2024 ALL MEMBER ADVOCACY MEETING

PARTICIPANTS' HANDBOOK

CAFP
California Academy of Family Physicians

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

We are very pleased you have chosen to join your family medicine colleagues and friends at the 2024 CAFP All Member Advocacy Meeting (AMAM). This year's AMAM will focus on utilizing a team-based approach to advance health equity. You will hear from policy and political experts, get hands-on experience advocating for issues important to family medicine, network with advocacy-oriented colleagues, and meet with your legislators! This will be a weekend of sharing, learning, advocating, being inspired, having fun and renewing your spirits. The Participants' Handbook includes almost everything you will need to know about AMAM. Please take the time to read through it.

The AMAM focuses on:

1. Advocacy: AMAM will provide tools and information to help develop family physicians trained and dedicated to being effective advocates for their patients and specialty – whether in their own communities, in Sacramento or even in Washington, D.C.

2. Governance: AMAM delegates elect the Academy's leaders for the coming year and make important decisions related to CAFP dues and bylaws.

3. Policy: AMAM provides the opportunity for family physicians to bring policy issues of urgent concern to the Academy for consideration.

AMAM is not primarily a clinical education opportunity. CAFP's Prism of Practice! (POP!) on August 23rd through August 25th in Orange County is the venue for excellent continuing professional development programming – the AMAM focuses on policy issues affecting the practice of medicine and care of patients.

Aside from topical presentations on key health care issues and leadership development, participants will have the opportunity to testify on policy resolutions submitted to the Board at this AMAM. Members submitted a record number of Resolutions this year, over twice as many as in any previous year. As a result, the schedule reflects some changes from previous years, including an earlier start time on Saturday (1pm) and Sunday (7:30 am).

Thank you for being here!

Anthony Chong, MD, FAAFP
Speaker

Kim Yu, MD, FAAFP
Vice Speaker

Detailed Schedule of Events

All Member Advocacy Meeting — Saturday, April 13, 2024 Opening Session ● Camellia/Gardenia Room — 1:00 pm – 4:45 pm	
12:00 pm – 1:00 pm	**All Member Advocacy Meeting (AMAM) Registration & Lunch** ***Delegates are invited to a Meet & Greet with the New Physician Director Candidates***
1:00 pm – 1:20 pm	**Opening Session of the AMAM – Welcome** *Lisa Folberg, MPP, CAFP CEO* **What Is the AMAM and What Will We Do During This Meeting** *Anthony Chong, MD, FAAFP, CAFP Speaker* • Certification of Delegates • Nominations from the floor, if any* • Presentation of Election Slate and vote on uncontested positions *Secretary/Treasurer Elected by the Board of Directors only
1:20 pm – 1:30 pm	**President's Address** *Raul Ayala, MD, MHCM*
1:30 pm – 3:00 pm	**Resolutions Hearing – CAFP Board of Directors** *Anthony Chong, MD, FAAFP, CAFP Speaker and Kim Yu, MD, FAAFP, CAFP Vice Speaker* • 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. • Refreshments will be available in the room, but there will not be a formal break, to accommodate testimony on the large number of resolutions.
3:00 pm – 3:30 pm	**Candidate Speeches and Delegate Voting for New Physician Director** *Anthony Chong, MD, FAAFP, CAFP Speaker*
3:30 pm – 4:45 pm	**Resolutions Hearing– CAFP Board of Directors** **Estimation of time; actual Adjournment depends upon disposition of resolutions** *Anthony Chong, MD, FAAFP, CAFP Speaker and Kim Yu, MD, FAAFP, CAFP Vice Speaker*
5:30 – 7:30 pm	**All Member Reception/Open House at CAFP Sacramento HQ** (816 21st Street)

All Member Advocacy Meeting — Sunday, April 14, 2024 Session ● Camellia/Gardenia — 7:45 am – 3:00 pm, 4:00 pm – 4:30 pm; Training Tracks — 3:00 pm – 4:00 pm	
7:00 am – 7:45 am	**Registration and Continental Breakfast**
7:45 am – 7:50 am	**All Member Advocacy Meeting Reconvenes – Welcome Back and Preview of the Day** *Anthony Chong, MD, FAAFP, CAFP Speaker*
7:50 am – 8:50 am	**Social Needs Screening: It Takes a Team**

	Margot Savoy, MD, FAAFP, Senior Vice President, Education, Inclusiveness and Physician Well-Being, AAFP
8:50 am – 9:05 am	**FP-PAC Weekend Update** *Shannon Connolly, MD, FAAFP, FP-PAC Chair*
9:05 am – 10:05 am	**Keynote Speaker** *Elizabeth A. Landsberg, Director, Health Care Access and Information (HCAI)*
10:05 am – 10:15 am	**BREAK**
10:15 am – 11:45 am	**Resolutions Hearing– CAFP Board of Directors** *Anthony Chong, MD, FAAFP, CAFP Speaker and Kim Yu, MD, FAAFP, CAFP Vice Speaker*
11:45 am – 12:00 pm	**CAFP Foundation Update & AMAM Scholarship Winners** Ronald Labuguen, MD, FAAFP, CAFP Foundation President
12:00 pm – 1:00 pm	**Celebration Lunch** *Tochi Iroku-Malize, MD, FAAFP – AAFP Past President* *Alex McDonald, MD, FAAFP – CAFP President* • *Convocation of Fellows* • *Installation of Officers* • *President's Address* • *Hero of Family Medicine Award Announcement*
1:00 pm – 3:00 pm	**Resolutions Hearing– CAFP Board of Directors** *Anthony Chong, MD, FAAFP, CAFP Speaker and Kim Yu, MD, FAAFP, CAFP Vice Speaker*
3:00 pm – 4:00 pm	**Training Tracks** **<u>Track One:</u>** **How to Talk with your Legislator and Mastering the Art of Bio Writing** *Marissa Montano, PhD – CAFP Vice President of Advocacy and Policy* *Vanessa Cajina – CAFP Legislative Advocate* **<u>Track Two:</u>** **The Sausage Making of Elections and Campaigns: An Insider's View** *Jasmeet Bains, MD – 35th District Assemblymember, California State Assembly* *Alex McDonald, MD, FAAFP – Trustee Area No. 4, Claremont Unified School District* *Daniel C. Weitzman – Client Relations Director, Daniel C. Weitzman Consulting Communications and Public Affairs Strategist*
4:00 pm – 4:30 pm	**Legislative Briefing on CAFP Priorities** *Jeff Luther, MD, FAAFP – CAFP Legislative Affairs Committee Chair* *Tiyesha Watts – CAFP Legislative and Policy Advocate* *Vanessa Cajina – CAFP Legislative Advocate*
	Evening Free

Lobby Day — Monday, April 15, 2024 **Session ● Camellia/Gardenia — 8:00 am – 9:00 am**	
8:00 am – 8:45 am	**Breakfast** • **Lobby Day Issue Briefing** *Jeff Luther, MD, FAAFP – CAFP Legislative Affairs Committee Chair* *Marissa Montano, PhD – CAFP Vice President of Advocacy and Policy* *Tiyesha Watts – CAFP Legislative and Policy Advocate* • **Champion of Family Medicine Award Presentation**
9:00 am	**Group Photo in Front of Capitol**
9:15 am – 12:00 pm	**Legislative Visits at the Capitol**
12:00 pm – 1:00 pm	**FP-PAC Donor Lunch Reception**
1:00 pm – 3:00 pm	**Legislative Visits at the Capitol**

Roster of 2024 Delegates and Alternates

County/Chapter	Delegates	Alternates
Alameda/Contra Costa (5)	Sarah McNeil, MD Prachi Priyam, MD Magdalen Edmunds, MD Sumedh Mankar, MD Chrissy Chavez-Johnson, MD	Jeremy Fish, MD Emily Lu, MD
Amador (1)		
Butte-Glenn-Tehama (1)		
Fresno-Kings-Madera (3)	Zhoobin Bateni, MD Diana Howard, MD Shruti Javali, MD	Alex Sheriffs, MD
Humboldt-Del Norte (1)		
Imperial (1)		
Inyo-Mono-Alpine (1)		
Kern (2)		
Lassen-Plumas-Modoc-Sierra (1)	Landon Hagge, DO	
Los Angeles (12)	Jerry Abraham, MD, MPH, CMQ Mark Benor, MD Rebecca Bertin, MD Phillip Brown, MD Cynthia Chen-Joea, DO, MPH, CPH Michael Core, MD Michelle Crespo, MD Emma Hiscocks, MD Elisabeth Kalve, MD C. Peony Khoo, MD Greg Lewis, MD Linda James, MD	Viviana Huang-Chen, MD Stacey Ludwig, MD Miriam Padilla, MD Monika Shenouda, MD Amy Tressan, MD Michelle Yim-Tang, MD Camilo Zaks, MD Yousuf Zaveri, MD
Mendocino-Lake (1)	Cameron MacInnis, MD	
Merced-Mariposa (2)		
Napa (1)	Tessa Stecker, MD	
North Bay (3)	Francesca Manfredi, DO Leigh Val Spinosa, MD Parker Duncan, MD	Panna Lossy, MD
Orange (5)	Jaesu Han, MD William Woo, MD Kun Chai Meas, MD* Matt Varallo, MD* Florence Yuan, MD*	
Placer-Nevada (2)	Julie Garchow, MD Karina Gookin, MD	
Riverside-San Bernardino (6)	Maricio Bonilla, MD Vanessa Cobian, MD Liz Dameff, MD	Mai-Linh Tran, MD Moazzum Bajwa, MD Scott Nass, MD

	Nadia Khan, MD Nazmeen Merfeld, MD Mayra Hernandez Schulte, MD	
Sacramento Valley (5)	Sheila Attaie, MD Ian Kim, MD Bill Eng, MD Thomas Anker, MD Dominique Quincy, MD	Toussaint Mears-Clarke Brea Bondi-Boyd, MD Kirsten Vitrakis, MD
San Diego (6)	Patrick Yassini, MD Lance Fuchs, MD Albert Ray, MD Randy Swartz, MD Kristin Brownell, MD David Bazzo, MD	Cecilia Gutierrez, MD Brad Stiles, MD Daniel Slater, MD Merritt S. Mattews, MD Joseph F. Leonard, MD Melissa Campos, MD
San Francisco (2)	Jonathan Lynne, MD Clarissa Kripke, MD*	
San Joaquin-Calavaras-Tuolomne (2)	Maryal Concpecion, DO David Arraiza, MD	
San Luis Obispo (2)		
San Mateo (2)	Gurpreet Padam, MD Rashmi Narayana, MD	
Santa Barbara (2)		
Santa Clara (4)	Angela Bymaster, MD Jake Evans, MD Michelle Engle, MD	
Santa Cruz- Monterey (3)		
Shasta-Trinity (2)	Elizabeth Evangelista, MD Debbie Lupieka, MD	Paul Davainis, MD Mark Todd Roback , DO
Siskiyou (1)		
Solano (2)	Rossan Chen, MD Adia Scrubb, MD	Matt Symkowick, MD
Stanislaus (2)	Erin Kiesel, DO Nicole McLawrence, MD	
Tulare (2)	Adnaan Edun, MD Muhammad Khan, MD	Shazeb Nadeem, MD Shruti Joseph, MD
Ventura (2)	Helen Petroff, MD Leslie Lynn Pawson, MD	Laura Murphy, DO
Yuba-Sutter-Colusa (1)		
Student and Resident Council (2 Students and 2 Residents)	Bianka Aceves Martin (S) Sylvana Marquina (S) Amanda D'Almeida, MD (R) Jodie Guller, MD (R)	Aaron Bautista (S) Carlos Calderon, MD (R)

CAFP Officers and Board of Directors – 2024-2025

**Received after the February 12, 2024 deadline. In red indicates they informed CAFP they will no longer be able to attend.*

CAFP Officers and Board of Directors – 2023-2024	
Raul Ayala, MD	President
Lauren Simon, MD	Immediate Past President
Alex McDonald, MD	President-elect
Anthony Chong, MD	Speaker
Kim Yu, MD	Vice Speaker
Lee Ralph, MD	AAFP Delegate
Lisa Ward, MD	AAFP Delegate
Michelle Quiogue, MD	AAFP Alternate Delegate**
Shannon Connolly, MD	AAFP Alternate Delegate**
Ron Labuguen, MD	CAFP-F President
Brent Sugimoto, MD	Secretary-Treasurer, District VIII
Maria Carriedo-Ceniceros, MD	District 1
Jorge Galdamez, MD	District II
Kevin Rossi, MD	District III
Rebecca Bertin, MD	District IV
Shayne Poulin, MD	District V
Robin Janzen, MD	District VI
Grace Chen Yu, MD	District VII
Lalita Abyhankar, MD	District IX
Erika Roshanravan, MD	District X
Amanda Mooneyham, MD	Rural Director
Rob Assibey, MD	Young Physician Director
Soomin Jung, MD	Resident Co-Director***
Amanda Helle	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.*

2024 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.

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 (CAFP). 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 primary duties of Delegates are: 1) Vote on 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) Propose policies or programs to the Board of Directors for discussion and consideration.**

Function: The CAFP AMAM proposes policies for consideration by the CAFP 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 CAFP 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 information on how to access the Report of Actions of the 2023 AMAM and how to access 2023 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 and the policies considered.

New 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 is posted on CAFP's website. Report of Actions for past resolutions are also posted on CAFP's website at 2023-Resolutions-Dashboard. Delegates are encouraged to visit familydocs.org, to review these documents. 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 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 prior to the meeting. **Registration for the AMAM will be open between 12:00 and 12:45 pm on April 13, 2024. All delegates must register during this window**, to establish quorum well before the meeting commences at 1:00 pm. After registering, delegates are invited to attend a casual Meet and Greet in the event ballroom to meet the candidates running for the New Physician Director seat on the CAFP Board.
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 (February 12, 2024). 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. 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 Governance Committee Report and Candidate Statements section of this handbook for information about this year's slate of candidates. Officer elections are conducted through acclamation or confidential ballot. There are three candidates running for the New Physician Director seat on the CAFP Board this year. Delegates will vote to elect one candidate, and this election will be conducted via confidential ballot.

Standing Rules of the All Member Advocacy Meeting:

When AMAM Convenes: The AMAM will convene at 1:00 pm, Saturday, April 13, 2024 and again on Sunday, April 14, 2024 at 7:30 am 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) days prior to the meeting during which they are to be considered (February 12, 2024). 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 to speak on the floor. If you wish to speak during the AMAM go to the nearest microphone. Once the Speaker has recognized you, please identify yourself. Please state clearly your name and chapter for the record. State whether you are for or against the resolution, any conflicts and offer your testimony. Time will be called at the end of your allotted time. No member may speak a second time during the discussion until all members have been given an opportunity to speak once. This will give as many Academy members as possible the opportunity to present his or her views.

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

Voting: When there is a contested election or need to manually count delegate votes, the Speaker and Vice Speaker will 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 Reference Committee Hearing? Any Academy member has the privilege of speaking at the reference committee hearing. Non-members may also be asked by the Speaker or Vice Speaker 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.

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 may refer a Resolution to a CAFP Committee or elsewhere for report back and recommendation. The Board will provide a report on its actions at the next AMAM and throughout the year via the CAFP website and member communications. 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 expertise and resources 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 Governance 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 Governance Committee nominated candidates for the following positions, to be elected by the AMAM (The Committee's report is found on page 126):

President-elect
Speaker
AAFP Delegate & Alternate
New Physician Director

Vice Speaker Governance Committee Member

The Committee may also submit nominations for District Directors when nominations were not made by a District. In addition, the Committee 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.* Governance Committee members from the Board are also elected by the Board of Directors. 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 at AMAM. The floor is open for additional nominations. Should there be nominations from the floor or contested elections, nominating speeches of two-three minutes each may be given at AMAM, prior to the election. Confidential voting will be used in the case of contested elections.

**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 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 process at the Board of Directors and committee levels in 2000. As part of that process, members are asked to consider the following 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

Resolution Instructions

CAFP Resolutions must meet the following criteria:

- Raise issues that strongly impact family physicians or family medicine;
- Not make references to point-in-time issues, such as specific bills, local initiatives, or one-time programs;
- Not duplicate existing policy; and,
- Align with CAFP's strategic plan.

Other Considerations for Adopting Resolutions:

- Does CAFP have the expertise necessary to carry out the directive in this resolution?
- Does CAFP have the necessary resources to carry out the directive in this resolution?
- Can CAFP influence the outcome desired in this resolution?

Important Context for 2024 Resolutions

Refer for National Action: Typically, CAFP delegates to AAFP bring four to six resolutions to AAFP annually. As with CAFP Resolutions, AAFP Delegates bring Resolutions to AAFP that are consistent with the AAFP strategic plan, do not reference specific point-in-time issues, make AAFP policy change, are within AAFP resources and within the expertise of AAFP and family physicians.

State Advocacy: Typically, there are 2,000-2,500 legislative bills introduced each year. Generally, well over 500 of these bills address health and social determinants of health. CAFP typically takes a position on roughly 50-65 legislative bills each year.

Resolutions and Background Materials

Speaker's Notes and Fiscal Notes are provided by CAFP staff. All other information is provided by the resolution author.

List of Resolutions

1. Resolution A-01-24 – Malpractice Coverage for 'High Risk' Providers
2. Resolution A-02-24 – Supporting Access to OB Services for All Californians
3. Resolution A-03-24 – Changing DEA Schedule Class of Psyilocybin
4. Resolution A-04-24 – Voter Registration in the Clinics and Offices of Family Physicians
5. Resolution A-05-24 – Therapy - a Necessary Investment for the Future of Medicine
6. Resolution A-06-24 – Protecting CA Residents Who Provider Out Of State Residents with Gender-Affirming Care
7. Resolution A-07-24 – Protecting Sensitive Medical Information from Inadvertent Sharing Across State Lines
8. Resolution A-08-24 – Resolution to Ban Private Equity Ownership of Medical Practices and Hospitals
9. Resolution A-09-24 – Affordable Child Care for All
10. Resolution A-10-24 – Universal Basic Income Is Urgently Needed for Our Patients
11. Resolution A-11-24 – Increase Nutrition Education in ACGME Residencies and Medical Schools
12. Resolution A-12-24 – Farmacology over Pharmacology- Diversifying School Meals to Reduce Chronic Disease, Improve Health Equity, and Improve Climate Health
13. Resolution A-13-24 – Screening, Intervening, and Advocating to Address Food Insecurity
14. Resolution A-14-24 – Medi-Cal Dietician Access Expansion
15. Resolution A-15-24 – Empowering Delegates for a Stronger Academy
16. Resolution A-16-24 – Decriminalize People Experiencing Homelessness
17. Resolution A-17-24 – Humanitarian Crisis in Gaza
18. Resolution A-18-24 – Family Medicine Physicians as Advocates for Climate Change
19. Resolution A-19-24 – Medi-Cal Audits
20. Resolution A-20-24 – New Age Band Ratio of 2-1 for Health Insurance
21. Resolution A-21-24 – Incentivizing Continuity and Comprehensive Care to Support Multidisciplinary Clinical Teams (Patient Centered Medical Homes)
22. Resolution A-22-24 – Support for Appropriate Visit Times in Primary Care
23. Resolution A-23-24 – Overdose Preparedness in Primary Care Settings
24. Resolution A-24-24 – Clarifying that Direct Primary Care Agreements are not Insurance
25. Resolution A-25-24 – Ensuring Equitable Representation- Inclusion of MENA Community in U.S. Census
26. Resolution A-26-24 – Protect Original Medicare
27. Resolution A-27-24 – Promoting Healthy Pregnancies for Farmworkers through the California State Disability Insurance Program
28. Resolution A-28-24 – Add Climate Change Health to CAFP Mission
29. Resolution A-29-24 – Support Rent Control Initiatives on a Local, State, and National Level
30. Resolution A-30-24 – Syringe Exchange Programs in Orange County
31. Resolution A-31-24 – Fair Bilingual Compensation to Advance Health Equity and Language-Concordant Care
32. Resolution A-32-24 – Ensuring Equity in Rural Health Policy
33. Resolution A-33-24 – Increasing Diversity for Research in Asian American and Native Hawaiian Pacific Islander Communities
34. Resolution A-34-24 – Supporting Medical Students Attending Educational and Research Conferences

35. Resolution A-35-24 – Interpreter Services for Perinatal Care
36. Resolution A-36-24 – Support for Medi-Cal and Medicaid Coverage of Medication Abortion Services Without Gestational Age Limits
37. Resolution A-37-24 – Transgender Medicine as Core Curriculum in Graduate Medical Education
38. Resolution A-38-24 – Patient Navigators as Part of Resident Education on Social Determinants of Health

Resolution A-01-24

Proposed Policy Title: Malpractice coverage for "high risk" providers

Author: Prachi Priyam

Co-Authors: Sarah McNeil, Magdalen Edmunds, Panna Lossy, Emily Lu

Endorsed by: CAFP East Bay Chapter

WHEREAS, large regions of California have no prenatal care access as there are no local maternity care providers

WHEREAS, a large driver of rural scarcity is the unaffordable cost of insurance for family physicians and others providing maternity care

WHEREAS, multiple groups of maternity care providers across the state are not able to afford malpractice insurance coverage to support their practice

WHEREAS, California providers offering abortion telehealth under the protection of California's shield laws are not able to find any malpractice to cover out-of-state care

WHEREAS, Washington state has a Volunteer and Retired Providers Program which is a state-funded program to support healthcare access to healthcare in Washington state using medical volunteers

WHEREAS, Oregon state passed legislation to provide state income tax credits and medical liability insurance assistance to rural OB/GYN providers as an incentive to ensure healthcare access

RESOLVED: the California Academy of Family Physicians supports the development of statewide solutions to lower or completely cover the cost of malpractice coverage for providers offering critical reproductive health services - which include but are not limited to maternity care, abortion, and gender-affirming services - in underserved areas of California and for providers offering these services under the state's shield laws as interstate telehealth medical providers

RESOLVED: the California Academy of Family Physicians explores options for a state based malpractice coverage, similar to the Federal Tort Claims Act

Speaker's Notes:
CAFP does not have specific policy to lower or completely cover the cost of malpractice coverage for physicians offering critical reproductive health services. CAFP has policy on MICRA/ professional Liability to keep malpractice premiums affordable. 5/98 BoD
CAFP policy supports access to timely health care services generally, and specifically supports advocacy for access to comprehensive reproductive health services without fear of intimidation or violence. BoD 2-1-2017.
AAFP policy supports timely access to health care services and specifically access to reproductive and maternity health services.
Fiscal Note:
There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be

more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents.
Providing input on proposed regulations could incur minimal to moderate costs depending on the level of engagement that is required.
Cost related to developing policy related to state-based malpractice coverage would be significant, including securing an attorney with expertise in the area.

Problem Statement:

Problem Universe:

Specific Solution: Over 5.5 million California residents live in rural counties per the Rural County Representatives of California.

Evidence:

Citations:

https://www.rcrcnet.org/counties

Resolution A-02-24

Proposed Policy Title: Supporting Access to OB Services for All Californians

Author: Robert Moore

Co-Authors:

Endorsed by:

WHEREAS, closure of hospital obstetrical care (OB) units has accelerated in California due to a number of converging causes (including staff shortages, financial stresses, and regulatory burden); and

WHEREAS, such OB unit closures have led to women in many rural and not-so-rural areas of California being left with no options for local basic or emergency OB services; and

WHEREAS, studies show that when the nearest OB services offered are more than 60 minutes transport away (with good weather), that the rate of maternal and newborn complications increases; and

WHEREAS, this lack of access to OB access with resulting adverse outcomes represents a public health emergency and a health equity issue

RESOLVED: access to safe OB services be reframed as a public good in which dedicated and energetic efforts be made to have basic hospital maternity services available within 60 minutes of vehicular transportation; and be it further

RESOLVED: That the CAFP support an effort to bring stakeholders together to define and enact measures needed to achieve access to obstetrical services in all California communities.

Speaker's Notes: CAFP has a general policy supporting timely access to healthcare service including perinatal services. Specifically, CAFP policy affirms the protections of obstetrics and for CAFP physicians to provide perinatal care to have rights and privileges. (6.92 BoD) In addition, CAFP has general health policy that affirms the protection of reproductive and birthing health, stating that "women's health must be protected. CAFP opposes policies designed to restrict access to comprehensive reproductive health care by placing medically unnecessary regulatory burdens on physicians." (BoD 2-1-2017) Historically, CAFP has advocated in support of the timely access regulations adopted by the state.

AAFP does not have direct policy pertaining to this matter, however, they do have general policy pertaining to reproductive and Maternity Health Services: AAFP policy states support for "access to comprehensive pregnancy and reproductive health services, including but not limited to abortion, pregnancy termination, contraception, and surgical and non-surgical management of ectopic pregnancy, and opposes nonevidence-based restrictions on medical care and the provision of such services. The AAFP believes pregnancy and reproductive health services are essential to general health care and should be covered under all insurance plans." (2014 COD) (September 2022 COD)

Fiscal Note: Fiscal impact will depend on the degree to which the CAFP board seeks to actively advocate for the proposal. If after convening with stakeholders it is deemed that legislation is needed, there would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for

updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents.

