



2026 ALL MEMBER ADVOCACY MEETING

PARTICIPANTS' HANDBOOK

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

We are very pleased you chose to join your family medicine colleagues and friends at the 2026 CAFP All Member Advocacy Meeting (AMAM). This year we're prescribing more than medicine, we're prescribing hope. At AMAM, you'll join family physicians, residents, and medical students from across California to transform that hope into tangible change. 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, advocacy, inspiration, and fun. The Participant Handbook includes important information 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 equip family physicians to become 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 CAFP'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 discuss and testify on policy issues of urgent concern to the Academy for consideration.

AMAM's focus is on advocacy, rather than clinical education. CAFP's [Prism of Practice! \(POP!\)](#) on August 21st through 23rd 2026 in San Diego 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 CAFP Board of Directors.

Thank you for being an advocate for Family Medicine!



Brent Sugimoto, MD, MPH, FAAFP
Speaker



Jorge Galdamez, MD, MPH
Vice Speaker

Detailed Schedule of Events

All Member Advocacy Meeting — Saturday, March 14, 2026	
Opening Session • Camellia/Gardenia— 1:00 pm – 5:15 pm	
12:00 pm – 1:00 pm	All Member Advocacy Meeting (AMAM) Registration & Lunch Delegates check in by 12:30 pm to establish a quorum
1:00 pm – 1:20 pm	Opening Session of the AMAM – Welcome <i>Lisa Folberg, MPP, CAFP CEO and Alex McDonald, MD, FAAFP, CAFP Immediate Past President</i>
	What is the AMAM and What Will We Do During This Meeting? <i>Brent Sugimoto, MD, MPH, FAAFP, CAFP Speaker</i> <ul style="list-style-type: none"> • 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 <i>Anthony Chong, MD, FAAFP, CAFP President</i>
1:30 pm – 1:35 pm	About FP-PAC <i>Shannon Connolly, MD, FAAFP, FP-PAC Chair</i>
1:35 pm – 3:10 pm	Resolutions Hearing – CAFP Board of Directors <i>Brent Sugimoto, MD, MPH, FAAFP, CAFP Speaker and Jorge Galdamez, MD, MPH, CAFP Vice Speaker</i>
3:10 pm – 3:20 pm	BREAK
3:20 pm – 5:15 pm	Resolutions Hearing (continued) – CAFP Board of Directors <i>Brent Sugimoto, MD, MPH, FAAFP, CAFP Speaker and Jorge Galdamez, MD, MPH, CAFP Vice Speaker</i>
5:15 pm	Election of Officers, AAFP Delegates and Alternates, Governance Committee Members (if contested elections) <i>Brent Sugimoto, MD, MPH, FAAFP, CAFP Speaker</i>
5:15 pm - 6:00 pm	ADJOURN Please help by cleaning up your table as you exit
6:00 pm – 7:00 pm	President’s Reception at CAFP Sacramento HQ (816 21 st Street)
7:30 pm	Sacramento Dine Arouds

All Member Advocacy Meeting — Sunday, March 15, 2026	
Session • Camellia/Gardenia — 7:00 am – 2:15 pm; Training Tracks — 2:30 pm – 4:00 pm	
7:00 am – 8:00 am	Registration and Breakfast Private Breakfast for Chapter Presidents (Beavis Room)
8:00 am – 8:05 am	AMAM Reconvenes – Welcome Back and Preview of the Day <i>Brent Sugimoto, MD, MPH, FAAFP, CAFP Speaker</i>
8:05 am – 8:20 am	AAFP Update <i>Russell Kohl, MD, FAAFP, AAFP Speaker</i>
8:20 am – 8:40 am	FP-PAC Challenge <i>Toussaint Mears-Clarke, MD, MBA, FAAFP</i>
8:40 am – 9:00 am	CAFP Foundation Update & AMAM Scholarship <i>Parastou Farhadian, MD, FAAFP, CAFP Foundation President</i>
9:00 am – 10:00 am	Keynote Speaker <i>Jessica Altman, MPP, Executive Director of Covered California</i> <i>Kim Yu, MD, FAAFP, CAFP President-Elect</i>
10:00 am – 10:20 am	BREAK
10:20 am – 11:00 am	Update on Resolution A-15-24 <i>Alex McDonald, MD, FAAFP and</i> <i>Anthony Chong, MD, FAAFP, Governance Committee Chairs</i>
11:00 am – 11:40 am	Legislative Update <i>Jeff Luther, MD, FAAFP – Chair, Legislative Affairs Committee</i> <i>Megan Houston, MPH – Policy Director, CAFP</i> <i>Natalie Pita, MPH – Legislative and Policy Advocate, CAFP</i> <i>Vanessa Cajina – Legislative Advocate, KP Public Affairs</i> <i>EJ Aguayo – Legislative Advocate, KP Public Affairs</i>
11:40 am – 12:00 pm	BREAK/LUNCH BUFFET
12:00 pm – 1:00 pm	Celebration Lunch <i>Russell Kohl, MD, FAAFP – AAFP Speaker</i> <i>Anthony Chong, MD, FAAFP – CAFP President</i> <i>Kim Yu, MD, FAAFP – CAFP Incoming President</i> <ul style="list-style-type: none"> • Convocation of Fellows • Installation of Officers • President's Address • Family Physician Advocate of the Year Award Announcement
1:00pm – 2:00 pm	Prescribing Safety: A Guide on Advocating for Immigrant Patients <i>Ignatius Bau, JD – Independent Consultant</i> <i>Shiu-Ming Cheer, JD – Deputy Director of Immigrant & Racial Justice, California Immigrant Policy Center</i> <i>Michael Core, MD – Family Physician and Regional Medical Director, AltaMed Health Services</i> <i>Michelle Lough, MD, MPH, FAAFP – Substance Use Disorder Physician, San Ysidro Health</i> <p><i>This panel discussion will include policy experts and family physicians who have experience with ICE raids in clinic, and the unique challenges faced by undocumented patient populations. Panelists will discuss policy opportunities to protect patients and resources for family physicians, including CAFP's recently published Healthy Harbors Guide.</i></p>
2:00 pm – 2:15 pm	PAC Challenge

	<i>FP-PAC Member to Provide Challenge</i>
2:15 pm – 2:30 pm	BREAK
2:30 pm – 4:00pm	<p>Training Tracks</p> <p><u>Track One: How to be an Effective Family Physician Legislative Advocate</u> <i>Vanessa Cajina - Legislative Advocate, KP Public Affairs</i> <i>EJ Aguayo – Legislative Advocate, KP Public Affairs</i></p> <p>This session will provide practical steps on how to meet with state legislators and key staff in order to promote family medicines and increased access to primary care.</p> <p><u>Track Two: Speaking With Impact: Communication Training for Family Physicians</u> <i>Alison MacLeod – Partner, KP Public Affairs</i></p> <p>This session will equip family physicians with practical communication tools to reinforce the message that <i>family physicians do it all</i>. The training will focus on how to clearly and confidently articulate the role of family physicians, particularly in pediatric care and vaccines, and how they provide a critical role in supporting the health of all Californians.</p>
4:00 PM	Sacramento Dine Arounds

Lobby Day — Monday, March 16, 2026	
Session • Camellia/Gardenia — 8:00 am – 3:00 pm	
8:00 am – 8:45 am	<p>Breakfast</p> <ul style="list-style-type: none"> Lobby Day Issue Briefing <i>Jeff Luther, MD, FAAFP – Chair, Legislative Affairs Committee</i> <i>Natalie Pita, MPH – Legislative and Policy Advocate, CAFP</i>
9:00 am	Group Photo in Front of Capitol – Bring your white coats!
9:15 am – 12:00 pm	Legislative Visits at the Capitol
12:00 pm – 1:00 pm	FP-PAC Donor Lunch Reception - Thirtyfour Mexican Cantina
1:00 pm – 3:00 pm	Legislative Visits at the Capitol

Roster of 2026 Delegates and Alternates

County/Chapter	Delegates	Alternates
Alameda/Contra Costa (5)	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
Amador (1)	1.	1.
Butte-Glenn-Tehama (1)	1.	1.
Fresno-Kings-Madera (3)	1. Dr. Diana Gutierrez 2. Dr. Shruti Javali 3. Dr. Zhoobin H. Bateni	1. 2. 3.
Humboldt-Del Norte (2)	1. 2.	1. 2.
Imperial (1)	1.	1.
Inyo-Mono-Alpine (1)	1.	1.
Kern (2)	1. Dr. David Powell 2.	1. 2.
Lassen-Plumas-Modoc (1)	1. Dr. Landin Hagge	1.
Los Angeles (12)	1. Dr. Mark Benor 2. Dr. Phillip Brown 3. Dr. Michael Core 4. Dr. Michelle Crespo 5. Dr. Chris Hiromura 6. Dr. Linda James 7. Dr. Soomin Jung 8. Dr. Peony Khoo 9. Dr. Kevin Rossi 10. Dr. Camilo Zaks 11. Dr. Yousuf Zaveri 12. Dr. Stacey Ludwig	1. Dr. Jerry Abraham 2. Dr. Emma Hiscocks 3. Dr. Amanda d'Almeida 4. Dr. Amanda Dupree 5. Dr. Viviana Huang-Chen 6. Dr. Greg Lewis 7. Dr. Miriam Padilla 8. Dr. Melissa See 9. Dr. Monika Shenouda 10. Dr. Amy Tressan 11. Dr. Michelle Yim-Tang 12.
Mendocino-Lake (1)	1.	1.
Merced-Mariposa (2)	1. 2.	1. 2.
Napa (1)	1.	1.
North Bay (3)	1. 2. 3.	1. 2. 3.
Orange (5)	1. Dr. Matt Varallo 2. Dr. Kun Chhai Meas 3. Dr. Carly Soo 4. Dr. Mayra Hernandez 5. Dr. Will Woo	1. Dr. Florence Yuan 2. 3. 4. 5.
Placer-Sierra-Nevada (2)	1. 2.	1. 2.
Riverside-San Bernardino (7)	1. Dr. Javier Sanchez 2. Dr. Scott Nass 3. Dr. Lauren Simon 4. Dr. Asha Dasika 5. Dr. Danae Smart	1. Dr. Moazzum Bajwa 2. Dr. Nelly Chuqui 3. Dr. Mai-Linh Tran* 4. Dr. Jasleen Singh* 5. Dr. Ellen Liang

	<ol style="list-style-type: none"> 6. Dr. Milo Dover 7. Dr. Carrie Bacon 	<ol style="list-style-type: none"> 6. Dr. Carlos Calderon* 7.
Sacramento Valley (5)	<ol style="list-style-type: none"> 1. Dr. Bill Eng 2. Dr. Suzanne Eidson-Ton 3. Dr. Tommy Anker 4. Dr. Dwiju Kumar 5. Dr. Kirsten Vitrikas 	<ol style="list-style-type: none"> 1. Dr. Ian Kim 2. Dr. Eric Reece 3. Dr. Victor Guerrero 4. Dr. Muhammad Daud* 5.
San Diego (6)	<ol style="list-style-type: none"> 1. Dr. Melissa Campos 2. Dr. Lance Fuchs 3. Dr. Julie Celebi 4. Dr. Kristin Brownell 5. Dr. Joseph Leonard 6. Dr. Caitlin MacMillen* 	<ol style="list-style-type: none"> 1. Dr. Cecilia Gutierrez 2. Dr. Brad Stiles 3. Dr. Sarah Merrill* 4. Dr. Merritt Matthews 5. Dr. Patrick Yassini 6. Dr. Randy Swartz
San Francisco (2)	<ol style="list-style-type: none"> 1. Dr. Clarissa Kripke* 2. 	<ol style="list-style-type: none"> 1. 2.
San Joaquin-Calaveras-Tuolumne (2)	<ol style="list-style-type: none"> 1. Dr. Maryal Concepcion 2. Dr. David Araiza 	<ol style="list-style-type: none"> 1. 2.
San Luis Obispo (2)	<ol style="list-style-type: none"> 1. 2. 	<ol style="list-style-type: none"> 1. 2.
San Mateo (2)	<ol style="list-style-type: none"> 1. 2. 	<ol style="list-style-type: none"> 1. 2.
Santa Barbara (2)	<ol style="list-style-type: none"> 1. 2. 	<ol style="list-style-type: none"> 1. 2.
Santa Clara (4)	<ol style="list-style-type: none"> 1. Dr. Angela Bymaster 2. Dr. Rubeena Dhami 3. Dr. Michelle Engle 4. Dr. Jake Evans 	<ol style="list-style-type: none"> 1. Dr. Rachel Gottlieb 2. 3. 4.
Santa Cruz – Monterey (2)	<ol style="list-style-type: none"> 1. 2. 	<ol style="list-style-type: none"> 1. 2.
Shasta-Trinity (2)	<ol style="list-style-type: none"> 1. 2. 	<ol style="list-style-type: none"> 1. 2.
Siskiyou (1)	<ol style="list-style-type: none"> 1. 	<ol style="list-style-type: none"> 1.
Solano (2)	<ol style="list-style-type: none"> 1. Dr. Adia Scrubb 2. Dr. Ian Bennett 	<ol style="list-style-type: none"> 1. Dr. Rossan Chen 2. Dr. Matthew Symkowick
Stanislaus (2)	<ol style="list-style-type: none"> 1. Dr. Erin Kiesel 2. Dr. Nicole McLawrence* 	<ol style="list-style-type: none"> 1. 2.
Tulare (2)	<ol style="list-style-type: none"> 1. Dr. Adnaan Edun 2. Dr. Shahzeb Nadeem 	<ol style="list-style-type: none"> 1. Dr. Christopher Terzian 2. Dr. Shiveta Cherwoo
Ventura (2)	<ol style="list-style-type: none"> 1. Dr. Helen Petroff 2. Dr. Leslie Lynn Pawson 	<ol style="list-style-type: none"> 1. 2.
Yuba-Sutter-Colusa (1)	<ol style="list-style-type: none"> 1. 	<ol style="list-style-type: none"> 1.
Student and Resident Council (2 Students and 2 Residents)	<ol style="list-style-type: none"> 1. John Robb (S) 2. Emily Korba (R) 3. 4. 	<ol style="list-style-type: none"> 1. Rebecca Braganca (S) 2. Elaha Noori (S) 3. Nadia Esquivel (R) 4.

* Names were submitted after the January 12, 2026 deadline and must be approved by the Delegates of the AMAM.

CAFP Officers and Board of Directors – 2025-2026

CAFP Officers and Board of Directors	
Anthony Chong, MD, FAAFP	President
Alex McDonald, MD, FAAFP	Immediate Past President, AAFP Alternate
Kim Yu, MD, FAAFP	President-elect
Brent Sugimoto, MD, FAAFP	Speaker
Jorge Galdamez, MD	Vice Speaker
Erika Roshanravan, MD, FAAFP	Secretary-Treasurer, District X
Lee Ralph, MD	AAFP Delegate
Lisa Ward, MD, FAAFP	AAFP Delegate
Shannon Connolly, MD, FAAFP	AAFP Alternate Delegate**
Parastou Farhadian, MD, FAAFP	CAFP-F President
Maria Carriedo-Ceniceros, MD, FAAFP	District I
Anna Askari, MD, FAAFP	District II
Samuel Po-Yin Huang, MD, FAAFP	District III
Rebecca Bertin, MD, FAAFP	District IV
Shayne Poulin, MD, FAAFP	District V
Robin Janzen, MD, FAAFP	District VI
Francis Chu, MD, FAAFP	District VII
Rob Assibey, MD, FAAFP	District VIII
Lalita Abyhankar, MD, FAAFP	District IX
Amanda Mooneyham, MD, FAAFP	Rural Director
Laura Murphy, DO	New Physician Director
Valerie Otti, MD	Resident Co-Director***
Avery Muniz	Student Co-Director***

** Non-voting member

*** One Resident and one Student Co-Director serve as Delegates at the AMAM.

2026 Instructions to Delegates and Alternates

CAFP All Member Advocacy Meeting

It is important that all Delegates and Alternates read this section to learn about their unique 2026 duties and responsibilities.

Introduction:

As a Delegate to the California Academy of Family Physicians (CAFP) All Member Advocacy Meeting (AMAM), you are charged with important responsibilities. **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) Review and provide comment on new Resolutions 5) Vote on any CAFP bylaws changes.**

Function: The CAFP AMAM discusses policies for consideration by the CAFP Board of Directors, changes to CAFP bylaws, 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 2025 AMAM and how to access 2025 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 Compendium 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 [2025-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 CAFPA AMAM staff prior to the meeting. **Registration for the AMAM will be open between 12:00 and 1:00 pm on March 14, 2026. All delegates must register by 12:30 pm**, to establish quorum well before the meeting commences at 1:00 pm. After registering, Delegates are invited to enjoy lunch in the event ballroom and mingle with colleagues.
2. **Certification of Delegates:** CAFPA bylaws require Delegates to AMAM to be reported to the secretary/treasurer sixty (60) working days prior to AMAM (January 12, 2026). 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 CAFPA AMAM staff, your name will be placed on the roll of the AMAM. According to CAFPA 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. If 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 CAFPA staff.
4. **Voting:** Each Delegate member of the AMAM shall have one vote when electing CAFPA 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.
5. **Extracting Resolutions:** This year, resolutions which were submitted by the deadline (December 7, 2025) were first referred to the appropriate CAFPA committee for review and recommendation prior to AMAM. Committee reports are included in this handbook and will be presented as a consent calendar at AMAM. Delegates, or in the absence of the Delegates, the Alternate Delegate(s), will have the authority to extract resolutions for discussion on the floor at AMAM. All other resolutions (not extracted) and corresponding committee recommendations will be sent to the CAFPA Board without further discussion.

Standing Rules of the All Member Advocacy Meeting:

When AMAM Convenes: The AMAM will convene at 1:00 pm, Saturday, March 14, 2026, and again on Sunday, March 15, 2026 at 8:00 am at The Sheraton Grand Hotel, 1230 J Street, Sacramento, CA. The order of business will be as outlined in the Participant Handbook and may be changed by the CAFP Speaker as necessary. Meeting rooms also are subject to change.

Parliamentary Procedure: The American Institute of Parliamentarians, Standard Code of Parliamentary Procedure (Sturgis) 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 by December 7, 2025. The Board of Directors will accept written testimony on all extracted 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 during the resolution hearing. 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, chapter, and whether you are speaking on behalf of a chapter, constituency or yourself for the record. State whether you are for or against the resolution, any conflicts you may have, and offer your testimony. Testimony time limits will be strictly enforced. 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 members as possible the opportunity to speak.

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.

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 of which action to take on each resolution during the year. The Board may re-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 adopt a resolution, adopt as amended, or not adopt a resolution. It may determine that actions proposed by some resolutions are beyond the expertise and resources of the Academy.

Affirmation/Acclamation Calendars: Affirmation and/or acclamation also may be used by the Board when a resolution is determined to be either affirmation 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 212):

President-elect	AAFP Delegate & Alternate
Speaker	Governance Committee Members
Vice Speaker	

The Committee may also submit nominations for District Directors when nominations are 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 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 between two and 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

Regarding 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

American Institute of Parliamentarians Standard Code

BASIC RULES GOVERNING MOTIONS								
Order of precedence ¹	Can interrupt?	Requires a second?	Debatable? ²	Amendable?	Vote Required?	Applies to what other motions	Can have what other motions applied to it? ³	Renewable?
PRIVILEGED MOTIONS								
1 Adjourn	No	Yes	No	Yes	Majority	None	Amend, close debate	Yes
2 Recess	No	Yes	No	Yes	Majority	None	Amend, close debate	Yes
3 Question of privilege	Yes	No	No	No	None	None	None	Yes
SUBSIDIARY MOTIONS								
4 Table	No	Yes	No	No	2/3	Main motion	None	No
5 Close debate & vote immediately	No	Yes	No	Yes	2/3	Amendable, debatable motions	Amend	Yes
6 Limit or extend debate	No	Yes	No	Yes	2/3	Amendable, debatable motions Main motion with	Amend, close debate	Yes
7 Postpone to a certain time	No	Yes	Yes	Yes	Majority ⁴	pending subsidiary motions	Amend, limit debate, close debate	Yes
8 Refer to committee	No	Yes	Yes	Yes	Majority	Main motion with pending amendm	Amend, limit debate, close debate	Yes
9 Amend	No	Yes	Yes ⁵	Yes	Majority	Rewordable motions	Amend, limit debate, close debate	Yes ⁶
MAIN MOTIONS								
10 a. The main motion	No	Yes	Yes	Yes	Majority	None	Subsidiary motions	No
b. Specific-purpose main motions								
Adopt in lieu of	No	Yes	Yes	Yes	Majority	Designated motions	Subsidiary motions	No
Amend a previous action	No	Yes	Yes	Yes	Same Vote	Adopted main motion	Subsidiary motions	No
Ratify	No	Yes	Yes	No	Same Vote	Adopted main motion	Subsidiary motions except amend	No
Recall from a committee	No	Yes	Yes	No	Majority	Referred main motion Main motion, some specific-	Close debate, limit debate	Yes
Reconsider	Yes ⁷	Yes	Yes	No	Majority	purpose main motions ⁸	Close debate, limit debate	No
Rescind	No	Yes	Yes	No	Same Vote	Adopted main motion	Subsidiary motions except amend	No
INCIDENTAL MOTIONS								
<i>No order of precedence</i>								
MOTIONS								
Appeal	Yes ⁷	Yes	Yes	No	Majority	Ruling of presiding officer	Close debate, limit debate	No
Suspend the rules	No	Yes	No	No	2/3	Procedural rules	None	Yes
Consider by paragraph	No	Yes	No	No	Majority	Main motion	None	Yes
Counted Vote	Yes	Yes	No	No	Majority	Vote with an unclear outcome	None	No
REQUESTS								
Point of order	Yes	No	No	No	None	Procedural error	None	No
Inquiries	Yes ⁹	No	No	No	None	All motions	None	No
Withdraw a motion	Yes	No	No	No	None	All motions	None	No
Division of question	No	No	No	No	None	Divisible motions	None	No
Division of assembly	Yes	No	No	No	None	Vote with an unclear outcome	None	No

¹ Motions are in order only if no motion higher on the list is pending.

² Debate must always be germane to the pending motion

³ Note that the Motion to Withdraw can be applied to all motions.

⁴ Postpone and make a special order requires 2/3 vote

⁵ Is not debatable when applied to an undebatable motion

⁶ At the discretion of the presiding officer

⁷ Can interrupt proceedings, but not a speaker

⁸ Adopt in Lieu of, Amend a Previous Action, Ratify, and Rescind

⁹ Only if it requires an immediate answer

For more general information on parliamentary procedure, please visit [here](#).

Resolution Instructions

CAFP Resolutions are intended to create, amend or delete policy, and are not intended to direct operations or strategic priorities. Resolutions must meet the following criteria:

1. Raise issues that strongly impact family physicians or family medicine;
2. Not make references to point-in-time issues, such as specific bills, local initiatives, or one-time programs;
3. Not duplicate existing policy; and,
4. 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 2026 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 are within the expertise of AAFP and family physicians.

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

Resolutions and Background Materials

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

List of Resolutions and Committee Reports

What follows is the report of each Committee summarizing its recommendations on the Resolutions referred to that Committee. This Committee report is followed by more detail for each Resolution, specifically; the Resolution as submitted by the author, Speaker's notes, Speaker's fiscal notes, and the Committee recommendation for that resolution.

