFP supports families. Please use your best judgment regarding bringing children to CME events;" and be it further **RESOLVED,** that CAFP ask the AAFP to provide an on-site play area for children and their caregivers at AAFP FMX and COD; and be it further **RESOLVED,** that CAFP ask the AAFP to enhance efforts to accommodate breastfeeding parents at AAFP FMX and COD by providing a lactation lounge with basic services including privacy, running water, refrigerated milk storage, and opportunities to donate excess breast milk.
Recommended Actions and Progress Notes:	BOD met on 3.27.19 and Adopted as amended below. **RESOLVED,** that the AAFP adjusts its recommendations regarding children at AAFP meetings from "Out of consideration for others, please do not bring children to CME events" to "AAFP supports families. Please use your best judgment regarding bringing children to CME events;" and be it further **RESOLVED,** that CAFP ask the AAFP to *explore providing* an on-site play area for children and their caregivers at AAFP FMX and COD; and be it further **RESOLVED,** that CAFP ask the AAFP to enhance efforts to accommodate breastfeeding parents at AAFP *meetings* by providing a lactation lounge with basic services including privacy, running water, *and other amenities*.
Final Action:	BOD met on 3.27.19 and adopted as amended. Authors informed. Resolution forwarded to the AAFP.
Resolution #/Title/Date Submitted	**A-04-19: Requiring Gender Pronouns on Nametags at All AAFP Events (3-10-19)**
Original RESOLVEDS:	**RESOLVED:** That CAFP propose to the AAFP that they require all individuals to identify their preferred pronouns upon event registration to be printed on name badges at all AAFP-sponsored events and conferences starting in 2020.
Recommended Actions and Progress Notes:	BOD met on 3.27.19 and adopted as amended below: **RESOLVED:** That CAFP propose to the AAFP that they require all individuals to identify their preferred pronouns upon event registration, *with the option to opt-out*, to be printed on name badges at all AAFP-sponsored events and conferences starting in 2020.
Final Action:	BOD met on 3.27.19 and adopted as amended. Authors informed. Resolution forwarded to the AAFP.
Resolution #/Title/Date Submitted	**A-06-19: Improve Access to Healthcare for Formerly Incarcerated Persons (3-10-19)**

Original RESOLVEDS:	**RESOLVED:** That CAFP improve access to health care for formerly incarcerated persons following release by advocating for the creation of an agency that helps patients enroll in health insurance and establish care with a primary care provider prior to their release, and be it further **RESOLVED:** That CAFP work with the California legislature to advocate for increased funding for the Transitions Clinic Program to further increase the number of clinics throughout the state, particularly in inland counties, and be it further **RESOLVED:** That CAFP refer this to AAFP for national action.
Recommended Actions and Progress Notes:	BOD met on 3.27.19 and referred the resolution to the CAFP Legislative Affairs Committee for recommendation, with report back to the Board at its July 2019 meeting.
Final Action:	BOD met on 7.13.19 to discuss the recommendation of the Legislative Affairs Committee and Adopted as amended below: **RESOLVED**: That CAFP support efforts to improve access to health care for formerly incarcerated persons following their release; and be it further **RESOLVED**: That CAFP support increased funding for evidence-based programs designed to meet the needs of people recently released from incarceration; and be it further **RESOLVED**: That CAFP refer this to AAFP for national action. Authors informed. Resolution forwarded to AAFP.
Resolution #/Title/Date Submitted	**A-07-19: Decriminalization of Abortion Provision (3-10-19)**
Original RESOLVEDS:	**RESOLVED**: That CAFP propose to the AAFP that they endorse all ACOG statements that oppose legislation that targets family doctors who provide abortion services, and **RESOLVED:** That CAFP propose that the AAFP issue a position paper against the practice of criminalizing physicians for providing abortion care.
Recommended Actions and Progress Notes:	BOD met on 3.27.19 and referred the resolution as amended below to the CAFP Legislative Affairs Committee for recommendation and report back to the July 2019 Board Meeting. **RESOLVED**: That *CAFP oppose all efforts in California to criminalize physicians* who provide abortion services; and be it further **RESOLVED:** That CAFP propose that the AAFP issue a position paper against the practice of criminalizing physicians for providing abortion care.