Problem Statement: Hospital maternity units are closing at a rapid rate, leading many pregnant patients to be forced to travel long distances to obtain services.

Problem Universe: Approximately 20% of CAFP members practice in communities that have lost obstetrical access in the past decade.

Specific Solution: Reframing maternity services as a public good, leading to activities to re-establish maternity services in some rural areas.
Working with other stakeholders to begin this work.

Evidence: Partnership HealthPlan's service area has lost hospital 10 maternity units in the past 8 years.

Citations:

AAFP (American Academy of Family Physicians). Striving for Birth Equity: Family Medicine's Role in Overcoming Disparities in Maternal Morbidity and Mortality. Policy Statement. Accessed December https://www.aafp.org/about/policies/all/birth-equity-pos-paper.html

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Stoll, Kathrin and Kornelsen Jude. Midwifery Care in Rural and Remote British Columbia: A Retrospective Cohort Study of Perinatal Outcomes of Rural Parturient Women with a Midwife involved in Their Care, 2003 to 2008. J Midwifery Womens Health. 2014 Jan-Feb; 59(1): 60-6. https://pubmed.ncbi.nlm.nih.gov/24588878/

Resolution A-03-24

Proposed Policy Title: Changing DEA Schedule Class of Psilocybin

Author: Brea Bondi-Boyd

Co-Authors:

Endorsed by: Sacramento Valley Chapter

WHEREAS, Psychedelics have been part of Indigenous/traditional healing practices for centuries, and could have enormous potential to address medical needs in the community and improve health outcomes, studying their potential is limited by their current DEA status as a schedule I substance, and

WHEREAS, Recent California Senate Bill 58 to decriminalize psilocybin was vetoed, due to lack of regulated treatment guidelines, including dosing information, therapeutic guidelines, and rules to prevent against exploitation during guided treatments, and

WHEREAS, psilocybin treatment guidelines cannot be ascertained unless their use is more widely studied in clinical trials, putting the substance in a Catch-22, and

WHEREAS, the DEA classifies Schedule I drugs as "substances, or chemicals defined as drugs with no currently accepted medical use and a high potential for abuse" and

WHEREAS, the DEA classifies Schedule IV drugs as, substances, or chemicals defined as drugs with a low potential for abuse and low risk of dependence. Some examples of Schedule IV drugs are: Xanax, Soma, Darvon, Darvocet, Valium, Ativan, Talwin, Ambien, Tramadol and

WHEREAS, medications such as benzodiazepines, categorized as Schedule IV medications, have updated warnings in 2020 from the DEA stating they are "widely abused and misused, often together with alcohol, prescription opioids, and illicit drugs…some patients have had serious withdrawal reactions after benzodiazepines were stopped suddenly or the dose was reduced too quickly" psilocybin has not shown similar abuse potential in available studies and

WHEREAS, National and International academic institutions such as UC Davis, Kaiser Permanente, UCSD, UCSF among others now have departments for Psychedelic Psychology/Psychiatry supporting studies of uses for psilocybin however applications for such studies are hindered by undue burden of surpassing requirements for schedule I substances and therefore be it

RESOLVED: That the California Academy of Family Physicians bring this resolution to the AAFP Congress of Delegates to support legislation to change psilocybin to a schedule IV substance.

Speaker's Notes: This resolution adds a directive for CAFP to refer this issue, de-scheduling psilocybin for AAFP policy. AAFP does not have explicit policy related to psilocybin scheduling. The AAFP does have related policy identifying their Legislative stance on Drug Enforcement Administration (DEA). AAFP policy states that "AAFP supports Controlled Substances Act (CSA) reforms to improve the DEA authority to support the practice of medicine, research, law enforcement, national security, public health, and substance classification. The AAFP also encourages partnerships with the DEA, medical societies, state and local governments, relevant federal

agencies, and stakeholders to improve CSA enforcement activities, program effectiveness, administration simplification, and anti-fraud awareness activities, including activities to clarify the prescription and distribution of controlled substances for "legitimate medical purposes."" (2002) (2019 COD)

In addition, CAFP does not have existing policy on this issue but does have related policy in a different context. CAFP policy on Adult Use of Marijuana states that CAFP supports the decriminalization of marijuana including policy to de-schedule the drug, in part, to support research on patient safety and efficacy in medicine: "The federal government should change the pharmaceutical cannabinoids from a Schedule I to a Schedule II to facilitate research and private manufacturing and distribution of marijuana should be permitted for research purposes; In states in which marijuana is legalized, research should be conducted into the overall safety and health effects of the recreational use of marijuana, as well as the effects of legalization on patient and societal health; and, The federal Food and Drug Administration, or a similar state agency, should thoroughly investigate recreational and medicinal marijuana for safety and efficacy, including monitoring for purity, standardization of strength and proper usage, as well as testing for harmful contaminants such as insecticides, herbicides or molds." CAFP policy on this issue also states that "CAFP believes our society must recognize drug use and abuse as medical and social problems that must be treated with medical and social solutions. CAFP calls on the President and Congress to empower an objective commission to recommend revision of national drug laws to reduce the harm caused by current policies." (BoD 7.16.16)

Fiscal Note: There would be minimal cost for referring for national action.

Problem Statement: No current policy position. Addresses need for more research into mental health treatment options currently not available

Problem Universe: Millions
Specific Solution: Allowing for more research into a potential treatment for many mental health conditions

Evidence: see citations.

Citations:
Bill Text: CA SB58 | 2023-2024 | Regular Session | Enrolled | LegiScan

Trial of Psilocybin versus Escitalopram for Depression | NEJM

Single-Dose Psilocybin for a Treatment-Resistant Episode of Major Depression | NEJM
Drug Scheduling (dea.gov)

https://psychiatry.ucsd.edu/research/programs-centers/interventional-psychiatry-research/index.html

DEA June 2023: Psychedelics: Consideration for Clinical Trials: https://www.regulations.gov/document/FDA-2023-D-1987-0002

Resolution A-04-24

Proposed Policy Title: Voter Registration in the Clinics and Offices of Family Physicians

Author: Kimberly Buss

Co-Authors: Brea Bondi-Boyd

Endorsed by:

WHEREAS, Voter registration, voting and civic engagement are associated with better health.1 2 3 4 And,

WHEREAS, One of the key reasons people don't vote is that they are not registered to vote.5 And,

WHEREAS, The rate of voter registration in California has dropped from 2021 to 2023.6

WHEREAS, People trust health care professionals and are willing to register to vote in clinics.7 8 And,

WHEREAS, Health care professionals themselves are the largest workforce sector in the US, yet are 12-23% less likely to vote then the general population. 8 9 And,

WHEREAS, Increased voting rates cause elected professionals to be more accountable to their constituents; and they change policy that improves health care when they believe they are being held accountable. 8 And,

WHEREAS, Registering voters in the clinics and offices of family physicians has three potential benefits: (1) improving the health of patients, (2) activating health care professionals, and (3) causing elected professionals to improve health policy. And,

WHEREAS, Vot-ER is a nonpartisan healthcare civic engagement organization that is successfully improving the health of communities by helping Americans register to vote in health care settings.10 Vot-ER is sponsored by 223 health care organizations across the US, but the California Academy of Family Physicians is not one of their sponsors.11

RESOLVED: That the California Academy of Family Physicians become a sponsor of Vot-ER.

RESOLVED: That the California Academy of Family Physicians encourages family physicians across the state of California to register people to vote in their clinics and offices.

RESOLVED: That the California Academy of Family Physicians help the clinics and offices of family physicians find information and resources to carry out voter registration.

RESOLVED: That the California Academy of Family Physicians bring this resolution to the AAFP Congress of Delegates for national action.

Speaker's Notes:
Neither CAFP or AAFP have policy regarding the Family Physician role in voter registration and information. Voter engagement is not specific in the CAFP strategic plan or workplan.

Generally, CAFP Resolutions should not include reference to specific programs as those may change.
CAFP developed material in advance of the 2020 election in English and Spanish for members to download, encouraging their patients to register to vote and cast a ballot. Materials also included a step-by-step "how to."

Fiscal Note:
The cost of joining and participating in the vot-ER organization is unknown.
The cost of an educational campaign for CAFP members would depend on the specific activities in which CAFP engages. There would be minimal cost to develop materials for members to download. The cost would increase substantially if CAFP printed and distributed materials.
The cost of bringing this for national action would be minimal.
Problem Statement: As of Feb 2023, 82.27% of eligible California voters are registered to vote. This is a decreased from 88.01% 2 years earlier. Higher voting registration and voting rates are associated with improved health outcomes of populations.

Problem Universe: All CAFP members are affected by voter registration and voting rates. All CAFP members who work in clinics or offices could benefit from this policy to help patients register to vote.

Specific Solution: The goal of this resolution is to encourage CAFP to become a sponsoring organization of Vot-ER and encourage Family Physicians to register people to vote in their clinics and offices, in order to increase voter registration rates.

Evidence: Voting registration rates have dropped in California from February 2021 to February 2023. 6 Higher voter registration rates and voting rates are associated with improved health outcomes. 1 2 3 4 Clinics can successfully enroll people to vote. 7 8

Citations:
1. Health & Democracy Index. Accessed February 12, 2024. https://democracyindex.hdhp.us/data/

2. Health & Democracy Index. Accessed February 12, 2024. https://democracyindex.hdhp.us/

3. Ballard PJ, Hoyt LT, Pachucki MC. Impacts of Adolescent and Young Adult Civic Engagement on Health and Socioeconomic Status in Adulthood. Child Dev. 2019;90(4):1138-1154. doi:10.1111/cdev.12998
4. Nelson C, Sloan J, Chandra A. Examining Civic Engagement Links to Health: Findings from the Literature and Implications for a Culture of Health. RAND Corporation; 2019. Accessed February 12, 2024. https://www.rand.org/pubs/research_reports/RR3163.html

5. Why don't people vote? | Ipsos. Published December 15, 2020. Accessed February 12, 2024. https://www.ipsos.com/en-us/news-polls/medill-npr-nonvoters-2020

6. The Secretary of State of California. REPORT OF REGISTRATION Odd Number Year Report. Accessed February 12, 2024. https://elections.cdn.sos.ca.gov/ror/ror-odd-year-2023/complete-ror.pdf

7. Liggett A, Sharma M, Nakamura Y, Villar R, Selwyn P. Results of a voter registration project at 2 family medicine residency clinics in the Bronx, New York. Ann Fam Med. 2014;12(5):466-469. doi:10.1370/afm.1686

8. We Will Vote Voting as an Important and Actionable Social Determinant of Health A Webinar | National Academies. Accessed February 12, 2024. https://www.nationalacademies.org/event/41855_02-2024_we-will-vote-voting-as-an-important-and-actionable-social-determinant-of-health-a-webinar?utm_source=HMD+Email+List&utm_campaign=27c0978a09-

EMAIL_CAMPAIGN_2024_01_19_08_22&utm_medium=email&utm_term=0_-27c0978a09-%5BLIST_EMAIL_ID%5D&mc_cid=27c0978a09&mc_eid=97f74e076d

9. Solnick RE, Choi H, Kocher KE. Voting Behavior of Physicians and Healthcare Professionals. J Gen Intern Med. 2021;36(4):1169-1171. doi:10.1007/s11606-020-06461-2

10. About Vot-ER - Vot-ER. Published July 1, 2022. Accessed February 12, 2024. https://vot-er.org/about/

11. Civic Health Month Partners - Vot-ER. Published May 22, 2022. Accessed February 12, 2024. https://vot-er.org/partners/

Resolution A-05-24

Proposed Policy Title: Therapy: a Necessary Investment for the Future of Medicine

Author: Britney Nguyen

Co-Authors: Wilson Lin, Sailesh Wignarajah, Mio Jiang, Ryan Sabour

Endorsed by:

WHEREAS, Throughout medical educational training and residency, the mental wellbeing of future physicians tends to be neglected in favor of productivity and academic excellence, in addition to the ironic stigma of mental health around healthcare practitioners themselves.

WHEREAS, In the long term, this oversight in mental health support for medical students and residents comes at the expense of their longevity in their careers and may be contributing to rates of burnout, depression, and suicide risk. This is further underscored by alarming statistics indicating higher rates of depression and anxiety among them compared to the general population. At institutions like UC Irvine, the situation is particularly stark, with only eight free therapy sessions provided per year and a staggering ratio of two therapists for 456 medical students (1 therapist : 228 students). This inadequate provision is not merely a shortfall but a profound oversight of the essential needs of these aspiring medical professionals.

WHEREAS, The journey to becoming a physician is more than absorbing textbooks and acing exams; it's an emotional and psychological marathon. We are exposed to human suffering, ethical dilemmas, and the relentless demand for perfection. These experiences take a toll, one that is too often left unaddressed.

WHEREAS, The current therapy offerings at UCI, although well-intentioned, fall significantly short of meeting our needs.

WHEREAS, The stigma surrounding mental health in the medical profession only exacerbates the issue, creating an environment where seeking help is often seen as a sign of weakness rather than an act of self-care.

WHEREAS, This isn't just about increasing a ratio; it's about fundamentally rethinking how we support the mental health of medical students. Therapy isn't a luxury; it's necessary for us to thrive both as students and as future physicians.

RESOLVED: UCI School of Medicine will increase the number of free therapy sessions available to all medical students from 6 to 12 each year. To accommodate this increase, UCISOM will also hire 3 additional therapists to reduce the burden on the existing therapists and increase accessibility to students.

To the administrators, policymakers, and everyone who plays a part in shaping the future of medical education: I ask you to listen to our stories, understand our struggles, and take concrete steps to address this critical need. Investing in the mental health of medical students is an investment in the quality of healthcare for all. As we learn to heal others, we ask for the opportunity to heal ourselves. It's time to lift the veil on this issue and usher in a new era of medical training, where mental health is treated with the same urgency and care as physical health. The wellbeing of medical students across the country depends on it.

Speaker's Notes:
CAFP does not have specific policy related to therapy provided at UCI or other specific residency programs. CAFP does have related policy that prioritizes physician wellness and health through various initiatives:
CAFP endorses guidelines from the California Public Protection and Physician Health Organization for selecting physician health services to assist impaired physicians effectively. (Page 127 policy manual). 11.03.12 BoD
Additionally, CAFP has a policy advocating for the Quadruple Aim, seeking to expand the Triple Aim to include improving the work-life balance of healthcare providers and making Physician Wellness a quality measure for healthcare systems. This advocacy extends to requesting the American Academy of Family Physicians to collaborate with Congressional leaders on this issue (See page 136 of the policy manual). BoD 4.12-13.18
Furthermore, CAFP supports the development of a wellness curriculum toolkit for family medicine residency programs, aiming to integrate wellness education into medical training. These cohesive efforts aim to promote physicians' well-being and improve healthcare delivery quality (See page 136 of the policy manual). A-01-23, BoD 7.22.23

AAFP does not have specific policy on this issue.

Generally, CAFP does not adopt policy specific to the operations of a specific program.

Fiscal Note: Minimal cost to adopt policy. Unknown cost for advocating for an operational change at a Medical Residency program.

Problem Statement: The mental wellbeing of future physicians is significantly neglected throughout their medical educational training and residency. This negligence not only hampers their academic and professional excellence but also contributes to alarming rates of burnout, depression, and suicide risk among them. The irony is profound as these healthcare practitioners, who are expected to be pillars of health and wellness, face stigma within their own fraternity when it comes to mental health. The existing mental health support, exemplified by the limited free therapy sessions and disproportionate therapist-to-student ratios at institutions like UC Irvine, is grossly inadequate. This lack of support not only overlooks the emotional and psychological rigor involved in medical training but also disregards the importance of mental wellbeing for these professionals' long-term career sustainability and overall contribution to healthcare.

Problem Universe: In California, specifically at the UC Irvine School of Medicine, this problem is starkly evident. The current provision of eight free therapy sessions per year, coupled with a staggering ratio of one therapist for every 228 medical students, paints a bleak picture of the mental health support landscape. If this is reflective of broader trends in medical education institutions across California, a significant number of healthcare practitioners in training – potentially thousands – are being underserved, their mental health needs woefully unaddressed.

Specific Solution: To rectify this critical oversight, it is imperative that UC Irvine School of Medicine takes decisive action. The resolution proposed is to increase the number of free therapy sessions available to all medical students from eight to twelve each year. Concurrently, to effectively manage this increased demand and ensure that quality mental health support is accessible, the institution should hire three additional therapists. This expansion will not only alleviate the excessive burden on the existing therapists but also substantially improve the therapist-to-student ratio, making mental health support more accessible and tailored to the needs of each individual student.

Evidence: The necessity of this resolution is underscored by the alarming mental health statistics among medical students and residents, indicating higher rates of depression and anxiety compared to the general population. Furthermore, the tangible impact of mental health on the quality of healthcare delivery, physician

longevity in their careers, and the overall well-being of medical professionals is well-documented. The current deficiencies in mental health support at institutions like UC Irvine serve as a microcosm of a pervasive issue that demands immediate attention and action. The proposed resolution is not just a call for resource expansion; it's a call to fundamentally rethink and revalue the mental health of medical students, acknowledging it as an indispensable facet of their holistic development and their capacity to contribute effectively to the field of healthcare.

Citations:

Hankir AK, Northall A, Zaman R. Stigma and mental health challenges in medical students. BMJ Case Rep. 2014;2014:bcr2014205226. Published 2014 Sep 2. doi:10.1136/bcr-2014-205226

Resolution A-06-24

Proposed Policy Title: Protecting California Residents Who Provide Out-of-State Residents with Gender-Affirming Care

Author: Prachi Priyam

Co-Authors: Sarah McNeil, Magdalen Edmunds, Panna Lossy, Emily Lu

Endorsed by: CAFP East Bay Chapter

WHEREAS, the state of California passed several laws in 2022 and 2023 to protect providers, staff and advocates providing and facilitating abortion and gender affirming care,

WHEREAS, California's shield laws have inconsistencies and gaps in protection that potentially expose providers, staff and advocates to hostile attacks from other states, simply for providing abortion or gender-affirming care that is otherwise legal and protected in California

WHEREAS, gender-affirming care is not currently explicitly included in Executive Order N-12-22

RESOLVED: That the California Academy of Family Physicians advocates to the California Governor to add gender-affirming care to Executive Order N-12-22 so that these providers can also be broadly protected against extradition

RESOLVED: That the California Academy of Family Physicians advocates to the Attorney General to issue guidance to law enforcement officers to ensure that they comply with existing shield law and Executive Order N-12-22

Speaker's Notes:
CAFP has policy to support comprehensive care that is gender-inclusive, including reproductive healthcare. This policy is part of CAFP's core principles on health care system financing, administration, and delivery. (BoD 7.15.17)

Executive Orders cannot be amended. In order to achieve the goals of this Resolution, the Governor would need to issue a new Executive Order. In addition, the CAFP does not have the expertise to provide specific guidance regarding law enforcement.

Further, CAFP does not adopt policy specific to a point-in-time issue (example: a specific bill, executive order, regulatory proposal, etc.).

Fiscal Note:
Advocating that the Governor issue a new Executive Order would result in moderate to significant costs depending on the level of engagement. The CAFP does not have the expertise to provide specific guidance regarding law enforcement. As such, this would result in significant costs as CAFP would need to engage outside expertise.

Problem Statement:

Problem Universe:

Specific Solution:

Evidence:

Citations:

1. https://www.gov.ca.gov/wp-content/uploads/2022/06/6.27.22-EO-N-12-22-Reproductive-Freedom.pdf

Resolution A-07-24

Proposed Policy Title: Protecting Sensitive Medical Information from Inadvertent Sharing Across State Lines

Author: Panna Lossy

Co-Authors:

Endorsed by: North Bay Chapter of AFP

WHEREAS, medical information is shared through health information exchanges with other health care providers even across state lines without a patient's or provider's knowledge,

WHEREAS, some health care such as abortion and gender affirming care is now legal and protected in some states but criminalized in others,

WHEREAS, according to If/When/How Lawyering for Reproductive Justice, the most common way that pregnant people are criminalized is through a report to law enforcement from a healthcare worker,

WHEREAS, California provides health care for patients seeking sensitive services from states where such care is banned, and patients expect these records to stay confidential from their health care providers in their home states,

WHEREAS, with increasing interoperability of medical records, the sharing of medical records is becoming much more common,

WHEREAS, patients currently participating in the largest national EHR, EPIC, can only fully opt in or fully opt out of information sharing; therefore, patients choosing to keep their abortion private must choose to prohibit all information sharing, which can negatively impact critical collaboration of health care providers for other medical conditions,

WHEREAS, a patient who chooses to opt out of information sharing at the time of the abortion, may be asked to opt in to information sharing in a future health care visit, without realizing this will reveal their abortion history,

WHEREAS, patients living in abortion ban states have faced discrimination, inappropriate involvement of child protection services, interpersonal violence, and criminalization for seeking services that are legal in California,

WHEREAS, there is currently no way for a health care provider to guarantee that other medical information marked confidential or sensitive will not be accessed without a patient's knowledge or consent,

WHEREAS, it the responsibility of the provider to prevent sharing of medical records across state lines,

WHEREAS, current AAFP Policy on Information Technology used in Health Care says "Data and information sharing should take a "push" rather than a "pull" approach. Patient health data and information should be proactively and automatically shared with their primary care physicians to promote coordinated care. Patients must maintain control over the privacy of their information but should not be burdened with communicating their health information between members of their care team,

WHEREAS, current CAFP policy does not explicitly address the need to segment reproductive health and other highly sensitive data from crossing state lines,

RESOLVED - That CAFP create and/or amend policy to ensure that both providers and patients can restrict automatic sharing of sensitive data across state lines.

RESOLVED - That CAFP educates providers about their responsibility to prevent sharing of sensitive records across state lines and encourage them to work with their EHR vendors to create appropriate data segmentation and privacy settings.

RESOLVED - That CAFP develop policy supporting the segmentation of data in the Electronic Medical Records and protections from sharing sensitive data across state lines and with other providers without explicit approval of patients.

RESOLVED - That CAFP work with the AAFP to amend/develop policy to make data segmentation standard across medical records and health information exchanges and ensure that sensitive health information is not inadvertently shared across state lines.

Speaker's Notes:
CAFP does not have policy on this issue but has policy on privacy in other contexts. For example, CAFP telehealth policy statement provides that, "[t]elehealth systems and interactions should prioritize privacy principles and adhere to legal and ethical requirements with respect to patient confidentiality and data integrity." (5.14 BoD) In addition, CAFP policy states, "[h]ealth insurers and health care plans should be required to collect and/or report socio-cultural health information (e.g., patient race and ethnicity, including subpopulations, primary language, etc.) to assist physician offices, while respecting the individual privacy of patients." (A-02-07, 03/07 CoD)

AAFP does not have specific policy on this issue, but does include related policy on Information Technology Used in Health Care. AAFP policy states that "privacy protections must apply to all parties that store, organize, manage, and transfer patients' personal information, not only to HIPAA-covered entities." (2007)(September 2022 COD) AAFP also has related policy on Patient/Physician Confidentiality stating "Data sharing is difficult, particularly across state lines given differing state patient privacy/confidentiality requirements. The AAFP believes that state and federal legislators should seek a greater degree of standardization by recognizing the following principles regarding the privacy of medical information:

A. The right to privacy is personal and fundamental.

B. Medical information maintained by physicians is privileged and should remain confidential.

C. The patient should have a right of access to his/her medical records and be allowed to provide identifiable additional comments or corrections. The right of access is not absolute. For example, in rare cases where full and direct disclosure to the patient might harm the patient's mental and/or physical well-being, access may be extended to his/her designated representative, preferably a physician.

D. Medical information may have legitimate purposes outside of the physician/patient relationship, such as billing, quality improvement, quality assurance, population-based care, patient safety, etc. However, patients and physicians must authorize release of any personally identifiable information to other parties. Third party payer and self-insured employer policies and contracts should explicitly describe the patient information that may be released, the purpose of the information release, the party who will

receive the information, and the time period limit for release. Policies and contracts should further prohibit secondary information release without specific patient and physician authorization.

E. Any disclosure of medical record information should be limited to information necessary to accomplish the purpose for which disclosure is made. Physicians should be particularly careful to release only necessary and pertinent information when potentially inappropriate requests (e.g., "send photocopies of last five years of records") are received. Sensitive or privileged information may be excluded at the option of the physician unless the patient provides specific authorization for release. Duplication of the medical record by mechanical, digital, or other methods should not be allowed without the specific approval of the physician, taking into consideration applicable law." (1979)(September 2022 COD)

Fiscal Note:
The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents.
There would be minimal costs to add a specific topic to existing CAFP educational events and/or communication materials.
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.

Problem Statement: This resolution addresses the issue of medical records of health care that is legal in some states but criminalized in others being shared through health information exchanges across state lines. The issue is that medical records have not been designed to segment health data to protect it from being shared across state lines. In addition in CA, providers are charged with protecting this information but may not know how to do so (because it may not be possible)

Problem Universe:

Specific Solution: Provide education to members about this issue and work with AAFP to update their polices of sharing of patient information in Health information Exchanges

Evidence: Interoperability of EMRs what not designed with the realities of a post Dobbs world.