1. [Committee Report – Committee on Continuing Professional Development \(CCPD\)](#)
 - a. [Resolution A-01-26](#) – Empowering Family Physicians to Provide Culturally Competent and Language Concordant Care Through Further Development of CME and Partnership of Existing Language Services
 - b. [Resolution A-02-26](#) – Enhancing Resources, Support, and Education for Immigrant Patient Health
 - c. [Resolution A-03-26](#) – Sustainable Practices for CAFP Conferences and Events
2. [Committee Report – Committee on Public Health and Equity \(CPHE\)](#)
 - a. [Resolution A-04-26](#) – CAFP Policy on Development of State-Wide Registry for Cervical Cancer Screening
 - b. [Resolution A-05-26](#) – Eliminating Fruit Juice from WIC Food Packages to Combat Childhood Obesity and Dental Caries
 - c. [Resolution A-06-26](#) – Food Literacy
 - d. [Resolution A-07-26](#) – Supporting School Policies that Substantially Reduce Items Containing High-Fructose Corn Syrup and Derivatives
 - e. [Resolution A-08-26](#) – Food Label Transparency
 - f. [Resolution A-09-26](#) – Ensuring Equitable Vaccine Access for Independent and Rural Family Physicians to Protect Public Health in California
 - g. [Resolution A-10-26](#) – Vaccine Information Mobile Application
 - h. [Resolution A-11-26](#) – Promotion of Resistance Training and Physical Activity as Standard Preventive Health Recommendations in Family Medicine
 - i. [Resolution A-12-26](#) – Supporting Expanded Research and Rescheduling of Therapeutic Psychedelics
3. [Committee Report – California Residency Network \(CRN\)](#)
 - a. [Resolution A-13-26](#) – Family Medicine GME Finance Reform
 - b. [Resolution A-14-26](#) – Vasectomy Training During Family Medicine Residency
 - c. [Resolution A-15-26](#) – Expand FM-OB Training to Address Maternity Care Deserts
4. [Committee Report – Governance Committee](#)
 - a. [Resolution A-16-26](#) – Increasing Family Medicine Resident Physician Representation as Delegates at the CAFP All Member Advocacy Meeting (AMAM)
5. [Committee Report – Justice, Equity, Diversity and Inclusion \(JEDI\) Committee](#)
 - a. [Resolution A-17-26](#) – Defend and Uphold Provision of Gender Affirming Care
 - b. [Resolution A-18-26](#) – CAFP Policy on Intellectual and/or Developmental Disability Care in Primary Care Setting
 - c. [Resolution A-19-26](#) – JEDI in Politics
 - d. [Resolution A-20-26](#) – Health Care Rights of Patients who are Detained by ICE
 - e. [Resolution A-21-26](#) – Protect Confidentiality and Access to Care for Immigrant Patients
 - f. [Resolution A-22-26](#) – Protecting Health Care as a Human Right Regardless of Immigration Status
6. [Committee Report – Legislative Affairs Committee \(LAC\)](#)
 - a. [Resolution A-23-26](#) – The Dementia Gap
 - b. [Resolution A-24-26](#) – Increasing State Investment to Expand Home and Community-Based Alternative Waiver Program (HCBA) Capacity and Access

- c. [Resolution A-25-26](#) – Advancing Patient Partnership in CAFP Health Policy Development and Advocacy
 - d. [Resolution A-26-26](#) – Ensuring the Availability and Affordability of H-1B Visas for Primary Care Physicians
 - e. [Resolution A-27-26](#) – Opposing the Expansion of SNAP Work Requirements
 - f. [Resolution A-28-26](#) – Oppose Work Requirements for Medicaid / Medi-Cal
 - g. [Resolution A-29-26](#) – Support Full-scope Medi-Cal Access for Californians, Regardless of Immigration Status
 - h. [Resolution A-30-26](#) – Preserving Continuous Full-Scope Medi-Cal Coverage for All Income-Eligible Adults
 - i. [Resolution A-31-26](#) – Development of Updated Medical Student Loan Education Resources
 - j. [Resolution A-32-26](#) – CAFP Supports Affordable Medical Education for Students from Low Social Economic Backgrounds
7. [Committee Report – Membership Engagement Committee \(MEC\)](#)
- a. [Resolution A-33-26](#) – Addressing Health Misinformation Through Physician Education and Community Engagement
 - b. [Resolution A-34-26](#) – Ensuring Equitable Representation of Independent and Physician-Led Practice
8. [Committee Report – Medical Practice Affairs Committee \(MPAC\)](#)
- a. [Resolution A-35-26](#) – Confidential Support Resources for Physicians with Impairing Illnesses
 - b. [Resolution A-36-26](#) – CAFP Support for Policies Limiting Government Organization Access to HIPAA Protected Data
 - c. [Resolution A-37-26](#) – Focusing on Interoperability to Improve Continuity of Care for Unhoused Patients in California
 - d. [Resolution A-38-26](#) – Equal Compensation
 - e. [Resolution A-39-26](#) – Payment Equity
 - f. [Resolution A-40-26](#) – Measure What Matters for Value-based Payment

Committee Report – Committee on Continuing Professional Development (CCPD)

2026 Report of the CAFP Committee on Continuing Professional Development (CCPD)

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Committee on Continuing Professional Development (CCPD) has considered the following resolution referred to it and submits the following report.

- A-01-26 – Empowering family physicians to provide culturally competent and language concordant care
- A-02-26 – Enhancing Resources, Support, and Education for Immigrant Patient Health
- A-03-26 – Sustainable Practices for CAFP Conferences and Events

(Original) Resolution # A-01-26: Empowering Family Physicians to Provide Culturally Competent and Language Concordant Care Through Further Development of CME and Partnership of Existing Language Services

RESOLVED: That this includes developing, promoting, and supporting CME in culturally competent clinic based medical language learning for primary care physician/providers such as Spanish and act as a pathway for development, promotion and support of medical language learning in other languages as well.

Committee Recommendation: AFFIRM AS EXISTING POLICY

Committee Discussion: The committee noted that CAFP already has existing policy supporting culturally competent care and related CME development. Members discussed that developing and sustaining longitudinal medical language education would be a significant and costly undertaking and may fall outside the current scope and resources of CAFP. While there was strong agreement with the intent and spirit of the resolution, the committee emphasized that the policy underpinning affirms existing policy. The committee noted that they must consider a number of factors before determining specific CME activities in which to engage. Several members expressed interest in addressing this growing area through more targeted and feasible approaches, such as conference sessions, workshops, or POP activities, including potential offerings like medical Spanish or conversations in medical Spanish. The committee also discussed CAFP's role as a possible pathway or repository for external resources rather than as a primary developer of comprehensive language education programs. Ultimately, the committee agreed that acknowledging the need without creating a new policy framework was the most appropriate course of action.

(Original) Resolution # A-02-26: Enhancing Resources, Support, and Education for Immigrant Patient Health

RESOLVED: That the California Academy of Family Physicians engages social media partners in the distribution and advertisement of the Healthy Harbors guide and its resources for protecting immigrant patient health, and it be further

RESOLVED: That the California Academy of Family Physicians creates more CME Credits on the topics of immigrant health and immigrants' rights in the healthcare setting, and be it further

RESOLVED: That the California Academy of Family Physicians lobby the LCME to encourage medical schools to include curriculum addressing immigrant patient health to prepare students to serve diverse patient populations across the United States.

Committee Recommendation: REFER THE FIRST RESOLVED TO MEMBER ENGAGEMENT COMMITTEE FOR FURTHER STUDY, AFFIRM AS EXISTING POLICY THE SECOND RESOLVED, DO NOT ADOPT THE THIRD RESOLVED

Committee Discussion: The committee recognized that elements of the first two resolves align with current CAFP activities and priorities, including promotion of resources such as the Healthy Harbors guide and educational efforts related to immigrant patient health. Members discussed that while progress has been made, engagement through social media warrants broader consideration beyond a single publication. It was recommended that CAFP's role in social media engagement be referred to the Member Engagement Committee for further evaluation, as this topic may merit a broader and more comprehensive policy approach. The third resolve was determined to be outside the scope of CAFP's organizational role and advocacy efforts, absent a specific directive from the Board. The committee voted to amend the resolution accordingly.

(Original) Resolution # A-03-26: Sustainable Practices for CAFP Conferences and Events

RESOLVED: That the CAFP prioritizes sustainability at all CAFP-sponsored meetings and conferences by providing clearly labeled, accessible three-tier waste stations with trash, recycling, and compost at events serving food and at a minimum two-tier stations, trash and recycling, at events where no food is served. If stations can't be installed due to venue limitations, an alternative plan must be implemented to ensure composting and recycling occur.

Committee Recommendation: AFFIRM AS EXISTING POLICY

Committee Discussion: The committee reviewed existing CAFP policies related to sustainability and environmental practices at meetings and conferences. After discussion, members agreed that the resolution reflects practices and priorities already supported by current policy.

Resolution A-01-26

Proposed Policy Title: Empowering Family Physicians to Provide Culturally Competent and Language Concordant Care Through Further Development of CME and Partnership of Existing Language Services

Author: Miranda Martinez-Moad, DO

Co-Authors: Elizabeth Celaya-Ojeda, MD; Ogechi McIntosh, MD

Endorsed by: None

Whereas, CAFPP policy on cultural and language proficiency in light of Assembly bill 1195 requiring CME courses/activity to include curriculum/elements in/of cultural and linguistic competency

RESOLVED: That this includes developing, promoting, and supporting CME in culturally competent clinic based medical language learning for primary care physician/providers such as Spanish and act as a pathway for development, promotion and support of medical language learning in other languages as well.

Equity Impact Score: 9/9

Problem Statement: Providing more resources and reducing barriers for medical students, residents and physicians in practice to more easily learn medical terminology in common languages spoken among patients, such as Spanish to continue to provide culturally competent and language concordant care.

Problem Universe: Likely a majority of members who have direct patient contact.

Specific Solution: Development of a subcommittee that annually aims to develop CME, review existing resources, obtain/create scholarships that assist medical students, residents, family physicians learn a common language (such as Spanish, etc.) with medical concentration to further strive for more language concordant care.

Evidence: In reviewing CAFPP and AAFP'S websites: locating where "toolkit on Addressing Language Access", found Medical Spanish CME on AAFP that provides CME however it may be cost prohibitive for some, and other resources AAFP in connection to ACGME on their website are up for review and not available (I contacted the The Learn at ACGME Team desupport@acgme.org).

Citations:

1. Language Equity in Health Care Toolkit: <https://www.acgme.org/newsroom/e-communication/2024/november-4-2024/>,
2. Medical Leadership Council on Cultural Proficiency, and has developed and presented curriculum and a toolkit on Addressing Language Access: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.familydocs.org%2Fwp-content%2Fuploads%2F2023%2F10%2F23.ADM_.CAFPPolicyManualUpdate.10.10.23.Current-Version.docx&wdOrigin=BROWSELINK,
3. <https://commongroundinternational.com/medical-spanish/crash-course/success/>
4. <https://www.aafp.org/credit-reporting/cmecenter/details?activityId=103518>
5. <https://medical-electives.net/medical-spanish-for-healthcare-professionals/>

Speaker's Notes: This resolution would direct CAFPP to expand its language-access work by promoting clinically oriented medical-language learning for primary care clinicians (e.g., Spanish). This aligns with CAFPP's strategic goal to champion health equity; feasibility depends on keeping the

activity within CAFP's education scope, rather than building a new statewide program for clinic-based medical language learning.

The California Academy of Family Physicians (CAFP) has long-established policy supporting continuing medical education (CME) that includes cultural and linguistic competency, consistent with current law.

Under California law, "linguistic competency" is defined as the ability of a physician and surgeon to provide patients who do not speak English, or who have limited English proficiency, direct communication in the patient's primary language.

Importantly, the law does not prescribe how this must be achieved, nor does it require individual clinicians to attain fluency in multiple languages.

In practice, linguistic competency can be achieved through a combination of strategies, including:

- Use of qualified medical interpreters (in person, video, or telephone)
- Team-based models where language-concordant staff are available
- Systems that ensure timely access to language services
- Training clinicians to work effectively with interpreters and communicate across language barriers

Relevant existing CAFP policies:

CAFP policy supports culturally and linguistically appropriate services, including interpreter and translation services (CAFP Policy Manual, "Language Access," p. 98; A-02-07, 03/07 CoD). AAFP likewise supports culturally sensitive care and the use of qualified interpreters (AAFP, "Cultural Sensitivity: The Importance of Cultural Sensitivity in Providing Effective Care to Patients from Diverse Cultures," (2008) (2020 BOD)).

Speaker's Fiscal Notes: Adoption of this resolution would result in significant cost, consistent with CAFP's standards for developing evidence-based, needs-driven CME.

Committee Recommendation on Resolution A-01-26

2026 Report of the CAFP Committee on Continuing Professional Development (CCPD)

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Committee on Continuing Professional Development (CCPD) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-01-26: Empowering Family Physicians to Provide Culturally Competent and Language Concordant Care Through Further Development of CME and Partnership of Existing Language Services

RESOLVED: That this includes developing, promoting, and supporting CME in culturally competent clinic based medical language learning for primary care physician/providers such as Spanish and act as a pathway for development, promotion and support of medical language learning in other languages as well.

Committee Recommendation: AFFIRM AS EXISTING POLICY

Committee Discussion: The committee noted that CAFP already has existing policy supporting culturally competent care and related CME development. Members discussed that developing and sustaining longitudinal medical language education would be a significant and costly undertaking and may fall outside the current scope and resources of CAFP. While there was strong agreement with the intent and spirit of the resolution, the committee emphasized that the policy underpinning affirms existing policy. The committee noted that they must consider a number of factors before determining specific CME activities in which to engage. Several members expressed interest in addressing this growing area through more targeted and feasible approaches, such as conference sessions, workshops, or POP activities, including potential offerings like medical Spanish or conversations in medical Spanish. The committee also discussed CAFP's role as a possible pathway or repository for external resources rather than as a primary developer of comprehensive language education programs. Ultimately, the committee agreed that acknowledging the need without creating a new policy framework was the most appropriate course of action.

Resolution A-02-26

Proposed Policy Title: Enhancing Resources, Support, and Education for Immigrant Patient Health

Author: Ashna Kumar

Co-Authors: Nadine Añel, Angela Estell, Ellie Gibbs, Andres Caballero, Kathy Casillas, Pauly Kwak, Marissa Lule

Endorsed by: None

Whereas, The California Academy of Family Physicians has stated that patients deserve access to health care, regardless of immigration status, and has developed resources like the Healthy Harbors guide in service of this goal 1, and

Whereas, healthcare providers report feeling unprepared to manage immigration enforcement encounters in clinical settings 2, and medical students report feeling unprepared to deliver culturally sensitive care to immigrant patients 3, and

Whereas, expanding educational resources to provide culturally sensitive care and empower physicians to protect their immigrant patients supports community trust and strengthens the physician-patient relationship while improving patient health outcomes 4,5, and

Whereas, social media is a widely used tool by healthcare providers, experts, and institutions to disseminate healthcare-related information, and can be an accessible and useful tool for the general public to obtain reliable healthcare-related information, and

Whereas, there are only four CAFP-sponsored CME courses that cover immigrant health, and none that address the legal rights of immigrants and the responsibilities of physicians in caring for immigrant patients, and current Liaison Committee on Medical Education (LCME) requirements for medical student education do not include curriculum specifically addressing immigrant health, be it

RESOLVED: That the California Academy of Family Physicians engages social media partners in the distribution and advertisement of the Healthy Harbors guide and its resources for protecting immigrant patient health, and it be further

RESOLVED: That the California Academy of Family Physicians creates more CME Credits on the topics of immigrant health and immigrants' rights in the healthcare setting, and be it further

RESOLVED: That the California Academy of Family Physicians lobby the LCME to encourage medical schools to include curriculum addressing immigrant patient health to prepare students to serve diverse patient populations across the United States.

Equity Impact Score: 5/9

Problem Statement: This resolution seeks to resolve the lack of healthcare providers' preparedness and confidence in providing informed care to immigrant populations in California. By engaging social media partners in the dissemination of existing information within CAFP and creating educational opportunities on the topic of immigrant health, this resolution aims to increase physician competence and protect the health of immigrant communities.

Furthermore, because medical schools are not currently required to teach immigrant health, students often enter practice underprepared to treat immigrant patients. This resolution therefore aims to enhance the competency of both medical students and practicing physicians, ultimately improving health outcomes for immigrant populations.

Problem Universe: We assert that all CAFP members providing clinical care to immigrants are affected by this problem and will be affected by the proposed policy.

California is home to the largest populations of both foreign-born and non-citizen individuals in the country (around 15 million)⁶. Despite this, healthcare providers still report feeling unprepared to manage immigration enforcement encounters in clinical settings ², and medical students report feeling unprepared to deliver culturally sensitive care to immigrant patients ³.

Specific Solution: We propose that the CAFP engages social media partners and dedicates more resources to the distribution of existing materials that support and protect immigrant health, such as its Healthy Harbors guide¹. We also propose that the CAFP creates more CME Credits on the topics of immigrant health and immigrant rights in the clinical setting. Lastly, we propose that the CAFP lobbies the LCME to encourage medical schools to similarly adopt more curriculum-based learning regarding the topics of immigrant health and rights in the clinical setting.

Evidence: Healthcare providers indicate that they do not feel adequately prepared to respond to immigration enforcement situations in clinical environments ².

Medical students report feeling unprepared to deliver informed care to immigrant patients ³.

The CAFP has limited official educational opportunities in immigrant health. While the Healthy harbor guide provides valuable resources, the information it contains should be made widely available and accessible to both providers and their patients.

Citations:

1. California Academy of Family Physicians. (n.d.). Healthy harbors: Addressing the health consequences of immigration policies. <https://www.familydocs.org/immigration/>
2. Physicians for Human Rights. (2025, April). Consequences of fear: How the Trump Administration's immigration policies and rhetoric block access to health care (Research brief). Physicians for Human Rights. https://phr.org/wp-content/uploads/2025/04/Consequences-of-Fear_Research-Brief_PHR_April-2025.pdf
3. Stryker, S. D., Conway, K., Kaeppler, C., Porada, K., Tam, R. P., Holmberg, P. J., Schubert, C., & and Medical Student Global Health study group (2023). Underprepared: influences of U.S. medical students' self-assessed confidence in immigrant and refugee health care. Medical education online, 28(1), 2161117. <https://doi.org/10.1080/10872981.2022.2161117>
4. Majumdar, B., Browne, G., Roberts, J., & Carpio, B. (2004). Effects of cultural sensitivity training on health care provider attitudes and patient outcomes. Journal of Nursing Scholarship, 36(2), 161-166. <https://doi.org/10.1111/j.1547-5069.2004.04029.x>
5. Son, C., Forsgren, E., Öhlén, J., & Sawatzky, R. (2025). Person-centered care for migrants: A narrative review of healthcare literature. Frontiers in Health Services, 5, 1573813. <https://doi.org/10.3389/frhs.2025.1573813>
6. Perez-Lua, F. M., Lazalde, G. E., Farias, C., Barajas, C. B., Pintor, J. K., Ponce, N. A., Ortega, A. N., & De Trinidad Young, M.-E. (2025). Measuring county-level immigration policy contexts that may influence Latino Health in California. SSM - Population Health, 30, 101790. <https://doi.org/10.1016/j.ssmph.2025.101790>

Speaker's Notes: The resolution requests expansion of CAFP resources, support, and education focused on immigrant patient health. The intent of the resolution aligns with CAFP's equity and public health goals. This proposal includes specific directives to the CAFP operations by directing CAFP to curate, oversee, and update content like CME educational resources in an area that continues to evolve rapidly. In addition, CAFP is already actively engaged in the distribution and

advertisement of its Healthy Harbors guide for members via social media and other communications channels.

CAFP has existing policy addressing cultural and linguistic competency. CAFPPolicy states that all people deserve access to high-quality health services regardless of race, ethnicity, primary language or immigration status. CAFPPolicy specifically mandates that all CME activities include elements of cultural and linguistic competency, as required by California law. CAFPPolicy states that cultural proficiency training should be incorporated into residency programs.

AAFP policy similarly supports [culturally and linguistically appropriate care](#). The AAFP has developed resources including the [Health Equity for EveryONE online CME activity](#) which includes sessions on embracing CLAS standards and conducting office visits with medical interpreters. AAFP policy recognizes healthcare as a basic human right regardless of social, economic, or political status and has policy stating that all people should have access to essential health services regardless of immigration status. The AAFP has authored letters to Congress advocating for expansion of Medicaid eligibility to undocumented immigrants.

Speaker's Fiscal Notes: There would be minimal to significant costs associated with the activities outlined in this resolution, depending on the scope of engagement and resources required.

Engaging social media partners to distribute and advertise the Healthy Harbors guide and its resources would likely incur minimal to moderate costs if CAFPP's role is limited to sharing content via existing social media channels. Costs could increase if paid promotions, extensive campaign management, or partnerships with external vendors are required.

Creating additional CME credits on immigrant health and patients' rights would involve significant costs, as developing new CME programs requires staff time for research, content development, expert review, coordination with CME providers, and potential consultant engagement. If travel or in-person CME sessions are included, costs would increase further.

Referral to AAFP for national action would incur minimal cost. Directly engage in advocacy with medical schools or provide ongoing consultation on curriculum development would increase staff time and costs.

Committee Recommendation on Resolution A-02-26

2026 Report of the CAFP Committee on Continuing Professional Development (CCPD)

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing **and** subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Committee on Continuing Professional Development (CCPD) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-02-26: Enhancing Resources, Support, and Education for Immigrant Patient Health

RESOLVED: That the California Academy of Family Physicians engages social media partners in the distribution and advertisement of the Healthy Harbors guide and its resources for protecting immigrant patient health, and it be further

RESOLVED: That the California Academy of Family Physicians creates more CME Credits on the topics of immigrant health and immigrants' rights in the healthcare setting, and be it further

RESOLVED: That the California Academy of Family Physicians lobby the LCME to encourage medical schools to include curriculum addressing immigrant patient health to prepare students to serve diverse patient populations across the United States.

Committee Recommendation: REFER THE FIRST RESOLVED TO MEMBER ENGAGEMENT COMMITTEE FOR FURTHER STUDY, AFFIRM AS EXISTING POLICY THE SECOND RESOLVED, DO NOT ADOPT THE THIRD RESOLVED

Committee Discussion: The committee recognized that elements of the first two resolves align with current CAFP activities and priorities, including promotion of resources such as the Healthy Harbors guide and educational efforts related to immigrant patient health. Members discussed that while progress has been made, engagement through social media warrants broader consideration beyond a single publication. It was recommended that CAFP's role in social media engagement be referred to the Member Engagement Committee for further evaluation, as this topic may merit a broader and more comprehensive policy approach. The third resolve was determined to be outside the scope of CAFP's organizational role and advocacy efforts, absent a specific directive from the Board. The committee voted to amend the resolution accordingly.

Resolution A-03-26

Proposed Policy Title: Sustainable Practices for CAFP Conferences and Events

Author: Arthur Bookstein, MPH

Co-Authors: David Rios Palmares, Justine Po

Endorsed by: None

Whereas, climate change is one of the largest threats to public health, with global temperatures surpassing the threshold of 1.5°C above pre-industrial levels, and healthcare accounting for 5% of global greenhouse gas emissions [1], and

Whereas, the United States accounts for roughly 25% of the world’s healthcare carbon emissions, the highest percentage attributed to any other country, further exacerbating climate change, leading to negative health and environmental outcomes [2], and

Whereas, medical conferences are essential for research and patient care, but can generate substantial single-use plastic and food waste [3], and

Whereas, the American Academy of Pediatrics Orange County Chapter is implementing sustainable practices within its conferences with its Environmental Health and Climate Change Committee, including efforts to collect and reuse plastic badge holders, use organic cotton attendee bags, and avoid single-use cups & utensils during meals and snacks [4]

RESOLVED: That the CAFP prioritizes sustainability at all CAFP-sponsored meetings and conferences by providing clearly labeled, accessible three-tier waste stations with trash, recycling, and compost at events serving food and at a minimum two-tier stations, trash and recycling, at events where no food is served. If stations can’t be installed due to venue limitations, an alternative plan must be implemented to ensure composting and recycling occur.