Final Action:	BOD met on 7.13.19 to discuss the recommendation of the Legislative Affairs Committee and Adopted as amended below: **RESOLVED**: That the CAFP oppose the criminalization of physicians providing abortion care; and be it further **RESOLVED**: That the CAFP urge the AAFP to adopt policy opposing the criminalization of physicians providing abortion care. Authors informed. Resolution forwarded to AAFP.
Resolution #/Title/Date Submitted	**A-08-19: Mifepristone Use in Early Pregnancy Loss Management (3-10-19)**
Original RESOLVEDS:	**RESOLVED:** That CAFP instruct its AAFP delegates to submit a resolution to the 2019 AAFP Congress of Delegates to support the safety and efficacy of mifepristone as the most evidence-based care for medical management of EPL; and **RESOLVED:** That CAFP instruct its AAFP delegates to submit a resolution to the 2019 AAFP Congress of Delegates to reaffirm its efforts to overturn restrictions on the prescribing of Mifepristone, especially in light of data supporting its use in early pregnancy loss; and **RESOLVED:** That CAFP instruct its AAFP delegates to submit a resolution to the 2019 AAFP Congress of Delegates to recommend that early pregnancy loss management be included in the Family Medicine Experience (FMX) and *American Family Physician* topics on a rotational basis.
Recommended Actions and Progress Notes:	BOD met on 3.27.19 and adopted as amended below (removing third resolved): **RESOLVED:** That CAFP instruct its AAFP delegates to submit a resolution to the 2019 AAFP Congress of Delegates to support the safety and efficacy of mifepristone as the most evidence-based care for medical management of EPL; and **RESOLVED:** That CAFP instruct its AAFP delegates to submit a resolution to the 2019 AAFP Congress of Delegates to reaffirm its efforts to overturn restrictions on the prescribing of Mifepristone, especially in light of data supporting its use in early pregnancy loss.
Final Action:	BOD met on 3.27.19 and adopted as amended. Authors informed. Resolution forwarded to the AAFP.
Resolution #/Title/Date Submitted	**A-10-19: Inappropriate Use of CDC Guidelines for Prescribing Opioids (3-10-19)**
Original RESOLVEDS:	**RESOLVED:** That our CAFP affirm that no entity should use MME (morphine milligram equivalents) thresholds as anything more than guidance, and physicians should not be subject to professional discipline, loss of board certification, loss of clinical privileges, criminal prosecution, civil liability, or other penalties or practice limitations