Citations:
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Benefits and drawbacks of electronic health record systems

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Security and privacy of electronic health records: Concerns and challenges

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Resolution A-08-24

Proposed Policy Title: Resolution to Ban Private Equity Ownership of Medical Practices and Hospitals

Author: Aidin Spina

Co-Authors: Kyro Grace, Star Lopez, Maryam Bharucha and Saman Andalib

Endorsed by:

WHEREAS, the primary mission of healthcare institutions and medical practices is to provide high-quality care and promote the health and well-being of patients; and

WHEREAS, private equity firms are investment management companies that seek to maximize profit and investor return, which can lead to prioritizing short-term financial gains over the long-term health and welfare of patients and communities; and

WHEREAS, the involvement of private equity in the healthcare sector has been associated with poorer health outcomes in patients as demonstrated with reports showing that private equity firms had a 27% increase in falls as well as a 38% increase in central-line placement associated infections; and

WHEREAS, the profit-driven approach of private equity firms can lead to cost-cutting measures that undermine patient care, such as reducing staffing levels, increasing patient load, and decreasing investment in essential medical equipment and infrastructure; and

WHEREAS, private equity ownership often results in a lack of transparency and accountability in healthcare operations and decision-making, hindering the ability of healthcare professionals to advocate for their patients and the quality of care they receive; and

WHEREAS, the consolidation of healthcare providers under private equity firms can reduce competition in the healthcare market, leading to higher prices and fewer choices for patients; and
Now, therefore, be it resolved that the American Association of Family Physicians (AAFP):

RESOLVED: Opposes the ownership and control of medical practices and hospitals by private equity firms and other entities whose primary objective is profit maximization rather than the provision of high-quality patient care.

RESOLVED: Urges local, state, and federal governments to enact legislation and regulations that prohibit private equity firms from owning or exerting control over medical practices, hospitals, and other healthcare institutions.

RESOLVED: Advocates for policies and regulations that promote transparency and accountability in healthcare ownership and operations, ensuring that healthcare decisions are made in the best interest of patient care and community health.

RESOLVED: Supports research and data collection on the impact of private equity ownership in the healthcare sector, to inform policymakers, healthcare professionals, and the public about the effects on patient care, healthcare costs, and the healthcare workforce.

RESOLVED: Encourages healthcare professionals and institutions to prioritize patient care and community health in their operations and partnerships, and to seek out ownership and investment structures that align with these priorities.

RESOLVED: Calls for the establishment of monitoring and enforcement mechanisms to ensure compliance with laws and regulations pertaining to the ownership and operation of healthcare institutions, protecting patients and communities from practices that compromise the quality and accessibility of healthcare.

Speaker's Notes:
CAFP and AAFP do not have specific policy relating to private equity firm ownership of medical practices.

Fiscal Note:
There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents.

Providing input on proposed regulations could incur minimal to moderate costs depending on the level of engagement that is required.
Developing original educational materials for members on how to prioritize patient care and community health in their operations and partnerships, and to seek out ownership and investment structures that align with these priorities would be significant, including: staff time, communications, hiring an attorney to draft language, etc...

Problem Statement:

Problem Universe:

Specific Solution:

Evidence:

Citations:

Resolution A-09-24

Proposed Policy Title: Affordable Child Care For All

Author: Rossan Chen

Co-Authors:

Endorsed by: Solano County

WHEREAS, pandemic-era federal relief funding that temporarily gave $24 billion dollars in aid to support 220,000 child care programs and expanded the child tax credit, which helped reduce child poverty and financial hardship and supported employment, ended in September 2023, and

WHEREAS, the expiration of the funding for child care programs (called the child-care cliff) is expected to lead to reduced staffing and lower quality educational programs at best, and the closing of thousands of preschools and child care centers around the nation at worst, and

WHEREAS, American parents have struggled to find and maintain stable affordable child care, regardless of family roles, paid work status, geography, or income, and

WHEREAS, half of Americans live in child care deserts (limited or no access to care), forcing families to make compromises over the quality of child care and/or travel farther from home to find care, and

WHEREAS, the average annual cost of child care for two children is higher than the average annual mortgage in the United States, and

WHEREAS, inadequate child care is an economic issue, costing states, families, and business billions of dollars annually, and missed or interrupted work, and

WHEREAS, inadequate child care is a gender issue, contributing to the widening pay gap between men and women, and

WHEREAS, inadequate child care is a policy issue, with congressional Republicans consistently blocking legislation that would guarantee access to affordable child care and permanently expand the child tax credit, and

WHEREAS, inadequate child care is a mental health issue, creating undue stress, depression, anxiety, and burnout on families, particularly mothers, who bear the extra caretaking responsibilities, and

WHEREAS, inadequate child care amplifies other chronic health stressors, such as heart disease, diabetes, and autoimmune disorders, and

WHEREAS, the perception of stable child care access decreases the risk of maternal depression, suggesting some researchers to view lack of child care as a social determinant of health, and

WHEREAS, inadequate child care is a population issue, with many families limiting the number of children they have because of financial considerations, and

WHEREAS, inadequate child care is an equity issue, with the worst impacts of the child care cliff affecting people of color, low-wage workers, and children with special needs, and

WHEREAS, the lack of affordable child care is exacerbated by the lack of a federal pre-K program and a federal paid-leave policy, and

WHEREAS, society benefits when parents are able to work outside the home and children are raised in financially secure families

RESOLVED: that the CAFP recognize that access to stable, affordable, accessible, high quality child care is preventative medicine and a social determinant of physical and mental health.

RESOLVED: that the CAFP advocate for federal and state governments to mandate that any company applying for new government subsidies must ensure that free or subsidized child care is available for the workers who build and operate their companies, as was mandated for semiconductor companies in 2023.

RESOLVED: that the CAFP advocate for the AAFP to lobby the federal government to restore and permanently codify the child tax credit for American families.

Speaker's Notes: CAFP does not have a direct policy about this matter. However, CAFP's meeting policy affirms that AAFP allows attendees to use their discretion regarding bringing children to AAFP meetings. In addition, the AAFP provides on-site play areas for children and their caregivers at certain events and makes efforts to be made to accommodate breastfeeding parents by offering lactation lounges with basic amenities such as privacy, running water, and refrigerated milk storage, among other services. (BoD 3.19) Furthermore, CAFP's public health policy calls for investing in community resources, including schools, childcare and youth programs, safe and affordable housing, fair wages, food pantries, specialized case workers and first responders, mental health workers, including programs that use crisis workers with mental health training to respond to emergency calls. (A-01-22, BoD 4.22.22)
AAFP does not have policy on this issue.

Fiscal Note: Advocating on issues outside of CAFP's expertise would be moderate to significant, as it would include significant staff time, research, and potentially outside expertise. It could also require hiring advocates as it may be outside the parameters of our current lobbying contract.

Problem Statement:

Problem Universe: All CAFP members who take care of families with children

Specific Solution:

Evidence:

Citations:
https://www.nytimes.com/2024/01/16/opinion/child-care-parenting-stress.html#:~:text=For%20many%20American%20parents%2C%20the,also%20add%20to%20financial%20stress.

https://tcf.org/content/report/child-care-cliff/

https://www.childcareaware.org/our-issues/public-policy/child-care-access-and-affordability/

JAMA Netw Open. 2022;5(7):e2221776. doi:10.1001/jamanetworkopen.2022.21776

https://www.whitehouse.gov/briefing-room/statements-releases/2023/10/25/fact-sheet-white-house-calls-on-congress-to-support-critical-domestic-needs/

Resolution A-10-24

Proposed Policy Title: Universal Basic Income is Needed Urgently for our Patients

Author: Harini Jaganathan

Co-Authors: Sheila Attaie

Endorsed by: Sacramento Valley Chapter

WHEREAS, there is ample evidence that poverty and low-income status are associated with a number of adverse health outcomes including decreased life expectancy and increased infant mortality rate, and

WHEREAS, A number of studies across the globe have demonstrated the effectiveness of universal basic income at addressing barriers to health, and

WHEREAS, universal basic income gained attention in our public discourse during Andrew Yang's presidential campaign in 2020, and

WHEREAS, the economic stimulus package passed by our federal government during the COVID pandemic, including the expansion of the Child Tax Credit, was shown to be effective in reducing food insecurity, medical hardship, and material hardship. Since the expiration of those benefits, measures including the child poverty rate, have gone backward, and

WHEREAS, In 2022 the AAFP stated their position on the impact of poverty on health, calling for action on a physician level, community-leadership level, and advocacy level, therefore be it

RESOLVED: That the California Academy of Family Physicians advocate for state-wide universal basic income, and

RESOLVED: That the California Academy of Family Physicians bring this resolution to the national academy for national support of universal basic income

Speaker's Notes: CAFP does not have a specific policy on universal basic income; however, CAFP's Healthcare System Reform policy declares that healthcare is a fundamental human right. According to this policy, every individual is entitled to receive comprehensive, high-quality health services delivered in a timely, culturally competent, and economically sustainable manner, regardless of age, gender identity, sexual orientation, geographic location, income, health status, or immigration status. This overarching policy underscores CAFP's commitment to ensuring equitable access to healthcare for all individuals, aligning with principles of social justice and health equity. Furthermore, the Health Care System Reform policy also states that the health system should address social determinants of health, including but not limited to economic inequality. (Adopted BoD 7.15.17)

AAFP also does not have a direct policy on universal basic income, it does have policy on the issue of poverty and its impact on health. AAFP states that it is important to transform healthcare to ensure optimal health outcomes for all individuals, including encouraging family physicians to educate themselves about the profound influence of poverty on health. By acknowledging the link between socioeconomic factors and health outcomes,

AAFP policy underscores the significance of addressing poverty as part of its broader mission to improve healthcare delivery and promote health equity. (2015 COD) (January 2022 COD)

Fiscal Note: Advocating on issues outside of CAFP's expertise would be moderate to significant, as it would include significant staff time, research, and potentially outside expertise. It could also require hiring advocates as it may be outside the parameters of our current lobbying contract. There would be minimal cost, however, for referring for national action.

Problem Statement: This resolution seeks to address the issue of poverty and income inequality, which have been shown by numerous studies to have an association with numerous adverse health outcomes. CAFP and the AAFP have already affirmed their commitment to improve social determinants of health, and specifically supporting a policy of universal basic income would lend specificity and urgency to that aim.

Problem Universe: For CAFP members practicing in low-income or low-resource settings, this could help offset time spent discussing non-medical needs with patients that could be devoted to addressing medical issues. UBI could improve our patient's ability to access basic resources like food, housing, and transportation and improve health outcomes in the long-term. A healthier population would make the practice of medicine easier for all of us.

Support for a policy of UBI by CAFP/AAFP would signal to legislators and payers that family physicians feel the impacts of income disparities and we are invested in finding a solution.

As a resident in an FQHC clinic in Sacramento, my patients often tell me of how they struggle to obtain their basic needs for survival. I think of my patient with postpartum depression who asked me if I had diapers to give her for her newborn. I think of my patient with stage IV cervical cancer who struggled to find transportation to her medical appointments while undergoing chemoradiation - even with the support of her case manager. It is unconscionable that our society burdens sick people with so much financial hardship.

There is ample evidence that poverty and low-income status are associated with a number of adverse health outcomes including decreased life expectancy and increased infant mortality rate. Low income is even linearly associated with the incidence of coronary artery disease, hypertension, and stroke.
Existing programs like SNAP, WIC, and Temporary Assistance for Needy Families (CalWorks), as well as local programs for transportation assistance each have their own complex eligibility criteria and regular recertification processes that can be very challenging for patients to navigate. I have seen my patients struggle when their services lapse or they no longer meet the eligibility criteria. Direct financial assistance that is readily available especially in times of emergency is urgently needed.

A number of studies across the globe have demonstrated the effectiveness of UBI at addressing these barriers. Numerous pilot programs including the SEED program here in Stockton have shown that UBI can improve employment rates, decrease depression/anxiety, and help people find more time to care for their sick loved ones, children, and elderly relatives. The state of California has recently funded guaranteed income pilot programs in a number of cities in the state of California including Sacramento.

As family physicians we have a front row seat into how the social, financial, and political circumstances of our patients shape their health outcomes. My medical practice in an underserved urban area has demonstrated that existing basic assistance programs are not enough to address the needs of my patients and keep them healthy. An evidence based, effective, and immediate solution can be the addition of UBI to the existing patchwork of programs. Our support for UBI as family physicians sends a message that we feel the pain of our patients'

financial stress and we see how it impacts their health. Poverty effectively places a ceiling on how healthy we can keep our patients and we demand an urgent solution.

Specific Solution: I am proposing that CAFP support lobbying efforts to make universal basic income a reality in the state of California. I am proposing the the CAFP also bring this action to the attention of the AAFP to support a policy of universal basic income nationally

Citations:

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6. USDA. "SNAP Eligibility | USDA-FNS." Usda.gov, 1 Oct. 2021, www.fns.usda.gov/snap/recipient/eligibility.

7. Ward, Logan. "The Pros and Cons of Universal Basic Income." UNC College of Arts & Sciences, 10 Mar. 2021, college.unc.edu/2021/03/universal-basic-income/.

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Resolution A-11-24

Proposed Policy Title: Increase Nutrition Education in ACGME Residencies and Medical Schools

Author: Zuyuan Huang

Co-Authors:

Endorsed by:

WHEREAS, nutrition education during the 3 or more years of graduate medical education is minimal, or more typically, absent. The limited education that are devoted in the 4 years of medical school are largely focused on biochemistry and vitamin deficiency states (i.e., Scurvy, wet beriberi), problems that are not major in the USA.

WHEREAS, metabolic syndrome like hypertension and diabetes mellitus affects 30% of the US population and poor-quality diet is the leading cause of death in the USA (2018 report by US Burden of Disease Collaborators).

WHEREAS, numerous evidence exists to show that a Mediterranean-style diet significantly reduces cardiovascular events and improves diabetic control compared to control.

WHEREAS, medical education should match the interest in education among patients and physicians with more action.

RESOLVED: that the California Academy of Family Physicians advocate for increased mandatory nutrition education embedded into the curriculum of ACGME residencies and medical schools.

Speaker's Notes: CAFP's Committee on Continuing Education and Professional Development (CCPD) has recognized the importance of nutrition education and has put this topic on the agenda for the 2024 Family Medicine POP conference in August. ACGME has also recognized that more needs to be done to provide nutrition education during residency. In collaboration with the Association of American Medical Colleges AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM), ACGME hosted a Summit on Nutrition in Medical Education and published " Nutrition and Health: Developing a GME Framework," along with a Proceedings Paper Proceedings Paper and a document that includes Research and Nutrition Education Research and Resources recommended by Panelists and Participants.

The resolution asks CAFP "to advocate" for mandatory nutrition education in ACGME residencies and medical schools. Since it is AAFP that typically works with other organizations (American Board of Family Medicine, American College of Osteopathic Family Physicians, Association of Departments of Family Medicine, North American Primary Care Research Group, Association of Family Medicine Residency Directors, and Society of Teachers of Family Medicine), to advocate on behalf of family medicine with ACGME and the Association of American Medical Colleges (AAMC), it may be more appropriate that the request for advocacy go to AAFP through either a letter to AAFP Vice President of Medical Education, Dr. Margot Savoy, or through a resolution directed to AAFP.

Fiscal Note: There would be minimal cost for CAFP to request that AAFP advocate for mandatory nutrition education in residency programs and medical schools.
Problem Statement:

Problem Universe:

Specific Solution:

Evidence:

Citations:

Resolution A-12-24

Proposed Policy Title: Farmacology Over Pharmacology: Diversifying School Meals to Reduce Chronic Disease, Improve Health Equity, and Improve Climate Health

Author: Brea Bondi-Boyd
Co-Authors: Daniel O'Kelly, Lauren Hisatomi, Brea Bondi-Boyd, and Kirsten Vitrikas

Endorsed by: Sacramento Valley Chapter

WHEREAS, Nearly 40% of all calories consumed by children and adolescents between the ages of 2 and 18 years old come from empty calories derived from solid fats and added sugars. About half of these calories are represented by soda, fruit drinks, dairy desserts, grain desserts, pizza, and whole milk,1 and

WHEREAS, California schools serve as a vital source of food and nutrition for students, with nearly 2.9 million of California's 5.8 million K-12 students receiving school lunch every day and 1.6 million receiving breakfast as of fall 2022,6 and

WHEREAS, The COVID-19 pandemic exacerbated rates of food insecurity. According to data provided by the U.S. Census Bureau's Census Household Pulse Survey, 23% of households and 28% of households with children in California were food insecure as of September 2023. In that same month, average estimates of food insecurity in Black households and Black households with children were 40% and 49%, respectively, and in Hispanic households and Hispanic households with children, rates of food insecurity were 30% and 33%, respectively,3 and

WHEREAS, A 2024 study in JAMA Internal Medicine, found that lower levels of food security, including marginal food security, were strongly associated with a higher risk of all-cause premature mortality and shorter life expectancy compared to those with full food security,4 and

WHEREAS, The Child Nutrition Act of 2022, AB 558, expands access to free meals through schools, improving access to healthy food options for low-income communities,2 and aims to promote the availability of plant-based meals in schools. In addition, the act encourages school districts to provide meals to non-school-aged children, half-siblings, and step-siblings of students who utilize the free or reduced-price lunch program, as well as foster children in the first to sixth grade,2 and

WHEREAS, Providing plant-based food options in school meals is vital in reducing health inequities among children in low-income families, particularly those who are black and brown. Furthermore, approximately 60-80% of African Americans and 50-80% of people from a Hispanic background are unable to tolerate lactose and need plant-based dairy alternatives,5 and

WHEREAS, The California Department of Education Meal Pattern Requirements (Grades K-12) calls for "Meats/Meat Alternates" rather than clearly stated protein requirements and "fluid milk" rather than calcium requirements,7 and

WHEREAS Engaging students in cooking activities can help steer choices towards more plant-based foods,8 and

WHEREAS, Current CAFP policies support efforts to improve population health and health equity and decrease the effects of climate change, and therefore be it

RESOLVED: That the CAFP endorse legislation that advocates for plant-based meal options for every K-12 grade child in public and charter California schools

RESOLVED: CAFP support the appointment of at least one health professional without financial ties/relationship with the Dept of Agriculture or Food Industry to all health committees tasked with evaluating the impact of school nutrition policy in California and/or committees charged with developing/revising current guidelines for school nutrition

RESOLVED: CAFP advocate for curriculum in K-8 education to teach food literacy, nutrition education and the environmental impact of food choices

Speaker's Notes: CAFP does not have specific policies addressing the diversification of school meals for K-12 grade children or food literacy for K-8 grade children. However, CAFP does have related policy on soft drinks that emphasizes the importance for family physicians to advocate that the health and nutritional interests of students serve as the basis for school nutritional policies. (A-2-04, 4/04 CoD)

AAFP has explicit policy directives concerning school nutrition and the promotion of healthy eating options within educational settings. AAFP policy states that behavior-focused nutrition education should be integrated into the curriculum from pre-K through grade 12. In addition, it emphasizes the necessity for staff providing nutritional education to receive appropriate training. (2004) (October 2023 COD)

Fiscal Note: There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents. Additionally, advocating on issues outside of CAFP's expertise would be moderate to significant, as it would include significant staff time, research, and potentially outside expertise. It could also require hiring advocates as it may be outside the parameters of our current lobbying contract.

Problem Statement: food insecurity, climate change

Problem Universe: millions

Specific Solution: We want CAFP to support legislation to incorporate plant-based options in CA school meal program and help get food industry off the table of discussions into school meals

Evidence: there is no current policy

Citations:

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Food Insecurity data - California Association of Food Banks. California Association of Food Banks. https://www.cafoodbanks.org/food-insecurity-data/.

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Resolution A-13-24

Proposed Policy Title: Screening, Intervening, and Advocating to Address Food Insecurity

Author: Camile Brzechffa

Co-Authors: Angie Nguyen, Steve Phan, Steven Chang, Lan Nguyen

Endorsed by: Dylan Hanami, MD

WHEREAS, in 2014, 14% of America, or 17.4 million households, was food insecure (1).

WHEREAS, food insecurity rate in Orange County alone in 2023 is estimated to affect over 400,000 people living in the county (2).

WHEREAS, food insecurity can lead to poor health outcomes related to diet, weight, and psychosocial wellbeing in mothers and children (3).

WHEREAS, food insecurity is associated with major depressive symptoms, increased risk of developing diabetes, poor diabetes control, and hypertension (1).

WHEREAS, through screening, physicians can improve the health of patients who experience food insecurity by following the SEARCH (screen, educate, adjust, recognize, connect, help) mnemonic (4).

WHEREAS, despite potential time constraints during appointments, screening could be completed during the intake process, allowing physicians to focus their time on helping patients who screen positive for food insecurity (4).

RESOLVED: That the CAFP supports policies that include increased physician screening of patients on food insecurity and tangible resources to address patient's food insecurity using the SEARCH (screen, educate, adjust, recognize, connect, and help) method.

RESOLVED: That the CAFP educates its members on the importance of educating patients at risk of food insecurity on nutrition and appropriate coping strategies.

Speaker's Notes: CAFP's policy on Social Determinants of Health includes direct guidance on food insecurity screening in healthcare settings. CAFP policy encourages family physicians and their teams to use two validated screening questions: 1) "Are you worried that your food will run out before you get money to buy more?" and 2) "Does the food you buy last, and if not, do you have money to get more?" (BoD 11.18) While the policy does not specify the SEARCH screening method, it emphasizes educating members on using and interpreting validated screening tools and identifying local resources for patient referrals. However, it does not explicitly mention educating at-risk patients on nutrition and coping strategies for food insecurity. Lastly, CAFP's 2024 Sponsored bill, AB 2250(Weber)-Social determinants of health: screening recommends that when providers of primary care are screening for SDOH that they include the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties.
AAFP does not have direct policy on screening for food insecurity, however AAFP policy includes general policy on screening for asymptomatic disease, and the EveryONE project, an AAFP initiative to help family physicians

confront health disparities and improve the health of all people-- including screening tools to identify patients' social needs and address health equity in their practice, such as food insecurity.

Fiscal Note: There would be minimal costs to add a specific topic to CAFP educational events and/or communication materials. Additionally, there would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents.

Problem Statement: This resolution seeks to address high food insecurity rates in the state of California.

Problem Universe: In California, in a study conducted by UCLA Center for Health Policy Research, more than a third of California adults with low incomes (below 200% of the federal poverty level) experience food insecurity.

Specific Solution: This resolution seeks to increase food insecurity education for providers and patients, specifically by implementing a new strategy known as SEARCH (screening, educating, adjusting, recognizing, connecting, and helping).

Evidence: In a survey conducted by the U.S. Department of Agriculture in 2022, it was shown that there has been an increase of more than 2.5% of American households that were food insecure compared to food insecurity rates in 2021. This indicates that current policies are inadequate in addressing worsening food insecurity rates in the United States.

Furthermore, the COVID-19 pandemic has further exacerbated food insecurity experienced by at risk populations in the United States.

Citations:

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Resolution A-14-24

Proposed Policy Title: Medi-Cal Dietician Access Expansion

Author: Ignacio Chavez

Co-Authors: Sania Luna, Ignacio Chavez, Grace Lee, Uma Rao, Jennifer Tan, Ciria Moya Fajardo

Endorsed by:

WHEREAS, the four top nutrition-related chronic diseases among 18 to 64-year-olds were estimated to cost the United States $16 trillion from 2011-2020; and

WHEREAS, it is well established that proper nutrition and dietary modifications contribute to the prevention of these costly chronic diseases; and

WHEREAS, there is a lack of consistent policy that establishes insurance-covered access to dietitians for patients at risk of diabetes, renal disease or nutritional deficiency; and

WHEREAS, Medi-Cal covers medical nutrition therapy services only with doctor referral and with diagnosis of specific medical conditions such as pre-diabetes;

RESOLVED: the CAFP supports policies that provide comprehensive insurance coverage of dietician referrals for all patients in primary care settings.

Speaker's Notes: Neither CAFP, nor AAFP, have a direct policy on supporting policies that provide comprehensive insurance coverage of dietician referral for all patients in primary care settings. CAFP does have related policy stating that CADP supports and encourages family physicians and their practice teams to screen for food insecurity using a validated screening tool as a higher standard of care. (11.18 BoD), but not policy related to providing insurance coverage of dietician referrals for patients in primary care.

Fiscal Note: There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents.

Problem Statement: This resolution seeks to resolve the gap in dietitian referrals and coverage for patients at risk of nutrition related chronic diseases. We would like for these nutrition related chronic diseases to be addressed without financial barriers with earlier interventions. Expanding preventative services will reduce costs in the long term.

Problem Universe: All CAFP members who see patients in a clinical capacity and all members' patients are affected by the proposed policy.

Specific Solution: We wish for the CAFP to support and advocate for policies that provide comprehensive insurance coverage of dietician referrals for all patients in primary care settings.