Equity Impact Score: 5/9

Problem Statement:

Problem Universe:

Specific Solution:

Evidence:

Citations:

1. Or, Z., & Seppänen, A.-V. (2024). The role of the health sector in tackling climate change: A narrative review. *Health Policy*, 143, 105053. <https://doi.org/10.1016/j.healthpol.2024.105053>
2. Dzau, V. J., Levine, R., Barrett, G., & Witty, A. (2021). Decarbonizing the U.S. health sector — A call to action. *New England Journal of Medicine*, 385(23), 2117–2119. <https://doi.org/10.1056/NEJMp2115675>
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Speaker’s Notes: The proposed resolution to prioritize sustainability at all CAFP-sponsored meetings and conferences aligns closely with existing CAFP policy and strategic goals and can thus

be reaffirmed as existing policy. In 2020, the CAFP Board Adopted “Working Toward Zero Waste”, directing the CAFP to support improving the environmental health of our patients and planet by requesting all future conference and meeting sites reduce waste; encourage participants to bring their own reusable items; request conference host sites not use disposable silverware, cups, napkins, beverage containers, etc., unless they are compostable; consider a site's ability or willingness to avoid waste-generation when contracting for meetings and conferences; urge CAFP “swag” seek to be reusable (water bottles, coffee mugs, utensils) or biodegradable items; and that safety practices be considered in environmental stewardship.

The 2025-2027 CAFP Strategic Plan also includes broader directives and initiatives to build capacity for family physicians to respond to the impact of climate health on the practice of medicine. The CAFP Committee on Public Health and Equity (CPHE) has a sub-committee working actively on climate health principles to guide the organization. Generally speaking, resolutions are intended to address CAFP policy, with the specifics of implementation placed in the purview and expertise of CAFP staff.

Speaker’s Fiscal Notes: There is a financial impact in adhering to this policy. For instance, hotels pass any additional costs of “going green” on to the consumer so we see typically higher costs associated with our requests to reduce waste.

Committee Recommendation on Resolution A-03-26

2026 Report of the CAFP Committee on Continuing Professional Development (CCPD)

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Committee on Continuing Professional Development (CCPD) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-03-26: Sustainable Practices for CAFP Conferences and Events

RESOLVED: That the CAFP prioritizes sustainability at all CAFP-sponsored meetings and conferences by providing clearly labeled, accessible three-tier waste stations with trash, recycling, and compost at events serving food and at a minimum two-tier stations, trash and recycling, at events where no food is served. If stations can't be installed due to venue limitations, an alternative plan must be implemented to ensure composting and recycling occur.

Committee Recommendation: AFFIRM AS EXISTING POLICY

Committee Discussion: The committee reviewed existing CAFP policies related to sustainability and environmental practices at meetings and conferences. After discussion, members agreed that the resolution reflects practices and priorities already supported by current policy.

Committee Report – Committee on Public Health and Equity (CPHE)

2026 Report of the Committee on Public Health and Equity

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the CAFP Committee on Public Health and Equity (CPHE) has considered the following resolution referred to it and submits the following report.

- A-04-26 CAFP Policy on Development of State-Wide Registry for Cervical Cancer Screening
- A-05-26 Eliminating Fruit Juice from WIC Food Packages to Combat Childhood Obesity and Dental Caries
- A-06-26 Food Literacy
- A-07-26 Supporting School Policies that Substantially Reduce Items Containing High-Fructose Corn Syrup and Derivatives
- A-08-26 Food Label Transparency
- A-09-26 Ensuring Equitable Vaccine Access for Independent and Rural Family Physicians to Protect Public Health in California
- A-10-26 Vaccine Information Mobile Application
- A-11-26 Promotion of Resistance Training and Physical Activity as Standard Preventative Health Recommendations in Family Medicine
- A-12-26 Supporting Expanded Research and Rescheduling of Therapeutic Psychedelics

(Original) Resolution # A-04-26 CAFP Policy on Development of State-Wide Registry for Cervical Cancer Screening

RESOLVED: That the California Academy of Family Physicians advocates for the creation of materials and resources for family physicians and patients to understand current guidelines for cervical cancer screening.

RESOLVED: That the California Academy of Family Physicians supports the development of a state-wide cervical cancer screening registry by partnering with organizations such as American College of Obstetrics-Gynecologists and California Department of Public Health.

RESOLVED: That the California Academy of Family Physicians encourages exploration of integrated information systems to promote appropriate and timely health maintenance and screenings.

Committee Recommendation: ADOPT AS AMENDED:

RESOLVED: That the CAFP supports strengthening the dissemination of current guidelines for cervical screening.

RESOLVED: That the CAFP supports the exploration of a state-wide cervical cancer screening registry.

Committee Discussion: The committee discussed that many of the resources referenced in the first resolved statement already exist, including materials developed by the American Society for

Colposcopy and Cervical Pathology, and noted that creating additional resources would require significant staff and financial capacity without necessarily providing added value. Given the rapidly evolving nature of this area, the committee emphasized the importance of strengthening dissemination of existing resources and ensuring family physicians remain up to date, rather than developing duplicative materials. As a result, the committee recommended adoption, as amended, of the first resolved statement.

The committee supported the intent of the second resolved statement to explore or support a statewide registry, noting that this reflects the core intent of the resolution. The committee recommended amendments to the language to be less specific to allow for any collaborations that may be beneficial to this effort. Accordingly, the committee recommended adoption, as amended, of the second resolved statement.

The third resolved statement was discussed as being overly vague and insufficiently defined, making it unclear what specific actions were being requested. The committee expressed reluctance to amend the resolution beyond the author's original intent and recommended against adoption of the third resolved statement.

(Original) Resolution # A-05-26 Eliminating Fruit Juice from WIC Food Packages to Combat Childhood Obesity and Dental Caries

RESOLVED: That the California Academy of Family Physicians (CAFP) advocate to the California Department of Public Health and the USDA Food and Nutrition Service to eliminate juice from WIC food packages for all child participants, replacing it with increased cash-value vouchers (CVV) for whole fruits and vegetables; and be it further

RESOLVED: That the CAFP support educational initiatives aimed at WIC beneficiaries to clarify that fruit juice is not a necessary component of a healthy pediatric diet and to promote water and milk as the primary beverages for young children; and be it further

RESOLVED: That the CAFP instruct its delegates to the AAFP Congress of Delegates to submit a resolution calling on the AAFP to advocate at the federal level for the removal of juice from the national WIC food package requirements.

Committee Recommendation: ADOPT AS AMENDED:

RESOLVED: That the CAFP advocate for continued reduction of juice allotment from WIC food packages for all child participants, replacing it with increased cash-value vouchers (CVV) for whole fruits and vegetables; and be it further

RESOLVED: That the CAFP support educational initiatives aimed at WIC beneficiaries to clarify that fruit juice is not a necessary component of a healthy pediatric diet.

RESOLVED: That the CAFP refer for national action to submit a resolution calling on the AAFP to advocate at the federal level for the reduced allotment of juice from WIC food packages for all child participants, replacing it with increased cash-value vouchers (CVV) for whole fruits and vegetables.

Committee Discussion: The committee discussed concerns that the use of the word "eliminate" was overly restrictive and too strong. Members noted that for some children, including those with autism or restrictive eating patterns, juice or similar options may provide necessary calories when whole fruit is not feasible. The committee also discussed the nutritional value of juice and emphasized that entirely removing certain benefits may not adequately replace the nutritional support currently provided.

The committee recommended removing overly directive language, avoiding references to specific agencies, and reframing the resolution to encourage continued work in this area rather than calling for elimination of benefits. Members emphasized that further reductions to public programs are not advisable at this time and noted that existing guidance, including AAFP policy, allows limited juice intake for children over one year of age within recommended daily limits.

Discussion of the second resolved statement raised questions about milk as a primary beverage, including concerns that excessive intake may contribute to iron deficiency. The committee amended the three resolved statements and recommended adoption as amended.

(Original) Resolution # A-06-26 Food Literacy

RESOLVED: That the California Academy of Family Physicians acknowledge the need for validated and comprehensive food literacy assessments that can be practically utilized by family physicians, and

RESOLVED: That the California Academy of Family Physicians advocate for governing bodies to fund the development and validation of food literacy assessments, as well as food literacy education programs, and

RESOLVED: That the California Academy of Family Physicians support medical and educational experts at the community and state levels in their means to develop and propagate educational programs addressing general nutrition competency and food literacy based on data collected from healthy literacy assessment tools.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP supports the need for validated and comprehensive food literacy assessment that can be practically utilized by family physicians,

RESOLVED: That the CAFP advocate for the funding, development, and validation of evidence based and culturally competent food literacy assessments, as well as evidence based food literacy education programs, and

RESOLVED: That the CAFP support medical and educational experts at the community and state levels in their means to develop and propagate evidence based, and culturally competent educational programs addressing general nutrition competency and food literacy based on data collected from validated health literacy assessment tools.

Committee Discussion: The committee discussed the first resolved statement and noted that it was not highly directive and did not require additional action. Members suggested that the use of “supports” would be more appropriate language. Discussion of the second and third resolved statements supported the addition of language emphasizing evidence-based and culturally competent approaches, particularly in response to recently released USDA dietary guidelines that raised concerns. The committee amended the three resolved statements and recommended adoption as amended.

(Original) Resolution # A-07-26 Supporting School Policies that Substantially Reduce Items Containing High-Fructose Corn Syrup and Derivatives

RESOLVED: That the California Academy of Family Physicians (CAFP) support policies at the state, county, and local school district level that either eliminate or substantially reduce the sale and serving of foods and beverages containing high-fructose corn syrup (HFCS) and concentrated fructose derivatives in all K-12 school food environments, including cafeterias, vending machines, school stores, and at school-sponsored events; and be it further

RESOLVED: That CAFP encourage school food service procurement standards and local wellness policies to prioritize beverages and foods without added fructose/HFCS compliant with nutrition standards, and to phase out HFCS-containing products where feasible; and be it further

RESOLVED: That CAFP, where feasible, advocate for reallocation of revenues derived from competitive sales of HFCS-containing products toward healthier school nutrition programs and student wellness initiatives, including hydration stations, fresh fruit/vegetable programs, school gardens, nutrition education; and be it further

RESOLVED: That CAFP support educational outreach for school administrators, food service staff, parents, and students about the health effects of concentrated added sugars and HFCS—including metabolic and emerging mental health risks—and provide model policy language, implementation guidance, and clinician-facing talking points to assist in local advocacy efforts; and be it further

RESOLVED: That CAFP encourage and support research and surveillance on the impact of HFCS-targeted school food policies on students' metabolic health, mental health, dietary intake, and equity outcomes.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP support policies that reduce the availability of foods and beverages containing high-fructose corn syrup (HFCS) and concentrated fructose derivatives in all K-12 school food environments.

RESOLVED: That the CAFP encourage school food service procurement standards and local wellness policies to prioritize beverages and foods without highly refined sugars compliant with nutrition standards.

RESOLVED: That the CAFP support the development of educational outreach for school administrators, food service staff, parents, and students about the health effects of concentrated added sugars and highly refined sugars, and provide model policy language, implementation guidance, and clinician-facing talking points to assist in local advocacy efforts.

Committee Discussion: The committee expressed support for the overall intent and spirit of the resolution and noted that existing policy already addresses the underlying issues. Members discussed whether references to high fructose corn syrup (HFCS) were overly specific and agreed that broader language such as “highly refined sugars” would be more appropriate and inclusive. The committee amended the first, second, and fourth resolved statements and recommended adoption as amended.

The third resolved statement was discussed as being overly directive and too specific, and the committee recommended against its adoption. The final resolved statement was also discussed as unclear, with uncertainty regarding whether it called for research, surveillance, or policy changes related to school practices. Given the lack of clarity and concern about interpreting the author's intent, the committee recommended against the adoption of the third and last resolved statement.

(Original) Resolution # A-08-26 Food Label Transparency

RESOLVED: That the California Academy of Family Physicians advocate for stricter regulatory definitions for the term “natural” and “natural flavors”, specifically acknowledging the use of artificial solvents, emulsifiers, and other chemicals utilized in the food production process, and

RESOLVED: That the California Academy of Family Physicians advocate for a stricter regulatory definition for the term “healthy”, underlining the diversity and complexity of nutrition as it relates to chronic conditions, including, but not limited to, elevated blood pressures, elevated cholesterol, and obesity, and

RESOLVED: That the California Academy of Family Physicians advocate for a stricter and more transparent regulatory definition for the term “serving size”, integrating recommended definitions and dietary guidelines from established professional medical and nutritional organizations.

Committee Recommendation: DO NOT ADOPT

Committee Discussion: The committee discussed that none of the resolved statements fall within the purview of CAFP, as the issue is primarily federal in nature and states do not play a role in regulating food labeling. While the committee expressed support for the spirit of the resolution, members noted that the language was overly vague and lacked clear, actionable direction.

In addition, the committee mentioned that the use of the term “stricter” was discussed as not reflective of best practices in policy drafting, as it was unclear what existing standards were being referenced. Members noted that while referral for national action could be appropriate, this was not specified by the author. The committee recommended not adopting and that the author significantly rework and clarify the resolution language to better define intent, scope, and appropriate jurisdiction.

(Original) Resolution # A-09-26 Ensuring Equitable Vaccine Access for Independent and Rural Family Physicians to Protect Health in California

RESOLVED: That CAFP advocate for state-level vaccine distribution reforms to ensure independent and rural physician practices have equal access to ordering, storing, and administering all recommended vaccines, including Hepatitis B birth dose, COVID vaccines, and childhood VFC vaccines; and

RESOLVED: That CAFP work with the California Department of Public Health, the West Coast Vaccine Alliance, and vaccine manufacturers to establish procurement pathways that allow small-quantity shipments and sharps-law-compliant packaging specifically accessible to independent practices; and

RESOLVED: That CAFP support the creation of a centralized ordering system for small practices that aggregates demand and facilitates bulk purchasing so independent physicians can access vaccines without minimum-order limitations; and

RESOLVED: That CAFP advocate for improved funding, staffing, and infrastructure for rural county public health departments to prevent future situations where children cannot receive vaccines required for school entry; and

RESOLVED: That CAFP issue a public statement reaffirming its support for universal newborn Hepatitis B vaccination and urging California to maintain evidence-based immunization standards regardless of changes in federal ACIP recommendations; and

RESOLVED: That CAFP annually evaluate and report on vaccine-access disparities among independent practices, rural counties, and large systems, including recommendations for system-level improvements.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP advocate for state-level vaccine policy reforms to ensure independent and rural physician practices have equal access to ordering, storing, and administering all evidence based recommended vaccines.

RESOLVED: That the CAFP supports the creation of an evaluation and report on vaccine-access disparities among independent practices, rural counties, and large systems, including recommendations for system-level improvements.

Committee Discussion:

The committee discussed that the first resolved statement is a general statement of support. Members noted that administering, storing, and ordering vaccines involves more than the distribution reforms referenced in the resolution. The committee recommended adopting as amended.

For the next three resolved statements, the committee noted that various group procurement pathways already exist and that the California Department of Public Health (CDPH) is not positioned to implement these changes. A centralized ordering system is already in place, and improving funding and staffing, while important, is a broader public health issue. Members emphasized CAFP's existing opposition to cuts in public health funding, noting that county health departments are already making difficult decisions, particularly in infectious disease programs. The committee recommended that further research is needed to clarify the role of county health departments in vaccinating children, including resource limitations and potential policy changes, before additional action is taken. Thus, they recommend to not adopt resolved statements 2-4.

Discussion of the fifth resolved noted that statements have already been issued by CAFP and AAFP reaffirming support for universal newborn Hepatitis B vaccination. The resolution as written is outdated and overly directive, particularly given more recent changes in vaccine recommendations from the federal government. However, the committee recommended affirming as existing policy.

The final resolved statement was considered overly prescriptive and beyond the capacity of CAFP to implement as originally written. Members expressed concern that adopting it would require assuming actions for other governing bodies and may not preserve the author's intent. However, the committee made amendments to broaden the language to make it less prescriptive and recommended to adopt as amended.

(Original) Resolution # A-10-26 Vaccine Information Mobile Application

RESOLVED: That the California Academy of Family Physicians (CAFP) develop and maintain a mobile application and/or mobile-friendly web-based platform that provides up-to-date vaccination information corresponding to the recommendations released by the West Coast Health Alliance, and be it further

RESOLVED: That the California Academy of Family Physicians (CAFP) include clearly written, evidence-based recommendations on the mobile application and/or mobile-friendly web-based platform presented in language that is readily understandable by the general public and that addresses common questions and misconceptions related to vaccinations.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP advocate for the development and maintenance of a mobile application and/or mobile-friendly web-based platform that provides up-to-date vaccination information corresponding to evidence-based recommendations, that is readily accessible to the general public that addresses common questions and misconceptions related to vaccination.

Committee Discussion:

The committee discussed that, as written, the first resolved statement should not be adopted. Members expressed general support for the concept of an app but emphasized that CAFP cannot develop one directly. Language was suggested to reflect support for the development of such a tool rather than specifying creation by CAFP. Members also recommended removing references to the West Coast Health Alliance, as the organization may not exist in the future, and questioned the intended audience and the problem the app is meant to address. The committee emphasized support for platforms providing evidence-based recommendations and noted that the whereas statements indicate the resolution is intended for public use. The committee recommends adoption of the first resolved statement as amended.

The committee recommends not adopting the second resolved statement, as it specifically calls for mobile app development and is seen as overly directive.

(Original) Resolution # A-11-26 Promotion of Resistance Training and Physical Activity as Standard Preventative Health Recommendations in Family Medicine

RESOLVED: That the CAFP amends its "Physical Exercise as a Vital Sign" policy to explicitly align with U.S. Department of Health and Human Services (HHS) guidelines by recommending adults engage in muscle-strengthening activities of moderate or greater intensity and that involve all major muscle groups on two or more days a week, in addition to aerobic activity; and be it further

RESOLVED: That the CAFP encourages family physicians to counsel patients specifically on the metabolic and protective benefits of resistance training, including improvements in insulin sensitivity, blood pressure, and the prevention of sarcopenia (age-related muscle loss).

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP amends its "Physical Exercise as a Vital Sign" policy to recommend adults engage in guideline-directed recommendation for muscle-strengthening activities of moderate or greater intensity and that involve all major muscle groups on two or more days a week, in addition to aerobic activity, and be it further

Committee Recommendation: ADOPT

RESOLVED: That the CAFP encourages family physicians to counsel patients specifically on the metabolic and protective benefits of resistance training, including improvements in insulin sensitivity, blood pressure, and the prevention of sarcopenia (age-related muscle loss).

Committee Discussion:

The committee discussed concerns that the first resolved statement was overly strong in its directive language, particularly with its call for explicit alignment with federal guidance. Members noted uncertainty regarding reliance on HHS recommendations, given that guidelines can change over time. The committee broadened the language and recommended adoption of the first resolved statement as amended. Members recommended to adopt the second resolved.

(Original) Resolution # A-12-26 Supporting Expanded Research and Rescheduling of Therapeutic Psychedelics

RESOLVED: the California Academy of Family Physicians (CAFP) supports legislation and regulatory changes that facilitate clinical research into the therapeutic use of psychedelics, including but not limited to psilocybin for the treatment of psychiatric and substance use disorders; and be it further

RESOLVED: that the CAFP supports the rescheduling of ibogaine, MDMA, and LSD from Schedule I to a schedule that permits clinical research and therapeutic use under medical

supervision, particularly for the treatment of Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) in veterans, refractory depression and anxiety and be it further

RESOLVED: that the CAFP refer this resolution to the American Academy of Family Physicians (AAFP) for national action to advocate for federal funding and "Safe Haven" protections for researchers investigating these therapies.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP bring this resolution to the AAFP Congress of Delegates to support legislation and regulatory changes that facilitate scientifically, rigorous, Institutional Review Board (IRB)-approved, physician-led clinical research into the therapeutic use of psychedelics, including but not limited to psilocybin for the treatment of psychiatric and substance use disorders; and be it further

RESOLVED: That the CAFP bring this resolution to the AAFP Congress of Delegates to support the rescheduling for clinical research and tightly regulated therapeutic frameworks of ibogaine, MDMA, and LSD, particularly for the treatment of Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) in veterans, refractory depression and anxiety and be it further

Committee Recommendation: ADOPT

RESOLVED: That the CAFP refer this resolution to the American Academy of Family Physicians (AAFP) for national action to advocate for federal funding and "Safe Haven" protections for researchers investigating these therapies.

Committee Discussion: The committee discussed whether there is sufficient clinical consensus to support the use of the additional drugs referenced for the disorders identified in the resolution. Members noted that current federal classification limits the ability to conduct rigorous clinical research, as Schedule I status restricts such studies. The committee also acknowledged the drug scheduling is a federal issue, fitting in AAFP's role, not CAFP. As a result, they amended the language in the first two resolved statements to specify referral for national action. The committee emphasized that any recommendation to reschedule should be narrowly framed to support and enable clinical research purposes only. Thus, the committee recommended to adopt the first two resolved statements as amended, and adopt the third statement with original language.

Resolution A-04-26

Proposed Policy Title: CAFP Policy on Development of State-Wide Registry for Cervical Cancer Screening

Author: Caryssa Lim Chang, MD

Co-Authors: Mai Nojima, MD; Nicole Aimua, MD; Warren Nakazawa, MD

Endorsed by: None

Whereas, The Healthy People 2030 has put forth a goal of 84.3% of people with female genitalia aged 21-65 years to be up to date on cervical cancer screening, yet currently, only 75.8% of people with female genitalia in this age group are up to date.

Whereas, There are significant disparities in screening for non-White persons, those at <200% of federal poverty level, and individuals with less than a high school education.

Whereas, Individuals frequently move or change health care providers and often are unable to maintain updated health records from provider to provider, with more significant disruptions for patients with unstable housing, employment, or health insurance.

Whereas, It is often difficult for patients to be up to date on the guidelines around timing and frequency of cervical cancer screening.

Whereas, State-wide registries are a tool to consolidate records, track screening across providers, prevent duplicate screenings, steward existing resources well, and ultimately, prevent cases of cervical cancer.

Whereas, The California Academy of Family Physicians maintains as one of its core principles that, "Women's health must be protected," as well as an existing recognition of the importance of state-wide registries (POLST Registry).

RESOLVED: That the California Academy of Family Physicians advocates for the creation of materials and resources for family physicians and patients to understand current guidelines for cervical cancer screening.

RESOLVED: That the California Academy of Family Physicians supports the development of a state-wide cervical cancer screening registry by partnering with organizations such as American College of Obstetrics-Gynecologists and California Department of Public Health.

RESOLVED: That the California Academy of Family Physicians encourages exploration of integrated information systems to promote appropriate and timely health maintenance and screenings.

Equity Impact Score: 8/9

Problem Statement: This resolution seeks to solve the inconsistencies around cervical cancer screening guidelines, as well as advocate for the creation of a systemic solution to reduce the number of redundant screens and ensure adequate follow-up of abnormal test results.

Problem Universe: There are approximately 11 million women ages 19-64 in California. The recommended screening age for cervical cancer screening is 21-65, so this proposed policy likely affects close to 11 million individuals.

Specific Solution: We are proposing that CAFP advocates for the creation of materials and resources for family physicians and patients to understand current guidelines for cervical cancer

screening.

We also propose that CAFP advocates for the development of a state-wide cervical cancer screening registry.

Evidence: In 2023, only 75% of individuals who were eligible for screening received proper cervical cancer screening, with significant disparities in individuals who are socioeconomically disadvantaged and those who are from racially marginalized groups.

Citations:

1. National Cancer Institute (https://progressreport.cancer.gov/detection/cervical_cancer)
2. KFF Demographics (<https://www.kff.org/interactive/womens-health-profiles/california/demographics/>)
3. Existing Pap Registries (<https://unmhealth.org/cancer/research/hpv-prev-ctr/pap-registry.html#:~:text=The%20New%20Mexico%20HPV%20Pap,registry%20in%20the%20United%20States.>)

Speaker's Notes: The resolution combines education/clinical guideline dissemination with a larger request to support development of a statewide cervical cancer screening registry. Guideline education aligns well with CAFP's education mission, although creation of materials and resources is a larger resource commitment when alternatives like familydoctor.org already exist. The type of advocacy for a state-wide registry is not specified in the resolution, but partnering with other organizations and CDPH suggests a significant resource commitment .