	solely for prescribing opioids at a quantitative level that prescribing the MME thresholds found in the CDC Guideline, and be it further **RESOLVED:** That our CAFP affirm that some patients with acute or chronic pain can benefit from taking doses of opioid pain medications at doses greater than generally recommended in the CDC Guideline for Prescribing Opioids for Chronic Pain and that such care may be medically necessary and appropriate, and be it further **RESOLVED:** That our CAFP advocate against misapplication of the CDC Guideline by pharmacists, health insurers, pharmacy benefit managers, legislatures, and governmental and private regulatory bodies in ways that prevent or limit patients' medical access to opioid analgesia, and be it further **RESOLVED:** That our CAFP collaborate with the AAFP and other medical societies such as the AMA to communicate with the nation's largest pharmacy chains to recommend that they stop writing threatening letters to physicians including family physicians and stop presenting policies, procedures, and directives to retail pharmacists that encourage denial of prescriptions for opioids that exceed certain numerical thresholds without taking into account the diagnosis and previous response to treatment for a patient and any clinical nuances that would support such prescribing as falling within standards of good quality patient care.
Recommended Actions and Progress Notes:	BOD met on 3.27.19 and referred the Resolution to the CAFP Medical Practice Affairs Committee/Committee on the Health of the Public for recommendation; with report back to the July 2019 Board.
Final Action:	BOD met on 7.13.19 to discuss the recommendations of the Medical Practice Affairs Committee and adopted as amended below: **RESOLVED**: That our California Academy of Family Physicians (CAFP) applaud the Centers for Disease Control and Prevention (CDC) for its efforts to prevent the incidence of new cases of opioid misuse, addiction, and overdose deaths, and misapplication of its guidelines, and be it further **RESOLVED**: That our CAFP affirms that no entity should use MME (morphine milligram equivalents) thresholds as anything more than guidance, and physicians should not be subject to professional discipline, loss of board certification, loss of clinical privileges, criminal prosecution, civil liability, or other penalties or practice limitations solely for prescribing opioids at a quantitative level that prescribing the MME thresholds found in the CDC Guideline, and be it further **RESOLVED**: That the CDC guidelines do not constitute a standard of practice and should be considered by physicians alongside other guidelines, such as those produced by the Medical Board of California. As such, CAFP will advocate against misapplication of the CDC Guideline by pharmacists, health insurers, pharmacy benefit managers, legislatures, and governmental and private regulatory bodies in ways that prevent or limit patients' medical access to opioid analgesia, and be it further

	RESOLVED: That CAFP collaborate with the AAFP, the American Medical Association, pharmacy associations and the pharmacy board to communicate with the nation's largest pharmacy chains to recommend a review of practices related to denial of prescriptions for opioids that exceed certain numerical thresholds, including, policies, procedures and directives to retail pharmacists. Authors informed. Staff to engage with other organizations to identify opportunities to collaborate. Authors informed. Staff to engage with other organizations to identify opportunities to collaborate.
RED: Resolutions NOT ADOPTED by the CAFP Board of Directors	
Resolution #/Title/Date Submitted	**A-09-19: Clear Communication and Upholding the Social Contract When Responding to Patients with Terminal Illness and/or Existential Distress (3-10-19)**
Original RESOLVEDS:	**RESOLVED:** that CAFP rescind policy A-07-17, and be it further **RESOLVED:** that CAFP reaffirm and recommit to implement CAFP's existing policy on End-of-Life Care which describes appropriate responses to patients who express existential distress, and be it further **RESOLVED:** that CAFP include representatives of vulnerable populations when developing and delivering CME on End-of-Life Care.
Recommended Actions and Progress Notes:	
Final Action:	BOD met on 3.27.19 and did not adopt the Resolution. The author was informed.
Resolution #/Title/Date Submitted	**A-11-19: Insulin Price Inflation (3-10-19)**
Original RESOLVEDS:	**RESOLVED,** That CAFP lobby our California State Attorney General, Xavier Becerra, to join Minnesota's lawsuit against the pharmaceutical companies to ensure proper pricing of insulin and access to our most vulnerable patients; and be it further **RESOLVED,** That CAFP work with Medi-Cal's Pharmacy benefits Manager (PBM) to investigate alternative sources for insulin, including allowing for alternate manufacturers.
Recommended Actions and Progress Notes:	BOD met on 3.27.19 and referred the Resolution to the CAFP Legislative Affairs Committee for recommendation and report back to the Board.
Final Action:	BOD met on 7.13.19 to discuss the recommendation of the Legislative Affairs Committee. BOD did not adopt the resolution. In lieu of the resolution, the Board approved writing to California State Attorney General, Xavier Becerra, regarding CAFP's concerns with rising drug prices, in particular the high cost of insulin to consumers and the consequences of those prices. The letter should also urge the Attorney General to explore the merits of State of Minnesota v. Sanofi-

	Aventis U.S. LLC, et al, U.S. District Court, District of New Jersey, No. 18-cv-14999 and join or replicate its efforts if likely to ensure proper pricing of insulin and access for vulnerable patients. Authors informed. Letter sent to Attorney General Becerra.