Evidence: Extensive evidence exists to indicate that a problem exists and that new policies are necessary to reduce the morbidity and mortality related to inadequate nutrition counseling. A recent 2022 study revealed that poor diet costs the US about $50.4 billion a year with suboptimal diet accounting for 18.2% of ischemic heart disease, stroke and type 2 diabetes costs in the US. As stated above, four top nutrition-related chronic diseases among 18 to 64-year-olds were estimated to cost the United States $16 trillion from 2011-2020.

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Resolution A-15-24

Proposed Policy Title: Empowering Delegates for a Stronger Academy

Author: Brent Sugimoto

Co-Authors: Lalita Abhyankar, Sheila Attaie, Brea Bondi-Boyd, Julie Celebi, Adnaan Edun, Touissant Mears-Clarke, Amanda Mooneyham, Shruti Javali, Shayne Poulin, Erika Roshanravan

Endorsed by: East Bay Chapter, Riverside-San Bernardino Chapter, Sacramento Valley Chapter

WHEREAS, serving as a delegate at the All Member Advocacy Meeting (AMAM) is a role of limited importance, and

WHEREAS, as stated in Article VII, Section 1, of the Academy Bylaws, the function of the AMAM is to "[…] convene at least annually to review Academy policy and direction implemented by the Board, Executive Committee, and committees of the Board," and

WHEREAS, the Oxford dictionary defines review as "a formal assessment or examination of something with the possibility or intention of instituting change if necessary," and

WHEREAS, without the power granted to deliberate, amend, and vote on resolutions (which is currently reserved for the Board of Directors), the AMAM cannot—as a body—fulfill its duty to review Academy policy and direction, and

WHEREAS, delegates voting on resolutions to drive policy exist elsewhere in organized family medicine, including the Washington Academy of Family Physicians, the New York Academy of Family Physicians Congress of Delegates, and the American Academy of Family Physicians, and

WHEREAS, delegate deliberation and voting on AMAM resolutions could have many benefits for the Academy, including heightened transparency and accountability of decision making within the Academy, and increased delegate engagement and energy at AMAM, and

WHEREAS, when the mission of the Academy is it "[…] empowers, educates, and connects current and future family physicians to improve the health of all Californians," giving delegates a greater voice can make members feel more empowered as family physicians, and

WHEREAS, increased delegate empowerment, engagement and energy would be desirable to broaden and strengthen the CAFP leadership pathway and chapter engagement, and

WHEREAS, giving policy making power to AMAM would require a bylaws amendment and structural changes to AMAM, now,

RESOLVED: the Academy create an AMAM Working Group—chaired by the Speaker—that is tasked with proposing the structure and bylaws needed to give policy making power to AMAM and be it further

RESOLVED: that the AMAM Working Group present its proposed changes for consideration by AMAM 2025.

Speaker's Notes: CAFP Delegate responsibilities are detailed in the CAFP bylaws and AMAM handbook.
CAFP Policy and Bylaws state that Delegates to the All Member Advocacy Meeting are responsible for electing officers of the CAFP, approving dues increases and submitting referendums to the membership. Membership may submit resolutions and advocate for them before the Board of Directors, which will have responsibility for vetting and reporting back on those resolutions to the All Member Advocacy Meeting at the next meeting…" A-03-12 - 3/04/12 CoD
In 2012, the CAFP Congress of Delegates was changed to the All Member Advocacy Meeting, with that change Delegates no longer were responsible for passage of specific language in a Resolution, but instead informed and guided the CAFP Board of Directors.

Fiscal Note: Development of a CAFP Task Force would result in significant organizational expense (including staff time) to identify a Workgroup, schedule meetings, provide research and analysis, prepare materials, hold Task Force meetings, and develop a report. It may not be feasible to develop a Task Force and complete a report by AMAM 2025, given the report would need to be completed by mid-January 2025 in order to meet AMAM deadlines.

The Resolution may result in very significant long-term costs depending on the recommendation of the Workgroup. Not limited to additional costs associated with an extended AMAM meeting, additional staff to research and prepare resolutions and the expansion of Committee responsibilities.

Problem Statement: This resolutions seeks to address transparency in the governance of the organization, strengthening CAFP as a member-driven organization, increasing member engagement and making our leadership pathways more robust.

Problem Universe: All CAFP members are affected by this problem

Specific Solution: This resolution would have the CAFP reform the policy making process through a by-laws amendment so that delegates who represent our members can have a direct say in the policy making process of the Academy.

Evidence:

Citations:

Resolution A-16-24

Proposed Policy Title: Decriminalize People Experiencing Homelessness

Author: Mili Adhikari

Co-Authors: Sheila Attaie, Maydha Dhanuka, Sarah Boyles-Muehleck

Endorsed by: CAFP Student-Resident Council

WHEREAS, Homelessness is an extremely prominent public health and humanitarian issue in California, which contains 30% of the unhoused population in the United States despite only hosting 12% of the total US population1,

WHEREAS, Homelessness decreases the average life expectancy from 78 years to 50 years, and at least 5,000 people died while homeless in California in 2021 alone1 12,

WHEREAS, Governor Newsom has allocated billions of dollars towards solving homelessness in California2,

WHEREAS, Lack of affordable housing has been shown to be the underlying primary cause of homelessness, and 90% of adults experiencing homelessness in California became homeless due to lack of affordable housing while residing in the state1 11,

WHEREAS, State and local officials have increasingly promoted forced displacement of homeless individuals via sweeps of encampments and called for further criminalization of drug possession and homelessness in order to solve the problem of homelessness in California3 4 5 6 7,

WHEREAS, Sweeps have been proven to be detrimental to the physical and mental health of people experiencing homelessness as sweeps result in the loss of survival supplies, medication, medical information, and prevent follow-up care and social support 8 9 10,

WHEREAS, the majority of people experiencing homelessness suffer from chronic medical conditions, including mental health conditions and substance use conditions1 13,

WHEREAS, Incarceration for homelessness and drug possession have been proven to continue patterns of substance use and homelessness, and 1 in 5 people become homeless after leaving an institution such as jail1 13 14,

WHEREAS, Criminalization of homelessness has been proven to be an expensive, ineffective, and counterproductive means to address homelessness and reinforces racial discrimination14 15,

WHEREAS, The AAFP affirms that "access to safe and affordable housing is a social determinant of health" (October 2023 COD) and that "efforts should be made to reduce stigma and remove barriers to mental health services" including substance use disorder treatment (BoD 2-1-2017); therefore be it

RESOLVED: The California Academy of Family Physicians supports policy measures that increase affordable and accessible housing including low income housing, rent control; and be it further

RESOLVED: that the California Academy of Family Physicians supports policy measures that end police sweeps displacing homeless populations; and be it further

RESOLVED: that the California Academy of Family Physicians supports policy measures decriminalizing camping, loitering, panhandling, blocking sidewalks, and storage of personal property on public property; and be it further

RESOLVED: that the California Academy of Family Physicians bring this resolution to the AAFP Congress of Delegates.

Speaker's Notes: CAFP does not have a direct policy on increasing housing access or decriminalization of homeless people; however, CAFP's fifth principal, sustainability, within the policy on health care system financing, administration, and delivery emphasizes addressing social determinants of health, such as economic inequality, housing, food security, environment, crime, and personal safety. *(BoD 7.15.17)* Furthermore, the CAFP's Public Health policy advocates for ending police brutality and redirecting resources toward public health, which includes investing in community resources like safe and affordable housing, and mobile crisis intervention teams to aid with people experiencing mental health crises, homelessness, and substance abuse. (A-22-20, BOD 11.19.22)

AAFP does not have an explicit policy about the decriminalization of homeless people. However, AAFP does have a policy on homelessness, supporting Housing First programs that offer rapid access to permanent, affordable housing integrated with health care and supportive services. In addition to affirming, housing is health care, and access to safe and affordable housing is a social determinant of health. (1988)(October 2023 COD)

Fiscal Note: There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents. Lastly, there would be minimal cost for referring for national action.

Problem Statement:

Problem Universe:

Specific Solution:

Evidence:

Citations:

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Resolution A-17-24

Proposed Policy Title: Humanitarian Crisis in Gaza

Author: Mili Adhikari

Co-Authors: Sarah Boyles-Muehleck, Maydha Dhanuka, Salma Shabaik, Fareeha Sattar, Prachi Priyam

Endorsed by: CAFP Student-Resident Council

WHEREAS, Since October 7, 2023, the escalating crisis in the Gaza Strip, home to over 2.3 million civilians with half being children, has led to the loss of civilian life surpassing that of any conflict in the past 24 years1-3; and

WHEREAS, Attacks have resulted in the deaths of over 26,083 civilians4, of which over 60% are women and children, and

WHEREAS, Over 1.7 million6 civilians have been displaced in Gaza, leading to severe overcrowding in refugee camps, which, coupled with loss of access to clean water and adequate medical care, has lead to a sharp increase in the prevalence of preventable and epidemic diarrheal, respiratory, and dermatologic diseases7; and

WHEREAS, United Nations (UN) officials proclaim there is "no safe place in Gaza8," as shelters, refugee camps, hospitals, ambulances, homes, bakeries, mosques, churches, toy stores, and UN-funded schools, clinics and shelters have faced airstrikes, shootings, and have been flooded with poisonous white phosphorous gases9-11; and

WHEREAS, Unprecedented attacks on healthcare facilities have resulted in the deaths of 337 healthcare personnel4; and

WHEREAS, Physicians and other medical personnel are forced to perform surgeries in corridors and waiting rooms, conserve supplies due to a lack of basic medical supplies, anesthetics or pain killers, and use vinegar instead of antibiotics on open wounds 12-15; and

WHEREAS, The destruction of homes and vital infrastructure, targeting of hospitals and refugee camps, and depletion of medical resources in the setting of a near complete blockade have led to a critical humanitarian crisis and near complete collapse of the Gazan healthcare system7; and

WHEREAS, The Geneva Conventions protects journalists, refugees, children, pregnant women and mothers with infants, civilians, patients, physicians, and other medical personnel during times of conflict5; and

WHEREAS, A humanitarian ceasefire is defined as a long term suspension of fighting in the entire geographic area that is agreed upon by all involved parties, and would allow for the continuous flow of humanitarian aid, with safe passage for aid workers into and injured civilians out of Gaza17 18, and

WHEREAS, Preventing famine and deadly disease outbreak in Gaza requires faster, safer aid access and more supply routes16, and

WHEREAS, A multitude of other international healthcare and humanitarian organizations recognize the dire situation in Gaza, issuing statements in support of a humanitarian cease-fire allowing for safe transit of aid, and

the protection of Gaza's civilian population and civilian infrastructure1,3,16-26; and

WHEREAS, medical students, residents27,28, fellows, and doctors across the United States have faced repercussions including threats to their practice due to their advocacy for a ceasefire in Gaza; and

WHEREAS, Many organizations are diligently recruiting volunteers to aid the civilian population in Gaza, however are unable to enter due to the increasingly unsafe conditions 29-35; and

WHEREAS, The International Court of Justice has ruled that Israel and its military must cease the killing and other bodily or mental harm of Palestinians in Gaza, and must "enable the provision of urgently needed basic services and humanitarian assistance to address the adverse conditions of life faced by Palestinians in the Gaza Strip36;" and

WHEREAS, Healthcare professionals and organizations are responsible for upholding medical neutrality and condemning violence against healthcare infrastructure, hospitals, first responders, patients, children, refugees, and the blockade of essential health supplies, water, and fuel including in times of war and siege1,7,24,35,37,38; and

WHEREAS, the AAFP condemns violence and other illegal acts against all health care professionals (October 2023 COD); and

WHEREAS, AAFP policy affirms that healthcare is a right, including access to reproductive and maternity health services (September 2022 COD, January 2022 COD); therefore be it

RESOLVED: the California Academy of Family Physicians supports a humanitarian cease-fire in Palestine and Israel in order to protect civilian lives and healthcare personnel within safety zones such as hospitals, shelters, refugee camps; and be it further

RESOLVED: that the California Academy of Family Physicians supports the protection of hospitals, shelters, refugee camps, and other safety zones during war times; and be it further

RESOLVED: that the California Academy of Family Physicians supports the right of free speech of medical students, residents, fellows, and doctors in their efforts to advocate for humanitarian efforts, and for the right to do so without repercussion and silencing from their schools and employers; and be it further

RESOLVED: that the California Academy of Family Physicians supports the use of existing resources and funds, such as the AAFP Foundation, to provide humanitarian aid and medical supplies to civilians and healthcare personnel in war zones.

Speaker's Notes: Generally, CAFP does not comment or advocate on international events unless it is family physician specific.

AAFP and CAFP do not have policy related to protecting free speech of medical students, residents, fellows, and doctors in their efforts to advocate for humanitarian efforts.

Fiscal Note: There would be minimal cost for drafting a letter and releasing a statement. There would be unknown costs for advocating on international issues. There would be significant costs associated with providing direct aid internationally.

Problem Statement:

Problem Universe: DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE's SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Specific Solution:

Evidence:

Citations:

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Resolution A-18-24

Proposed Policy Title: Family Medicine Physicians as Advocates for Climate Change

Author: Many Helle

Co-Authors: CAFP Student-Resident Council Advocacy Committee (Jesslyn Magee-Gonzalez, Zaide Rodriguez, Rachel Gottlieb, Andrea Banuelos Mota, Bright Zhou, Jodie Guller, Susan Wang, Rachel Isaacs)

Endorsed by: CAFP Student-Resident Council

WHEREAS, the rate of temperature change has increased significantly in the last few decades, with data showing the five-year average ice melting in west Antarctica from 2012 to 2017 was three times faster than from 1992 to 1997; these temperature changes are leading to increased occurrences of extreme weather changes like hurricanes, heat waves, and wildfires;

WHEREAS, warmer temperatures are leading to increased heat injury, including heat exhaustion and heat stroke, which proportionally affects farmworkers and other outdoor workers more than the general population;

WHEREAS, changes in temperatures have led to increased rates of food insecurity, which not only lead to nutritional deficits but also increased rates of anxiety and depression in these affected populations;

WHEREAS, changes in weather are causing increasing ground ozone and particulate matter, further worsening the already high levels of air pollution;

WHEREAS, air pollution is contributing to increasing rates of asthma, COPD, and cardiovascular disease;

WHEREAS, according to the World Health Organization, the people whose health is being harmed by climate change the most are low-income and disadvantaged communities- the very people who contribute least to its causes and who are least able to protect themselves and their families against it;

WHEREAS, family medicine physicians, being advocates for patients' overall health, have the duty to educate their patients on this ongoing issue that is going to affect us all for the rest of our lives;

WHEREAS, it is essential now more than ever for current and future physicians to be educated on the health impacts of climate change as the issue continues to progress;

RESOLVED: CAFP will promote the integration of climate change topics into medical school and residency curricula as well as continuing medical education programs to equip healthcare providers with the knowledge and skills to further inform their patients on environmental health impacts.

RESOLVED: CAFP will support family medicine physicians to educate their patients on the potential health impacts of climate change and ways their patients can individually help alleviate the negative effects of climate change; including but not limited to increasing energy efficiency, recycling, walking or biking to work, and avoiding heavily processed foods.

RESOLVED: CAFP supports physicians in advocating for environmental sustainability within their workplaces and local organizations.

RESOLVED: CAFP will advocate for solutions to mitigate the health effects of climate change through lobbying efforts in order to contribute to a broader movement toward climate resilience and environmental sustainability.

Speaker's Notes: CAFP does not have a direct policy on promoting climate change topics into medical school and residency curricular and/or CME, nor does CAFP have policy on supporting family physicians in educating patients on the potential health impacts of climate change, or supporting physicians in advocating for environmental sustainability within their workspaces and local organizations; however, CAFP does have policy that encourages physician representation on government advisory committees working on climate change and environmental issues, and policy to support and advocate for legislation that overall decreases the effects of climate change, including the impact of the healthcare system on carbon emissions. In addition, CAFP has current policy that support efforts that promote investment of resources in state and local public health departments as guided by the current needs of the communities, which may include mitigation of climate change effects on health. (A-01-22, BoD 4.22.22)

AAFP does not have an explicit policy on promoting climate change topics into medical school and residency curricular and/or CME, nor does AAFP have policy on supporting family physicians in educating patients on the potential health impacts of climate change or supporting physicians in advocating for environmental sustainability within their workspaces and local organizations. However, AAFP does have related policy on environmental health and climate change, supporting strong action on the part of all public and private institutions to reduce pollution of our land, atmosphere, and water. (1969) (2019 COD)

Fiscal Note: There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents. Lastly, there would be minimal cost for referring for national action.

Problem Statement:

Problem Universe:

Specific Solution:

Evidence:

Citations:

1. Parker CL, et. al. The changing climate: managing health impacts. American Family Physician. 2019

2. The Intergovernmental Panel on Climate Change. Global Warming of 1.5°C. IPCC Report, published October 2018.

3. United States Environmental Protection Agency. Climate Change Impacts on Air Quality. Published online November 16, 2023.

4. World Health Organization. Climate change- key facts. Published online October 12, 2023.

Resolution A-19-24

Proposed Policy Title: Medi-Cal Audits

Author: Angela Bymaster

Co-Authors:

Endorsed by:

WHEREAS, Medi-Cal reimbursements for non-FQHC primary care visits are poor, and,

WHEREAS, no other health plans routinely audit primary care physicians, and,

WHEREAS, Medi-Cal audits are very time consuming and expensive, and

WHEREAS, Medi-Cal audits create an unnecessary barrier for primary care physicians who might otherwise accept Medi-Cal, and

WHEREAS, Medi-Cal expansions have made it more difficult for low-income patients to access primary care physicians, and

WHEREAS, unnecessary and arduous bureaucratic practices are a primary cause of physician burnout, and

WHEREAS, there is no evidence that Medi-Cal audits improve morbidity or mortality among patients served by a primary care clinic, and

WHEREAS, it is certain that a paucity of primary care clinics treating Medi-Cal patients does contribute to worse morbidity and mortality among low-income patients,

RESOLVED: Be it so resolved that Medi-Cal cease and desist all current and future audits of primary care clinics in non-FQHC settings.

Speaker's Notes:

CAFP, nor AAFP, has existing policy on this issue. CAFP does have policy to reduce administrative burden and has historically accepted reasonable Medi-Cal audits as part of controlling costs in the Medi-Cal program.

Fiscal Note: There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents.

Providing input on proposed regulations could incur minimal to moderate costs depending on the level of engagement that is required.

Problem Statement: Medi-Cal wasting private docs' time and money with meaningless audits

Problem Universe: a lot

Specific Solution: Stop the audits, they don't help and they are very onerous

Evidence: I have been through two Medi-Cal audits and they are horrible. No other health plan does this. It makes me want to stop accepting Medi-Cal, but I love caring for low-income patients.

Citations:

Hsiang WR, Lukasiewicz A, Gentry M, Kim CY, Leslie MP, Pelker R, Forman HP, Wiznia DH. Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis. Inquiry. 2019 Jan-Dec;56:46958019838118. doi: 10.1177/0046958019838118. PMID: 30947608; PMCID: PMC6452575.

Resolution A-20-24

Proposed Policy Title: New Age Band Ratio of 2:1 for Health Insurance

Author: Whitney Li

Co-Authors: Jenny Zhu, Whitney Li, Leena Lim

Endorsed by:

WHEREAS, with a new age band ratio of 2:1, insurance companies are prohibited from charging the oldest group receiving insurance more than two times what they charge the youngest group; and

WHEREAS, in 2018, an Affordable Care Act amendment altered the age band from 5:1 to 3:1, mandating that insurance companies charge the oldest group less than three times what they charge the youngest group; and

WHEREAS, the adjustment to a 3:1 age band does not accurately reflect actual health spending between the two age groups, considering that individuals older than 64 years old spend 4.8 times more than those who are 21 years old; and

WHEREAS, the proposed 2:1 age band, while potentially reducing premiums for older individuals, may lead to an increase in premiums for younger individuals and the possible departure of young people with lower expected costs from the insurance market, thereby impacting premiums for everyone; and

WHEREAS, transitioning from a 3:1 band to a 2:1 band may result in varying impacts on premiums for different age groups, with one study indicating a potential increase of $2500 for the elderly and a decrease of roughly $700 for the youngest age group; and

WHEREAS, arguments in favor of a 2:1 age band highlight the potential for significantly lower premiums for the elderly, increased accessibility to health insurance for older individuals, and a decrease in federal spending; and

WHEREAS, concerns against a 2:1 band include the potential departure of young individuals with low expected costs from the market, leading to increased premiums for everyone, and the financial strain on young individuals with unstable jobs or college-related debts; and

WHEREAS, additional policies, such as implementing an individual mandate and penalties for non-compliance, as demonstrated by the State of Massachusetts, could help mitigate negative externalities associated with a 2:1 age band; and

WHEREAS, subsidies for young lower-income individuals and support for at-risk elderly individuals, as proposed by the State of California, could further balance the impact of a 2:1 age band.

RESOLVED: the consideration of a 2:1 age band requires a thorough evaluation of its potential benefits and drawbacks, as well as the implementation of complementary policies to address associated challenges.

Speaker's Notes:

Neither CAFP, nor AAFP, have closely related policy to this resolution. Both CAFP and AAFP have policy stating that health care is a human right and that the right to health is universal, comprehensive, accessible and timely, quality, affordable, and sustainable. (2017 COD) (January 2022 COD) (BoD 7.15.17)

CAFP has related policy on the principles of healthcare stating that "premiums in the individual and small group markets should vary only by family structure, geography, the actuarial value of the benefit, age, and tobacco use (in an actuarially sound ratio to ensure adequate risk pools); and, the financing of health care must be affordable, not regressive, and not cause disproportionate barriers to health care access among poorer people." (BoD 7.15.17)

Fiscal Note: There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents. This resolution is not specific about the level of advocacy resolved to CAFP on this issue.

The costs of developing research and new educational material would be significant, including partner engagement, research, staff time for developing content, potentially engaging a consultant and travel, if this resolution intends for CAFP to conduct the mentioned evaluation of the benefits and drawbacks of the issue.

Problem Statement:

Problem Universe:

Specific Solution:

Evidence:

Citations:

Resolution A-21-24

Proposed Policy Title: Incentivizing Continuity and Comprehensive Care to Support Equitable Availability of Primary Care Physicians to All Californians and to Support Multidisciplinary Clinical Teams (Patient-Centered Medical Homes)

Author: Dominique Quincy

Co-Authors: Salma Shabaik

Endorsed by: Sacramento Valley Chapter

WHEREAS, National Academy Science Engineering and Medicine (NASEM) 2021 report's "High quality primary care is the foundation of a high functioning healthcare system and is critical for achieving healthcare's quadruple aim (enhancing patient experience, improving population health, reducing costs, and improving the health care team experience)"; [1] and

WHEREAS, the World Health Organization (WHO) characterizes the 5 core functions of primary care as: "accessibility, continuity, comprehensiveness, coordination and person-centeredness"[2] ; and

WHEREAS, Dr. Barbara Starfield and others showed in the 1990s that increased continuity in primary care leads to better health outcomes, increase longevity, and decrease total cost of care; and

WHEREAS, California has a shortage of equitable continuous, comprehensive, coordinated primary care; and

WHEREAS, Rhode Island has seen an increase in primary care providers per capita [3], after encouraging PCMH (patient-centered medical home) and legislating increase in PC percent spend ; and

WHEREAS, Oregon saw a decrease in total cost of care (TCOC) when they required increase in Patient-Centered Primary Care Home Program (PCPCHs) [4]; and

WHEREAS, the spend in primary care nationally has "trended downward from 6.2% of all health care spending in 2013 to 4.6% in 2020" [5] and concurrently longevity has continued to go down, increasingly below Europe ; and

WHEREAS, we are seeing a critical decrease in continuity of primary care with increases in fragmented acute care Primary Care (PC) settings, with overall shortages of PCP throughout the state; and

WHEREAS, continuity, comprehensive, coordinated care is currently financially disincentivized in the RVU model of payment compared to fragmented acute care; and

WHEREAS, continuity of care is cited by many family physicians as one of their primary reasons to become and remain a primary care physician especially in the current shortage climate [6],

RESOLVED: that the CAFP supports additive payment models that incentivize and financially support continuity, comprehensive, coordinated care ; and be it further

RESOLVED: that the CAFP supports financial models that incentivize person-centered multidisciplinary clinical care teams; and be it further

RESOLVED: that the California Academy of Family Physicians bring this resolution to the AAFP Congress of Delegates.

Speaker's Notes: CAFP does not have policy specific to additive payment models or incentivizing person-centered multidisciplinary care teams explicitly. CAFP does have related policy that is inclusive of- but not specific to the proposed resolved statements. Within CAFP's policy on health care system financing, administration, and delivery there are five core principles: Universal, Comprehensive, Timely, High Quality, and Sustainable. Within these core principles, CAFP policy states that "wherever possible, care should be delivered via the team-based patient centered medical home care delivery model." and that "a health system financing and revenue provisions be sufficient to account for the costs of providing universal, comprehensive, timely, and high-quality health care." (BoD 7.15.17)

The AAFP also has related policy on physician payment that states that the AAFP believes and supports efforts made to devise reliable payment system that addresses a specified set of principles. These principles include: "A payment system must be based on continuous, comprehensive care and should encourage treatment on an ambulatory basis rather than in a costly institutional setting. Consistent with the continuous, comprehensive care they provide, primary care physicians should be paid for all of a patient's conditions addressed, whether done synchronously or asynchronously." (1993)(October 2023 COD)

Fiscal Note: There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents.