Current CAFP policy broadly supports preventive care, evidence-based medicine, and the use of clinically integrated information systems and registries in other contexts. CAFP does not have specific policy related to cervical cancer screening registries or guidelines. The CAFP Committee for Continuing Professional Development (CCPD) makes recommendations on CAFP's focus for clinical education.

Similarly, AAFP does not have specific policy related to cervical cancer screening but does maintain clinical recommendations on how to screen for cervical cancer. AAFP is currently aligned with ACOG in its support of U.S. Preventive Services Task Force (USPSTF) recommendations related to cervical cancer screenings, and both organizations participate as key stakeholders in developing the American Society for Colposcopy and Cervical Pathology Risk-Based Management Consensus Guidelines. AAFP and ACOG are both currently reviewing and providing public comment on the 2024-2025 USPSTF draft recommendations which include new discussions on self-collection methods for HPV testing.

AAFP has also historically supported the development of clinical data registries to organize patient care and close care gaps for preventive screenings. This publication from 2021 titled [Put Your Clinical Data to Work With a Registry](#) educates family physicians on the ways that registries can track high-risk patients and ensure screenings are delivered according to guidelines.

Speaker's Fiscal Notes: There would be minimal to significant costs associated with the activities outlined in this resolution, depending on the level of involvement expected from CAFP and whether the work remains within established advocacy and communications processes.

Advocating for the creation of materials and resources for family physicians and patients to understand current cervical cancer screening guidelines could incur minimal costs if CAFP's role is limited to adding information to existing communication channels or educational events. However, if CAFP is expected to develop new educational materials, this would result in significant costs, as producing new CME or educational content requires extensive staff time for research, drafting,

clinical review, and potentially consultant or partner engagement. Development, travel, CME placement, and collaboration with clinical experts could substantially increase expenses.

Supporting the development of a statewide cervical cancer screening registry by partnering with organizations such as ACOG and the California Department of Public Health would incur minimal to moderate costs, depending on the level of engagement required. If CAFP's involvement is limited to issuing supportive statements or providing input when requested, costs would remain minimal. Costs could increase to moderate if participation involves sustained coordination, meetings, technical review, or engagement in regulatory processes. If expectations extend to leadership, development, or management of a registry system—an activity outside CAFP's typical expertise—costs could become significant and may require specialized external support.

Encouraging exploration of integrated information systems to support timely screenings would likely incur minimal costs if CAFP's involvement is limited to advocating for state-led efforts or supporting stakeholder discussions. Costs may rise to moderate if CAFP is expected to participate in technical working groups, review data standards, or engage in ongoing coordination with health information technology systems, which may be outside CAFP's core expertise and require additional staff resources.

Committee Recommendation on Resolution A-04-26

2026 Report of the Committee on Public Health and Equity

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the CAFP Committee on Public Health and Equity (CPHE) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-04-26 CAFP Policy on Development of State-Wide Registry for Cervical Cancer Screening

RESOLVED: That the California Academy of Family Physicians advocates for the creation of materials and resources for family physicians and patients to understand current guidelines for cervical cancer screening.

RESOLVED: That the California Academy of Family Physicians supports the development of a state-wide cervical cancer screening registry by partnering with organizations such as American College of Obstetrics-Gynecologists and California Department of Public Health.

RESOLVED: That the California Academy of Family Physicians encourages exploration of integrated information systems to promote appropriate and timely health maintenance and screenings.

Committee Recommendation: ADOPT AS AMENDED:

RESOLVED: That the CAFP supports strengthening the dissemination of current guidelines for cervical screening.

RESOLVED: That the CAFP supports the exploration of a state-wide cervical cancer screening registry.

Committee Discussion: The committee discussed that many of the resources referenced in the first resolved statement already exist, including materials developed by the American Society for Colposcopy and Cervical Pathology, and noted that creating additional resources would require significant staff and financial capacity without necessarily providing added value. Given the rapidly evolving nature of this area, the committee emphasized the importance of strengthening dissemination of existing resources and ensuring family physicians remain up to date, rather than developing duplicative materials. As a result, the committee recommended adoption, as amended, of the first resolved statement.

The committee supported the intent of the second resolved statement to explore or support a statewide registry, noting that this reflects the core intent of the resolution. The committee recommended amendments to the language to be less specific to allow for any collaborations that may be beneficial to this effort. Accordingly, the committee recommended adoption, as amended, of the second resolved statement.

The third resolved statement was discussed as being overly vague and insufficiently defined, making it unclear what specific actions were being requested. The committee expressed reluctance to amend the resolution beyond the author's original intent and recommended against adoption of the third resolved statement.

Resolution A-05-26

Proposed Policy Title: Eliminating Fruit Juice from WIC Food Packages to Combat Childhood Obesity and Dental Caries

Author: Rossan Chen, MD

Co-Authors: Tiffany Zai, DO

Endorsed by: Solano Chapter

Whereas, The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a critical public health program serving approximately half of all infants born in the United States; and

Whereas, The American Academy of Pediatrics (AAP) states that fruit juice offers no nutritional benefit over whole fruit for infants and children and plays a significant role in excessive caloric intake and the development of dental caries; and

Whereas, While whole fruit provides essential dietary fiber and promotes satiety, fruit juice lacks fiber and contains high concentrations of free sugars, contributing to rapid spikes in blood glucose and "flavor programming" that encourages a preference for sweetened beverages; and

Whereas, The AAP explicitly recommends that juice should not be introduced to infants under one year of age and that intake should be strictly limited for toddlers and young children to reduce the risk of obesity and malnutrition; and

Whereas, Despite updates to WIC food packages in 2009 that reduced juice allowances, the program continues to provide juice credits for children ages 1–4, effectively endorsing juice as a daily staple contrary to current evidence-based nutritional guidance; and

Whereas, The USDA has acknowledged in proposed rule revisions that the provision of juice in WIC packages may displace the purchase and consumption of more nutrient-dense options like whole fruits and vegetables and low-fat milk; and

Whereas, Family physicians frequently treat low-income pediatric populations for preventable conditions exacerbated by high sugar intake, including early childhood caries and type 2 diabetes;

RESOLVED: That the California Academy of Family Physicians (CAFP) advocate to the California Department of Public Health and the USDA Food and Nutrition Service to eliminate juice from WIC food packages for all child participants, replacing it with increased cash-value vouchers (CVV) for whole fruits and vegetables; and be it further

RESOLVED: That the CAFP support educational initiatives aimed at WIC beneficiaries to clarify that fruit juice is not a necessary component of a healthy pediatric diet and to promote water and milk as the primary beverages for young children; and be it further

RESOLVED: That the CAFP instruct its delegates to the AAFP Congress of Delegates to submit a resolution calling on the AAFP to advocate at the federal level for the removal of juice from the national WIC food package requirements.

Equity Impact Score: 7/9

Problem Statement:

Problem Universe:

Specific Solution:**Evidence:****Citations:**

1. Heyman MB, Abrams SA; Section on Gastroenterology, Hepatology, and Nutrition; Committee on Nutrition. Fruit Juice in Infants, Children, and Adolescents: Current Recommendations. *Pediatrics*. 2017;139(6):e20170967
2. U.S. Department of Agriculture, Food and Nutrition Service. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC): Revisions in the WIC Food Packages. *Fed Regist*. 2022;87(223):71090-71163. Proposed Rule.
3. National Academies of Sciences, Engineering, and Medicine. Review of WIC Food Packages: Improving Balance and Choice: Final Report. Washington, DC: The National Academies Press; 2017.
4. Chi DL, Scott JM. Added Sugar and Dental Caries in Children: A Scientific Update. *Dent Clin North Am*. 2019;63(1):17-33
5. Wojcicki JM, Heyman MB. Reducing Childhood Obesity by Eliminating 100% Fruit Juice. *Am J Public Health*. 2012;102(9):1630-1633.
6. Academy of Nutrition and Dietetics. Position of the Academy of Nutrition and Dietetics: Nutrition Guidance for Healthy Children Ages 2 to 11 Years. *J Acad Nutr Diet*. 2014;114(8):1257-1276.

Speaker's Notes: CAFP has existing policy supporting healthy nutrition including providing healthy and diverse plant-based meal options for K-12 students in California schools. Additionally, CAFP policy supports evidence-based practices to strengthen follow-up care for patients experiencing food insecurity, including primary-care integrated referral pathways to both local and national resources. CAFP does not have specific policy addressing fruit juice consumption or WIC food packages.

AAFP policy on healthy foods supports easy, equitable access to affordable and nutritious foods, particularly among populations vulnerable to food insecurity. AAFP supports sustained funding for programs that eliminate disparities in healthy food access including WIC. AAFP policy also affirms the important role that family physicians play in counseling patients on nutrition and healthy behaviors across the lifespan. AAFP maintains clinical dietary recommendations and resources for family physicians related to infant feeding, and child nutrition. AAFP [nutrition guidance for toddlers](#) recommends daily intake of fruit juice to be limited to 4 oz between one and three years of age and between 4 to 6 oz between four and six years of age.

Supporting evidence-based nutritional guidelines related to WIC aligns with CAFP's 2025-2027 Strategic Plan goal to "Champion Public Health, Health Equity, and Evidence-based Medicine" and is germane to health equity by ensuring that WIC participants have access to nutritional food options.

Speaker's Fiscal Notes: There would be minimal to moderate costs associated with the activities proposed in this resolution, depending on the level of engagement required and whether the work remains within CAFP's established advocacy processes. CAFP engages in advocacy efforts only at the state level, and therefore activities involving federal agencies (USDA) would be limited to referral or communication through AAFP channels rather than direct advocacy.

Advocating to the California Department of Public Health to adjust WIC food packages would likely incur minimal costs if CAFP's involvement is limited to submitting letters, public comment, or

supporting state-led regulatory or administrative efforts. Costs could increase if a more sustained effort is required, including ongoing regulatory engagement or coalition participation.

Making available information family physicians can share with patients would have minimal cost if CAFP's contribution is limited to utilizing existing communication channels or events. Costs could increase if CAFP is expected to develop new educational materials or campaigns, as creating new educational or training products typically requires significant staff time, research, expert consultation, and coordination, and may fall outside CAFP's strategic plan and expertise.

Submitting the Resolution for national action would result in minimal cost.

Committee Recommendation on Resolution A-05-26

2026 Report of the Committee on Public Health and Equity

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFPP Board of Directors

Speaker, the CAFPP Committee on Public Health and Equity (CPHE) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-05-26 Eliminating Fruit Juice from WIC Food Packages to Combat Childhood Obesity and Dental Caries

RESOLVED: That the California Academy of Family Physicians (CAFP) advocate to the California Department of Public Health and the USDA Food and Nutrition Service to eliminate juice from WIC food packages for all child participants, replacing it with increased cash-value vouchers (CVV) for whole fruits and vegetables; and be it further

RESOLVED: That the CAFPP support educational initiatives aimed at WIC beneficiaries to clarify that fruit juice is not a necessary component of a healthy pediatric diet and to promote water and milk as the primary beverages for young children; and be it further

RESOLVED: That the CAFPP instruct its delegates to the AAFP Congress of Delegates to submit a resolution calling on the AAFP to advocate at the federal level for the removal of juice from the national WIC food package requirements.

Committee Recommendation: ADOPT AS AMENDED:

RESOLVED: That the CAFPP advocate for continued reduction of juice allotment from WIC food packages for all child participants, replacing it with increased cash-value vouchers (CVV) for whole fruits and vegetables; and be it further

RESOLVED: That the CAFPP support educational initiatives aimed at WIC beneficiaries to clarify that fruit juice is not a necessary component of a healthy pediatric diet.

RESOLVED: That the CAFPP refer for national action to submit a resolution calling on the AAFP to advocate at the federal level for the reduced allotment of juice from WIC food packages for all child participants, replacing it with increased cash-value vouchers (CVV) for whole fruits and vegetables.

Committee Discussion: The committee discussed concerns that the use of the word “eliminate” was overly restrictive and too strong. Members noted that for some children, including those with autism or restrictive eating patterns, juice or similar options may provide necessary calories when whole fruit is not feasible. The committee also discussed the nutritional value of juice and emphasized that entirely removing certain benefits may not adequately replace the nutritional support currently provided.

The committee recommended removing overly directive language, avoiding references to specific agencies, and reframing the resolution to encourage continued work in this area rather than calling for elimination of benefits. Members emphasized that further reductions to public programs are not advisable at this time and noted that existing guidance, including AAFP policy, allows limited juice intake for children over one year of age within recommended daily limits.

Discussion of the second resolved statement raised questions about milk as a primary beverage, including concerns that excessive intake may contribute to iron deficiency. The committee amended the three resolved statements and recommended adoption as amended.

Resolution A-06-26

Proposed Policy Title: Food Literacy

Author: Warren Nakazawa, MD

Co-Authors: Valerie Otti, MD; Caryssa Lim, MD

Endorsed by: None

Whereas, The United States Departments of Agriculture and Health and Human Services have released the Dietary Guidelines for Americans (1), providing individuals advice on what to eat and drink to promote health and prevent disease, updated periodically with the latest developments in medicine, nutrition science, and public health, and

Whereas, Studies at the Harvard School of Public Health published in the Journal of the American Medical Association have found large scale associations between lower risk of total and cause-specific mortality and eating patterns associated with the Dietary Guidelines for Americans (2), and

Whereas, Many additional studies purport various tools to characterize food literacy, though there is no standardized tool or recommendation for comprehensive and validated assessment (3,4), and

Whereas, Evaluation of educational interventions has also been correlated with positive effects on both subjects' knowledge of nutritional sciences and on practical decision making (5), and

Whereas, The mission and vision of American Academy of Family Physicians emphasize sustainable, equitable, and evidence-based practice to teach and empower patients, families, and communities in their health decisions

Whereas, The policies of the California Academy of Family Physicians currently support the use and education surrounding assessment tools for evaluation of food insecurity (6)

RESOLVED: That the California Academy of Family Physicians acknowledge the need for validated and comprehensive food literacy assessments that can be practically utilized by family physicians, and

RESOLVED: That the California Academy of Family Physicians advocate for governing bodies to fund the development and validation of food literacy assessments, as well as food literacy education programs, and

RESOLVED: That the California Academy of Family Physicians support medical and educational experts at the community and state levels in their means to develop and propagate educational programs addressing general nutrition competency and food literacy based on data collected from healthy literacy assessment tools.

Equity Impact Score: 6/9

Problem Statement: Nutrition is a key tenet of health and disease. It is a cornerstone for discussion in addressing many chronic diseases, including, but not limited to, high blood pressure, high cholesterol, obesity, insomnia, liver disease, gallbladder disease, among others, within the United States. In order to assess food literacy, there is a need for validated tools and assessments to guide us towards identifying affected populations and community needs, as well as developing evidence-based models for educating our patients.

Problem Universe: Again, nutrition is one of the foundations of counseling and educating patients on their chronic conditions. Everybody is affected by the food that they eat and consume and, by extension, by their knowledge of the relationship between nutrition and health.

Specific Solution: I propose that CAFP acknowledge a need for validated, practical, and comprehensive tools to assess food literacy in the general public and in special subpopulations as necessary. I also propose that CAFP advocate for evidence-based educational programs targeting children and adolescents based on the data provided by these tools.

Evidence: Obesity prevalence in the US has jumped from around 30% in 2000 to 42% in 2017-2020, over the last two decades, according to the CDC. In particular, Black and Hispanic populations tend to have higher rates of obesity and associated morbidity. Rates of hypertension and diabetes are also growing. These chronic conditions, among others, represent an epidemic within the United States, an epidemic that relies on the accuracy and quality of education around nutrition as it relates to health.

Citations:

1. Dietary Guidelines for Americans. Dietary Guidelines for Americans, 2020-2025 and Online Materials | Dietary Guidelines for Americans. www.dietaryguidelines.gov. Published December 2020. <https://www.dietaryguidelines.gov/resources/2020-2025-dietary-guidelines-online-materials>
2. Shan Z, Wang F, Li Y, et al. Healthy Eating Patterns and Risk of Total and Cause-Specific Mortality. *JAMA Internal Medicine*. 2023;183(2). doi: <https://doi.org/10.1001/jamainternmed.2022.6117>
3. Synne Groufh-Jacobsen, Anine Christine Medin. Food literacy competencies in youth – a mini-review. *Frontiers in Public Health*. 2023;11. doi: <https://doi.org/10.3389/fpubh.2023.1185410>
4. Vidgen HA, Gallegos D. Defining food literacy and its components. *Appetite*. 2014;76(1):50-59. doi: <https://doi.org/10.1016/j.appet.2014.01.010>
5. Rana T, Archana Konapur, Mishra P, et al. The impact of educational interventions on food label comprehension and food choices among adolescents: a scoping review. *BMC Public Health*. 2025;25(1). doi: <https://doi.org/10.1186/s12889-025-23940-5>
6. California Academy of Family Physicians. Policy Digest. California Academy of Family Physicians. Published September 24, 2025. https://www.familydocs.org/wp-content/uploads/2025/09/25.ADM_CAFPPolicyManualUpdate.9.23.25.Current-Version.pdf

Speaker's Notes: CAFP Policy supports and encourages family physicians and their practice teams to screen for food insecurity and supports the education of its membership about how to use and interpret food insecurity screening tools. CAFP does not have specific policy addressing comprehensive food literacy assessment tools or food literacy education programs beyond food insecurity screening.

Education about and access to healthy foods is aligned with CAFP's strategic priorities of advancing health equity and supporting evidence-based practice. CAFP has not recently focused on food literacy assessment or comprehensive nutrition education programs.

The AAFP recognizes that nutrition education is foundational to addressing chronic disease, but there is no specific AAFP policy advocating for validated food literacy assessment tools or comprehensive food literacy education programs at the population level. The AAFP has been actively engaged in nutrition policy development at the federal level. In January 2023, the AAFP [encouraged family physicians to participate](#) in shaping the 2025-2030 edition of the *Dietary Guidelines for Americans* through the 2025 Dietary Guidelines Advisory Committee process. The AAFP has published clinical guidance on [translating the 2020-2025 Dietary Guidelines into clinical](#)

[practice](#), acknowledging that physicians and health care teams "generally have little training in nutrition and the science of dietary recommendations."

It is important to note that there are more recent questions about the current validity of the USDA's Dietary Guidelines for Americans updated in January 2026. While AAFP has worked on shaping the Dietary Guidelines for Americans in the past, CAFP policy may not want to reference these guidelines if AAFP/CAFP determines they are no longer evidence-based.

Speaker's Fiscal Notes: There would be minimal to moderate costs for CAFP to undertake the activities outlined in this resolution, depending on the level of engagement required and whether the work remains within existing advocacy processes.

Overall, the fiscal impact would be low to moderate if CAFP's involvement is advisory and limited to supporting existing efforts. Costs could increase if the work requires new initiatives, ongoing coordination, or activities outside the current strategic plan or staff expertise.

Committee Recommendation on Resolution A-06-26

2026 Report of the Committee on Public Health and Equity

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the CAFP Committee on Public Health and Equity (CPHE) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-06-26 Food Literacy

RESOLVED: That the California Academy of Family Physicians acknowledge the need for validated and comprehensive food literacy assessments that can be practically utilized by family physicians, and

RESOLVED: That the California Academy of Family Physicians advocate for governing bodies to fund the development and validation of food literacy assessments, as well as food literacy education programs, and

RESOLVED: That the California Academy of Family Physicians support medical and educational experts at the community and state levels in their means to develop and propagate educational programs addressing general nutrition competency and food literacy based on data collected from healthy literacy assessment tools.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP supports the need for validated and comprehensive food literacy assessment that can be practically utilized by family physicians,

RESOLVED: That the CAFP advocate for the funding, development, and validation of evidence based and culturally competent food literacy assessments, as well as evidence based food literacy education programs, and

RESOLVED: That the CAFP support medical and educational experts at the community and state levels in their means to develop and propagate evidence based, and culturally competent educational programs addressing general nutrition competency and food literacy based on data collected from validated health literacy assessment tools.

Committee Discussion: The committee discussed the first resolved statement and noted that it was not highly directive and did not require additional action. Members suggested that the use of "supports" would be more appropriate language. Discussion of the second and third resolved statements supported the addition of language emphasizing evidence-based and culturally competent approaches, particularly in response to recently released USDA dietary guidelines that raised concerns. The committee amended the three resolved statements and recommended adoption as amended.

Resolution A-07-26

Proposed Policy Title: Supporting School Policies that Substantially Reduce Items Containing High-Fructose Corn Syrup and Derivatives

Author: Deepa Srinivasan, DO

Co-Authors: Dennis Li, MD; Suzie Lee, DO; Kenyon Wright, MD; Dennis Chou, DO

Endorsed by: None

Whereas, the California Academy of Family Physicians (CAFP) has previously adopted policy supporting the elimination of soft drinks and sugar-sweetened beverages from schools and the promotion of healthier beverage alternatives; and the American Academy of Pediatrics and state/federal nutrition standards encourage the removal of sugar-sweetened beverages from the school environment; and.

Whereas, high-fructose corn syrup (HFCS) and other concentrated sources of added fructose are not only major components of many sugar-sweetened beverages but also significant components of processed meals, condiments, and snacks commonly available in school cafeterias and vending machines; and.

Whereas, several peer-reviewed studies link high intake of fructose-rich foods and sugar-sweetened beverages to adverse metabolic outcomes, including weight gain, insulin resistance, metabolic dysfunction-associated steatotic liver disease (MASLD), dyslipidemia, hypertension, and increased cardiometabolic risk; and.

Whereas, emerging preclinical and early clinical evidence suggests that excessive early-life and adolescent intake of high levels of dietary fructose/HFCS is associated with neurobehavioral changes and increased risk of anxiety and depression-like phenotypes in animal models, and epidemiologic analyses have observed associations between high added-sugar intake and worse mood and depressive symptoms in youth and adults; and.

Whereas, K-12 schools are uniquely positioned to shape children's dietary norms, promote equitable access to healthy beverages, and model community standards that support long-term health, thereby serving as a critical setting for early prevention of chronic disease; now, therefore, be it

RESOLVED: That the California Academy of Family Physicians (CAFP) support policies at the state, county, and local school district level that either eliminate or substantially reduce the sale and serving of foods and beverages containing high-fructose corn syrup (HFCS) and concentrated fructose derivatives in all K-12 school food environments, including cafeterias, vending machines, school stores, and at school-sponsored events; and be it further

RESOLVED: That CAFP encourage school food service procurement standards and local wellness policies to prioritize beverages and foods without added fructose/HFCS compliant with nutrition standards, and to phase out HFCS-containing products where feasible; and be it further

RESOLVED: That CAFP, where feasible, advocate for reallocation of revenues derived from competitive sales of HFCS-containing products toward healthier school nutrition programs and student wellness initiatives, including hydration stations, fresh fruit/vegetable programs, school gardens, nutrition education; and be it further

RESOLVED: That CAFP support educational outreach for school administrators, food service staff, parents, and students about the health effects of concentrated added sugars and HFCS—including metabolic and emerging mental health risks—and provide model policy language, implementation guidance, and clinician-facing talking points to assist in local advocacy efforts; and be it further

RESOLVED: That CAFP encourage and support research and surveillance on the impact of HFCS-targeted school food policies on students' metabolic health, mental health, dietary intake, and equity outcomes.

Equity Impact Score: 6/9

Problem Statement:

Problem Universe:

Specific Solution:

Evidence:

Citations:

1. California Academy of Family Physicians Policy Manual — Soft Drinks in Schools.
2. Lott M, et al. Public policies to reduce sugary drink consumption in children and adolescents. Pediatrics (AAP policy/review).
3. Febbraio MA, et al. Fructose as a metabolic toxin that targets the gut-liver axis. Cell Metabolism. 2021.
4. Baumann A, et al. Fructose, a trigger of metabolic diseases? Narrative review. 2022.
5. Lancaster KJ, et al. Intake and disparities in the association of fructose-rich foods and metabolic syndrome. JAMA Network Open, 2020.
6. Chakraborti A, et al. HFCS-moderate fat diet potentiates anxio-depressive behavior (animal model). PMC article, 2021.
7. Andersen SH, et al. Early-life high fructose exposure increases anxiety/depression risk (review). 2023.
8. Taber DR, et al. Did state-mandated restrictions on sugar-sweetened drinks in schools affect student consumption? PNAS/PMC. 2015.
9. CDC. The Guide to Strategies for Reducing the Consumption of Sugar-Sweetened Beverages in Communities.