Engaging in regulatory action to provide input on proposed regulations related to the resolution could incur minimal to moderate costs depending on the level of engagement that is required. Lastly, there would be minimal cost for referring for national action.

Problem Statement: This resolution seeks to: 1. highlight FM physician needs to do provide continuity, comprehensive, coordinated personalized, high quality for all Californians and 2. acknowledge/appreciate this work CAFP is already doing in support and 3. formally add this to our policy book.

Problem Universe:

Specific Solution:

Evidence:

Citations:

Implementing High Quality Primary Care, Rebuilding the Foundation of Health Care. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Implementing High-Quality Primary Care; Linda McCauley, Robert L. Phillips, Jr., Marc Meisnere, and Sarah K. Robinson, Editors

"WHO. Primary Care. 2022. Accessed December 19, 2022.https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/primay-care.
Koller CF, Khullar D. Primary care spending rate - a lever for encouraging investment in primary care. N Engl J Med. 2017;377(18):1709-1711.

Gelmon S, Wallace N, Sandberg B, Petchel S, Bouranis N. Implementation of Oregon's PCPCH program: exemplary practice and program findings. September 2016. Accessed June 27, 2019. https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-Report-Sept2016.pdf.

AAFP's Primary Care Investment Toolkit

Kryzhanovskaya I, Cohen BE, Kohlwes RJ. Factors Associated with a Career in Primary Care Medicine: Continuity Clinic Experience Matters. J Gen Intern Med. 2021 Nov;36(11):3383-3387. doi: 10.1007/s11606-021-06625-8. Epub 2021 Feb 23. PMID: 33620629; PMCID: PMC8606375.

Resolution A-22-24

Proposed Policy Title: Support for Appropriate Visit Times in Primary Care

Author: Harini Jaganathan

Co-Authors: Sheila Attaie

Endorsed by:

WHEREAS, The AAFP has defined a primary care physician as a physician who provides "definitive care to the undifferentiated patient at the point of first contact, and takes continuing responsibility for providing the patient's comprehensive care," and

WHEREAS, the AAFP has voiced support for payment systems that support "quality care, access to care, and positive health outcomes" and that the "unique partnership embodied in the physician/patient relationship be preserved," and

WHEREAS, the AAFP has expressed the need for family physician workforce reform and expansion to meet the needs of our populations, and

WHEREAS, the AAFP has acknowledge that physician burnout must be addressed at the health systems level, and therefore be it

RESOLVED: That the California Academy of Family Physicians support primary care models and alternative payment systems in all practice settings that allow for patient-physician visit times to be extended to meet the complex medical needs of the populations we serve, and

RESOLVED: That the California Academy of Family Physicians advocates for the creation of a new industry standard of a 40-minute average primary care visit, and

RESOLVED: That the California Academy of Family Physicians write a letter to the California Department of Health Care Services advocating for a new industry standard of a 40-minute average primary care visit with appropriate reimbursement.

Speaker's Notes: CAFP does not have direct policy on creating a new industry standard of a 40-minute average primary care visit; however, CAFP does have related policy that states support for efforts to increase coordination between primary care teams and public health programs to improve population health and health equity in the face of evolving public health challenges. In addition, CAFP has related policy in the context of payment stating that CAFP will fight state proposals that will sharply reduce access to care, including cuts to reimbursement rates in Medi-Cal.

AAFP does not have an explicit policy on a new industry standard of a 40 minute average primary care visit.

Fiscal Note: Providing input on proposed regulations could incur minimal to moderate costs depending on the level of engagement that is required. There would also be cost associated with research and drafting a letter and releasing a statement. There could be more significant costs if a communication strategy is required.

Problem Statement: This resolution also seeks to address the growing medical complexity of our patients and growing demands on primary care providers to address more issues within single visits. CAFP/AAFP have already affirmed their commitment to expand primary care given the national shortage of providers. This resolution seeks to go a step further and advocate for models of primary care that allow physicians to do the work of really meeting their patient's many health needs.
This resolution seeks to address physician burnout by allowing physicians more time to devote to develop meaningful relationships with their patients. This resolution also intends to help physicians regain a sense of control by being able to address more of their patients' health needs.

Problem Universe: All CAFP members practicing primary care are affected by this proposed policy.

Specific Solution:

Evidence: I wish for the CAFP to bring this resolution to the attention of the California Department of Health Care Services so that our Medical/Medicare payer here understands that we as family physicians demand more time with our patients and an expansion of the primary care workforce as previously stated to do the work of really keeping our state healthy.
I wish for CAFP to bring this resolution to the AAFP to make this a national priority for medical directors and private payers across the country.

Recent studies have shown that primary care physicians require 27 hours per day to provide all guideline-recommended preventive, chronic disease, and acute care for a typical patient panel of 2500.

The average primary care visit is 18 minutes. The number of clinical items addressed during a typical visit has increased over time, while visits times have stayed the same. Recent studies have shown that shorter visit times are associated with inappropriate prescribing of antibiotics and even inappropriate co-prescribing of opiates and benzodiazepines.

Surveys consistently show that both patients and physicians want more time with their patients. This is especially true in cases for non-English speaking patients and patients with complex psychosocial needs. Time pressure, in addition to other associated work-place factors outside the physician's control have also been shown to correlate with physician burnout.

The heart of Family Medicine is longitudinal relationship-centered care that average clinic templates and panel sizes in our current healthcare systems are not designed to support. Average clinic templates and panel sizes are not even designed to meet the acute, chronic, and preventative needs of our patients. We must demand the time and support from healthcare systems that is needed to keep our patients healthy. It is time for physicians who do the work of caring for patients to put forth and stand by our own vision of what a fulfilling health care model and healthy society can look like. Payers have dictated what health care should look like for long enough. They can adapt to our vision.

Citations:
1. Primary Care [Internet]. AAFP. Available from: https://www.aafp.org/about/policies/all/primary-care.html

2. Payment, Physician [Internet]. AAFP. Available from: https://www.aafp.org/about/policies/all/payment-physician.html

3. Workforce Reform [Internet]. AAFP. Available from: https://www.aafp.org/about/policies/all/workforce-reform.html

4. Family Physician Burnout, Well-Being, and Professional Satisfaction (Position Paper) [Internet]. AAFP. Available from: https://www.aafp.org/about/policies/all/family-physician-burnout.html

5. Porter J, Boyd CM, Skandari MR, Laiteerapong N. Revisiting the Time Needed to Provide Adult Primary Care [Internet]. Journal of General Internal Medicine. 2022;147–155(1). Available from: https://doi.org/10.1007/s11606-022-07707-x

6. Tai-Seale M, McGuire TG, Zhang W. Time Allocation in Primary Care Office Visits [Internet]. Health Services Research. 2007;1871–1894(5). Available from: https://doi.org/10.1111/j.1475-6773.2006.00689.x

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9. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions [Internet]. Journal of Internal Medicine. 2018;516–529(6). Available from: https://doi.org/10.1111/joim.12752

Resolution A-23-24

Proposed Policy Title: Overdose Preparedness in Primary Care Settings

Author: Tricia Bautista

Co-Authors:

Endorsed by: Fresno-Kings-Madera

WHEREAS, we are currently in the midst of the 4th wave of the opioid epidemic that is characterized by fentanyl/stimulant fatalities and polysubstance overdose, and

WHEREAS, marked respiratory depression results from the use of multiple sedating substances including opioids, alcohol and benzodiazepines and the increasing prevalence of counterfeit pills like alprazolam containing illicit fentanyl, and

WHEREAS, the rate of opioid-related overdose deaths has more than doubled from 2010 to 2017 and has been followed by a significant increase of 69% in 2021 (totaling 80,4114), and

WHEREAS, a potentially similar increasing rate of substance-related intoxication can present not only in acute care settings but also ambulatory care, and

WHEREAS, the American Heart Association has implemented naloxone administration into the Basic Life support algorithm, but most primary care clinics have varying levels of overdose preparedness, and

WHEREAS, preparedness efforts including (1) naloxone storage in clinic emergency kits, (2) coordinating all-clinic training with mock overdose drills, and (3) emphasizing the importance of supporting respiration/ventilation in protocols, especially when overdoses are not fully responsive to naloxone, are implemented inconsistently in the clinic setting, and

WHEREAS, few guidelines from national public health and medical organizations (SAMHSA, ASAM, ACP, AAFP, Joint Commission) currently exist, and

WHEREAS, awareness around medico-legal considerations when acutely managing intoxication in relation to patient privacy, informed consent/refusal of care and risk of injury when leaving the clinic setting is inconsistent amongst providers, now, therefore, be it

RESOLVED that the CAFP:
(1) encourage state-wide and national requirement of primary care facilities to implement overdose preparedness protocols that include naloxone storage with on-site emergency kits and all-clinic staff training in naloxone administration;
(2) provide physician-facing information about medico-legal aspects in providing intoxication and overdose treatment; and,
(3) encourage AAFP to formally recommend clinical guidelines addressing overdose in the ambulatory setting.

Speaker's Notes:

CAFP's existing policy regarding Expanded Use of Naloxone states that CAFP recommend the AAFP consider measures to work through existing channels in the federal government, such as the Food and Drug Administration, the National Institutes of Health, and the U.S. Congress, to ensure the safety and availability of drugs to the American public. (A-6-05, 4-05 CoD)
In addition, CAFP also has existing policy on expanded use of Naloxone to prevent drug overdose-related deaths including:

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)

AAFP existing policy regarding harm reduction states that:

- "AAFP supports a comprehensive public health policy to prevent infectious diseases and other complications associated with injection drug use;
- AAFP supports effective harm reduction strategies to prevent the spread of HIV, hepatitis C, and Hepatitis B; reduce the risk of death from opioid overdose and engage individuals in treatment for substance use disorders. Needle-syringe exchange programs and safe injection sites reduce the transmission of disease, do not increase the rate of substance use, and increase the likelihood that individuals will enter drug treatment programs. Such strategies may also provide additional health and preventive services to vulnerable and high-risk populations. Physicians should be knowledgeable about their states' statutes regarding such harm reduction strategies. Additionally, the AAFP recommends that physicians and other healthcare workers counsel patients who are injecting substances about using sterile needles and syringes while simultaneously educating those patients about the harms of continued drug use and their treatment options; and,
- Drug overdose deaths have significantly increased since 1999, particularly overdose deaths involving opioids and benzodiazepines. The AAFP supports education of the lay public and medical community about prevention, early recognition and treatment of overdoses. Effective strategies to decrease substance use disorder and overdose death require interdisciplinary coalitions, often including law enforcement, legislators, educators, jurisdictional leaders, and other community resources;
- AAFP supports efforts to promote naloxone kits for lay public usage as part of overdose prevention programs and the implementation of legislation which protects any individuals who administer naloxone from prosecution for practicing medicine without a license. The AAFP supports policies which promote the provision of naloxone to patients using opioids or other individuals in close contact with those patients, including personnel at safe injection sites. The AAFP supports the implementation of programs which allow first responders and non-medical personnel to possess and administer naloxone in emergency situations; and,
- AAFP promotes the passage of 911 Good Samaritan Immunity laws to exempt the lay public from prosecution when contacting emergency medical services (EMS) to report overdoses and physicians from treating an overdose at a safe injection site. (2003) (2019 COD)

Fiscal Note: There would be minimal cost to refer for national action regarding encouragement for AAFP to provide formal recommendations for clinical guidelines addressing overdose in ambulatory settings.

There would be moderate costs to provide physician facing information to members through existing communication channels.

There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents.

Problem Statement: Given the increasing rate of opioid-related overdose deaths during this nationwide 4th wave and the potential for increased cases of acute intoxication in the ambulatory setting, overdose preparedness plays a critical role. Although the AHA has implemented naloxone administration into the Basic Life Support algorithm, most primary care clinics have varying levels of naloxone access and overdose emergency protocols. In addition, few guidelines from national public health and medical organizations (SAMHSA, ASAM, AAFP, ACP) currently exist. Clear ambulatory guidelines are needed. Furthermore, providers should be aware of medico-legal considerations when managing intoxication in relation to privacy and informed consent.

Problem Universe: All

Medico-Legal Considerations:

Patient competency = ability to understand condition, proposed treatment & consequences of refusing or agreeing with treatment (Harman KM, Laing BA, Hospital Physician, 1999. Thomas J, Moore G. West J Emerg Med, 2013.)
• Evaluation of competency is clinical and not sufficiently met with presence of intoxicating substance or blood/-urine toxin level (Aldridge J, Charles V, Drug Alcohol Dependence, 2008)
• Craig L Miller v Rhode Island Hospital: "intoxication may…impair the patient's ability to give informed consent" in emergent, life-threatening situations

HIPPA:
• Impaired capacity to give accurate history & understand discharge instructions —> may need to request/give information to others
• HIPPA Privacy Rule section 164.510(b)(3): provider allowed to disclose relevant PHI to relatives if patient is intoxicated and in his/her best interest

Safe Discharge Options include continued observation in clinic, transfer to higher level of care, or driven home vs public transportation
• Coombes v Florio: if patient's ability to drive is affected, provider has duty to warn patient of that fact
• Kowalski v St. Francis Hospital and Health Centers: no duty to involuntarily hold intoxicated patient who presented voluntarily

Specific Solution: (1) encourage state-wide and national requirement of primary care facilities to implement overdose preparedness protocols that include naloxone storage with on-site emergency kits and all-clinic staff training in naloxone administration, and
(2) provide physician-facing information about medico-legal aspects in providing intoxication and overdose treatment, and
(3) encourage AAFP to formally recommend clinical guidelines addressing overdose in the ambulatory setting.

Evidence: (Please see "citations")

Citations:

1. Friedman J, Shover CL. Charting the fourth wave: Geographic, temporal, race/ethnicity and demographic trends in polysubstance fentanyl overdose deaths in the United States, 2010–2021. Addiction. 2023; 118(12): 2477–2485.

2. Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

3. Leyde, S., Rife, T., & Kryzhanovskaya, I. (2021). "Quick, Grab the Naloxone": Overdose Preparedness for Ambulatory Clinics. Family Practice Management, 28(1), 17-22.

4. Donroe JH, Tetrault JM. Recognizing and Caring for the Intoxicated Patient in an Outpatient Clinic. Med Clin North Am. 2017 May;101(3):573-586.

5. Maghsoudi N, Tanguay J, Scarfone K, Rammohan I, Ziegler C, Werb D, et al. Drug checking services for people who use drugs: a systematic review. Addiction. 2022; 117(3): 532–544.

Resolution A-24-24

Proposed Policy Title: Clarifying that Direct Primary Care Agreements are Not Insurance

Author: Maryal Concepcion

Co-Authors: Dr. Jeannine Rodems, Dr. Aimee Ostick, Dr. Emilie Scott, Dr. Erin Kiesel, Dr. Melissa Mondala

Endorsed by: CAFP San Joaquin/Amador/Calaveras chapter and CAFP Stanislaus Chapter

WHEREAS: The CAFP has existing policy that supports the Direct Primary Care (DPC) model as one that is structured to emphasize and prioritize the intrinsic power of the relationship between a patient and their family physician to improve health outcomes and lower overall health care costs.

WHEREAS: The DPC contract between a patient and their physician provides for regular, recurring monthly revenue to practices that typically replaces traditional fee-for-service billing through third party insurance plan providers.

WHEREAS: For family physicians, this revenue model can stabilize practice finances, allowing the physician and office staff to focus on the needs of the patient and improving their health outcomes rather than coding and billing.

WHEREAS: Patients, in turn, benefit from having a DPC practice because the contract fee covers the cost of all primary care services furnished in the DPC practice.

WHEREAS: This effectively removes any additional financial barriers the patient may encounter in accessing routine care primary care, including preventative, wellness, and chronic care services.

WHEREAS: the American Academy of Family Physicians has supported the legislation in the Section 1301(a)(3) of the Affordable Care Act, which appropriately defines DPC as an advanced primary care model outside insurance, which, when offered together with a Qualified Health Plan (QHP) may meet all Essential Health Benefit requirements for primary care services working with a QHP. ACA Regulations promulgated in 2011 by the US Dept. of Health and Human Services state that DPC practices are providers, not insurance.

WHEREAS: to date, at least 33 states have passed legislation or regulations in a bipartisan manner that correctly define a Direct Primary Care agreement as an agreement for medical services, not for insurance.

WHEREAS: California has yet to adopt such a provision in regulation. Despite the fact that the California code currently permits DPC practices in California, there should be clarification in the California insurance and managed care statutes.

RESOLVED: That the CAFP continue to advocate for the Direct Primary Care model based on their previous policy, and support policies in California that define a Direct Primary Care agreement as being between a physician and patient* for primary care medical services and does not constitute the business of insurance.

*and/or between a patient's representative paying for medical services e.g. a family member or an employer who agrees to pay the periodic fees.

Speaker's Notes:
CAFP policy supports Family Physicians practicing Direct Primary Care (DPC). The CAFP advocates for physician and patient choice in healthcare delivery systems, including DPC practices. CAFP policy notes that the DPC model aligns with support of the Patient-Centered Medical Home (PCMH) and supports a blended payment method for family medicine practices (See page 43 of the policy manual).11.15.14 BoD on recommendation of Medical Practice Affairs Committee Minutes of 7.29.14

AAFP policy supports the DPC model as an innovative practice model and provides member resources to support its implementation.

CAFP has made information available to members regarding the DPC model.

Fiscal Note:
There would be minimal cost to CAFP to continue to advocate for DPC and to amend and clarify CAFP policy related to DPC.

Problem Statement: DPC is a growing model used by thousands of practices in almost every state. Over thirty states have passed laws and regulations to clarify that DPC is not insurance but a medical service, and the Affordable Care Act recognizes DPC as an advanced payment model outside of insurance. DPC:
Delivers care in any setting, including using virtual care, telemedicine, and office visits beyond normal business hours;

Reduces the burden on emergency rooms and clinics and encourages patients to develop personal relationships with their doctors; and

Replaces copays and deductibles with flat, affordable periodic, typically monthly, fee.

There remains, however, confusion in the IRS regulations that has not made clear the use of HSA monies for the payment of primary care services through a Direct Primary Care model. Federal legislation has been very slow with the current political environment to clarify these regulations in spite of bipartisan support (see legislation below). There have also been challenges by the insurance industry in some states that have called out DPC as an insurance model, which prompted some of the original state legislation, which is also listed below. We are asking that CAFP support state and/or federal legislation that may develop or be enacted that clearly defines DPC as a primary care practice payment model and does not constitute insurance.

Problem Universe: All

Specific Solution: We are asking that the CAFP continue to advocate for the Direct Primary Care model based on their previous policy, and support policies in California that define a Direct Primary Care agreement as being between a physician and patient* for primary care medical services and does not constitute the business of insurance.

*and/or between a patient's representative paying for medical services e.g. a family member or an employer who agrees to pay the periodic fees.

Evidence: Please see citations below.

Citations:

AAFP Statement on DPC:
https://www.aafp.org/about/policies/all/direct-primary-care.html

CAFP Policy on DPC 2014: (2013 AAFP COD-approved policy)
11.15.14 BoD on recommendation of Medical Practice Affairs Committee Minutes of 7.29.14

33 Bipartisan State DPC Laws:

Laws define DPC as a medical service outside of state insurance regulation, offer consumer protections. *
DPC Laws passed – signed by the governor.
State with solid regulatory guidance.
Washington – 48-150 RCW
Utah – UT 31A-4-106.5
Oregon – ORS 735.500
West Virginia – WV-16-2J-1
Arizona – AZ 20-123
Louisiana – LA Act 867
Michigan – PA-0522-14
Mississippi – SB 2687
Idaho – SB 1062
Oklahoma – SB 560
Missouri – HB 769
Kansas – HB 2225
Texas – HB 1945
Nebraska – Legislative Bill 817
Tennessee – SB 2443
Wyoming – SF0049
Arkansas – SB 168
Kentucky – SB 79
Colorado – HB 17-1115
Indiana – SB 303
Virginia - HB 2053
Alabama - SB 94
Maine - S.P. 472
Florida – HB 37
Iowa – HF 2356
Georgia – SB-18
New Hampshire - HB508
Ohio – HB166
Montana – SB 101
South Dakota – HB 1131

Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans:

DEPARTMENT OF HEALTH AND HUMAN SERVICES; 45 CFR Parts 155 and 156
Federal Register/Vol. 76, No. 136/Friday, July 15, 2011/Proposed Rules
https://www.govinfo.gov/content/pkg/FR-2011-07-15/pdf/2011-17610.pdf

Current Pending Legislation:
Primary Care Enhancement Act, S. 628/ H.R.3029 https://www.congress.gov/bill/118th-congress/house-bill/3029/text
H.R. 1520 - Veterans Access to Direct Primary Care Act https://www.congress.gov/bill/117th-congress/house-bill/1520?s=1&r=19
H.R. 3836, the Medicaid Primary Care Improvement Act: https://www.congress.gov/bill/118th-congress/house-bill/3836

Data on DPC as an Innovative Practice Model:

Milliman and Society of Actuaries:
DPC reduces overall demand for and cost of healthcare services outside primary care
https://www.soa.org/resources/research-reports/2020/direct-primary-care-eval-model/

Resolution A-25-24

Proposed Policy Title: Ensuring Equitable Representation: Inclusion of MENA Community in U.S. Census

Author: Faris Halaseh

Co-Authors:

Endorsed by:

WHEREAS, the absence of a Middle East and North African (MENA) category in the U.S. Census hinders our ability to address the unique health conditions and outcomes experienced by individuals within the MENA community.

WHEREAS, a substantial body of research underscores the disparities faced by the MENA community in comparison to their white counterparts, highlighting the need for targeted healthcare initiatives.

WHEREAS, accurate census data is crucial for shaping healthcare policies, allocating resources, and ensuring that diverse communities, including the MENA community, receive the support they require.

RESOLVED: that the California Academy of Family Physicians advocates for the inclusion of a specific Middle East and North African (MENA) category in the U.S. Census.

RESOLVED: that the CAFP commits to supporting initiatives that address the unique health challenges faced by the MENA community, as evidenced by research demonstrating disparities in health conditions and outcomes.

RESOLVED: that the CAFP calls for increased awareness and education within the healthcare system regarding the specific needs of the MENA community, emphasizing the importance of tailored healthcare strategies.

Speaker's Notes: CAFP and AAFP do not have policy regarding the inclusion of a specific set of race/ethnicity categories in the U.S. Census. CAFP has policy related to health equity and access, but no policy exclusively naming the MENA community. CAFP has promoted health equity in legislative, educational and policy development.

AAFP and CAFP have policy opposing the use of race as a proxy for biology or genetics in clinical evaluation and management and in research. The AAFP encourages clinicians and researchers to investigate alternatives indicators to race to stratify medical risk factors for disease states.

Fiscal Note: There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents. Given how broad the request to support "initiatives that address the unique health challenges faced by the MENA community" costs would be dependent on the level of engagement and specific actions included in advocacy.

The US Census is a national survey. Generally, CAFP does not engage in national advocacy issues unless they disproportionately impact California Family Physicians.

Problem Statement:

Problem Universe:

Specific Solution:

Evidence:

Citations:

Resolution A-26-24

Proposed Policy Title: Protect Original Medicare

Author: Leslie-Lynn Pawson

Co-Authors:

Endorsed by:

WHEREAS, The enactment of Original Medicare in 1964 resulted in the desegregation of American hospitals.(1)

WHEREAS, Medicare Advantage (MA) and ACO REACH are threats to the future of Traditional Medicare.

WHEREAS, Original Medicare operates with a 2% administrative overhead. Medicare Advantage (MA) operates with a 15% overhead plus profit. ACO REACH (Realizing Equity, Access, and Community Health) can keep 25% of the capitation funds they are paid by Medicare for overhead plus profit. Medicare Advantage and ACO REACH are very inefficient compared to simple and efficient Original Medicare. (2)

WHEREAS, The Privatization of Medicare via Medicare Advantage and ACO REACH is for the benefit of private insurers. Patients, the government and the American taxpayer are left to pick up the tab.

WHEREAS, Medicare Advantage has never achieved the outcomes for which it was ostensibly begun in 2003.The initial reasons were to decrease cost, improve quality of care and enable consumer choice. Payments to MA over 20 years have always been higher than they would have been in TM. (3) Medicare Advantage has been overpaid by CMS by a minimum of $88 billion per year. (4)

WHEREAS, MA uses aggressive, confusing and fraudulent advertising practices to attract seniors into MA where beneficiaries experience restrictive networks, cumbersome prior authorizations and denials of care that they would not have experienced in Traditional Medicare. (5)(6)(10)

WHEREAS, 8 of the 10 biggest MA insurers have submitted inflated bills to Medicare according to federal audits. 4 of the 5 largest have faced federal fraud lawsuits. (7)

WHEREAS, MA pays slowly and sometimes not at all pushing more rural hospitals to the brink of closure endangering access to medical care in rural areas across the country. (8)

WHEREAS, 30 high income countries, all with some form of National Health Insurance, have higher life expectancy by 5 years than the life expectancy of the US at almost half the healthcare expenditure per capita of the US. The US models rely on markets and enables profiteering such as with MA and ACO REACH (9) .

WHEREAS, Original Medicare is the publicly funded and publicly administered lean, simple, efficient and effective health insurance system in the US that is best poised to be a model for a universal health insurance system in the US.

RESOLVED: that the CAFP supports protecting Traditional/Original Medicare from for-profit entities such as insurance companies and private equity firms. The CAFP calls upon the Center for Medicare and Medicaid

Services (CMS) to end ACO REACH and to increase the auditing of Medicare Advantage plans and demand increased accountability from Medicare Advantage plans.

Speaker's Notes:
Neither CAFP, nor AAFP, have existing policy on this issue.
In other contexts, however, CAFP position on health care system financing, administration, and delivery, which is inclusive of Medicare (Original/Traditional and Medicare Advantage Plans), is that the five core principles are:

- **Universal**: providing insurance coverage to every person.
- **Comprehensive**: providing insurance that includes all essential and needed health services.
- **Timely**: providing sufficient workforce and access to the appropriate health care clinician within reasonable time and distance standards.
- **High Quality**: delivering health services according to medically- and culturally-determined standards of practice.
- **Sustainable**: accounting for overall system financing, as well as the financial sustainability of family medicine practices.

AAFP has policy that states support for MA plan payment to be at least at the level of traditional Medicare. (1973)(September 2022 COD)

Fiscal Note:
AAFP generally leads advocacy and policy efforts related to Medicare and other federal issues and programs. CAFP generally only comments on Medicare and other federal issues and programs if they disproportionately impact California family physicians. CAFP staff does not have expertise on the Medicare program. CAFP may be able to provide comment on how Medicare changes would impact California family physicians at minimum to moderate cost, depending on the level of engagement. However, deeper level analysis or policy expertise would result in significant cost as CAFP would need engage outside expertise.

Problem Statement: The privatization of Medicare through Medicare Advantage and ACO REACH threaten the future of Original Medicare. Family Physicians spend time and money dealing with confusing prior authorization rules of Medicare Advantage plans that they don't encounter with original Medicare. Family Physicians waste time and money appealing denials of care by MA plans. Family Physicians wait longer for payment by many MA plans compared to Original Medicare. The Privatization of Medicare is redirecting funds from the Medicare Trust Fund to the profits of insurance companies and private equity firms threatening the future of Medicare.

Problem Universe: There are 6.6 million Californians with Medicare coverage. As of 3/2023 there were over 65 million Medicare enrollees in the US. All of these are affected currently by the privatization of Medicare. All future Medicare beneficiaries will be harmed if Original Medicare is destroyed by the profiteering takeover. This resolution supports CAFP's 2022-2024 strategic plan goals. This resolution would prioritize equity by providing the same good health insurance to all Medicare beneficiaries irrespective of degree of illness or where they live. It would decrease the moral injury suffered by Family Physicians when they have to fight for profit insurance companies for care their patients need.

Specific Solution: Original Medicare needs to be protected. It provides lean, efficient and effective health care coverage . The CAFP should exert its influence to protect Original Medicare and call for an end to the federal policies that threaten it by privatization.

Evidence: Almost 50% of Medicare Beneficiaries are enrolled in Medicare Advantage plans in 2023. (12) ACO REACH plans can and are enrolling beneficiaries often without their knowledge. See all Whereas clauses and citations .

Medicare Advantage plans have been overpaid every year since they began in 2003 by a minimum of $88 billion. This overpayment is enough to improve and expand what is covered in Original Medicare. This amount is greater than the entire budget of NASA plus the U.S. Customs and Border Protection plus the EPA. (11)

Citations:

1.Smith, D. The Power to Heal. 2016.
https://loc.gov/pictures/resource/cph.3b22541/

2.2021 data reported by the National Association of Insurance Commissioners at
https://content.naic.org/sites/default/files/2021-Annual-Health-Insurance-Industry-Analysis-Report.pdf
Accessed Mar 6 2023

3. https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf
Pg 344 Fig 11-4. Accessed Mar 27 2023

4. 2023 report by Physicians For A National Health Program " Our Payments Their Profits"

5.https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf
Accessed Nov 4 2022

6. 15 selected MAOs during June 1-7 2019, reported by OIG April 2022
https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

7. Source of data: https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html

8. 10/17/23 Kaiser Family Foundation News "Medicare Advantage keeps growing. Tiny, rural hospital say that's a huge problem. NPR

9. World Bank data https://data.worldbank.org/indicator/SH.XPD.CHEX.PC.CD

10. Source of data: https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

11. https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf
Figures represent outlays in 2020 fiscal year.
https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html Accessed Oct 26 2020

12. Source of data: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/

Resolution A-27-24

Proposed Policy Title: Promoting Healthy Pregnancies for Farmworkers through the California State Disability Insurance (SDI) Program

Author: Carlos O'Bryan-Becerra, MD, FAAFP

Co-Authors: Laura Murphy, DO

Endorsed by: Ventura California Academy of Family Physicians (CAFP) Chapter; Center for WorkLife Law, UC Law SF; Central Coast Alliance United for a Sustainable Economy (CAUSE); California WIC Association; Mixteco Indigena Community Organizing Project (MICOP); Watsonville Law Center; Salud Para La Gente; Melissa Smith, MD; Carolyn Griffith, MD; Joaquin Charles, MD

WHEREAS, Agriculture is one of the most high-risk industries, with hazards including falls, heat exposure, heavy lifting, joint and ligament injuries, and exposure to dust and agricultural chemicals, including pesticides, mold, bacteria, and animal droppings, and,

WHEREAS, Prenatal pesticide exposure increases the risk of negative health effects for the pregnancy and developing fetus, and,

WHEREAS, The high physical demands commonly associated with farm work, such as heavy pushing, pulling, and lifting; stoop labor; prolonged standing; or repetitive bending; may increase adverse birth outcomes, and,

WHEREAS, The California Academy of Family Physicians existing policy currently only advocates for the California Employment Development Department (EDD), the agency that administers State Disability Insurance (SDI) benefits, to extend these benefits "to breastfeeding women who are exposed to pesticides in the workplace up to 6 months after giving birth.", and,

WHEREAS, The EDD makes SDI benefits available to farmworkers, regardless of citizenship or immigration status, and others whose job makes it unsafe to work during pregnancy due to exposure to chemicals or other hazardous conditions, and,

WHEREAS, Healthcare providers may certify a patient for SDI benefits at any point in pregnancy if they believe it is not medically advisable for the patient to perform their regular or customary work, and workers may apply for SDI benefits as early as a positive pregnancy test to avoid prenatal pesticide exposure or other job hazards.

RESOLVED That the CAFP raise awareness about the health risks associated with exposure to pesticides during pregnancy and while breastfeeding to patients and healthcare providers, and be it further

RESOLVED That the CAFP provide education to its members on the availability of workplace accommodations and paid leave (State Disability Insurance) for farmworkers experiencing workplace pesticide exposure during pregnancy, and their roles in supporting patients in accessing them regardless of citizenship or immigration status, and be it further

RESOLVED That the CAFP expand its current policy advocating for the extension of disability benefits for breastfeeding mothers who are exposed to pesticides in the workplace to include comprehensive access to paid

leave (State Disability Insurance, Paid Family Leave, sick days, etc.) for farmworkers during pregnancy and while breastfeeding.

Speaker's Notes: CAFP has policy advocating for the California EDD to expand supplementary income assurances to breastfeeding women who are exposed to pesticides in the workplace up to 6 months after giving birth. (BoD 11.05.13)
AAFP does not have explicit policy on raising awareness about health risks associated with exposure to pesticides during pregnancy and while breastfeeding, providing education to its members on the availability of workplace accommodations and paid leave (State Disability Insurance) for farmworkers experiencing workplace pesticide exposure during pregnancy, or advocating to expand supplementary income assurances to breastfeeding women who are exposed to pesticides in the workplace up to 6 months after giving birth.

However, AAFP does have policy on Pregnancy, Perinatal, and Newborn Care by Family Physicians, recognizing that there are health care disparities for people living in both rural and urban underserved areas, including disparities in critical access to pregnancy, perinatal, and newborn care. The AAFP is committed to improving access to quality health care, including comprehensive pregnancy, perinatal, and newborn care, for all people regardless of where they live. (1989 COD) (October 2023 COD)

Fiscal Note: There would be minimal costs to add a specific topic to CAFP educational events and/or communication materials. There would also be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents.

Problem Statement: Protecting the health of farmworkers during pregnancy by avoiding pesticide exposures and other job hazards as farmworkers.

Problem Universe: This problem impacts thousands of patients in the state of California and is central to the practice of Family Medicine. According to the AAFP, "[p]regnancy, perinatal, and newborn care is a core discipline of the specialty of Family Medicine." One study reported that approximately one third of pregnant women (34.4%) receive care from a Family Physician. However, both the AAFP and the American College of Obstetricians and Gynecologists (ACOG) acknowledge that Family Physicians often provide 100% of the obstetric care in rural communities.

In 2022, the California Employment Development Department (EDD) estimated an annual average of 422,900 workers employed in agriculture. According to the 2017 USDA Census of Agriculture, more than 37% of farmworkers in California are women, with around 16% of those female farmworkers being of childbearing age (note: 2017 data reflects estimated 124,405 farmworkers). However, these figures may not accurately reflect the true size of the impacted population as farmworkers are historically undercounted in the census and other data sources due to several factors such as geographic isolation, language barriers, and immigration status. In fact, in a 2021 policy brief, the California Institute for Rural Studies and community-based partners estimated that California employs about 800,000 farmworkers.

In California, there is a lack of primary care available in many agricultural areas, which leads farmworkers to rely on Federally Qualified Health Centers (FQHCs) or other clinics for their healthcare needs. According to the 2022 Farmworker Health Study by the Community and Labor Center at the University of California, Merced and the California Department of Health, 58% of farmworkers surveyed reported visiting a Community Health Clinic or

Migrant Clinic. A 2022 report by the Public Policy Institute of California states that "among farmworkers who received health care in the US, the majority relied on clinics, with documented workers more likely to visit a doctor's office and undocumented workers more likely to visit a public clinic." Additionally, the California State Profile of Community Health Clinics and Health Centers by the California Primary Care Association reports serving over 915,000 farmworker patients in 2022 which corroborates the fact that the 2017 Census of Agriculture data is no longer as accurate and cannot account for a large portion of the farmworker population because of the various barriers described above (note: the 2017 Census of Agriculture contains the most recent nationwide agricultural census data as of now; the 2022 Census of Agriculture will be released on February 13, 2024).

Specific Solution: Through a strong policy recommendation and through educating CAFP members on the importance of certifying pregnant farmworkers for SDI, we hope to promote healthy pregnancies and healthy children.

Evidence: Exposure to pesticides during pregnancy has been linked to a number of adverse health outcomes during childhood and adolescence, including delayed neurodevelopment, respiratory problems, and an increased risk of cancer. In California's agricultural Salinas Valley, prenatal exposure to organophosphate (OP) insecticides and other pesticides has been associated with adverse birth outcomes (e.g., shortened gestational duration, abnormal reflexes in neonates), lower IQ at ages 7 and 10, and an increased risk of attention problems/attention deficit hyperactivity disorder (ADHD) and respiratory problems such as asthma and wheeze during childhood. Studies across California have shown that prenatal pesticide exposure may be associated with an increased risk of autism and cancers such as childhood leukemia. Recent studies have also suggested that certain pesticides that have increased in use in recent decades may also be associated with adverse birth outcomes and decreased neurodevelopment during childhood. Notably, prenatal exposure to glyphosate, an herbicide global use has increased 15-fold in the last two decades has been associated with adverse birth outcomes including shortened gestational length and preterm birth. It is important to note that many of these studies have been conducted in the general population or among children living in agricultural areas, but have not been restricted to children of mothers working in agriculture during pregnancy. Studies have very consistently shown higher levels of pesticide exposure among farmworkers compared to the general population, indicating that some of these findings could be even stronger for children whose mothers worked in agriculture during pregnancy.

In November 2023, the 8th Circuit Court of Appeals overturned the Environmental Protection Agency's (EPA) ban on the use of chlorpyrifos, an organophosphate linked to adverse birth outcomes and other detrimental health effects. Red River Valley Sugarbeet Growers Ass'n v. Regan, No. 22-1422 (8th Cir. 2023). The Court stated that the EPA should have considered modification of tolerances (in addition to complete revocation) when it issued its 2021 rule revoking all chlorpyrifos tolerances. The EPA has stated its intent to propose a new rule, but a timeline has not been announced as of the drafting of this resolution. The agency will have to follow the rulemaking process under the Administrative Procedure Act, which could be of considerable length. In the interim, it is important that healthcare providers take steps necessary to mitigate harm to pregnant patients who may be exposed to chlorpyrifos in the workplace.

In California, healthcare providers may certify their patients for State Disability Insurance (SDI), a worker-funded paid leave program administered by the Employment Development Department (EDD), if their "job requirements (e.g., lifting, continuous standing, chemical exposure, etc.) pose a danger to the health of [the] pregnant patient or the fetus." The EDD has stated that workers may apply for and receive SDI regardless of their citizenship or immigration status. Access to SDI can make the difference between a worker being able to take time off work to protect themselves from prenatal pesticide exposure, or being forced to continue working due to economic pressures. Paid leave can be particularly beneficial for mothers and children from less

advantaged backgrounds. In fact, paid maternity leave through the SDI system in five states has been shown to lead to a reduction in the share of low birthweight and preterm births. Family Physicians should be aware of SDI as a tool to prevent prenatal pesticide exposure amongst farmworkers.

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Resolution A-28-24

Proposed Policy Title: Add Climate Change Health to The CAFP Mission

Author: Diana Howard

Co-Authors: Diana Howard, Alex Sherriffs and Robin Linscheid

Endorsed by: CAFP Fresno-Kings-Madera Chapter

WHEREAS, research shows that climate change, desertification, and unrelenting wildfires across the Western United States are all associated with harmful health impacts, air pollution-related conditions, maternal and newborn poor health outcomes(2), including increased outpatient visits, hospitalizations, and death from cardiovascular and respiratory diseases, and (1)

WHEREAS, the Natural Resource Defense Council (NRDC) estimates the financial cost of health care from fossil-fuel-generated air pollution and climate change surpasses $820 billion each year (3), and the annual health costs due to extreme weather and climate events are $ 263 million, and

WHEREAS, The World Health Organization identified climate change as the greatest threat to human health in the 21st century. Since then, the AMA, AAFP, ACP, ACOG, and AAP have advocated for protecting human health by mitigating climate change in legislation and increasing medical education around this topic (1). The need for a policy change was recognized, but no CLIMATE CHANGE mission has been established yet, and

WHEREAS, The CMA adopted the resolution 109-16 that recognizes that climate change threatens the health and well-being of the patients served by California's physicians, encourages healthcare institutions to review and improve their carbon footprint and that of their supply chain, and supports efforts to communicate with our local state and national legislators about the need to take action to adapt to and mitigate the effects of climate change (4), and

WHEREAS, the CAFP has the potential to take numerous actions to promote better climate stewardship. Some of these actions include developing materials to assist members and their patients in better understanding the current best science of the nexus of climate change and health; creating online climate resource links on the CAFP website; adding climate health CME to annual CAFP POP; designating a staff member as a climate lead; identifying steps the CAFP and other health organizations can take during meetings to be more climate supportive; and identifying personal choices members can make to be more climate supportive, and

RESOLVED: that the CAFP develop a Climate Change Task Force to identify opportunities for CAFP and its membership to contribute to sustainable Climate and Climate Health Solutions with a report to the board and membership no later than January 2025, and

RESOLVED: that the CAFP board will report annually to membership on ways CAFP is engaging and will engage in climate crisis beginning no later than January 2025.

Speaker's Notes:
CAFP does not have specific policy related to prioritizing climate change in CAFP operations and policy. CAFP has related policy that advocates for stronger regulations on energy sources for hospitals, setting specific renewable energy targets, encouraging energy-saving measures such as solar panels and LED bulbs. The policy also

promotes energy efficiency in medical office buildings. Additionally, CAFP supports physician representation on climate change advisory committees and advocates for wildfire prevention and preparedness, referring these efforts to AAFP for national action (see page 56 of the policy manual).A-08-22, BoD 4.22.22

Furthermore, CAFP's public health policy supports efforts that promote investment of resources in state and local public health departments as guided by the current needs of the communities, which may include, but are not limited to mitigation of climate change effects on health (See page 134 of the policy manual). A-01-22, BoD 4.22.22

AAFP has policy that encourages AAFP members to contribute to climate solutions, "for members to contribute to sustainable Climate and Climate Health Solutions." AAFP emphasizes the urgent need for action to reduce pollution, greenhouse gas emissions, and ozone depletion, particularly due to their severe adverse health effects on vulnerable populations. AAFP opposes government actions limiting public access to environmental health research data or weakening environmental protections. They pledge collaboration with healthcare organizations to raise awareness about the health impacts of climate change and advocate for policies promoting clean air and water. AAFP supports research and management of toxic environmental exposures, focusing on protecting vulnerable populations from irreversible health damage. (1969) (2019 COD)
The Resolution does not specifically request that CAFP add Climate Change to the organizational mission statement, although the Title and Problem Statement reflect that intent.
Increased engagement in Climate Change is not specifically identified in the CAFP Strategic goals or Strategic Workplan.

Fiscal Note: Development of a CAFP Task Force would result in significant organizational expense (including staff time) to develop a Task Force charter and calendar, prepare materials, hold Task Force meetings, and develop a report. It would not be feasible to develop a Task Force and complete a report by January 2025.
The cost to CAFP to increase engagement on Climate Change issues would depend on the level of effort.

Problem Statement: The current mission of the California Academy of Family Physicians does not explicitly address the critical issue of climate change, despite its significant impact on public health. As a result, there is a lack of formal recognition and commitment to addressing the health implications of climate change within the organization. This omission hinders the CAFP 's ability to effectively advocate for policies and practices that mitigate the health risks associated with climate change and promote environmental sustainability.

Problem Universe: More than 10,000 members of the CAFP, including medical students, residents, and family physicians, are affected by this proposed policy.

Specific Solution: The CAFP can develop materials to assist members and their patients in better understanding the current best science of the nexus of climate change and health; creating online climate resource links on the CAFP website; adding climate health CME to the annual CAFP POP; designating a staff member as a climate lead.

The CAFP can develop a Climate Change Task Force to contribute to sustainable Climate and Climate health solutions. The CAFP board will report annually to the membership on ways CAFP is engaging and will engage in climate crisis beginning no later than January 2025.

Evidence: The California Medical Association (CMA) passed resolution 109-16 which acknowledges that climate change poses a threat to the health and well-being of patients under the care of California's physicians. However, no Climate Change Curriculum or annual report has been published and circulated to the members yet.

Citations:

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Resolution A-29-24

Proposed Policy Title: Support Rent Control Initiatives on a Local, State, and National Level

Author: Harini Jaganathan

Co-Authors: Sheila Attaie

Endorsed by: Sacramento Valley Chapter

WHEREAS the AAFP endorses a Health in All Policies approach to addressing the social determinants of health, and

WHEREAS the AAFP has affirmed that housing is health care and supports "rapid access to permanent, affordable housing integrated with health care and supportive services," (October t 2023 COD), therefore be it

RESOLVED, that the California Academy of Family Physicians advocate for affordable housing initiatives in California, including rent-control measures and rental assistance programs (housing vouchers) for very low-income families and be it further,

RESOLVED, that the California Academy of Family Physicians bring this resolution to the American Academy of Family Physicians Congress of Delegates asking to add "rent-control measures" and "rental assistance programs" to existing policy "Homelessness" as it is an effective way to prevent homelessness.

Speaker's Notes: CAFP does not have a direct policy on rent control or housing affordability; however, CAFP's fifth core principal on health care system financing, administration, and delivery , sustainability, emphasizes addressing social determinants of health, such as economic inequality, housing, food security, environment, crime, and personal safety. (BoD 7.15.17) Furthermore, the CAFP's Public Health policy advocates for ending police brutality and redirecting resources toward public health, which includes investing in community resources like safe and affordable housing, and mobile crisis intervention teams to aid with people experiencing mental health crises, homelessness, and substance abuse. (A-22-20, BoD 11.19.22)
AAFP does not have an explicit policy on housing affordability or rent control. However, AAFP does have a policy on homelessness, supporting Housing First programs that offer rapid access to permanent, affordable housing integrated with health care and supportive services. In addition to affirming, housing is health care, and access to safe and affordable housing is a social determinant of health. (1988) (October 2023 COD)

Fiscal Note: At the state level, there would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents. Additionally, there would be minimal cost for referring for national action.

CAFP staff also does not have expertise on the housing policy, nor does CAFP have the expertise to address local level rent control issues. CAFP may be able to provide comment on how rent control and housing initiatives would impact healthcare access and California family physicians at minimum to moderate cost, depending on

the level of engagement. However, deeper level analysis or policy expertise would result in significant cost as CAFP would need engage outside expertise.

Problem Statement:

Problem Universe:

Specific Solution:

Evidence:
This resolution seeks to end a statewide ban on rent control, which allows local governments to help renters stabilize rents and prevent yearly hikes.

This resolution is already endorsed by many community organizations across California including the California Nurses Association, The Dolores Huerta Foundation, Veterans Voices, and Housing is a Human Right, which is funded by the AIDS Healthcare Foundation.

It is well established that people without housing experience innumerable barriers to accessing health care and poor health outcomes compared to people who are housed. I am reminded of my patient with gestational diabetes and a history of a prior c-section whom I was seeing for prenatal care. She was only about to make it to two prenatal appointments before her delivery. I think of my patient with diabetic foot ulcers that never fully heal because he is unable to refrigerate his insulin.

Experts who have studied homelessness have recommended that making affordable housing a priority for those with the lowest incomes is necessary. Support for rent control on a local level can move the needle on this issue.

Citations:

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4. California Statewide Study of People Experiencing Homelessness | Benioff Homelessness and Housing Initiative. (2024, February 2). Benioff Homelessness and Housing Initiative. https://homelessness.ucsf.edu/our-impact/studies/california-statewide-study-people-experiencing-homelessness

Resolution A-30-24

Proposed Policy Title: Syringe Exchange Programs in Orange County

Author: Maxwell Lee

Co-Authors: Brandon Camp, Danny Flores, Maxwell Lee, Maha Rauf, Riley Scherr

Endorsed by:

WHEREAS, injection drug use is associated with infectious disease spread, including HIV and hepatitis C virus (HCV),

WHEREAS, people who inject drugs (PWID) in California make up 68% of new infections of HCV, and California has seen a 55 percent increase in HCV infection among males ages 20-29 and a 37 percent increase among females ages 20-29 from 2007-2015,

WHEREAS, the American Medical Association (AMA) has recommended that all communities establish and fund needle exchange programs as part of effective community health initiatives

WHEREAS, fatal drug overdoses disproportionately increased in 2020 among structurally marginalized populations and showed a strong geographic gradient within the state of California,

WHEREAS, the combined cost of opioid use disorder and fatal opioid overdose was estimated at $61 billion in 2017 in the state of California,

WHEREAS, the rate of opioid-related emergency department (ED) visits has increased 141% since 2005 and there were 7,457 opioid overdose cases treated in the ED between 2011 and 2015,

WHEREAS, Orange County, California established a Syringes Services Program (SSP) from 2016 to 2018 that exchanged sterile syringes 1:1 for used syringes, which was blocked by local governments and a San Diego Superior Court,

WHEREAS, SSPs both nationally and in Orange County have decreased discarded syringes on city streets.

RESOLVED:
That the Santa Ana City Council re-establish needle exchange programs in service of adequate and equitable health care for all.

Speaker's Notes: CAFP does not generally engage in local initiatives. Current CAFP does have policy supporting harm reduction strategies including supervised injection facilities. (BoD 7.18)
AAFP does not have policy on needle exchange programs or other harm reduction strategies.

Fiscal Note: There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the

extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents.

Problem Statement:
Injection drug use is associated with infectious disease spread, including HIV and hepatitis C virus (HCV). People who inject drugs (PWID) in California make up 68% of new infections of HCV, and California has seen a 55 percent increase in HCV infection among males ages 20-29 and a 37 percent increase among females ages 20-29 from 2007-2015. The American Medical Association (AMA) has recommended that all communities establish and fund needle exchange programs as part of effective community health initiatives. Fatal drug overdoses disproportionately increased in 2020 among structurally marginalized populations and showed a strong geographic gradient within the state of California. The combined cost of opioid use disorder and fatal opioid overdose was estimated at $61 billion in 2017 in the state of California. The rate of opioid-related emergency department (ED) visits has increased 141% since 2005 and there were 7,457 opioid overdose cases treated in the ED between 2011 and 2015. Orange County, California established a Syringes Services Program (SSP) from 2016 to 2018 that exchanged sterile syringes 1:1 for used syringes, which was blocked by local governments and a San Diego Superior Court. Both SSPs both nationally and in Orange County have decreased discarded syringes on city streets.