Speaker's Notes: CAFP has a related policy on diversifying school meals which endorses legislation to provide healthy and diverse plant-based meal options in California K-12 schools. CAFP policy also supports eliminating sweetened drinks in schools, and advocates for taxation of sugar-sweetened beverages. Reducing HFCS in school nutrition programs aligns with CAFP's 2025-2027 Strategic Goal to Champion Public Health, Health Equity, and Evidence-based Medicine.

AAFP has an established policy on School Nutrition which states that sound nutrition is a cornerstone of health and that items of little or no nutritional value should be replaced with healthy alternatives. AAFP policy on sugar sweetened beverages includes support for taxation of sugar sweetened beverages and directing tax monies toward programs that improve public health. AAFP recommends limiting "free sugars" which includes HFCS, to less than 10% of total daily calories.

Speaker's Fiscal Notes: There would be minimal to significant costs associated with the activities outlined in this resolution, depending on the level of engagement required and whether the expectations extend beyond CAFP's current advocacy scope and strategic priorities. It is important to note that CAFP typically engages in advocacy efforts at the state level; therefore, actions at county

or local school district levels may fall outside CAFP's typical advocacy channels and could require additional clarification or adjustment.

Supporting policies to eliminate or reduce high-fructose corn syrup (HFCS) in K–12 school environments would fall within CAFP's public health policy priorities. If CAFP's role is limited to issuing statements or letters in support of state-level policy changes sponsored by others, the cost would be minimal. Costs could rise to moderate if additional sustained engagement, coalition participation, or regulatory commentary is required. Efforts to influence county or local school district regulations or procurement frameworks would require significant staff time, coordination with external partners, or expertise beyond current capacity.

Advocating for revenue reallocation from HFCS-containing competitive food sales into wellness programs would likely incur minimal cost if CAFP supports legislation or regulatory efforts initiated by others. Costs would become significant if CAFP is expected to sponsor legislation, as sponsoring bills requires substantial staff time, sustained lobbying, and communications resources not covered under standard advocacy activities.

Providing model policy language, implementation guidance, and clinician-facing talking points would require moderate to significant staff time to research, draft, review, and coordinate with experts. If the expectation is for CAFP to develop more extensive educational materials or training programs, costs could become significant, especially if CME development, external consultation, or new content production is required.

Encouraging or supporting research and surveillance on the impact of HFCS-related school food policies would incur minimal cost if CAFP serves in an advisory or endorsement role. Cost would increase if CAFP is expected to convene data systems, conduct research, or manage evaluation efforts—activities that fall outside CAFP's typical expertise and infrastructure.

Committee Recommendation on Resolution A-07-26

2026 Report of the Committee on Public Health and Equity

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the CAFP Committee on Public Health and Equity (CPHE) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-07-26 Supporting School Policies that Substantially Reduce Items Containing High-Fructose Corn Syrup and Derivatives

RESOLVED: That the California Academy of Family Physicians (CAFP) support policies at the state, county, and local school district level that either eliminate or substantially reduce the sale and serving of foods and beverages containing high-fructose corn syrup (HFCS) and concentrated fructose derivatives in all K–12 school food environments, including cafeterias, vending machines, school stores, and at school-sponsored events; and be it further

RESOLVED: That CAFP encourage school food service procurement standards and local wellness policies to prioritize beverages and foods without added fructose/HFCS compliant with nutrition standards, and to phase out HFCS-containing products where feasible; and be it further

RESOLVED: That CAFP, where feasible, advocate for reallocation of revenues derived from competitive sales of HFCS-containing products toward healthier school nutrition programs and student wellness initiatives, including hydration stations, fresh fruit/vegetable programs, school gardens, nutrition education; and be it further

RESOLVED: That CAFP support educational outreach for school administrators, food service staff, parents, and students about the health effects of concentrated added sugars and HFCS—including metabolic and emerging mental health risks—and provide model policy language, implementation guidance, and clinician-facing talking points to assist in local advocacy efforts; and be it further

RESOLVED: That CAFP encourage and support research and surveillance on the impact of HFCS-targeted school food policies on students' metabolic health, mental health, dietary intake, and equity outcomes.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP support policies that reduce the availability of foods and beverages containing high-fructose corn syrup (HFCS) and concentrated fructose derivatives in all K-12 school food environments.

RESOLVED: That the CAFP encourage school food service procurement standards and local wellness policies to prioritize beverages and foods without highly refined sugars compliant with nutrition standards.

RESOLVED: That the CAFP support the development of educational outreach for school administrators, food service staff, parents, and students about the health effects of concentrated added sugars and highly refined sugars, and provide model policy language, implementation guidance, and clinician-facing talking points to assist in local advocacy efforts.

Committee Discussion: The committee expressed support for the overall intent and spirit of the resolution and noted that existing policy already addresses the underlying issues. Members discussed whether references to high fructose corn syrup (HFCS) were overly specific and agreed that broader language such as “highly refined sugars” would be more appropriate and inclusive. The committee amended the first, second, and fourth resolved statements and recommended adoption as amended.

The third resolved statement was discussed as being overly directive and too specific, and the committee recommended against its adoption. The final resolved statement was also discussed as unclear, with uncertainty regarding whether it called for research, surveillance, or policy changes related to school practices. Given the lack of clarity and concern about interpreting the author’s intent, the committee recommended against the adoption of the third and last resolved statement.

Resolution A-08-26

Proposed Policy Title: Food Label Transparency

Author: Warren Nakazawa, MD

Co-Authors: Valerie Otti, MD; Caryssa Lim, MD

Endorsed by: None

Whereas, The United States Departments of Agriculture and Health and Human Services have released the Dietary Guidelines for Americans (1), providing individuals advice on what to eat and drink to promote health and prevent disease, updated periodically with the latest developments in medicine, nutrition science, and public health, and

Whereas, Studies at the Harvard School of Public Health published in the Journal of the American Medical Association have found large scale associations between lower risk of total and cause-specific mortality and eating patterns associated with the Dietary Guidelines for Americans (2), and

Whereas, In various studies, education level has been correlated with positive effects on both subjects' knowledge of nutritional sciences and on practical decision making (3), and

Whereas, Terminology, including terms such as "natural", "healthy", and even "serving size", maintain vague definitions as regulated by the Food and Drug Administration (FDA) and United States Department of Agriculture (USDA), in that

Whereas, The FDA has not established a formal definition for the term "natural", and the FDA's current stance does "not intend to address food production methods, such as the use of pesticides, nor [does] it explicitly address food processing or manufacturing methods, such as thermal technologies, pasteurization, or irradiation" (4), and

Whereas, By FDA codes (5), this definition of "natural" effectively extends to the term "natural flavors", which is defined by the FDA as "derived from a spice, fruit or fruit juice, vegetable or vegetable juice, edible yeast, herb, bark, bud, root, leaf or similar plant material, meat, seafood, poultry, eggs, dairy products, or fermentation products thereof", without mention of processing means, and

Whereas, While the FDA has established a final rule (6) as of 2024 to update the definition of "healthy", its scope is limited to two major aspects: (1) associated food group (e.g., fruit, vegetables, grains, etc.) amounts and (2) limits on added sugar, saturated fat, and sodium; moreover

Whereas, The term "serving size" refers to portions, referred to as Reference Amounts Customarily Consumed (RACCs), based on how much food people actually consume; these data are collected through national surveys and, as of 2025, the current RACCs are based on data from 2003-2008 (7), and

Whereas, Studies have also shown that uncertainty around the "serving size" definition may also result in barriers related to accuracy in computing nutrition data based on serving size, as well as misunderstandings on how much people should eat. (8)

Whereas, The mission and vision of American Academy of Family Physicians emphasizes sustainable, equitable, and evidence-based practice to teach and empower patients, families, and communities in their health decisions.

RESOLVED: That the California Academy of Family Physicians advocate for stricter regulatory definitions for the term "natural" and "natural flavors", specifically acknowledging the use of artificial

solvents, emulsifiers, and other chemicals utilized in the food production process, and

RESOLVED: That the California Academy of Family Physicians advocate for a stricter regulatory definition for the term “healthy”, underlining the diversity and complexity of nutrition as it relates to chronic conditions, including, but not limited to, elevated blood pressures, elevated cholesterol, and obesity, and

RESOLVED: That the California Academy of Family Physicians advocate for a stricter and more transparent regulatory definition for the term “serving size”, integrating recommended definitions and dietary guidelines from established professional medical and nutritional organizations.

Equity Impact Score: 6/9

Problem Statement: Nutrition is a key tenet of health and disease. It is a cornerstone for discussion in addressing many chronic diseases, including, but not limited to, high blood pressure, high cholesterol, obesity, insomnia, liver disease, gallbladder disease, among others, within the United States. Current regulating bodies unfortunately maintain vague definitions for the use of nutritional terms in food advertising, failing to protect the interests of the people. The design of food labels should aim to be transparent, intuitive, and easily accessible.

Problem Universe: Again, nutrition is one of the foundations of counseling and educating patients on their chronic conditions. Everybody is affected by the food that they eat and consume and, by extension, by their knowledge of the relationship between nutrition and health.

Specific Solution: I propose that CAFP acknowledge the disparities and confusion caused by nutrition label terms and designs. In turn, I propose also that the CAFP advocate for improvements in regulatory body definitions and codes that help to address misunderstandings related to food labels that contribute to health disparities for underprivileged groups and the public at large.

Evidence: Obesity prevalence in the US has jumped from around 30% in 2000 to 42% in 2017-2020, over the last two decades, according to the CDC. In particular, Black and Hispanic populations tend to have higher rates of obesity and associated morbidity. Rates of hypertension and diabetes are also growing. These chronic conditions, among others, represent an epidemic within the United States. These disparities in health are exacerbated by barriers introduced by vague and potentially misleading terms used to advertise food products.

Citations:

1. Dietary Guidelines for Americans. Dietary Guidelines for Americans, 2020-2025 and Online Materials | Dietary Guidelines for Americans. www.dietaryguidelines.gov. Published December 2020. <https://www.dietaryguidelines.gov/resources/2020-2025-dietary-guidelines-online-materials>
2. Shan Z, Wang F, Li Y, et al. Healthy Eating Patterns and Risk of Total and Cause-Specific Mortality. *JAMA Internal Medicine*. 2023;183(2). doi: <https://doi.org/10.1001/jamainternmed.2022.6117>
3. Rana T, Archana Konapur, Mishra P, et al. The impact of educational interventions on food label comprehension and food choices among adolescents: a scoping review. *BMC Public Health*. 2025;25(1). doi: <https://doi.org/10.1186/s12889-025-23940-5>
4. Human Foods Program. Use of the Term Natural on Food Labeling. U.S. Food and Drug Administration. Published 2024. <https://www.fda.gov/food/nutrition-food-labeling-and-critical-foods/use-term-natural-food-labeling>
5. McEvoy M. Policy Memorandum - Use of Natural Flavors.; 2024. Accessed November 30, 2025. <https://www.ams.usda.gov/sites/default/files/media/NOP-PM-11-1-NaturalFlavors.pdf>

6. FDA. Use of the “Healthy” Claim on Food Labeling. U.S. Food and Drug Administration. Published 2025. <https://www.fda.gov/food/nutrition-food-labeling-and-critical-foods/use-healthy-claim-food-labeling>
7. FDA. Food Serving Sizes Have a Reality Check. U.S. Food and Drug Administration. Published March 29, 2022. <https://www.fda.gov/consumers/consumer-updates/food-serving-sizes-have-reality-check>
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Speaker’s Notes: The resolution seeks advocacy for enhanced food label transparency (e.g., disclosure of certain additives/processing aids). This is a public health policy request, but much of food labeling authority is federal (FDA/USDA), where the state’s role can regulate in a more limited way that is not in conflict with federal label rules. As a state chapter, CAFP’s feasible role is advocacy/education rather than directing labeling changes.

CAFP has policy supporting health and diverse plant-based meal options in schools and evidence-based practices to strengthen follow-up care for patients experiencing food insecurity. CAFP's Health Policy principles state that health care should be comprehensive and include "health promotion and maintenance" and "appropriate levels of patient education and counseling." AAFP has been actively involved in dietary guidelines work and commented on the FDA's updated "healthy" label definition in January 2025. Both AAFP and CAFP recognize that nutrition education is a key part of preventing chronic diseases like obesity, diabetes, and heart disease.

CAFP advocacy activities primarily focus on legislative and regulatory issues at the state level. The resolution calls for stricter regulatory definitions of “natural,” “natural flavors,” “healthy,” and “serving size.” These terms are defined and regulated primarily by federal agencies such as the FDA and USDA.

Of note, recently questions have been raised about the science supporting the USDA’s revised Dietary Guidelines for Americans updated in January 2026.

Speaker’s Fiscal Notes: There would be minimal to moderate costs associated with the activities outlined in this resolution, depending on the level of engagement required and the extent to which CAFP is expected to participate in regulatory processes that occur at the federal level.

Since CAFP engages in advocacy only at the state level, its role in influencing federal regulatory definitions is inherently limited. Any action CAFP takes would likely involve supporting or referring the matter to AAFP for national advocacy. Referral to AAFP would incur minimal cost, as submitting items for national consideration falls within established processes.

If CAFP’s involvement is limited to drafting statements or letters supporting stricter definitions to state-level bodies or in support of national action, costs would be minimal. An approach requiring outside expertise, consultation with regulatory specialists, or coordination with partner organizations would result in moderate to significant costs.

Regulatory engagement, such as submitting regulatory comments or reviewing proposed language, would increase costs.

If the resolution is interpreted to require CAFP to develop or disseminate educational materials on evolving definitions of “natural,” “healthy,” or “serving size,” that would introduce additional costs. Creating new educational content requires research, drafting, expert review, and integration into communications platforms.

Overall, fiscal impact is minimal if CAFP's involvement is limited to drafting letters, referring the matter to AAFP, or supporting existing advocacy efforts. Costs become moderate to significant if CAFP is expected to conduct in-depth regulatory work, provide scientific analysis outside its core expertise, or engage in activities beyond its state-level advocacy role and strategic priorities.

Committee Recommendation on Resolution A-08-26

2026 Report of the Committee on Public Health and Equity

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the CAFP Committee on Public Health and Equity (CPHE) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-08-26 Food Label Transparency

RESOLVED: That the California Academy of Family Physicians advocate for stricter regulatory definitions for the term “natural” and “natural flavors”, specifically acknowledging the use of artificial solvents, emulsifiers, and other chemicals utilized in the food production process, and

RESOLVED: That the California Academy of Family Physicians advocate for a stricter regulatory definition for the term “healthy”, underlining the diversity and complexity of nutrition as it relates to chronic conditions, including, but not limited to, elevated blood pressures, elevated cholesterol, and obesity, and

RESOLVED: That the California Academy of Family Physicians advocate for a stricter and more transparent regulatory definition for the term “serving size”, integrating recommended definitions and dietary guidelines from established professional medical and nutritional organizations.

Committee Recommendation: DO NOT ADOPT

Committee Discussion: The committee discussed that none of the resolved statements fall within the purview of CAFP, as the issue is primarily federal in nature and states do not play a role in regulating food labeling. While the committee expressed support for the spirit of the resolution, members noted that the language was overly vague and lacked clear, actionable direction.

In addition, the committee mentioned that the use of the term “stricter” was discussed as not reflective of best practices in policy drafting, as it was unclear what existing standards were being referenced. Members noted that while referral for national action could be appropriate, this was not specified by the author. The committee recommended not adopting and that the author significantly rework and clarify the resolution language to better define intent, scope, and appropriate jurisdiction.

Resolution A-09-26

Proposed Policy Title: Ensuring Equitable Vaccine Access for Independent and Rural Family Physicians to Protect Public Health in California

Author: Maryal Concepcion, MD

Co-Authors: None

Endorsed by: None

Whereas, CAFP's mission is to empower, educate, and connect family physicians to improve the health of all Californians, and its vision prioritizes thriving communities with equitable health resources; and

Whereas, Independent family physicians serve as essential access points for preventive care, especially in rural, frontier, and underserved communities where large systems either do not operate or do not provide immunizations; and

Whereas, Many pharmaceutical companies and vaccine distributors refuse to contract with or ship to independent practices, either because they require minimum order quantities, cannot comply with California sharps disposal laws in small shipments, or choose to contract only with large systems; and

Whereas, These structural barriers result in rural communities lacking access to routine immunizations, including VFC pediatric vaccines, influenza vaccines, and COVID vaccines — despite legally mandated immunization requirements for school entry; and

Whereas, In Calaveras County and other rural regions, independent clinics have been forced to volunteer their own time and staff capacity to vaccinate children when county public health departments lacked personnel, demonstrating a failure of existing public health infrastructure; and

Whereas, The CDC ACIP's recent vote to withdraw universal Hepatitis B vaccination at birth jeopardizes infant health, increases risk for chronic disease, and undermines longstanding evidence-based practice standards; and

Whereas, California has already taken steps to shield state recommendations from unsafe federal rollbacks by joining the West Coast Vaccine Alliance, reaffirming a commitment to evidence-based public health; and

Whereas, Despite these protections, independent practices still lack guaranteed access to the vaccines they are expected to administer under California law and under evidence-based family medicine guidelines; now,

RESOLVED: That CAFP advocate for state-level vaccine distribution reforms to ensure independent and rural physician practices have equal access to ordering, storing, and administering all recommended vaccines, including Hepatitis B birth dose, COVID vaccines, and childhood VFC vaccines; and

RESOLVED: That CAFP work with the California Department of Public Health, the West Coast Vaccine Alliance, and vaccine manufacturers to establish procurement pathways that allow small-quantity shipments and sharps-law-compliant packaging specifically accessible to independent practices; and

RESOLVED: That CAFP support the creation of a centralized ordering system for small practices that aggregates demand and facilitates bulk purchasing so independent physicians can access vaccines

without minimum-order limitations; and

RESOLVED: That CAFP advocate for improved funding, staffing, and infrastructure for rural county public health departments to prevent future situations where children cannot receive vaccines required for school entry; and

RESOLVED: That CAFP issue a public statement reaffirming its support for universal newborn Hepatitis B vaccination and urging California to maintain evidence-based immunization standards regardless of changes in federal ACIP recommendations; and

RESOLVED: That CAFP annually evaluate and report on vaccine-access disparities among independent practices, rural counties, and large systems, including recommendations for system-level improvements.

Equity Impact Score: 9/9

Problem Statement: Independent and rural family physicians face systemic barriers preventing them from obtaining vaccines needed to administer evidence-based preventative care. Manufacturers and distributors refuse to work with small clinics, county public health departments lack capacity, and regulatory barriers prevent equitable access. This results in children and adults in rural California lacking access to required immunizations.

Problem Universe: Affected populations include:

- All independent and rural family physicians in California
- Tens of thousands of children needing school-entry vaccines
- Newborns needing Hep B birth dose
- Rural communities without large health systems
- Clinics relying on VFC programs but unable to order or store vaccines
- Patients requiring COVID, influenza, HPV, Tdap, shingles, and other routine vaccines
- Estimated population impact: hundreds of clinics and several hundred thousand patients.

Specific Solution: The resolution proposes:

- Creation of accessible, small-quantity vaccine ordering pathways
- Structural reform of state distribution systems
- Inclusion of independent physicians in West Coast Vaccine Alliance planning
- Public reaffirmation of universal Hep B birth-dose vaccination
- State-supported procurement infrastructure
- Improved rural public health staffing

Evidence:

- Independent clinics routinely denied access to vaccine shipments or minimum quantities
- Rural counties experiencing zero public health capacity for vaccine administration
- Independent physicians volunteering unpaid time to vaccinate children
- ACIP's Hep B rollback increases risk of infant infection
- Large systems in multiple CA counties do not administer VFC COVID vaccines, leaving independent clinics as sole access points
- West Coast Vaccine Alliance acknowledges threats to evidence-based vaccine policy
- CAFP's own federal update (12/5/25) condemns ACIP's Hep B decision and highlights need for system protection

Citations:

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Speaker's Notes: The resolution seeks broad CAFP advocacy to improve vaccine access for independent and rural practices, including procurement pathways and infrastructure for ordering/storage/administration. The public health goal is aligned with existing CAFP policy, but breadth of the advocacy, partnership, and oversight would require a significant redistribution of resources away from other academy priorities and the strategic plan. This proposal includes specific directives to the CAFP operations by directing CAFP to curate, oversee, and update content like a vaccine-access disparities report.

CAFP has existing policy supporting equity in rural health policy, which requires that a rural health perspective be considered and accounted for as part of CAFP's legislative and regulatory advocacy activities.

CAFP has comprehensive policy supporting independent practice, stating that CAFP will endeavor to support and promote the private or independent practice of medicine, whether solo practice, small group, or large group. CAFP's health care system reform principles emphasize 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 geographic location. CAFP policy further supports investment in public health, including efforts to increase coordination between primary care teams and public health programs to improve population health and health equity.

AAFP policy encourages vaccine manufacturers, distributors, and government-funded programs to deliver adequate, timely, and complete orders of recommended immunizations to family physicians in a prioritized manner to most effectively achieve universal vaccination of patients from their usual source of primary care. AAFP policy specifically states that doing so supports public health vaccination efforts, increases vaccine confidence, and helps physicians meet quality measurement goals. The AAFP supports universal immunizations regardless of socioeconomic or insurance status for all immunizations recommended by the AAFP. AAFP policy also advocates for vaccination manufacturers and distributors to exercise fair and reasonable purchasing policies to minimize family physicians' financial liability in maintaining a vaccine inventory and calls for government programs that subsidize vaccine costs to be adequately funded by federal and state governments. Notably, AAFP has recognized that for families living in rural areas, receiving immunizations from an office-based family physician may be the only option, and has called for policies and programs aimed at increasing access to vaccines as well as better coordination of vaccine distribution to help improve vaccine uptake in rural and underserved areas.

Access to vaccines aligns with CAFP's 2025-2027 Strategic Plan goals, particularly in championing public health, health equity, and evidence-based medicine. Ensuring that independent and rural practices have equal access to vaccine ordering, storage, and administration directly supports the strategic priority of reducing health disparities and improving access to preventive services across all California communities.

Both CAFP and AAFP have been active in protecting and expanding vaccine access and in building public health infrastructure. In 2025, the AAFP has been highly engaged in federal changes affecting vaccine policy, including sending multiple letters to Congress and federal agencies regarding immunization-related activities in appropriations bills, preservation of ACIP processes, and ensuring continued access to COVID-19 vaccines. CAFP issued a public statement reaffirming its support for universal newborn Hepatitis B vaccination and played an active role in the development of a new law in California maintaining evidence-based immunization standards regardless of changes in federal ACIP recommendations. Both CAFP and AAFP have emphasized the critical role of primary care physicians in vaccine distribution. The AAFP specifically highlighted in communications to federal officials that unaffiliated community practices have tremendous challenges obtaining vaccines and called for prioritizing community primary care physicians in vaccination strategies.

Speaker's Fiscal Notes: There would be minimal to moderate costs for CAFP to undertake the activities described in this resolution, depending on the scope, duration, and level of engagement required. However, it is important to note that the majority of the resolved clauses are action-oriented directives rather than policy statements, which may necessitate ongoing operational work beyond CAFP's typical role of setting policy positions.

Advocacy for state-level vaccine distribution reforms, collaboration with the California Department of Public Health, the West Coast Vaccine Alliance, and vaccine manufacturers, and support for improved funding and infrastructure for rural public health departments would generally fall within CAFP's existing legislative and regulatory advocacy framework. Supporting or opposing legislation or providing regulatory input sponsored by others would likely result in minimal cost if conducted through established procedures. Costs could rise to moderate if sustained engagement, coalition leadership, or detailed policy development is required.

Issuing another public statement reaffirming support for universal newborn Hepatitis B vaccination would incur minimal cost, though costs could increase if a broader communications strategy is necessary.