Problem Universe: Orange County, 3.17 million people

Specific Solution: Re-implementation of a needle exchange program in Orange County ; That needle exchanges provide benefit to both persons who inject drugs and the larger community via decreased rates of infectious disease spread, decreased economic cost of substance use disorder, and increased proper disposal of needles.

Evidence: See problem statement.

Citations:

1. https://policysearch.ama-assn.org/policyfinder/detail/%22Safe%20Disposal%20of%20Used%20Syringes,%20Needles%20and%20Other%20Sharps%20in%20the%20Community%20H-95.942%22?uri=%2FAMADoc%2FHOD.xml-0-5321.xml

2. https://www.cdc.gov/ssp/syringe-services-programs-summary.html

3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8934030/

Resolution A-31-24

Proposed Policy Title: Fair Bilingual Compensation to Advance Health Equity and Language-Concordant Care

Author: Rachel Gottlieb
Co-Authors: Andrea Banuelos, Mandy Helle, Jesslyn Magee, Rachel Isaacs, Jodie Guller, Bright Zhou

Endorsed by: CAFP Student-Resident Council

WHEREAS, The US population is increasingly more linguistically diverse. In California, more than 200 languages and dialects are spoken, and according to the US Census Bureau (2015), almost 44% of California households speak a language other than English, and nearly seven million Californians (19%) report speaking English "less than very well" and 44.1%, or about 5.8 million households are considered "limited English-speaking."(1)

WHEREAS, The five most common non-English languages spoken in California are Spanish, Cantonese, Mandarin, Tagalog, and Vietnamese; Primary Care Providers (PCPs) are not proportionately proficient in speaking in those languages; PCPs in California are competent in these languages at a proportion of 33%, 3%, 6%, 6%, and 4% respectively. (2)

WHEREAS, "Patients [with limited English proficiency] are more likely than others to report being in fair or poor health, defer needed medical care, leave the hospital against medical advice, miss follow-up appointments, and experience drug complications; They are also less likely to have a regular health care provider" (9)

WHEREAS, Language-discordant care leads to more diagnostic resources, invasive procedures, and/or over-prescribing medications ordered by physicians; Language barriers are associated with an increased risk of adverse events during hospitalizations; Limited English-Proficient patients have poorer health outcomes, are at greater risk for medical errors, and place a higher financial burden on the health-care system than patients who can effectively communicate with their physician. (5)

WHEREAS, Studies have shown that language-congruency improves patient communication, satisfaction, patient-centeredness, and trust, leading to improved clinical outcomes (2). For example, language-concordant care was negatively associated with poor glycemic control and poor health perception in Spanish-speaking patients with diabetes.(6)

WHEREAS, Studies have shown that language-congruency in medical care can lead to increased clinical efficiency and decreased healthcare spending, such as an observed negative association of language-concordance with number of diabetes-related ER visits and overall number of diabetes-related hospitalizations/ER visits.(7)

WHEREAS, Bilingual employees across American industries are typically incentivized with 5-20% wage and salary increases compared to single-language-speaking employees (8)

WHEREAS, California Family Medicine residency programs do not offer standardized bilingual compensation, and may only incentivize 1-3% of the resident's salary;

WHEREAS, The Office of Management and Budget estimates that the cost for professional interpreters varies from $20-$26 per hour (9). Utilization of bilingual physicians can likely lower utilization costs by streamlining interpretation and more efficiently conducting the patient encounter.

WHEREAS, The American Academy of Family Physicians supports legislation to make funding available for culturally sensitive interpretive services for those who have limited English proficiency, or who are deaf, or who are otherwise language impaired. (2002) (October 2023 COD)

WHEREAS, AAFP supports the broad adoption of cultural sensitivity standards by government, payers, health care organizations, practices and individuals. When cultural sensitivity is an expected standard in health care delivery, "optimal health for everyone" means every one.(10)

WHEREAS, CAFP Policy currently states "there should be consideration of compensation for bilingual physicians who would otherwise require an interpreter", as well as "medical school admission policies should reflect the importance of increasing the representation of underrepresented minority students";

RESOLVED: The CAFP encourages the recruitment and retention of medical students, residents, fellows, and physicians with language competency aligned with the linguistic needs of the California population

RESOLVED: The CAFP surveys and reports existing bilingual pay structures among its members' practices and institutions to create transparency around bilingual compensation

RESOLVED: The CAFP advocates for the inclusion of higher compensation for multilingual proficiency in residency, fellowship, and physician contracts,

RESOLVED: The CAFP promotes medical language training programs at the medical school, residency, and continuing medical education level.

Speaker's Notes: CAFP does not have direct policy pertaining to bilingual compensation; however, CAFP's cultural language and proficiency policy emphasizes the importance of addressing cultural and linguistic diversity in medical education to improve patient care and health outcomes. CAFP adopted the policy in June 2006 in response to a new law (AB 1195, Chapter 514, Statutes of 2005), which mandated that medical education courses include curriculum on cultural and linguistic competency in medicine. Cultural competency refers to attitudes, knowledge, and skills enabling effective care for diverse patient populations. Linguistic competency ensures physicians can communicate directly with patients in their primary language.

CAFP has actively promoted cultural and linguistic competency since 2002, convening discussions and developing educational materials. The policy recognizes the increasing cultural and linguistic diversity in the United States and aims to address health outcome disparities associated with these differences.

The policy mandates that all CME activities must incorporate cultural and/or linguistic competency elements, as defined by AB 1195. Compliance involves integrating cultural and linguistic considerations into educational activities, materials, and documentation. Exemptions exist for activities solely dedicated to research or those not involving patient care.

Mechanics of compliance include:

- Incorporating cultural and linguistic elements into sessions.
- Dedicating sessions to these topics.
- Providing resources.
- Ensuring documentation of compliance in the planning process and activity content.

The policy appreciates the collaborative efforts of individuals and organizations in developing standards for cultural and linguistic competency. (06/06 BoD)

AAFP does not have a direct policy about bilingual compensation; however, AAFP's culturally proficient Health Care policy recognizes the significance of cultural and ethnic differences in the patient-physician relationship. They emphasize the importance of cultural sensitivity and education for physicians, urging all medical schools and family medicine residencies to include cultural competency training. Physicians are encouraged to learn about and respect their patients' cultural backgrounds, incorporating sensitivity to cultural perceptions of health and illness into patient care and treatment plans.

When patients speak a different language, physicians must provide appropriate interpretive services according to federal regulations. The AAFP recommends using the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to enhance the cultural and linguistic accessibility of medical practices. (1985) (October 2023 COD).

Furthermore, AAFP has a position paper, "Cultural Sensitivity: The Importance of Cultural Sensitivity in Providing Effective Care for Diverse Populations (Position Paper)," supporting the broad adoption of cultural sensitivity standards by government, payers, health care organizations, practices, and individuals. In addition, AAFP has policy supporting legislation that makes funding available for culturally sensitive interpretive services for those with limited English proficiency, who are deaf, or who are otherwise language impaired. (2002) (October 2023 COD)

Fiscal Note: Seeking funding or using the CAFP budget to establish new training requirements into family medicine residency program curriculum 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 expenses exceeding $1 million. Furthermore, advocating on issues outside of CAFP's expertise would be moderate to significant, as it would include significant staff time, research, and potentially outside expertise. It could also require hiring advocates as it may be outside the parameters of our current lobbying contract.

Problem Statement:

Problem Universe:

Specific Solution:

Evidence:

Citations:

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2. Garcia ME, Bindman AB, Coffman J. Language-Concordant Primary Care Physicians for a Diverse Population: The View from California. Health Equity. 2019 Jul 1;3(1):343-349. doi: 10.1089/heq.2019.0035. PMID: 31312781; PMCID: PMC6626968. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6626968/

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Resolution A-32-24

Proposed Policy Title: Ensuring Equity in Rural Health Policy

Author: Robert Moore

Co-Authors:

Endorsed by:

WHEREAS, because between 85-95% (depends on definition used) of all Californians live in an urban or suburban setting, including individuals who develop the regulations in various state departments, so much of the legislation and policy in California is written with an urban or suburban point of view; and

WHEREAS, inequitable health outcomes associated with rural residence are currently of equal or greater magnitude than ethnicity-associated inequities, and

WHEREAS, although poverty exists in both cities and rural areas, a higher-density of clinicians, patients, and support services provide urban/suburban areas with more governmental and community resources and funding to help address underlying economic drivers of inequitable health outcomes, and

WHEREAS, health policies and funding streams written to apply to both urban and rural areas of California are often written to be not implementable in rural areas, leading to exacerbation of rural inequities,

WHEREAS, health outcomes of American Indians in rural California have the highest rates of inequity, so that any policy that is inequitable from a rural perspective, is also inequitable from a California Indian perspective, with an effect that multiplies their historic trauma and discriminatory policies; and

WHEREAS, health-related policies that systematically, if unintentionally, disadvantage residents and health care providers in rural areas is a reflection of "Structural Urbanism," which lead to poorer health outcomes; and

WHEREAS, just as intentionality is needed to address Structural Racism, so too is intentional policy analysis needed to ensure that health policy and regulations are not perpetuating inequities for rural Californians, including Native Americans;

RESOLVED: That CAFP ensure that a Rural Health perspective is considered and accounted for as part of their legislative and regulatory advocacy activities; and be it further

RESOLVED: That CAFP promote or support State legislation requiring the following:
1. As State departments develop regulation, a rural analysis must be performed that identifies any challenges in applying the policy equally and equitably in rural communities. This analysis should include direct feedback from key advisors and associations that represent rural communities.
2. If a challenge affecting rural application is identified, the policy shall be amended to equitably impact rural areas, with accommodations in regulations and requirements that remedy these challenges. When necessary, this may include a higher level of funding for rural areas compared to urban areas so that the policy can be applied equitably.
3. The documentation of each policy that is promulgated attests that the above process has been followed.

Speaker's Notes: CAFP existing policy states that "health care is a human right and every person has a right to comprehensive, high-quality health services delivered in a timely, culturally-competent and economically sustainable manner regardless of their age, gender identity, sexual orientation, geographic location, income, health status or immigration status." This CAFP policy is inclusive of rural health perspectives but does not elevate the equity needs of rural healthcare as specified in the resolution. (BoD 7.15.17)
AAFP does have specific policy on supporting rural health equity. AAFP policy states that "AAFP supports programs and initiatives that will ensure financial stability and delivery system support for physicians serving rural communities to eliminate these disparities to access to quality care for all populations." (1987) (2020 COD)

Fiscal Note: There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. These costs would be more significant for promoting legislation to develop a rural analysis, if this does not already exist, for key health departments. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents.
Providing input on proposed regulations could incur minimal to moderate costs depending on the level of engagement that is required.

Problem Statement: Many California regulations and health policies unintentionally negatively impact rural communities

Problem Universe: Approximately 15% of California Family Physicians have practices that include rural communities.

Specific Solution: Promote legislation that would require analysis of all new health policies include a specific analysis of impact on rural communities.

Evidence: From a health policy perspective, the Enhanced Care Management (ECM) program is a current example of an urban focus that creates challenges for rural communities. The Department of Health Care Services (DHCS) is directing Medi-Cal Health Plans to contract with non-traditional Medi-Cal providers and organizations for ECM Services, directing plans to contract with community- based organizations (CBOs). In urban communities, with hundreds or thousands of CBOs, this represents an attempt to direct resources to organizations who are working directly with communities in nimble ways, getting at the underlying social drivers of health status – this work is often more challenging for mega-Primary Care Physician (PCP) sites.

In rural areas, Health Centers are smaller and more deeply connected with the special needs of their communities, and sometimes, the only provider of social and medical services. Unfortunately, DHCS has shared that community health centers were not the provider types they had envisioned for this new benefit – although they may be the only ones in their community able to perform the work. The number of local, rural, CBOs interested in developing a business infrastructure to deliver Medi-Cal regulated services is small, certainly not enough to meet the need for care management in the first few years of the program.

A few other examples:

1. Medicare's policy of paying rural providers less than urban providers.

2. Medi-Cal's Pediatric Palliative Care Benefit, whose service requirements are not possible in rural areas.

3. Medi-Cal's non-medical transportation benefit (NMT) which does not account for limited public transportation options, limited internet availability, limited public infrastructure such as passable roads, highways, etc. and challenges with time and distance for rural and remote communities.

4. Medi-Cal's new Community Health Worker benefit, whose service delivery relies heavily on in-person outreach and engagement that will not have a quick update in rural communities due to rural and remote communities, along with a lack of readily available workforce.
   Density accounts for the difference in the implementation of health policy in urban and rural settings: the density of clinicians, the density of patients, and the density of available support services. Poverty exists in cities and rural areas, but higher-density provides larger urban areas with more governmental resources and economies to help address underlying economic inequities.

Citations:

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Resolution A-33-24

Proposed Policy Title: Increasing Diversity for Research in Asian American and Native Hawaiian/Pacific Islander (AAHPI) Communities

Author: Ashley Huynh

Co-Authors: Cindy Vu

Endorsed by:

WHEREAS, in 2022, approximately 15.5% of California's general population identifies as Asian American and Native Hawaiian/Pacific.

WHEREAS, current research on AAHPI populations often categorizes the vast cultural, linguistic, and socioeconomic diversity of these communities as a monolithic group, resulting in broad mis-generalizations and obscuration of significant health care disparities.

WHEREAS, an analysis of clinical research from 1992 to 2018 found that only 0.17% of the National Institution of Health (NIH) total budget is dedicated to research that involves AAHPI health.

WHEREAS, research has mainly focused on the six largest subgroups (e.g., Chinese, Japanese, Filipino, Indonesian, Malaysian, and Burmese), while several Asian American subgroups listed in the 2010 U.S. Census were not represented in any of the studies, and studies showed that health outcomes varied greatly across subgroups.

WHEREAS, about 19.4% of Asian adults compared to 12.9% of whites report being without a usual source of health care, and Cambodians and Vietnamese are three times more likely to skip doctor visits due to cost compared to all Asians or U.S. residents.

WHEREAS, only 60.5% of Vietnamese women reported receiving a pap test in the past three years compared to 86.2% of all women in California, showing the gaps in preventative care amongst AAHPI populations.

WHEREAS, in a 2013 study about smoking behavior, the overall prevalence of smoking is 18.6% in whites and 14.1% in Asian Americans, but when data was separated within AAHPI subgroups, the prevalence of smoking in different groups were higher, with prevalence of smoking in Korean Americans 35.5%

RESOLVED: the CAFP supports policies that encourage greater funding for research such as creating and establishing grants for projects that examine AAHPI health

RESOLVED: That the CAFP supports policies that implores current research to diversify the sampling of AAHPI groups and identify barriers in care that exist amongst subgroups

Speaker's Notes: Neither CAFP, nor AAFP, have explicit policy on supporting policies that encourage greater funding for research that examine AAHPI health or that encourages current research to diversify the sampling of AAHPI groups and identify barriers in care that exist among subgroups. However, AAFP does have policy endorsing the principle of collaborative research between clinicians including practice-based research networks

and researchers and encourages expansion of collaborative research at the national and state levels. (1971) (May 2023 BOD)
In addition, CAFP also has related policy regarding the importance of cultural proficiency in the delivery of healthcare services—in the context of language access in healthcare-- that states that "all persons, regardless of race, ethnicity, or primary language deserve access to high quality health care services." CAFP policy on research and data collection related to cultural proficiency states that "Diseases and conditions disproportionately affecting those with limited English proficiency [which is inclusive of AAPH], racial and ethnic medically-underserved populations should be adequately investigated. Research on specific populations should be conducted to document health issues and successful interventions." (A-02-07, 03/07 CoD)
Fiscal Note: There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents.

Problem Statement:

Problem Universe:

Specific Solution:

Evidence:

Citations:
Kim JHJ, Lu Q, Stanton AL. Overcoming constraints of the model minority stereotype to advance Asian American health. Am Psychol. 2021;76(4):611-626. doi:10.1037/amp0000799

Decker MJ, Atyam TV, Zárate CG, Bayer AM, Bautista C, Saphir M. Adolescents' perceived barriers to accessing sexual and reproductive health services in California: a cross-sectional survey. BMC Health Serv Res. 2021;21(1):1263. Published 2021 Nov 22. doi:10.1186/s12913-021-07278-Yom S, Lor M. Advancing Health Disparities Research: The Need to Include Asian American Subgroup Populations. J Racial Ethn Health Disparities. 2022;9(6):2248-2282. doi:10.1007/s40615-021-01164-8

Li S, Kwon SC, Weerasinghe I, Rey MJ, Trinh-Shevrin C. Smoking among Asian Americans: acculturation and gender in the context of tobacco control policies in New York City. Health Promot Pract. 2013;14(5 Suppl):18S-28S. doi:10.1177/1524839913485757

Resolution A-34-24

Proposed Policy Title: Supporting Medical Students Attending Educational and Research Conferences

Author: Mark Liang

Co-Authors: Lea Tan, Kyra Dingle, Jinho Jung, Cynthia Tsang

Endorsed by: Dylan Hanami

WHEREAS, the current policy at certain public medical schools in California mandates that if students want to attend educational opportunities outside of the mandated curriculum, that they must use vouchers allotted to personal days.

WHEREAS, schools such as UCSF give five separate allotted days during MS1 year and three during MS2 year that students are allowed to take if they are interested in attending advocacy days, medical conferences, or policy days.

WHEREAS, conferences are unique and invaluable experiences that enrich the medical student experience. It offers networking opportunities and showcases their research, allowing further competitiveness during the residency match period.

WHEREAS, in a survey of 88 first-year medical students, 95% expressed a strong interest in advocacy and a desire to become more involved in advocacy work.

RESOLVED: Public medical schools in California will create three vouchers per year in the M1 and M2 years of medical school that students with attending physician or research mentor approval, can use to supplement their medical education outside of campus.

Speaker's Notes It is unclear from the Resolved what CAFP policy change is being proposed and no problem statement, evidence or other information was provided by the author.
Neither CAFP, nor AAFP, have existing policy regarding medical school vouchers for students to attend supplemental educational/research/advocacy experiences, such as conferences. This resolution aims to support medical students' interests in advocacy and involvement in extracurricular activities by providing them with additional opportunities to engage in conferences and similar events without compromising their days.
However, the resolution needs more specificity regarding the actions or directives the CAFP should take. It is recommended that the authors revise the resolution to include specific actions they would like CAFP to take, such as advocating for creating three vouchers per year in the M1 and M2 years of medical school at public institutions in California, etc.

Fiscal Note: There is no direct action for CAFP to undertake for the work described in the resolved, so no fiscal notes are applicable.

Problem Statement:

Problem Universe:

Specific Solution:

Evidence:

Citations:

Resolution A-35-24

Proposed Policy Title: Interpreter Services for Perinatal Care

Author: Valentina Sedlacek, MD

Co-Authors: Micah Gamble, MD; Laura Murphy, DO

Endorsed by: Ventura CAFP Chapter

WHEREAS, AAFP and CAFP have made it clear in policy and resolution work that birth equity and culturally competent access to care are priority areas.

WHEREAS, the American College of Obstetricians and Gynecologists (ACOG) has adopted language to support providing access to interpreter services for all patient interactions when patient language is not the clinician's language.

WHEREAS, language-discordance is a critical lens for health inequities in obstetrics and gynecology given the sensitivity and nature of the work,

WHEREAS language and communication barriers are proven structural drivers of inequities in reproductive health outcomes,

WHEREAS, there is growing evidence that language discordance between patients and their health care teams yield worse quality of care, experience of care, and health outcomes compared.

WHEREAS, there is no requirement for private insurers nor mechanism in place for Medi-Cal to reimburse for language-access services.

WHEREAS, other states have adopted policy that mandates provision of timely and culturally competent language services within state agencies, including the Language Access and Inclusions Act in Massachusetts.

RESOLVED: That the CAFP support advocacy and state-level policy efforts directed at relevant stakeholders, such as California Hospital Association and the California Association of Public Hospitals and Health Systems, to increase access to language concordant interpreter services for labor and delivery floors.

RESOLVED: That the CAFP supports legislation promoting Medi-Cal and private insurers to include coverage for access to language services for all perinatal care.

Speaker's Notes:
CAFP policy includes organizing principles on Language and Cultural Proficiency, inclusive of payment principles. CAFP policy states that

- "Payment for interpreter services in both publicly- and privately-funded health care systems must be the responsibility of the insuring or purchasing entity;
- The primary financial entity (state, insurance company, or managed care company) should contract with and pay interpreters directly unless medical groups or physicians explicitly choose to accept risk for such services in their contracts. Health professionals, including medical groups, shouldn't unwillingly bearing the burden or expense of providing interpreter services;

- The State of California should seek federal matching funds for the provision of interpreter services for patients in the Medi-Cal and Health Families programs; and,
- That both public and private HMOs and health plans should be asked to take explicit responsibility for paying and arranging for interpreter services as a covered benefit for members with the caveat that such services are the responsibility of the primary financial entity (HMO or purchaser) and are not to be borne by fiscal intermediaries such as local medical groups or physicians and other health professionals, unless they have explicitly contracted for the provision of such interpreter services." (COD 3/07)

CAFP policy on language access support is not specific to labor and delivery floors, in particular. The CAFP existing policy, as stated above, would be inclusive of CAFP supporting legislation to ensure access to interpreter services for perinatal care, as stated in the second resolved statement.
AAFP does not have policy, related or explicit, on interpreter services in perinatal care.

Fiscal Note: There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required. The potential cost of sponsoring legislation would be significant and dependent on many factors over which CAFP has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents.

Problem Statement: Current CAFP and AAFP priority areas are birth equity and culturally competent access to care (see citations #1 and #2). Language and communication barriers are proven structural drivers of inequities in reproductive health outcomes. The CAFP does not currently have language to support providing access to interpreter services for all perinatal care. This resolution seeks to address this missing piece.

Problem Universe: All CAFP members providing perinatal care.

Specific Solution: Support for advocacy and state-level policy and legislation related efforts to increase access and coverage for language concordant services for all perinatal care.

Evidence: See citations below. ACOG has adopted language to support providing access to interpreter services for all patient interactions. We wish for the CAFP to do similarly.

Additionally, such a statement indicating CAFP support for legislation, advocacy and state-level policy efforts directed at relevant stakeholders, would likely have an impact in California's ability to support language access and inclusion. Example: promoting Medi-Cal and private insurers to include coverage for access to language services for all perinatal care.

Citations:

10. Striving for Birth Equity: Family Medicine's Role in Overcoming Disparities in Maternal Morbidity and Mortality | AAFP

2. Institutional Racism in the Health Care System | AAFP

3. Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care | ACOG

4. Truong S, Foley OW, Fallah P, Lalla AT, Osterbur Badhey M, Boatin AA, Mitchell CM, Bryant AS, Molina RL.

Transcending Language Barriers in Obstetrics and Gynecology: A Critical Dimension for Health Equity. Obstet Gynecol. 2023 Oct 1;142(4):809-817. doi: 10.1097/AOG.0000000000005334. Epub 2023 Sep 7. PMID: 37678884; PMCID: PMC10510840.

5. Schaefer, Kimberly MSc; Modest, Anna M. PhD; Chie, Lucy MD, MPH; Connor, Yamicia MD, PhD; Golen, Toni MD; Molina, Rose L. MD, MPH. Risk of Primary Cesarean Delivery: Role of Language Preference and Language-Concordant Labor Support [17D]. Obstetrics & Gynecology 133():p 47S-45S, May 2019. | DOI: 10.1097/01.AOG.0000558973.59891.67

6. An Act Relative To Language Access and Inclusion, H.3084, 193rd, 2023. https://malegislature.gov/Bills/193/HD3616.

Resolution A-36-24

Proposed Policy Title: Support for Medi-Cal and Medicaid Coverage of Medication Abortion Services Without Gestational Age Limits

Author: Prachi Priyam

Co-Authors: Sarah McNeil, Magdalen Edmunds, Panna Lossy, Emily Lu

Endorsed by: CAFP East Bay Chapter

WHEREAS, California Academy of Family Physicians policy already notes that they should "support FDA deregulation of mifepristone or other evidence-based medication for miscarriage management and abortion"

WHEREAS, medication abortions post-2020 comprise the majority of abortions in the United States and, pre-2020, about 60% of abortions were performed before 70 weeks

WHEREAS, the Food and Drug Administration has approved mifepristone for medication abortion up to 70 days and prescribing over 70 days is off-label

WHEREAS, off-label prescribing is an essential part of American medicine: a third of all US-prescribed medications are off-label, and almost half of all cardiovascular medications are prescribed are off-label

WHEREAS, the National Abortion Federation issues national Clinical Policy Guidelines, which recognized in 2022 the safety and efficacy of medication abortion beyond 77 days

WHEREAS, the World Health Organization supports medication abortion pregnancy termination up to 91 days and provides guidelines for later gestational ages with no limit

WHEREAS, the Society for Family Planning has suggested guidelines for second trimester use of medication abortion, which patients with Medi-Cal insurance coverage may elect for a range of reasons and for which they would require Medi-Cal coverage

WHEREAS, Medi-Cal's billing policies prohibit reimbursement of medication abortion services above 77 days gestational age

WHEREAS, medication abortion has been proven to be safe and effective well beyond 77 days gestational age

WHEREAS, patients with private insurance can receive medication abortion above 77 days while patients on Medi-Cal are denied this option

WHEREAS, telehealth medication abortion provides critically needed access to patients in remote regions of California without local access, and patients on Medi-Cal above 77 days are therefore required to travel long distances for procedural care

RESOLVED: the California Academy of Family Physicians supports both legislation and executive action to remove the unnecessary Medi-Cal limitation on medication abortion access, thereby leaving the decision about

appropriate medication use to the patient and provider.