Establishing or supporting centralized ordering systems, facilitating procurement pathways for small-quantity shipments, and conducting annual evaluations and reports on vaccine-access disparities—that imply ongoing implementation, coordination, and analytical work. These activities may require moderate to significant staff time for research, data collection, stakeholder

engagement, and reporting. If such work extends beyond CAFP's existing expertise, strategic plan, or current lobbying and staffing capacity, costs could become moderate to significant, potentially requiring outside consultants or additional advocacy resources.

Committee Recommendation on Resolution A-09-26

2026 Report of the Committee on Public Health and Equity

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the CAFP Committee on Public Health and Equity (CPHE) has considered each of the resolutions referred to it and submits the following report.

(Original) Resolution # A-09-26 Ensuring Equitable Vaccine Access for Independent and Rural Family Physicians to Protect Health in California

RESOLVED: That CAFP advocate for state-level vaccine distribution reforms to ensure independent and rural physician practices have equal access to ordering, storing, and administering all recommended vaccines, including Hepatitis B birth dose, COVID vaccines, and childhood VFC vaccines; and

RESOLVED: That CAFP work with the California Department of Public Health, the West Coast Vaccine Alliance, and vaccine manufacturers to establish procurement pathways that allow small-quantity shipments and sharps-law-compliant packaging specifically accessible to independent practices; and

RESOLVED: That CAFP support the creation of a centralized ordering system for small practices that aggregates demand and facilitates bulk purchasing so independent physicians can access vaccines without minimum-order limitations; and

RESOLVED: That CAFP advocate for improved funding, staffing, and infrastructure for rural county public health departments to prevent future situations where children cannot receive vaccines required for school entry; and

RESOLVED: That CAFP issue a public statement reaffirming its support for universal newborn Hepatitis B vaccination and urging California to maintain evidence-based immunization standards regardless of changes in federal ACIP recommendations; and

RESOLVED: That CAFP annually evaluate and report on vaccine-access disparities among independent practices, rural counties, and large systems, including recommendations for system-level improvements.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP advocate for state-level vaccine policy reforms to ensure independent and rural physician practices have equal access to ordering, storing, and administering all evidence based recommended vaccines.

RESOLVED: That the CAFP supports the creation of an evaluation and report on vaccine-access disparities among independent practices, rural counties, and large systems, including recommendations for system-level improvements.

Committee Discussion:

The committee discussed that the first resolved statement is a general statement of support. Members noted that administering, storing, and ordering vaccines involves more than the distribution reforms referenced in the resolution. The committee recommended adopting as amended.

For the next three resolved statements, the committee noted that various group procurement pathways already exist and that the California Department of Public Health (CDPH) is not positioned to implement these changes. A centralized ordering system is already in place, and improving funding and staffing, while important, is a broader public health issue. Members emphasized CAFP's existing opposition to cuts in public health funding, noting that county health departments are already making difficult decisions, particularly in infectious disease programs. The committee recommended that further research is needed to clarify the role of county health departments in vaccinating children, including resource limitations and potential policy changes, before additional action is taken. Thus, they recommend to not adopt resolved statements 2-4.

Discussion of the fifth resolved noted that statements have already been issued by CAFP and AAFP reaffirming support for universal newborn Hepatitis B vaccination. The resolution as written is outdated and overly directive, particularly given more recent changes in vaccine recommendations from the federal government. However, the committee recommended affirming as existing policy.

The final resolved statement was considered overly prescriptive and beyond the capacity of CAFP to implement as originally written. Members expressed concern that adopting it would require assuming actions for other governing bodies and may not preserve the author's intent. However, the committee made amendments to broaden the language to make it less prescriptive and recommended to adopt as amended.

Resolution A-10-26

Proposed Policy Title: Vaccine Information Mobile Application

Author: Lilly Helmuth-Malone

Co-Authors: Asha Khanna, Ellya Gholmieh, Eman Ahmad, Katelyn Alvarado, Nicole Da Costa, Mmasiolu Gamero

Endorsed by: None

Whereas, inconsistent communication about risks and benefits of vaccines, including recommendations that differ between professional medical organizations and the Centers for Disease Control (CDC), has fueled public confusion about vaccine safety and efficacy; and,

Whereas, vaccine rates among children have been declining, particularly since the onset of the COVID-19 pandemic, with coverage among schoolchildren for the MMR, DTap, polio, and varicella vaccines continuing to decline in the 2024-2025 school year [1]; and,

Whereas, currently, reliance on social media for vaccine information is linked to increased exposure to misinformation and disinformation, which is associated with increased vaccine hesitancy, less confidence in vaccine safety, and reduced vaccination coverage at the population level [2, 3], highlighting the need for reliable information about vaccines on social media and,

Whereas, the California Academy of Family Physicians (CAFP) affirms its clear commitment to vaccine guidance grounded in reliable scientific evidence and proven safety and efficacy, and maintains that individuals should be equipped with the necessary information and resources to make informed decisions about their health [4]; and

Whereas, mobile-based apps are easy-to-access, and can quickly disseminate information to the general public, especially marginalized communities without access to other reliable resources [5],

RESOLVED: That the California Academy of Family Physicians (CAFP) develop and maintain a mobile application and/or mobile-friendly web-based platform that provides up-to-date vaccination information corresponding to the recommendations released by the West Coast Health Alliance, and be it further

RESOLVED: That the California Academy of Family Physicians (CAFP) include clearly written, evidence-based recommendations on the mobile application and/or mobile-friendly web-based platform presented in language that is readily understandable by the general public and that addresses common questions and misconceptions related to vaccinations.

Equity Impact Score: 7/9

Problem Statement: In recent years, increasing vaccine hesitancy has resulted in higher exemption rates and vaccination levels that no longer meet herd immunity thresholds. During the 2024–2025 school year, kindergarten vaccine exemption rates rose from 3.3% to 3.6%, with 17 states reporting exemption rates above 5% [1]. This trend is reflected in declining national vaccination rates and a subsequent rise in vaccine-preventable diseases, as evidenced by the numerous recent measles outbreaks.

Although California continues to report childhood vaccination rates above the national average, the state is still seeing a concerning decline in overall herd-immunity protection. Between the 2022–2023 and 2023–2024 school years, the percentage of kindergartners who had all of their childhood vaccines dropped by 0.4% [6]. During the same period, the number of counties that no longer meet the recommended herd-immunity thresholds for all vaccinations increased from 35 to 38, indicating

that gaps in protection are widening across the state.

Unfortunately, these alarming trends will only be worsened by the misinformation and dangerous practices spread by our nation's top health organization, the Centers for Diseases Control and Prevention (CDC). For example, on November 19, 2025, the CDC changed their website to reflect that the vaccines could be a cause for autism [7], even though numerous studies have demonstrated that there is no association. This has led to harmful public mistrust in the healthcare system and increased vaccine hesitancy among newborns.

Additionally, for the past three decades, the CDC has also recommended that the hepatitis B vaccine be administered within 24 hours of birth. However, on December 5, 2025, the CDC advisory panel voted to change this recommendation, now suggesting that infants born to mothers who test negative for hepatitis B may instead receive the vaccine at two months of age [8]. This change is expected to leave a significantly increased number of young children vulnerable to a disease that, if contracted, can persist as a lifelong illness; despite decades of research pointing to the vaccines safety and efficacy.

Together, these developments highlight a growing erosion of public trust and vaccination coverage in the United States, heightening the risk of widespread resurgence of vaccine-preventable diseases.

Problem Universe: The issue of declining vaccination rates and misinformation affects all CAFP members and their patients, especially pediatric patients and their parents. Family physicians provide comprehensive care throughout their patients' lifetimes, with a heavy emphasis on preventative measures such as vaccines. Pediatric populations rely heavily on their own vaccinations and the vaccinations of their peers for disease prevention, and all patients must have accessible and evidence-based information about the vaccines they are receiving. However, while many core vaccines are recommended in childhood, this problem is not limited to pediatrics, as patients are advised to receive varying vaccines throughout their entire lifetime.

Specific Solution: We propose resource consolidation into the development of a robust, user-friendly mobile app or other mobile-friendly web-based platform intended for the general public of California to access evidence-based vaccine information based on the West Coast Health Alliance's vaccine recommendations [9]. This app should provide answers with cited resources to commonly asked questions about each vaccine/series to equip the general public with consolidated state-backed information and reduce the negative impact of misinformation.

Evidence: Since the decline of vaccination rates, outbreaks of once thought of as "rare diseases" have been increasing around the United States. For example, measles has seen an increase in recent years, which is thought to be attributed to the decline in populations receiving the MMR vaccine. In the summer of 2025, the United States reported the highest number of measles cases since 2000, when the disease was deemed to be eliminated [10]. Of the total reported cases in 2025 as of December 7, 92% occurred in individuals who were unvaccinated or whose vaccination status was unknown [11]. These diseases are not benign, and can even be deadly. Safe and effective vaccines exist to prevent the spread of these diseases — the two-dose series of the MMR vaccine provides 97% protection and long-term immunity against measles [12]. It is therefore imperative that CAFP supports initiatives to increase vaccination rates to ultimately reduce the spread of disease and promote preventive health among children.

Citations:

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11. "Measles Cases and Outbreaks." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 3 Dec. 2025, <https://www.cdc.gov/measles/data-research/index.html>
12. "Measles Vaccination." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 17 Jan. 2025, <https://www.cdc.gov/measles/vaccines/index.html>

Speaker's Notes: This resolution asks CAFP to support development of a vaccine information mobile application aligned with the West Coast Health Alliance recommendations. The goal aligns with immunization promotion, but developing and maintaining a new app is a significant ongoing operational commitment (content updates, user support, security) that may exceed CAFP's capacity

CAFP has existing policy that supports access to evidence-based vaccine information, but does not have specific policy addressing mobile applications for vaccine information.

AAFP previously developed and maintained the [Shots Immunizations App](#) in collaboration with the Society of Teachers of Family Medicine, which provided clinicians with current immunization schedules in a mobile format. However, AAFP discontinued this app due to frequent updates to vaccine recommendations by the Advisory Committee on Immunization Practices (ACIP) and the CDC, making it difficult to keep the app current, and because the CDC developed its own vaccine schedules app. AAFP has policies to increase access to vaccines, improve immunization information systems, and reduce vaccine hesitancy through funding for awareness campaigns to educate the

public about vaccine-preventable diseases. AAFP provides evidence-based up-to-date [immunization schedules](#) on its website.

Providing clear, evidence-based vaccine education aligns with CAFP's 2025–2027 Strategic Plan goal to “Champion Public Health, Health Equity, and Evidence-based Medicine.” Ensuring that members and the public have access to accurate vaccination information is consistent with CAFP's ongoing efforts to counter misinformation and support informed clinical decision-making. However, the specific proposal to develop and maintain a mobile application or mobile-friendly platform is not identified within the current strategic plan and would require additional consideration of resources, capacity, and alignment with existing communication strategies.

CAFP has been active in vaccine advocacy throughout 2025, including issuing press releases and statements responding to misleading vaccine information from the federal government. Additionally, CAFP played an active role in the development of California Assembly Bill 144 in September 2025, which authorizes the state to base immunization guidance on credible, independent medical organizations rather than the CDC's Advisory Committee on Immunization Practices. CAFP has been actively engaged in supporting California's connection to the [West Coast Health Alliance](#) in response to federal vaccine policy changes, reinforcing the critical need for reliable, accessible vaccine information for California residents during this period of significant public health uncertainty.

Speaker's Fiscal Note: There would be significant costs associated with the activities outlined in this resolution, as the proposed actions require building, maintaining, and continuously updating a technology platform—activities that fall well outside CAFP's existing advocacy and communications framework and staff expertise.

Developing and maintaining a new mobile application and/or mobile-friendly web-based platform would require substantial technical infrastructure, software development, design, hosting, security, ongoing maintenance, and content-update workflows. This work would far exceed the scope of routine communications and educational activities. CAFP does not currently maintain or develop mobile apps with clinical information, and doing so would require external vendors, ongoing technical contracts, and sustained staff oversight. Depending on complexity, costs would likely fall into the tens to hundreds of thousands of dollars, with ongoing annual maintenance expenses.

Including clearly written, evidence-based recommendations accessible to the general public would also require significant staff time for content research, clinical review, translation into public-facing language, and routine updating whenever the West Coast Health Alliance issues revised guidance. This work is comparable to developing new educational materials, which is consistently a significant expense, potentially requiring outside consultants and expert reviewers. Additionally, because recommendations would need to be updated in real time, CAFP would need to dedicate ongoing resources to monitoring updates, editing, content governance, and version control.

Beyond development costs, hosting public-facing clinical guidance also introduces liability, communication, and risk-management considerations, potentially requiring legal review or additional insurance coverage—further increasing costs. A mobile application with vaccination information would also not be necessary because this information is already accessible to family physicians through AAFP's immunization schedule and the California Department of Public Health's website.

Overall, the fiscal impact of this resolution would be significant, reflecting both the initial development costs and the ongoing resources required to maintain a technology platform and ensure accurate, up-to-date content. This work is outside CAFP's current strategic plan and operational capacity, and would require dedicated funding, external expertise, and long-term staff involvement. While the policy intent of the resolution aligns with CAFP's mission, the action-directives nature of many resolves could result in higher and more sustained costs requiring new programmatic infrastructure.

Committee Recommendation on Resolution A-10-26

2026 Report of the Committee on Public Health and Equity

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFPP Board of Directors

Speaker, the CAFPP Committee on Public Health and Equity (CPHE) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-10-26 Vaccine Information Mobile Application

RESOLVED: That the California Academy of Family Physicians (CAFP) develop and maintain a mobile application and/or mobile-friendly web-based platform that provides up-to-date vaccination information corresponding to the recommendations released by the West Coast Health Alliance, and be it further

RESOLVED: That the California Academy of Family Physicians (CAFP) include clearly written, evidence-based recommendations on the mobile application and/or mobile-friendly web-based platform presented in language that is readily understandable by the general public and that addresses common questions and misconceptions related to vaccinations.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFPP advocate for the development and maintenance of a mobile application and/or mobile-friendly web-based platform that provides up-to-date vaccination information corresponding to evidence-based recommendations, that is readily accessible to the general public that addresses common questions and misconceptions related to vaccination.

Committee Discussion:

The committee discussed that, as written, the first resolved statement should not be adopted. Members expressed general support for the concept of an app but emphasized that CAFPP cannot develop one directly. Language was suggested to reflect support for the development of such a tool rather than specifying creation by CAFPP. Members also recommended removing references to the West Coast Health Alliance, as the organization may not exist in the future, and questioned the intended audience and the problem the app is meant to address. The committee emphasized support for platforms providing evidence-based recommendations and noted that the whereas statements indicate the resolution is intended for public use. The committee recommends adoption of the first resolved statement as amended.

The committee recommends not adopting the second resolved statement, as it specifically calls for mobile app development and is seen as overly directive.

Resolution A-11-26

Proposed Policy Title: Promotion of Resistance Training and Physical Activity as Standard Preventive Health Recommendations in Family Medicine

Author: David Powell, MD

Co-Authors: None

Endorsed by: None

Whereas, current CAFP policy on "Physical Exercise as a Vital Sign" focuses primarily on aerobic activity (150 minutes moderate or 75 minutes vigorous), but does not explicitly detail the necessity of resistance training found in national guidelines; and

Whereas, the Physical Activity Guidelines for Americans (2nd Edition) explicitly state that adults need at least two days of muscle-strengthening activity each week to provide additional health benefits not achieved by aerobic activity alone; and

Whereas, resistance training has been proven to independently improve metabolic health markers, including significant reductions in HbA1c for patients with diabetes and improvements in insulin sensitivity, which are critical for chronic disease management; and

Whereas, sarcopenia is a major predictor of frailty and mortality in older adults, and resistance training is the primary non-pharmacologic intervention capable of reversing or delaying this muscle loss.

RESOLVED: That the CAFP amends its "Physical Exercise as a Vital Sign" policy to explicitly align with U.S. Department of Health and Human Services (HHS) guidelines by recommending adults engage in muscle-strengthening activities of moderate or greater intensity and that involve all major muscle groups on two or more days a week, in addition to aerobic activity; and be it further

RESOLVED: That the CAFP encourages family physicians to counsel patients specifically on the metabolic and protective benefits of resistance training, including improvements in insulin sensitivity, blood pressure, and the prevention of sarcopenia (age-related muscle loss).

Equity Impact Score: 7/9

Problem Statement: Current CAFP policy on "Physical Exercise as a Vital Sign" (Source 3084) focuses primarily on aerobic activity (150 minutes moderate or 75 minutes vigorous), but does not explicitly detail the necessity of resistance training found in national guidelines

Problem Universe: Fair majority

Specific Solution: CAFP adopts a formal policy recommending that family physicians include assessment of physical activity levels and promote regular exercise — including both aerobic activity and resistance (strength) training — as part of preventive care and routine health maintenance for adult patients, tailored to patient age, comorbidities, and functional status.

Supporting advocacy for coverage (public and private insurance) for preventive-care services that include lifestyle counseling and exercise prescription — and for funding of community-based programs (e.g., accessible gym, senior-safe exercise, community fitness, strength training) to reduce barriers to implementation.

CAFP promotes research and data collection in California on outcomes of exercise interventions in primary-care settings, to better inform future evidence-based policy and guidelines.

Evidence:

Strong evidence supports the role of regular physical activity — including resistance (strength) training — in reducing risk of chronic diseases (cardiovascular disease, type 2 diabetes, osteoporosis, sarcopenia), improving mental health, and enhancing functional capacity across the lifespan.

As primary care physicians, family physicians are uniquely positioned to counsel patients on lifestyle and preventive health, but there is no formal CAFP policy explicitly endorsing resistance training as part of standard preventive care.

Establishing a policy would encourage consistent physician counseling, integration into preventive-care visits, and potentially improved public health outcomes across California.

Citations:

1. U.S. Department of Health and Human Services. (2018). Physical Activity Guidelines for Americans, 2nd Edition. Washington, DC.
2. American College of Sports Medicine. (2011). Quantity and Quality of Exercise for Developing and Maintaining Cardiorespiratory, Musculoskeletal, and Neuromotor Fitness in Apparently Healthy Adults: Guidance for Prescribing Exercise. *Medicine & Science in Sports & Exercise*, 43(7), 1334–1359
3. Paluch, A. E., et al. (2022). Promoting Physical Activity for Health and Clinical Benefit: A Scientific Statement From the American Heart Association. *Circulation*, 146(21), e363–e379.
4. Exercise is Medicine. (2021/Updated guidance). The Physical Activity Vital Sign.
5. Golightly, Y. M., et al. (2017). Physical Activity as a Vital Sign: A Systematic Review. *Preventing Chronic Disease*, 14, 170030

Speaker's Notes: This resolution proposes amending CAFP policy (“Physical Exercise as a Vital Sign”) to explicitly recommend resistance training/muscle-strengthening as a standard preventive recommendation. CAFP has existing policy that encourages family physicians to recommend that adults aged 18-64 engage in at least 150 minutes of moderate-intensity aerobic physical activity throughout the week or at least 75 minutes of vigorous-intensity aerobic physical activity throughout the week or an equivalent combination of moderate- and vigorous-intensity activity. The policy also encourages family physicians to make a routine, standardized and widespread practice of measuring patients' habitual physical activity and consider physical activity a "vital sign" to be assessed at clinical visits as appropriate. However, the current CAFP policy does not explicitly support recommendations related to resistance and strength training.

AAFP policy and educational materials extensively address physical activity guidelines that include both aerobic activity and muscle-strengthening components. [AAFP publications](#) recommend at least 150 minutes of moderate-intensity aerobic activity or 75 minutes of vigorous-intensity aerobic activity and at least two days of muscle-strengthening activities per week, consistent with federal guidelines. The AAFP has actively promoted the [2018 Physical Activity Guidelines for Americans](#) which emphasize that adults should perform muscle-strengthening activities on at least two days per week. More recently, [AAFP highlighted a 2023 HHS report](#) recommending that older adults perform muscle-strengthening activities of moderate or greater intensity involving all major muscle groups at least two days a week. While AAFP does not have a specific standalone policy on resistance training as a vital sign component, AAFP has consistently incorporated muscle-strengthening recommendations into its educational materials and clinical guidance, recognizing the importance of comprehensive physical activity assessment in primary care.

CAFP policy generally avoids referencing specific legislation or point-in-time standard, program, or guideline.

Speaker's Fiscal Notes: The cost of updating CAFP policy is minimal as it is a routine activity. Tracking, reviewing and updating policy based on changing recommendations would result in additional staff time.

Encouraging family physicians to counsel patients on the benefits of resistance training could also be accomplished with minimal cost by integrating this content into existing communication channels such as newsletters or guidance documents. Costs would remain minimal unless a broader communications strategy or dedicated campaign is required.

Committee Recommendation on Resolution A-11-26

2026 Report of the Committee on Public Health and Equity

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the CAFP Committee on Public Health and Equity (CPHE) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-11-26 Promotion of Resistance Training and Physical Activity as Standard Preventative Health Recommendations in Family Medicine

RESOLVED: That the CAFP amends its "Physical Exercise as a Vital Sign" policy to explicitly align with U.S. Department of Health and Human Services (HHS) guidelines by recommending adults engage in muscle-strengthening activities of moderate or greater intensity and that involve all major muscle groups on two or more days a week, in addition to aerobic activity; and be it further

RESOLVED: That the CAFP encourages family physicians to counsel patients specifically on the metabolic and protective benefits of resistance training, including improvements in insulin sensitivity, blood pressure, and the prevention of sarcopenia (age-related muscle loss).

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP amends its "Physical Exercise as a Vital Sign" policy to recommend adults engage in guideline-directed recommendation for muscle-strengthening activities of moderate or greater intensity and that involve all major muscle groups on two or more days a week, in addition to aerobic activity, and be it further

Committee Recommendation: ADOPT

RESOLVED: That the CAFP encourages family physicians to counsel patients specifically on the metabolic and protective benefits of resistance training, including improvements in insulin sensitivity, blood pressure, and the prevention of sarcopenia (age-related muscle loss).

Committee Discussion:

The committee discussed concerns that the first resolved statement was overly strong in its directive language, particularly with its call for explicit alignment with federal guidance. Members noted uncertainty regarding reliance on HHS recommendations, given that guidelines can change over time. The committee broadened the language and recommended adoption of the first resolved statement as amended. Members recommended to adopt the second resolved.

Resolution A-12-26

Proposed Policy Title: Supporting Expanded Research and Rescheduling of Therapeutic Psychedelics

Author: David Powell, MD

Co-Authors: None

Endorsed by: None

Whereas, Current CAFP policy supports the rescheduling of psilocybin to facilitate research, yet other substances such as ibogaine, LSD, and MDMA remain classified as Schedule I drugs, hindering necessary clinical trials despite showing promise in treating opioid use disorder treatment resistant depression, refractory anxiety, and PTSD; and

Whereas, The state of Texas recently enacted Senate Bill 2308 (2025), authorizing up to \$50 million in state matching funds to research ibogaine for veterans, recognizing the urgent need for novel treatments for those who have exhausted standard of care options; and

Whereas, Many U.S. veterans currently travel internationally to unregulated settings to access ibogaine therapy for TBI and PTSD, exposing them to medical risks that could be mitigated through regulated, medically supervised treatments within the United States; and

Whereas, A 2024 study published in Nature Medicine demonstrated that military veterans with TBI experienced significant improvements in disability and mental health functioning following ibogaine treatment, suggesting a potential breakthrough for conditions often considered intractable.

Whereas, major depressive disorder, PTSD, and substance use disorders remain leading contributors to morbidity, disability, and health disparities in California, and many patients do not respond adequately to current first-line treatments; and

Whereas, randomized clinical trials demonstrate that psilocybin-assisted therapy significantly reduces depressive symptoms and may provide sustained improvement up to 12 months in some patients with major depressive disorder;^{1,2,3} and

Whereas, the first Phase 3 randomized controlled trial of MDMA-assisted therapy for post-traumatic stress disorder (PTSD) demonstrated clinically and statistically significant reductions in PTSD symptom severity compared with placebo-controlled psychotherapy;⁴ and

Whereas, systematic reviews and emerging clinical evidence suggest that psychedelic-assisted psychotherapy—including psilocybin, MDMA, and other classic and non-classic psychedelics—may hold therapeutic promise for depression, anxiety, PTSD, and substance use disorders, though further research is warranted to establish safety, dosing, and long-term outcomes;^{5,6,9} and

Whereas, psilocybin-assisted therapy has shown benefit in treating alcohol use disorder and tobacco use disorder in early randomized and observational trials, demonstrating significantly higher rates of abstinence and reduction in harmful use compared to controls;^{7,8} and

Whereas, emerging evidence, including a recent 2024–2025 clinical trial among military veterans treated at Stanford, indicates that medically supervised, magnesium-stabilized ibogaine may reduce symptoms of PTSD, depression, anxiety, and traumatic brain injury–related cognitive impairment, suggesting that further controlled research is warranted;¹⁰ and

Whereas, multiple neuroscience studies demonstrate that psychedelics can promote structural and functional neuroplasticity, offering a plausible mechanistic explanation for their potential therapeutic effects across psychiatric disorders;^{11, 12} and

Whereas, the Schedule I classification of psychedelics—including psilocybin, MDMA, LSD and ibogaine—substantially restricts federally funded research and increases barriers to high-quality clinical trials, contributing to limited evidence despite promising early data; and

Whereas, professional medical organizations, including CAFP in 2024, have already recognized the need for expanded research by supporting federal scheduling reform for psilocybin-related clinical trials.

RESOLVED: the California Academy of Family Physicians (CAFP) supports legislation and regulatory changes that facilitate clinical research into the therapeutic use of psychedelics, including but not limited to psilocybin for the treatment of psychiatric and substance use disorders; and be it further

RESOLVED: that the CAFP supports the rescheduling of ibogaine, MDMA, and LSD from Schedule I to a schedule that permits clinical research and therapeutic use under medical supervision, particularly for the treatment of Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) in veterans, refractory depression and anxiety and be it further

RESOLVED: that the CAFP refer this resolution to the American Academy of Family Physicians (AAFP) for national action to advocate for federal funding and "Safe Haven" protections for researchers investigating these therapies.

Equity Impact Score: 7/9

Problem Statement: Endorse efforts to reschedule or reclassify certain psychedelics (e.g., psilocybin, and where supported by evidence, ibogaine, LSD and MDMA) under federal and/or California law to facilitate and expand clinical research under appropriate regulatory and ethical oversight.

Call for development of clinical-research frameworks, including physician-led, IRB-approved trials, to evaluate psychedelic-assisted therapy for mental health conditions (e.g., PTSD, depression, substance use disorders), with rigorous outcome tracking (efficacy, safety, long-term follow-up).

Problem Universe: Fairly large percentage

Specific Solution: In addition to items to be resolve would encourage the following:

CAFP encourages inclusion of underrepresented and vulnerable populations (e.g., racial/ethnic minorities, low-income, those with limited access to mental health services) in research to ensure equitable access and avoid exacerbating health disparities.

Urge the state and federal regulatory bodies to expedite (or provide a clear pathway for) compassionate-use or expanded-access programs for psychedelic therapies shown to have favorable safety/efficacy profiles.

Monitor and update CAFP policy as evidence evolves, including potential development of clinical-practice guidance if psychedelic therapies become approved for therapeutic use.

Evidence: There is growing preclinical and early clinical evidence that certain psychedelics may offer benefit for treatment-resistant psychiatric conditions such as post-traumatic stress disorder (PTSD), depression, and substance use disorders.

Current federal and state regulatory classification (e.g., Schedule I) significantly restricts clinical research, impeding rigorous evaluation of safety, efficacy, dosing, and long-term outcomes.

Many patients, particularly those with treatment-resistant disorders, lack effective options; enabling research could open pathways to novel, evidence-based, and potentially life-changing treatments under physician supervision.

As a statewide professional society representing family physicians — many of whom deliver mental health, substance-use, and primary care — CAFP has a role in ensuring policy supports evidence-based innovation, patient safety, health equity, and access to emerging therapies.

Citations:

1. U Carhart-Harris RL, Giribaldi B, Watts R, et al. Psilocybin with psychological support for depression: A randomized clinical trial comparing psilocybin to escitalopram. *N Engl J Med*. 2021;384(15):1402-1411.
2. Gukasyan N, Davis AK, Barrett FS, et al. Efficacy and safety of psilocybin-assisted therapy for major depressive disorder: Prospective 12-month follow-up. *J Psychopharmacol*. 2022;36(2):151-158.
3. Davis AK, Barrett FS, So S, et al. Psilocybin-assisted therapy and depressive symptoms among frontline clinicians: A randomized clinical trial. *JAMA Netw Open*. 2024;7(1):e2031452.
4. Mitchell JM, Bogenschutz M, Lilienstein A, et al. MDMA-assisted therapy for severe PTSD: A randomized, double-blind, placebo-controlled phase 3 trial. *Nat Med*. 2021;27:1025-1033.
5. Aday JS, Bloesch EK, Davoli CC. A systematic review of psychedelic-assisted therapy for anxiety, depression, and PTSD. *Ther Adv Psychopharmacol*. 2020;10:1-16.
6. Winkelman M. Psychedelics as therapeutics for PTSD: A systematic review. *J Psychoactive Drugs*. 2021;53(2):85-95.
7. Bogenschutz MP, Ross S, Bhatt S, et al. Psilocybin-assisted treatment for alcohol dependence: A randomized clinical trial. *JAMA Psychiatry*. 2022;79(10):953-962.
8. Johnson MW, Garcia-Romeu A, Cosimano MP, Griffiths RR. Pilot study of psilocybin-assisted smoking cessation therapy. *J Psychopharmacol*. 2014;28(11):983-992.
9. Roberts T, Lockhart A, MacLean K. Psilocybin-assisted treatments for substance use disorders: A systematic review. *Addiction*. 2024;119(2):289-302.
10. Nesbitt M, Alavi A, Williams NR, et al. Magnesium-stabilized ibogaine decreases PTSD, depression, anxiety, and cognitive impairment in veterans with traumatic brain injury: Early clinical findings. *Nat Med*. 2024; epub ahead of print.
Cherian, K.N., Keynan, J.N., Anker, L. et al. Magnesium-ibogaine therapy in veterans with traumatic brain injuries. *Nat Med* 30, 373–381 (2024). <https://doi.org/10.1038/s41591-023-02705>
11. Ly C, Greb AC, Cameron LP, et al. Psychedelics promote structural and functional neural plasticity. *Cell Rep*. 2018;23(11):3170-3182.
12. Vollenweider FX, Preller KH. Psychedelic drugs: Neurobiology and potential for treatment of psychiatric disorders. *Nat Rev Neurosci*. 2020 ;21(11) :611-624.
Gasser P, Kirchner K, Wölner-Hanssen A, et al.
Safety and efficacy of lysergic acid diethylamide-assisted psychotherapy for anxiety associated with life-threatening diseases.
13. Gasser P, Holstein D, Michel Y, et al.
Lysergic acid diethylamide-assisted psychotherapy for anxiety associated with a life-

threatening disease: A 12-month follow-up. *J Psychopharmacol.* 2015;29(5):572-582.

14. Krebs TS, Johansen PØ. Lysergic acid diethylamide (LSD) for alcoholism: Meta-analysis of randomized controlled trials. *J Psychopharmacol.* 2012;26(7):994-1002.

Speaker's Notes: CAFP has existing policy supporting expanded clinical research into the therapeutic use of psychedelics, including the rescheduling of psilocybin to facilitate scientifically rigorous study.

This resolution references federal scheduling and federal regulatory structures, CAFP does not generally engage in federal advocacy. Any CAFP position related to federal actions would be limited to internal policy alignment or referral to the American Academy of Family Physicians (AAFP).

While the [AAFP has published clinical evidence reviews](#) noting that high-dose psilocybin demonstrated benefit for depression treatment, the organization has not adopted formal policy supporting expanded research or rescheduling of these substances. AAFP does maintain robust policy on substance use disorder treatment, mental health parity, and evidence-based medicine that provides a framework for evaluating emerging therapies.

The FDA has granted breakthrough therapy designation to psilocybin for treatment-resistant depression and major depressive disorder, and to MDMA for post-traumatic stress disorder, though the MDMA application was recently rejected pending additional research.

Speaker's Fiscal Notes: This resolution would have minimal to moderate fiscal impact for CAFP. Supporting legislation and regulatory changes related to psychedelic research at the state level could be accommodated within existing advocacy processes; however, costs may increase if extensive staff research, stakeholder engagement, or external expertise is required, as psychedelic policy is a specialized and rapidly evolving area that may extend beyond CAFP's traditional expertise. Because CAFP does not engage in federal advocacy, any activity related to federal rescheduling of substances would be limited to aligning internal policy or issuing a supporting statement, which would result in minimal cost unless a larger communications effort were deemed necessary.

Referring the resolution to AAFP for national action would incur minimal cost, as this aligns with standard procedures.

Committee Recommendation on Resolution A-12-26

2026 Report of the Committee on Public Health and Equity

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the CAFP Committee on Public Health and Equity (CPHE) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-12-26 Supporting Expanded Research and Rescheduling of Therapeutic Psychedelics

RESOLVED: the California Academy of Family Physicians (CAFP) supports legislation and regulatory changes that facilitate clinical research into the therapeutic use of psychedelics, including but not limited to psilocybin for the treatment of psychiatric and substance use disorders; and be it further

RESOLVED: that the CAFP supports the rescheduling of ibogaine, MDMA, and LSD from Schedule I to a schedule that permits clinical research and therapeutic use under medical supervision, particularly for the treatment of Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) in veterans, refractory depression and anxiety and be it further

RESOLVED: that the CAFP refer this resolution to the American Academy of Family Physicians (AAFP) for national action to advocate for federal funding and "Safe Haven" protections for researchers investigating these therapies.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP bring this resolution to the AAFP Congress of Delegates to support legislation and regulatory changes that facilitate scientifically, rigorous, Institutional Review Board (IRB)-approved, physician-led clinical research into the therapeutic use of psychedelics, including but not limited to psilocybin for the treatment of psychiatric and substance use disorders; and be it further

RESOLVED: That the CAFP bring this resolution to the AAFP Congress of Delegates to support the rescheduling for clinical research and tightly regulated therapeutic frameworks of ibogaine, MDMA, and LSD, particularly for the treatment of Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) in veterans, refractory depression and anxiety and be it further

Committee Recommendation: ADOPT

RESOLVED: That the CAFP refer this resolution to the American Academy of Family Physicians (AAFP) for national action to advocate for federal funding and "Safe Haven" protections for researchers investigating these therapies.

Committee Discussion: The committee discussed whether there is sufficient clinical consensus to support the use of the additional drugs referenced for the disorders identified in the resolution. Members noted that current federal classification limits the ability to conduct rigorous clinical research, as Schedule I status restricts such studies. The committee also acknowledged the drug scheduling is a federal issue, fitting in AAFP's role, not CAFP. As a result, they amended the language in the first two resolved statements to specify referral for national action. The committee emphasized that any recommendation to reschedule should be narrowly framed to support and

enable clinical research purposes only. Thus, the committee recommended to adopt the first two resolved statements as amended, and adopt the third statement with original language.

Committee Report – California Residency Network (CRN)

2026 Report of the CAFP California Residency Network

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the California Residency Network (CRN) has considered the following resolution referred to it and submits the following report.

- A-13-26 Family Medicine GME Finance Reform
- A-14-26 Vasectomy Training During Family Medicine Residency
- A-15-26 Expand FM-OB training to address maternity care deserts

(Original) Resolution # A-13-26: Family Medicine GME Finance Reform

RESOLVED: That the CAFP advocate for the reform of GME financing in California to focus on Family Medicine by providing stable grant funding, utilizing existing governmental funding sources, that is based on program need, provision of care to underserved populations, and recruitment of trainees who reflect the patients served, reported on an annual basis, in order to strengthen primary care residency training and maintain a pipeline of well-trained primary care physicians to care for Californians in every corner of the state.

CRN Recommendation: ADOPT

Discussion: CRN co-chairs supported this resolution.

(Original) Resolution # A-14-26: Vasectomy Training During Family Medicine Residency

RESOLVED: That the California Academy of Family Physicians (CAFP) support the training of vasectomy in all ACGME-accredited family-medicine residency programs in California; and

RESOLVED: That CAFP collaborate with the American Board of Family Medicine (ABFM), ACGME, and state medical boards to integrate vasectomy training standards into procedural curricula and maintenance-of-certification pathways, including ongoing Continuing Medical Education (CME).

CRN Recommendation: ADOPT THE FIRST RESOLVED. DO NOT ADOPT SECOND RESOLVED

RESOLVED: That the California Academy of Family Physicians (CAFP) support the training of vasectomy in all ACGME-accredited family-medicine residency programs in California.

Committee Discussion: CRN co-chairs supported the spirit of this resolution but had concerns about making it mandatory to train family medicine residents on vasectomy procedures. Co-chairs acknowledged that FM residency programs already face significant training requirements and felt hesitant to add another procedure to the list of requirements. There were also concerns that residency programs that are supported by catholic health systems may not be able to fulfill this requirement very easily. There was further discussion about what value there is to add policy of general support for a specific procedure, as CAFP policy does not necessarily need to call out every procedure that we may or may not support training for. Ultimately, the committee decided to adopt the first resolved to indicate general support for vasectomy training, but to not adopt the second resolved due to concerns related to adding another procedure requirement where it may not be feasible.

(Original) Resolution # A-15-26: Expand FM-OB Training to Address Maternity Care Deserts

RESOLVED: The CAFP advocate for increased funding and support for the rapid expansion of training programs that prepare family medicine physicians for full scope maternity care, including Cesarean and operative vaginal births. This could include 1) OB training tracks within FM residencies (for those residencies with capacity to support this) and 2) 1-2 year FMOB fellowships.

RESOLVED: The CAFP promote the development of regional collaborative networks linking FM-OBs with other perinatal clinicians, including the integration of FMOB's into laborist groups so that there is sufficient full-service coverage to serve their communities.

RESOLVED: The CAFP promotes policies that support the credentialing of family physicians with competence in obstetrical training.

RESOLVED: The CAFP creates opportunities for mentorship networks for FM-OB graduates, peer support to promote professional well-being, and develop strategies to encourage long-term retention in providing obstetrical care including deliveries.

RESOLVED: CAFP refer this to AAFP to promote rapid expansion, on a national level, of training programs that prepare family medicine physicians for full scope maternity care, including Cesarean and operative vaginal births. This could include 1) OB training tracks within FM residencies (for those residencies with capacity to support this) and 2) 1-2 year FMOB fellowships to help meet the clinician shortage contributing to maternity care deserts across the US.

CRN Recommendation: ADOPT AS AMENDED

RESOLVED: The CAFP advocate for increased funding and support for the rapid expansion of training programs for full scope maternity care to supplement the training of family medicine physicians, including Cesarean and operative vaginal births. This could include 1) OB training tracks within FM residencies (for those residencies with capacity to support this) and 2) 1-2 year FMOB fellowships.

RESOLVED: The CAFP promote the development of regional collaborative networks linking Family physicians providing maternity care (FM-OB) with other perinatal clinicians, including the integration of FM-OB into laborist groups.

RESOLVED: The CAFP promotes policies that support the credentialing and affordable liability coverage of family physicians with competence in obstetrical training.

RESOLVED: The CAFP support opportunities for mentorship networks for FM-OB graduates, peer support to promote professional well-being, and develop strategies to encourage long-term retention in providing obstetrical care including deliveries.

RESOLVED: CAFP should advocate to the AAFP to promote expansion, on a national level, of full scope maternity care training programs that supplement the training of family medicine physicians, including operative births. This could include 1) OB training tracks within FM residencies (for those residencies with capacity to support this) and 2) FMOB fellowships

Committee Discussion: CRN co-chairs supported the intent of the resolution to enhance training opportunities for family physicians to support broader access to maternity care. However, they brought up a number of concerns that led to amendments to all of the resolved statements. One concern the co-chairs identified was related to using the term "FM-OB". There was consensus that amendments were needed to clarify that all board-certified family physicians are trained in delivery,

not just those that have done an FM-OB fellowship. Amendments were made to the resolved statements to clarify that additional training opportunities are supplementary to the training of family physicians, and emphasize additional training is on operative births. There were also concerns related to the fact that even some family physicians that do receive enhanced obstetrics training are not able to provide these services because of the high cost of malpractice insurance. Because of this issue, the co-chairs amended the third resolved statement to account for this issue. The co-chairs also agreed to amendments to the language that emphasized that family physicians should not just be asked to provide maternity services in the case where there are underserved areas but in all areas, because their training has equipped them to do so. Further amendments were adopted to make the language in the resolved statements slightly less directive toward the operations of the CAFP.

Resolution A-13-26

Proposed Policy Title: Family Medicine GME Finance Reform

Author: Francis Chu, MD

Co-Authors: None

Endorsed by: None

Whereas, we have experienced in recent volatile times, federal and state governments that are at odds and often dysfunctional, leading to unstable healthcare financing and an uncertain future for GME funding,

Whereas, primary care (PC) is the cornerstone of any high functioning healthcare system and having adequate PC must be a priority for our citizens,

Whereas, Family Physicians (FPs) provide broad spectrum PC specialty and are the chief source of PC, especially in communities where access to care is challenged,

Whereas, the pathway to healthcare and specifically Family Medicine (FM) needs significant resources to ensure development of future FPs, which are often supported by existing FM residency programs,

Whereas, residency training of FPs is a complex and long process, and residents typically stay in the location where they train,

Whereas, the CAFP and AAFP have, based on previous policies and the diligence of its advocacy teams and CRN, been successful in expanding Song Brown, and more recently, CalMedForce, grant funding to support residency training,

Whereas, the current process for applying for grant funding for residency programs (Song-Brown and CalMedForce, etc.) is siloed, fragmented, time consuming, administratively burdensome, and not PC focused,

And whereas, CA has the largest state network of residency programs in the nation who lead the US in high quality training.

RESOLVED: That the CAFP advocate for the reform of GME financing in California to focus on Family Medicine by providing stable grant funding, utilizing existing governmental funding sources, that is based on program need, provision of care to underserved populations, and recruitment of trainees who reflect the patients served, reported on an annual basis, in order to strengthen primary care residency training and maintain a pipeline of well-trained primary care physicians to care for Californians in every corner of the state.

Equity Impact Score: 5/9

Problem Statement: GME funding has increased significantly over the last few years. Song-Brown grew from a few million dollars annually (2000-2013) to having \$100M over 3 years to support PC GME, but also includes funds for PA, CNM, and NP training. CalMedForce (Prop 56 and Prop 35 funding) grew from \$38M (2018) to \$85 (2025), and originally focused on PC and EM, but now includes other specialties and fellowships with CalMedForce+.

As attested to by the growth in FM residency programs over the last 10 years (from just over 50 in 2014, when the CAFP Residency Network was established, to nearly 80 programs now in 2025), we are still in need of larger pipeline of FPs to support the need for PC in our state..

Problem Universe: A large proportion of over 1500 Family Medicine residents in 75+ FM residency programs in California would be affected by a change in Family Medicine GME finance reform. The larger impact of this reform would be felt by many communities that still lack access to PC and would be better supported by programs that train in or near areas of need.

Specific Solution: The idea for this resolution was inspired by the Colorado AFP's model of developing a partnership with the state government to establish a Colorado Commission on Family Medicine (COFM) in 1977 to ensure adequate FM residency programs for the state and resources for these training programs.

Evidence: The COFM has increased FM programs, including rural training tracks, improved graduate retention and strengthened public-private partnerships to promote FM in the state. With the challenges FM residency programs face at the state level around grant funding, reform of the process would help to bolster FM's presence and development throughout the state.

Citations:

1. T Bodenheimer 10 building blocks of High-Performing PC
<https://www.annfam.org/content/annalsfm/12/2/166.full.pdf>
2. CAFP Policy Manual
3. Robert Graham Center for Policy Studies in FM and PC
<https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/phys-workforce/California.pdf>
4. AAFP Policy re: GME financing & Workforce Reform:
<https://www.aafp.org/about/policies/all/graduate-medical-education-financing.html>
<https://www.aafp.org/about/policies/all/workforce-reform.html>
5. CHCF Resources
<https://www.chcf.org/wp-content/uploads/2021/03/PhysiciansAlmanac2021.pdf>
<https://www.chcf.org/wp-content/uploads/2018/09/GMEFundingSixKeyFactsPoster.pdf>
<https://www.chcf.org/resource/understanding-graduate-medical-education-ca/>
6. CRN FMR program directory
<https://www.familydocs.org/family-medicine-residency-program-directory-2021/>
7. Colorado Commission on Family Medicine
<https://www.cofmr.org/about-us>
<https://spl.cde.state.co.us/artemis/govserials/gov469internet/gov469202324brinternet.pdf>

Speaker's Notes: The resolution asks CAFP to advocate for GME finance reform with adjusted governmental funding based on program need. GME financing is primarily federal; CAFP's most direct levers are advocacy for California-specific investments (e.g., Song-Brown) and elevating this issue through AAFP for federal reform.

CAFP has policy on GME funding including policy that supports "working with AAFP and other organizations including the AMA, family medicine residency programs, and other organizations to explore alternative funding sources at the state and federal level for graduate medical education". CAFP also has policy supporting increased investment in recruitment to address the primary care physician shortage.

AAFP's Graduate Medical Education Financing Policy outlines six core principles that call for modernizing the current GME funding structure. These principles include ensuring an adequate number of family medicine residency positions, holding institutions accountable for federal GME

payments to address geographic maldistribution, and replacing the current IME/DGME payment structure with a more transparent per-resident payment system. AAFP supports relaxing GME caps in Health Professional Shortage Areas (HPSAs) and prioritizing funding for first-certificate residency training in primary care specialties.

Reforming California's GME funding streams is aligned with CAFP's strategic plan goal of developing and diversifying the family medicine workforce. Both CAFP and AAFP recognize that current GME financing mechanisms perpetuate workforce maldistribution and fail to align with the nation's health needs. CAFP has representatives on the CalMedForce advisory council, ensuring family physicians perspectives are represented in efforts to evaluate and recommend funding distribution. CAFP has consistently advocated for stable, secure funding for residency programs and supports the Song-Brown Healthcare Workforce Training Program.

AAFP has also been active in advocating for new funding collaborations between federal and state governments, private payers, and other stakeholders to create a more equitable and effective system. Recent legislative efforts have focused on expanding Medicare GME residency positions with priority given to programs in geographic HPSAs, developing impact factors to measure which programs successfully place graduates in underserved areas, and providing flexibility in Medicare GME funding caps for new teaching hospitals establishing family medicine residency programs in underserved communities.

Speaker's Fiscal Notes: This resolution would likely result in moderate to significant fiscal impact for CAFP. Advocating for broad reform of Graduate Medical Education (GME) financing in California would require substantial staff time for policy analysis, coalition engagement, and ongoing monitoring of state-level budget and regulatory processes. While CAFP already engages in state-level advocacy related to primary care workforce and GME funding, the specific activities described—such as advocating for stable grant funding, annual reporting requirements, and prioritization based on program need and equity metrics—would require deeper and more sustained involvement.

Because GME financing reform is a complex state-level budget and regulatory issue, CAFP's engagement could extend beyond routine advocacy processes and may require coordination with multiple stakeholders, including state agencies, legislative budget committees, academic institutions, and health workforce coalitions. This level of engagement may also necessitate additional research or consultation to evaluate funding structures, analyze program needs, and develop policy proposals aligned with the resolution's requirements.

Costs could remain moderate if CAFP's role is limited to supporting existing legislative proposals or providing input within established advocacy workflows.

Committee Recommendation on Resolution A-13-26

2026 Report of the CAFP California Residency Network

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the California Residency Network (CRN) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-13-26: Family Medicine GME Finance Reform

RESOLVED: That the CAFP advocate for the reform of GME financing in California to focus on Family Medicine by providing stable grant funding, utilizing existing governmental funding sources, that is based on program need, provision of care to underserved populations, and recruitment of trainees who reflect the patients served, reported on an annual basis, in order to strengthen primary care residency training and maintain a pipeline of well-trained primary care physicians to care for Californians in every corner of the state.