RESOLVED: the California Academy of Family Physicians presents this resolution to the American Academy of Family Physicians to also support the removal of any gestational limits for patients who are seeking an abortion and are insured by Medicaid

Speaker's Notes:
CAFP does not have policy specifically addressing the gestational limits for abortion services in Medi-Cal. CAFP has substantial policy on reproductive health care and termination of pregnancy. CAFP policy indicates that health care coverage should be comprehensive, including reproductive and women's health care inclusive of contraception, abortion, maternity, and newborn care services. (BoD 7.15.17) CAFP policy also states that "The CAFP believes physicians should seek, through extensive education and patient counseling, to decrease the number of unwanted pregnancies. However, should a woman become pregnant, it is her legal right to make reproductive decisions, including the decision to carry the pregnancy to term or to have a safe, legal abortion." AAFP also does not have specific policy on gestational limits for abortion care in Medicaid. AAFP related policy states that "reproductive health services, including but not limited to abortion, pregnancy termination, contraception, intrauterine insemination (IUI), and surgical and non-surgical management of ectopic pregnancy, and opposes nonevidence-based restrictions on medical care and the provision of such services." (September 2022 COD)(October 2023 COD)

In addition, CAFP and AAFP both have relevant policy on medication abortion access that is not specific to gestational age. CAFP policy states that CAFP "endorses the principle that REMS classification on mifepristone is not based on scientific evidence and limits access to abortion care." (BoD 4.12-13.18) AAFP also supports the safety and efficacy of mifepristone and advocacy efforts to remove REMS classification in concordance with current evidence. (BoD 3.19)

Both CAFP and AAFP policy supports evidence-based practices in reproductive health care, including medication abortion services. This resolution seeks to add to CAFP to support the removal of gestational limits for patients insured through Medi-Cal.

Fiscal Note:

There would be minimal cost for supporting or opposing legislation sponsored by others that would fall within established procedures for updating and taking positions on proposed legislation and policy. There could be more significant costs if a greater level of engagement is required.

There would be minimal cost for referring for national action.

Problem Statement:

Problem Universe: In 2021, there were nearly 8 million (specifically 7,973,291) women of reproductive age in California per the March of Dimes.

Specific Solution:

Evidence:

Citations:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9998554/#:~:text=Off%2Dlabel%20prescriptions%20for%20drugs,32.3%254%20of%20prescriptions%20overall.

World Health Organization Medication Abortion Guideline -> Wall chart

https://www.guttmacher.org/article/2022/11/abortion-incidence-and-service-availability-united-states-2020

https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/bulletins/2023.04_A_Medication_Abortion_Coverage_Misoprostol-Only_Regimen.pdf

https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/26092CC9-AAAF-432E-A672-85D649215F8A/abort.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/bulletins/2023.04_A_Medication_Abortion_Coverage_Misoprostol-Only_Regimen.pdf

https://abortion.ca.gov/update-on-medication-abortion/#information-for-pharmacies-and-providers

https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm

https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-of-gestation

https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions

Resolution A-37-24

Proposed Policy Title: Transgender Medicine as Core Curriculum in Graduate Medical Education

Author: Diana Howard

Co-Authors:

Endorsed by: CAFP Fresno-Kings-Madera Chapter

WHEREAS, healthcare access for transgender patients faces major barriers due to the shortage of culturally competent physicians who provide gender-affirming health care (GAH). Family physicians are suited to provide care for transgender patients, but few are trained in this care during residency (1),and

WHEREAS, The increase of transgender individuals in the US over the last 6 years went from 1.6 million to 2.6 million(5), the number of accessible physicians has not changed; having California as the second state with the highest number of transgender individuals (2), they will remain at risk for health inequities, and

WHEREAS, the American Academy of Family Physicians has developed a curricular guideline of LGBTQI+ health, Family Medicine Residency Program Directors face challenges in implementing a GAH curriculum due to a lack of faculty expertise in GAH for transgender patients (24.6%), limited curriculum availability (4.2%), and lack of PD expertise in GAH for transgender patients (3.8%) (1), and

WHEREAS, research shows no change in resident knowledge of sexual and gender minority health issues as measured by both pre-resident and post-grad testing(3), and

WHEREAS, patients who receive access to gender-affirming care are 73% less likely to experience suicidality and 60% less likely to experience depression(4), including TRANSGENDER MEDICINE as a core curriculum training can improve mental health outcomes and

RESOLVED: that the American Academy of Family Physicians encourage at least one core faculty to receive transgender medicine and non-binary health care training and

RESOLVED: that the American Academy of Family Physicians draft a letter to the ACGME to advocate for the inclusion of transgender medicine and LGBTQI+ health as a core curriculum in family medicine residency programs.

Speaker's Notes: This resolution is directed at AAFP and not CAFP; however, in the "specific solution" section, the request is for CAFP to advocate to AAFP.
CAFP has provided education on this topic and CAFP has current policy encouraging medical schools and graduate medical education programs to develop and incorporate educational material, tools, and training that will allow physicians to provide knowledgeable and respectful care to transgender and gender-expansive patients. (BoD 1.02.19) CAFP also has policy supporting the concept of transgender education for all levels of medical providers and supports the provision of comprehensive care for the transgender community. (BoD 07.24.21)

Fiscal Note:

There would be minimal cost for CAFP to request that AAFP transgender medicine and LGBTQI+ health be included as a core curriculum in family medicine residency programs.

Problem Statement: A recommended curriculum to support gender-affirming medical care for children and adolescents, including puberty suppression and hormonal treatment, as part of the scope of family medicine was developed by the AAFP. Despite increasing awareness and acceptance of transgender individuals in society by the AAFP, residency programs have not developed educational opportunities to implement transgender medicine and nonbinary health care training.

Problem Universe: California has the second-highest number of transgender and nonbinary individuals in the US, after Hawaii. The lack of physician education in transgender and nonbinary health has resulted in unacceptable health inequities. As primary care physicians and proud members of the CAFP, we demand immediate action. This policy will impact over 10,000 members and is a crucial step towards addressing this issue.

Specific Solution: The CAFP will advocate to the American Academy of Family Physicians to encourage at least one core faculty to receive transgender medicine and non-binary health care training. This action will increase the opportunity for research in this field.

The CAFP will advocate for the American Academy of Family Physicians to draft a letter to the ACGME to advocate for including transgender medicine and LGBTQI+ health as a core curriculum in family medicine residency programs.

Evidence: PRIOR RESOLUTION NO. 410 - Supporting the Provision of Gender-Affirming Health Care for Transgender Youth, the AAFP adopted a resolution to include gender-neutral language in its publications. Most of the residency programs have not implemented or developed a transgender medicine curriculum or educational opportunities for the residents.

Citations:

(1)https://journals.stfm.org/familymedicine/2021/october/donovan-2020-0554/

(2)https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Adults-US-Aug-2016.pdf

(3)https://link.springer.com/article/10.1007/s11606-019-04855-5

(4)https://pubmed.ncbi.nlm.nih.gov/35212746/

(5)https://usafacts.org/articles/what-percentage-of-the-us-population-is-transgender/#footnote-1

Resolution A-38-24

Proposed Policy Title: Patient Navigators as Part of Resident Education on Social Determinants Of Health (SDOH) Barriers and Health Equity within Family Medicine Residency Programs

Author: Mohamed Manswer

Co-Authors: Dr. Robin Linscheid, Dr. John Zweifler, Dr. Joshua Strunk

Endorsed by: CAFP Fresno-Kings-Madera

WHEREAS, Social Determinants Of Health (SDOH) proves to be impacting every aspect of health outcomes contributing to increased mortality risk, homelessness, mental health diseases and disorders which creates a barrier for effective healthcare access for many patients seen residency clinics, predominantly insured by Medi-Cal, that require non-medical services that delay necessary care and treatment for these patients (3).

WHEREAS, Family Medicine Residents are learning to provide comprehensive care including access and education of local resources to support their patients by helping address important issues such as low health literacy that is associated with increased hospitalizations and ED usage, poorer overall health status and increased mortality among the elderly found in a systematic review (1).

WHEREAS, Family Medicine Residents are learning how to screen and address SDOH with patients to satisfy section IV.B.1F put forth by the Accreditation Council for Graduate Medical Education (ACGME) that "residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care."

WHEREAS, Most physicians are unaware of the California Health Care Foundation's CalAIM program or how to access it's services which serves to improve access to more equitable coverage and care to existing Med-Cal patients.

RESOLVED: That California Academy of Family Physicians (CAFP) advocate for the employment of patient navigators such as community health workers or social workers to help enhance resident education and improve patient outcomes by teaching residents how to identify gaps and common barriers to health.

RESOLVED: That CAFP advocate to Accreditation Council for Graduate Medical Education (ACGME) that patient navigators be a part of the team based multidisciplinary care within family medicine residency clinics to help further emphasize and support section IV.B.1F for family medicine residency training.

Speaker's Notes: There is no existing policy within CAFP or AAFP that addresses patient navigators as part of resident education. However, CAFP policy does address "Mid-level Providers", where CAFP supports a greater focus on, and support for, team-based training in physician residency programs. The CAFP supports residency training that ensures "adequate health manpower in the state, particularly in underserved areas." (98 BoD) The CAFP also has related policy in regard to End-of-Life Care which may include working together with social workers. (BoD 4.24.15)

AAFP policy states that the best training in the knowledge, skills and attitudes of family medicine is provided through family medicine residency education.

Fiscal Note: There would be minimal cost for referring for national action or drafting a letter, requesting expansion of residency education to include patient navigators in order to better meet ACGME requirements.

Problem Statement: This problem helps seek to address SDoH in each community by helping and teaching residents how to utilize available in each community through the help of a community navigator.

Problem Universe: Most Members are, especially those in underserved communities.

Specific Solution: This resolution would have the CAFP reform the policy making process through a by-laws amendment so that delegates who represent our members can have a direct say in the policy making process of the Academy.

Evidence:

Citations:

1. Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Crotty K. Low health literacy and health outcomes: an updated systematic review. Ann Intern Med. 2011 Jul 19;155(2):97-107. doi: 10.7326/0003-4819-155-2-201107190-00005. PMID: 21768583.

2. Sulley S, Bayssie M. Social Determinants of Health: An Evaluation of Risk Factors Associated With Inpatient Presentations in the United States. Cureus. 2021 Feb 11;13(2):e13287. doi: 10.7759/cureus.13287. PMID: 33728220; PMCID: PMC7955789.

3. Wright KM, Ravenna P, Wheat S, Villarreal CM, Clements DS, Cronholm PF. Social Determinants of Health in Family Medicine Residency: A National Survey of Program Directors. [published September 25, 2023]. Fam Med. https://doi.org/10.22454/FamMed.2023.871989.

Elections

Report of the 2023 Governance Committee/Election Slate

The role of the CAFP Governance 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 2024 All Member Advocacy Meeting (AMAM) or Board of Directors meeting. The 2023 committee members are Drs. Ecler Jaqua, Tipu Khan, Ron Labuguen, Kirsten Vitrikas, Grace Yu, and CAFP President, Dr. Raul Ayala. The Governance committee met in October 2023 and presented this recommended slate of officers, which was approved by the Board of Directors at its December 2023 meeting.

Elected by Delegates at the All Member Advocacy Meeting

President-elect	Anthony Chong	2024
Speaker	Kim Yu	2024
Vice Speaker	Brent Sugimoto	2024
AAFP Delegate	Lee Ralph	2024-26
AAFP Alternate Delegate	Alex McDonald	2024-26
Governance Committee *	Mary Hanna	2024-26
(from AMAM)	Sarah McNeil	2024-26
New Physician Director	Elect One	2024-27
Candidates: Cynthia Chen-Joea, Emily Lu, Laura Murphy		

Elected or appointed by and from the Board

Governance Committee (from the BOD)	Maria Carriedo-Ceniceros	2024-26
Secretary/Treasurer**	Jorge Galdamez	2024-25
CAFP Magazine Editor	Scott Nass	2024-27

* The All Member Advocacy Meeting (AMAM) nominates and elects a total of three members of the Governance 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.

Candidates' Statements

For the Office of President-elect – Anthony F. Chong, MD, FAAFP
I am honored to be nominated as the next CAFP President-elect and to have the opportunity to continue to represent and support California's family medicine physicians. For more than 20 years, I have worked with my colleagues on the CAFP Foundation and Academy to strengthen the California House of Family Medicine. We have focused on improving family medicine, primary care, and health care in general for California. However, in my regular day job as Chief Medical Officer of a large primary care group in San Diego, I continue to see the struggles of family physicians, particularly in this post-COVID pandemic era. The strong bond between family physicians and our patients has been disrupted. We have seen patients question our mission and purpose as we struggle to be on the frontline taking care of the community. We have seen an increase in physician burnout and a decrease in our members' wellness. Family medicine is critical for delivering high quality care for our patients. CAFP has always stood up for our patients and our members. We are stronger because of our family in the academy - from medical students to practicing physicians. As the next President-elect, I will continue to champion family medicine and work to improve our patients' health, while continuing to address those aspects of medicine that hampers family physicians - from compensation to wellness to recognition of the vital role we plan in healthcare. Thank you for the opportunity and for your consideration. – *Anthony F. Chong, MD, FAAFP*

For the Office of Speaker – Kim K. Yu, MD, FAAFP
I am honored to be nominated as CAFP Speaker. For the past 24 years since graduating from Family Medicine residency at Henry Ford Hospital in Detroit, I have been actively involved with the AAFP, having found a love of advocacy and service to our specialty. I have worked with multiple chapters including the Michigan Academy of Family Physicians serving on its board of directors as President and Board Chair, and more recently, California Academy of Family Physicians as President of Orange County and as Vice Speaker this past year. My experience stems from also having served on multiple committees and commissions, most recently the Member Engagement Committee of CAFP, as an AAFP delegate to the American Medical Association, and as a representative for AAFP to NQF's EHR Care Coordination Committee. In my work as PRIME National Strategy Consultant for the American Board of Family Medicine and as Director for Health Care Strategy for KCS, a multisite community health center in Orange County, I see how critical it is to have a firm foundation of primary care to shore up healthcare in both California and our country. It is humbling to see the inspiring work that family physicians do every day, and the impact on their communities. I am often asked why I do all that I do, what drives me? Perhaps you have heard the term ikigai; it's a Japanese term that means "the reason for being, the reason I get up in the morning." My ikigai is to inspire, create and lead, (#InspireCreateLead) - to inspire others, create change and lead the future of family medicine for generations to come. Whether it is being AAFP social media ambassador, or being a mentor to medical students and residents, or presiding over reference committees and digging into parliamentary procedure (which I love to do!), my hope is to bring joy, excellence, and transparency, so all may understand the essence and heart of Family Medicine. It would truly be an honor to serve as Speaker, to continue to serve CAFP and all the family physicians in California, to advocate for our specialty, patients and communities. Thank you again for the opportunity and your kind consideration. – *Kim K. Yu, MD, FAAFP*

For the Office of Vice Speaker – Brent K. Sugimoto, MD, MPH, FAAFP
During my six years as Editor of the CAFP magazine *California Family Physician*, I had an intimate view of the diversity, dynamism, and talent of Family Physicians in our state. It was important in that job to give a platform to the voices of our membership faithfully and representatively. As I end my term as CAFP District Director and Secretary-Treasurer, giving voice is also an important responsibility of being Vice Speaker. Our collective voice is the source of our strength as Family Physicians. Working with the Speaker, I would (1) work to ensure your voice is reflected in the priorities of the Academy, and (2) further support our deliberative forums as spaces for

leadership development. When I reflect on the opportunities I was afforded throughout my career, I have grown up professionally with the help of the CAFP. Being supported and surrounded by California's network of talent has been indispensable to my own leadership development. AMAM is an opportunity for the development of our future leaders through the practice of the skills needed to lead. We can prioritize both our voice and our future leaders to make us a stronger specialty. As a candidate for Vice Speaker, I am determined to serve you ably and faithfully, and humbly ask for your vote. Thank you for your consideration. – *Brent K Sugimoto, MD, MPH, FAAFP*

For the Office of AAFP Delegate – Lee P. Ralph, MD
I am honored to be selected by the Nominating Committee to run for the office of CAFP Delegate for the AAFP Congress of Delegates. Health care in our country continues to be under attack from many fronts. Access to care remains suboptimal, cost increases are becoming even more unaffordable, and recognition and reimbursement for the complicated and complex care provided by family physicians is under appreciated. These are just a few of the issues that must be dealt with at the National, State and community levels. I have been privileged to have attended many of the AAFP Congress of Delegates representing CAFP and would like to continue the journey to help fight for those issues most relevant to you, the members of the CAFP. I have been a member of the CAFP for over 35 years since coming for my residency training at UCSD. I have worked as a family medicine faculty member, pre-doctoral director and now helping to lead a medium sized group private practice. Each of these positions has given me insight into the complexities of problems that we face every day. We have a wonderful group of physicians that have represented us well on the national level and I would be honored to continue working with all of them at the AAFP. Thank you for your consideration. Respectfully submitted – *Lee P. Ralph, MD*

For the Office of AAFP Alternate Delegate - Alex M McDonald, MD, FAAFP, CAQSM
It is an honor to be nominated as CAFP's Alternate Delegate to the AAFP Congress of Delegates. I have had the privilege to attend AAFP Congress of Delegates as a resident and new physician alternate and delegate in the past and have built many relationships within the congress over the past 10 years. I would be honored to continue this work to ensure I advocate for CAFP priorities within the AAFP. I have also worked to broaden the impact we can have not only within California, but also within the AAFP to advocate for CAFP priorities and Family Medicine beyond the borders of CAFP. Leadership is not about a position or title, it's about a passion for inspiring and organizing others to make a difference, not just individually for our patients, but collectively for our specialty and all of the communities we serve, locally, statewide and nationally. As a member of the CAFP executive committee, I take the trust placed in me as a leader and voice of our academy very seriously and am excited to continue on the amazing work we have done together over the past several years. Servant leadership is about leaving things better than you find them and that's my goal and I am excited to help continue within the journey. – *Alex M McDonald, MD, FAAFP, CAQSM*

For the Office of Governance Committee Member 2024 – 2026 – Sarah McNeil, MD
I would be honored to serve on the Governance Committee of the CAFP for so many reasons. I applied to Family Medicine residencies because I just found family docs as "my people," and this has stayed true throughout my career. Additionally, I am super proud to be a family doctor. I absolutely love the work that I do with underserved patients and the broad scope of my practice: delivering babies, staffing urgent care, playing an administrative role, providing abortion services, and so much more. I definitely "specialize" in women's health, but I'm most passionate about being a generalist -- what we bring to patients and communities. My involvement in the CAFP has been a critical part of my identity and pride in being a family doctor. For multiple years, I served on the Committee for Continuing Professional Development and had a blast. I was "termed off" and offered to do Governance, not because I'm an expert, but rather because I deeply believe in the work that the CAFP does - for our specialty and for our patients - and I know that the staff will help teach me all the ropes.

I know that the governance committee plays a crucial role in strategic decision-making, policy development, and ensuring the organization's alignment with its core values. I am excited about this opportunity. – *Sarah McNeil, MD*

For the Office of Governance Committee Member 2024-2026 – Mary Hanna, MD, FAAFP
It is an honor to be nominated for the Governance Committee Member position at the California Academy of Family Physicians. I am thrilled to have the chance to support the leadership and administration of our esteemed CAFP as a committed family medicine physician passionate about growing our specialty. Throughout my career, I have witnessed the vital role of advocacy for the needs of both patients and healthcare professionals. Strong, effective governance is essential for the CAFP to remain responsive to the evolving challenges and opportunities facing family medicine in California. In addition to my work as core faculty and inpatient director in the family medicine residency program and my experience as a practicing family physician, I am involved in various leadership roles at Loma Linda University Health. I have also served at the CAFP Riverside-San Bernardino chapter for several years and am currently the chapter secretary/treasurer. I am privileged to contribute a cooperative and progressive mindset to decision-making, emphasizing openness, responsibility, and diversity inside our CAFP – *Mary Hanna, MD, FAAFP, AAHIVS*

For the Office of New Physician Director - Cynthia Chen-Joea MD
Being a Family Physician is an honor for which I am incredibly proud and grateful. We are privileged to serve our patients, and uniquely positioned to help optimize their wellbeing within our healthcare system. I am honored to be considered a candidate for CAFP New Physician Director, where I may work collaboratively with others to represent the best interests of Family Physicians everywhere. My journey with CAFP started with the Resident-Student Council, where I was incredibly inspired and motivated by the advocacy work Family Physicians do across our communities. I am passionate about engaging medical students, residents and new physicians with CAFP so they may be aware of the resources CAFP has to offer, but also become more actively involved with the healthcare issues that may be important to them. My background in medicine and public health has afforded me a unique insight into how the pandemic has affected physicians working in diverse settings, and the natural aftermath of what medicine has become post COVID. As Associate Program Director and Inpatient Director of the Emanate Health Family Medicine Residency Program, I work with medical students and residents closely introducing them to advocacy within our specialty. As Secretary-Treasurer and past Department Chair at Emanate Health, I promote the best interests of our medical staff and am highly involved in quality improvement projects in our hospitals. I also serve on the board of our local LA-AFP chapter, am involved in the CAFP Committee of Public Health and Equity and will serve as Co-Chair of the Member Engagement Committee this upcoming year. I look forward to my own growth and learning as Co-Convener of the Women's Constituency at NCCL and as NCCL Delegate to AAFP Congress of Delegates this year. I believe our specialty is the backbone of our healthcare system, and we have the power to affect legislation that may improve the health of the population. With my experience, I hope to continue engaging CAFP members across our state to motivate them to fight for the change that they hope to see and inspire a new generation of leaders who may continue leading change for the better in California. Thank you for your time, consideration, and opportunity to share my ideas. I hope to help make our specialty and your healthcare goals for our state a reality as CAFP New Physician Director. – *Cynthia Chen-Joea, MD*

For the Office of New Physician Director – C. Emily Lu, MD
I am running for the New Physician Director position because I represent the large proportion of new family physicians who are relatively new to organized medicine, but have nevertheless been working hard to try different ways to care for our patients and change the healthcare system. I want to reach those CAFP members no matter where they practice so that we can elevate their diverse voices and build a family medicine community that doesn't just care for our patients but also for each other as we grow our careers. Though I haven't held leadership positions in CAFP until recently, I have sought career experiences that have allowed me

to lead primary care innovation in different settings: from academic safety-net care to private practice tech-enabled care, from fully-capitated risk contracts to fee for service volume management, from building tech products to leading multidisciplinary care coordination teams, from coordinating FQHC quality care collaboratives to speaking at health tech conferences, from caring for the sickest of the sick Medicaid/Medicare patients to caring for CEOs and other female professionals hitting the burnout ceiling. I believe my diversity of experience helps me understand some of the diversity of practice that new physicians face today. I have already had the opportunity to bring that experience to the CAFP as an AMAM delegate, a member of CAFP's medical practice affairs committee, and very recently this year as Vice President of the newly reconstituted CAFP East Bay chapter. I hope as the New Physician Director to build other ways for new physicians to engage with CAFP leadership and receive CAFP support. Being a family physician in our fragmented system is hard enough – we should not have to do it alone. Thank you!!!! – *C. Emily Lu, MD*

For the Office of New Physician Director – Laura Murphy, DO

I am very excited to announce my candidacy to serve as the New Physician Director board member. The CAFP became my community when I was a medical student after I noticed a pattern: every time I would tell my peers that I was going into Family Medicine, they would question my choice. It was as if they did not know that primary care is the only field in medicine that increases lifespan and health equity. Or worse, if they did know, that medicine was no longer about the patients, but about the physician. The #FMRevolution embodied by the CAFP was a counterforce to that, aiming to shift the focus back to the patients, and so began my advocacy journey on the board of directors as a medical student. I organized workshops for medical students introducing them to the breadth of family medicine. I later became the resident member of the Committee on Continuing Professional Development, which I continue to serve on today, listening to our members needs to help strengthen our ability to care for our patients effectively, and our profession unapologetically. As core faculty at Ventura County Medicine Center Family Medicine Residency, I have begun an advocacy curriculum to empower residents to break down the barriers to health equity that our patients face outside of the clinic walls every day. Of course, our hard work does not stop when we graduate. As the New Physician representative on the board, this work to increase, mobilize, and revolutionize the family medicine workforce is what I aim to carry forward so that when future medical students decide to enter family medicine, rather than question the choice, others will join the cause. Thank you for considering me as your New Physician board member. – *Laura Muphy, DO*

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