CRN Recommendation: ADOPT

Discussion: CRN co-chairs supported this resolution.

Resolution A-14-26

Proposed Policy Title: Vasectomy Training During Family Medicine Residency

Author: Zhoobin Heidari Bateni, MD

Co-Authors: None

Endorsed by: CAFP Fresno-Kings-Madera Chapter

Whereas, vasectomy is a highly effective, permanent contraceptive method with a failure rate below 0.15%, comparable to tubal ligation but safer, less invasive, and substantially less costly (CDC, Contraceptive Effectiveness, 2022); and

Whereas, despite its safety and simplicity, vasectomy remains under-utilized in the United States, accounting for fewer than 10% of contraceptive methods among couples, with particularly low rates among populations lacking access to urologists or specialized clinics (Barone et al., Global Health: Science and Practice, 2017); and

Whereas, family physicians are well positioned to perform vasectomies in office settings, expanding access for rural and underserved populations, reducing cost, and normalizing male participation in reproductive responsibility, and research demonstrates that vasectomies performed by trained family physicians yield complication and success rates equivalent to those performed by urologists, with patient satisfaction exceeding 95% (Shih et al., J Am Board Fam Med, 2020; Labrecque et al., J Urol, 2005; Barone et al., Contraception, 2011); and

Whereas, current ACGME family-medicine residency requirements list vasectomy as a “recommended procedure” rather than a “required competency,” creating significant variability in resident exposure and procedural confidence across programs (ACGME Program Requirements for Family Medicine, 2024); and

Whereas, requiring vasectomy training aligns with CAFP’s goals of comprehensive, equitable, and preventive reproductive healthcare, empowering family physicians to provide full-spectrum care for all genders;

RESOLVED: That the California Academy of Family Physicians (CAFP) support the training of vasectomy in all ACGME-accredited family-medicine residency programs in California; and

RESOLVED: That CAFP collaborate with the American Board of Family Medicine (ABFM), ACGME, and state medical boards to integrate vasectomy training standards into procedural curricula and maintenance-of-certification pathways, including ongoing Continuing Medical Education (CME); and

RESOLVED: That CAFP escalate this resolution to the American Academy of Family Physicians (AAFP) and request that AAFP send a formal letter to ACGME urging creation of stronger requirements and support for vasectomy training within GME residency programs to ensure residents gain adequate opportunities to learn and perform vasectomy procedures

Equity Impact Score: 8/9

Problem Statement: Reproductive Health and Contraception

Problem Universe: Approximately all of them are affected with taking care of patients in need of reproductive health or contraception

Specific Solution: Support the training, collaborate with ABFP for training purposes and write a formal letter to ACGME for facilitating the training for the residents

Evidence: Refer to the citation below.

Citations:

1. Centers for Disease Control and Prevention (CDC). Contraceptive Effectiveness: Male Sterilization (Vasectomy). 2022.
2. Barone MA, et al. Vasectomy: Review of Safety, Effectiveness and Acceptability. Global Health: Science and Practice. 2017.
3. Shih G, et al. Primary Care Vasectomy Services: Expanding Access and Normalizing Men's Contraception. J Am Board Fam Med. 2020.
4. Labrecque M, et al. Effectiveness and Safety of Vasectomy Performed by Family Physicians. J Urol. 2005.
5. American Board of Family Medicine. Family Medicine Certification Data Book. 2021.
6. ACGME Program Requirements for Graduate Medical Education in Family Medicine. 2024.
7. Barone MA, et al. Vasectomy by Family Physicians: Expanding Male Contraception Access. Contraception. 2011

Speaker's Notes: CAFP does not have policy specific to requiring all residency programs to provide vasectomy training.

AAFP does not have standalone policy on vasectomy training. AAFP policy does note the importance of procedural competence in vasectomy for family physicians and supports training opportunities to increase the number of family physicians able to provide this service. It should be noted that as a state chapter, CAFP's ability to work with national organizations like ABFM and ACGME are limited, and efforts are generally more effective at the national level, such as within the AAFP.

Speaker's Fiscal Notes: CAFP generally limits advocacy to California state-level issues and typically would not advocate directly to ACGME, ABFM, and non-California state medical boards. Therefore, CAFP's role would be limited to state-level advocacy.

This resolution would likely result in moderate fiscal impact for CAFP, depending on the level of activity required for implementation. Meaningful engagement in this area may necessitate additional research or consultation to understand procedural training requirements, certification pathways, and scope-of-practice considerations.

Referring the resolution to AAFP for national action would incur minimal cost.

Committee Recommendation on Resolution A-14-26

2026 Report of the CAFP California Residency Network

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the California Residency Network (CRN) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-14-26: Vasectomy Training During Family Medicine Residency

RESOLVED: That the California Academy of Family Physicians (CAFP) support the training of vasectomy in all ACGME-accredited family-medicine residency programs in California; and

RESOLVED: That CAFP collaborate with the American Board of Family Medicine (ABFM), ACGME, and state medical boards to integrate vasectomy training standards into procedural curricula and maintenance-of-certification pathways, including ongoing Continuing Medical Education (CME).

CRN Recommendation: ADOPT THE FIRST RESOLVED. DO NOT ADOPT SECOND RESOLVED

RESOLVED: That the California Academy of Family Physicians (CAFP) support the training of vasectomy in all ACGME-accredited family-medicine residency programs in California.

Committee Discussion: CRN co-chairs supported the spirit of this resolution but had concerns about making it mandatory to train family medicine residents on vasectomy procedures. Co-chairs acknowledged that FM residency programs already face significant training requirements and felt hesitant to add another procedure to the list of requirements. There were also concerns that residency programs that are supported by catholic health systems may not be able to fulfill this requirement very easily. There was further discussion about what value there is to add policy of general support for a specific procedure, as CAFP policy does not necessarily need to call out every procedure that we may or may not support training for. Ultimately, the committee decided to adopt the first resolved to indicate general support for vasectomy training, but to not adopt the second resolved due to concerns related to adding another procedure requirement where it may not be feasible.

Resolution A-15-26

Proposed Policy Title: Expand FM-OB Training to Address Maternity Care Deserts

Author: Robin Linscheid Janzen, MD

Co-Authors: Christine Pecci, MD; Leah Suarez-Abraham, MD; W. Suzanne Eidson-Ton, MD; Kirsten Vitrikas, MD; Amanda Mooneyham, MD

Endorsed by: Northern California Pregnancy Educational Collaborative

Whereas, California has established new rural-based perinatal stand-by medical services with funding to support Family Physicians to provide leadership and clinical services in these maternity deserts (SB669) and

Whereas, California has revised regulatory requirements for Alternative Birth Centers licensure and ability to bill for Medi-Cal deliveries, and

Whereas, 50% of births in CA are paid for by Medi-Cal and

Whereas, 10 counties in CA have no hospitals providing OB services and labor and delivery units are closing 3 times faster in CA compared to the rest of the US and

Whereas, the Federal Government via recent federal legislation will be severely cutting Medi-Caid payments and

Whereas, in a national survey of over 26,000 family physicians, about 2% reported being trained to do cesarean births—yet among that group, over 40% provide operative obstetrical care in rural counties, including areas without any obstetrician-gynecologists.

RESOLVED: The CAFP advocate for increased funding and support for the rapid expansion of training programs that prepare family medicine physicians for full scope maternity care, including Cesarean and operative vaginal births. This could include 1) OB training tracks within FM residencies (for those residencies with capacity to support this) and 2) 1-2 year FMOB fellowships.

RESOLVED: The CAFP promote the development of regional collaborative networks linking FM-OBs with other perinatal clinicians, including the integration of FMOB's into laborist groups so that there is sufficient full-service coverage to serve their communities.

RESOLVED: The CAFP promotes policies that support the credentialing of family physicians with competence in obstetrical training.

RESOLVED: The CAFP creates opportunities for mentorship networks for FM-OB graduates, peer support to promote professional well-being, and develop strategies to encourage long-term retention in providing obstetrical care including deliveries.

RESOLVED: CAFP refer this to AAFP to promote rapid expansion, on a national level, of training programs that prepare family medicine physicians for full scope maternity care, including Cesarean and operative vaginal births. This could include 1) OB training tracks within FM residencies (for those residencies with capacity to support this) and 2) 1-2 year FMOB fellowships to help meet the clinician shortage contributing to maternity care deserts across the US.

Equity Impact Score: 8/9

Problem Statement: There is a shortage of maternity care clinicians in CA especially in rural populations and robust interest in family physicians to get further training in obstetrical care

including cesarean sections and operative vaginal deliveries. Few fellowships exist with an abundance of applicants interested who can not get the training they need to practice obstetrical care including cesarean sections and operative vaginal deliveries.

Problem Universe: 46,000 women age 15 to 44 live in counties with no hospitals with obstetrics care or birth centers, and an additional 76,000 live in counties with only one hospital with obstetrics care or a birth center . Fifty-one thousand women age 18 to 44 live in counties with fewer than 29 obstetricians or certified nurse midwives per 10,000 births. Roughly 1 million Californians live outside of the safe zone of a hospital with L&D services.

Specific Solution: Increased training and support for family physicians to be competent in obstetrical care and continue to practice obstetrical care including deliveries. Family physicians are the primary clinician in rural populations where we are seeing more maternal care deserts occurring. There is an abundance of applicants for the few FMOB fellowships that exist leaving many family physicians without the opportunity to gain competence in obstetrical care. They are unable to continue to provide this care including deliveries after graduation from residency.

Evidence: The supply of licensed ob/gyns varied across the state . The US Department of Health and Human Services projects that demand for ob/gyns in California will exceed supply by 1,160 full-time equivalents by 2030, based on current use patterns. Family physicians are the primary physician practicing in many rural areas which overlap the same areas that are seeing maternal care deserts. FMOB fellowship trained and high volume OB FM residency tracks provide competence in obstetrical care and can help meet the need of obstetrical clinicians in rural areas and deliver high quality maternal and infant care.

Citations:

1. Federal S.380: <https://www.congress.gov/bill/119th-congress/senate-bill/380>
2. State SB669: <https://legiscan.com/CA/text/SB669/id/3135063>
3. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/<https://www.chcf.org/wp-content/uploads/2023/11/MaternityCareAlmanac2023.pdf>
<https://www.finance.senate.gov/chairmans-news/wyden-and-hassan-lead-introduction-of-legislation-to-stop-labor-and-delivery-unit-closures-in-rural-and-underserved-communities>
4. Maternity ward closures in California result in much more than strained health care. July 24, 2025 by John McHugh <https://calmatters.org/commentary/2025/07/maternity-ward-closures-health-care/>
5. Family Physicians Can Increase Access to Maternity Care. Heather Stringer. Published October 31, 2025. <https://www.chcf.org/resource/midwives-help-fill-maternity-care-gaps-california-faces-ob-gyn-shortage/>
6. Robert William Owens, Mimi Dahlin, Emmanuel Adediran, Andrew Curtin, Saskia Spiess, Laura Elizabeth Moreno, Katherine T Fortenberry, Thomas Carlyle Whittaker, Dominik Ose, Pregnancy-care intentions and practice among family medicine physicians: residents, obstetric fellows, and fellowship alumni, Family Practice, Volume 42, Issue 5, October 2025, cmaf006, <https://doi.org/10.1093/fampra/cmaf006>
7. Kearney MD, O'Brien CS, Donze ML, et al. Assessing Family Medicine Obstetrics Training Needs to Strengthen Maternal Health in Underserved and Rural US Communities. J Prim Care Community Health. 2025;16:21501319251384539. doi:10.1177/21501319251384539
<https://calhospital.org/file/cha-environmental-scan-maternity-care/>
<https://calmatters.org/health/2024/09/new-maternity-care-closures/>
8. Gleeson DE, Busch SH, Ickovics JR. State-Level Prevalence of Maternity Care Deserts: Association With Healthcare Access, Utilization, and Outcomes Among Medicaid Recipients. AJPM Focus. 2025 May 3;4(5):100362. doi: 10.1016/j.focus.2025.100362. PMID: 40735223; PMCID: PMC12305214.

Speaker's Notes: This resolution asks CAFP to advocate for expanded FM-OB training and funding to address maternity care deserts. The goal strongly aligns with workforce and health equity priorities; however, several RESOLVED clauses imply substantial programmatic or funding initiatives

that may require prioritization within CAFP resources and coordination with state agencies and residency sponsors. This proposal includes specific directives to the CAFP operations by directing CAFP to create mentorship networks and develop regional collaborative networks.

CAFP policy supports access to safe obstetrical services as a public good and advocates for basic hospital maternity services are available within reasonable transportation timeframes. CAFP also supports collaborative practice between family physicians and obstetricians, including formalized back-up agreements to ensure coverage. CAFP policy promotes credentialing family physicians with competence in obstetrical care and opposes discrimination in obstetrical credentialing.

AAFP has robust policy affirming that pregnancy, perinatal, and newborn care is a core discipline of the specialty of Family medicine with wide-ranging scope of practice including preconception and prenatal care, management of medical complications during pregnancy and comprehensive care of low and high-risk pregnancy, including cesarean deliveries.

AAFP has also recognized the critical role of family physicians in providing maternity care, especially in underserved and rural communities. AAFP policy supports board certification pathways for family physicians in obstetrics, including options with surgical qualifications, to validate competency and facilitate hospital privileging. AAFP also encourages the development of maternity care tracks within family medicine residencies to enhance training for interested residents. AAFP offers educational resources such as the Family-Centered Pregnancy Care CME program to enhance family physicians' skills in maternity care.

Affirming the role of family physicians in obstetrics and maternity care is aligned with CAFP's strategic plan goal of developing and diversifying the family medicine workforce.

Speaker's Fiscal Notes: This resolution would likely result in a significant fiscal impact for CAFP because it directs a broad set of operational tasks rather than establishing enduring policy principles. The proposal outlines extensive actions—such as researching current obstetrical training capacity, analyzing funding mechanisms, developing recommendations for expanded FM-OB tracks and FMOB fellowships, and engaging multiple state agencies—that would require substantial staff time and resources. While routine state-level advocacy generally carries minimal cost, the activities described in this resolution move far beyond standard advocacy and into sustained project management and program development.

Promoting the development of regional collaborative networks linking FM-OBs with perinatal clinicians and supporting integration into laborist models would result in moderate to significant costs. This work would involve convening stakeholders, facilitating discussions, and potentially developing toolkits or guidance documents. Creating mentorship networks, peer support structures, and retention strategies for FM-OB graduates would may require ongoing facilitation, communications support, and possibly in-person convenings, which may result in moderate to significant expense. If the resolution is interpreted as requiring CAFP to administer or host such programs directly, the cost could be considerable and may exceed existing budget capacity. Referral of the resolution to AAFP for national action would incur minimal cost.

Committee Recommendation on Resolution A-15-26

2026 Report of the CAFP California Residency Network

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the California Residency Network (CRN) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-15-26: Expand FM-OB Training to Address Maternity Care Deserts

RESOLVED: The CAFP advocate for increased funding and support for the rapid expansion of training programs that prepare family medicine physicians for full scope maternity care, including Cesarean and operative vaginal births. This could include 1) OB training tracks within FM residencies (for those residencies with capacity to support this) and 2) 1-2 year FMOB fellowships.

RESOLVED: The CAFP promote the development of regional collaborative networks linking FM-OBs with other perinatal clinicians, including the integration of FMOB's into laborist groups so that there is sufficient full-service coverage to serve their communities.

RESOLVED: The CAFP promotes policies that support the credentialing of family physicians with competence in obstetrical training.

RESOLVED: The CAFP creates opportunities for mentorship networks for FM-OB graduates, peer support to promote professional well-being, and develop strategies to encourage long-term retention in providing obstetrical care including deliveries.

RESOLVED: CAFP refer this to AAFP to promote rapid expansion, on a national level, of training programs that prepare family medicine physicians for full scope maternity care, including Cesarean and operative vaginal births. This could include 1) OB training tracks within FM residencies (for those residencies with capacity to support this) and 2) 1-2 year FMOB fellowships to help meet the clinician shortage contributing to maternity care deserts across the US.

CRN Recommendation: ADOPT AS AMENDED

RESOLVED: The CAFP advocate for increased funding and support for the rapid expansion of training programs for full scope maternity care to supplement the training of family medicine physicians, including Cesarean and operative vaginal births. This could include 1) OB training tracks within FM residencies (for those residencies with capacity to support this) and 2) 1-2 year FMOB fellowships.

RESOLVED: The CAFP promote the development of regional collaborative networks linking Family physicians providing maternity care (FM-OB) with other perinatal clinicians, including the integration of FM-OB into laborist groups.

RESOLVED: The CAFP promotes policies that support the credentialing and affordable liability coverage of family physicians with competence in obstetrical training.

RESOLVED: The CAFP support opportunities for mentorship networks for FM-OB graduates, peer support to promote professional well-being, and develop strategies to encourage long-term retention in providing obstetrical care including deliveries.

RESOLVED: CAFP should advocate to the AAFP to promote expansion, on a national level, of full scope maternity care training programs that supplement the training of family medicine physicians, including operative births. This could include 1) OB training tracks within FM residencies (for those residencies with capacity to support this) and 2) FMOB fellowships

Committee Discussion: CRN co-chairs supported the intent of the resolution to enhance training opportunities for family physicians to support broader access to maternity care. However, they brought up a number of concerns that led to amendments to all of the resolved statements. One concern the co-chairs identified was related to using the term “FM-OB”. There was consensus that amendments were needed to clarify that all board-certified family physicians are trained in delivery, not just those that have done an FM-OB fellowship. Amendments were made to the resolved statements to clarify that additional training opportunities are supplementary to the training of family physicians, and emphasize additional training is on operative births. There were also concerns related to the fact that even some family physicians that do receive enhanced obstetrics training are not able to provide these services because of the high cost of malpractice insurance. Because of this issue, the co-chairs amended the third resolved statement to account for this issue. The co-chairs also agreed to amendments to the language that emphasized that family physicians should not just be asked to provide maternity services in the case where there are underserved areas but in all areas, because their training has equipped them to do so. Further amendments were adopted to make the language in the resolved statements slightly less directive toward the operations of the CAFP.

Committee Report – Governance Committee

2026 Report of the CAFP Governance Committee

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing **and** subsequent action by the CAFP Board of Directors

Speaker, the CAFP Governance Committee has considered the following resolution referred to it and submits the following report.

- A-33-26 – Addressing Health Misinformation Through Physician Education and Community Engagement
- A-34-26 – Ensuring Equitable Representation of Independent and Physician-Led Practice

(Original) Resolution # A-16-26: Increasing Family Medicine Physician Representation as Delegates at the CAFP All Member Advocacy Meeting (AMAM)

RESOLVED: That the California Academy of Family Physicians (CAFP) establish designated positions for family medicine resident physicians to be selected and/or serve as chapter delegates at the annual All Member Advocacy Meeting (AMAM); and be it further

RESOLVED: That CAFP ensure participating resident delegates receive appropriate mentorship, orientation, and support to contribute effectively to policy deliberation and representation ; and be it further

RESOLVED: That CAFP explore mechanisms including but not limited to collaboration with residency programs, structured time-off advocacy policies, or available scholarships—to ensure equitable resident participation regardless of financial or scheduling barriers.

Committee Recommendation: NOT ADOPT THE FIRST RESOLVED, AFFIRM AS EXISTING POLICY THE SECOND RESOLVED, REFER TO CALIFORNIA RESIDENCY NETWORK FOR FURTHER STUDY THE THIRD RESOLVED.

Committee Discussion: The Governance Committee enthusiastically supports Resident (and Student) participation in AMAM, and deeply values their contributions to family medicine, patient care, organized medicine and this specific meeting.

Regarding the first resolved statement: Residents (and Students) are already represented as Delegates. As referenced in the Speaker's notes, CAFP has already granted formal Delegate status to Residents at the All Member Advocacy Meeting. Resident Delegates are selected by the Student and Resident Council, as outlined in CAFP's governing bylaws, and participate with full Delegate rights and responsibilities. These numbers exactly mirror the numbers elected as Delegates to AAFP Congress of Delegates (a much larger body than CAFP), whereby two Delegates and two Alternates from the AAFP's family medicine resident constituency are elected by the National Conference of Family Medicine Residents (NCFMR) to serve as official representatives to the COD. Because of these considerations the committee recommended to not adopt the first resolved statement.

Regarding the second resolved statement: CAFP and the CAFP Foundation already offer participating Resident Delegates mentorship, orientation, and support to contribute effectively to policy deliberation and representation. As a result of this, the committee recommended to affirm this resolved statement as existing policy.

Regarding the third resolved statement: The CAFP Foundation and CAFP already offer stipends and scholarship to offset any financial barriers. However, because the resolution includes language to explore additional mechanisms including but not limited to collaboration with residency programs, and structured time-off advocacy policies, this resolved requires additional study. The committee recommends referring this to the CRN.

Resolution A-16-26

Proposed Policy Title: Increasing Family Medicine Resident Physician Representation as Delegates at the CAFP All Member Advocacy Meeting (AMAM)

Author: Deepa Srinivasan, DO

Co-Authors: Dennis Li, MD; Suzie Lee, DO; Kenyon Wright, MD; Dennis Chou, DO

Endorsed by: None

Whereas, family medicine residents deliver frontline, full-spectrum primary care across California's clinics, hospitals, and safety-net systems, and therefore bring critical lived clinical experience to policymaking in the California Academy of Family Physicians (CAFP);

Whereas, residents provide a significant portion of direct patient care in teaching health systems, often serving medically underserved populations, and are well positioned to identify emerging challenges in patient care and medical education across California's diverse communities;

Whereas, residents represent a diverse and growing segment of the California family medicine workforce, and have long been active contributors at the All Member Advocacy Meeting through resolution authorship, testimony, and policy debate, yet have not been granted formal delegate status at the All Member Advocacy Meeting;

Whereas, early involvement in advocacy and organized medicine leadership strongly predicts sustained engagement throughout a physician's career, strengthening CAFP's long-term leadership pipeline;

Whereas, participation in advocacy and organizational governance supports ACGME competencies in systems-based practice, professionalism, and practice-based learning, providing essential educational benefits to trainees;

Whereas, the AMA, many state chapters, and the AAFP successfully integrate residents as full delegates, demonstrating the feasibility, value, and organizational benefit of including trainees in formal governance structures;

Whereas, expanding resident participation as delegates can be implemented with minimal administrative burden and would enhance continuity of advocacy efforts across training cohorts;

RESOLVED: That the California Academy of Family Physicians (CAFP) establish designated positions for family medicine resident physicians to be selected and/or serve as chapter delegates at the annual All Member Advocacy Meeting (AMAM); and be it further

RESOLVED: That CAFP ensure participating resident delegates receive appropriate mentorship, orientation, and support to contribute effectively to policy deliberation and representation ; and be it further

RESOLVED: That CAFP explore mechanisms including but not limited to collaboration with residency programs, structured time-off advocacy policies, or available scholarships—to ensure equitable resident participation regardless of financial or scheduling barriers.

Equity Impact Score: 5/9

Problem Statement:

Problem Universe:

Specific Solution:**Evidence:****Citations:**

1. Agrawal N, Lucier J, Ogawa R, Arons A. Advocacy Curricula in Graduate Medical Education: an Updated Systematic Review from 2017 to 2022. *J Gen Intern Med.* 2023 Sep;38(12):2792-2807. doi: 10.1007/s11606-023-08244-x. Epub 2023 Jun 20. PMID: 37340255; PMCID: PMC10507002.

Speaker's Notes: This resolution asks CAFP to establish resident physician representation as AMAM delegates, including selection/appointment processes and training/support. It should be noted that such representation already exists.

As outlined in Article VII, Section 5 of the CAFP Bylaws, two resident and two student delegates, and two resident and two student alternates are chosen by the respective resident and student state organization (namely, the Student & Resident Council) to serve as Delegates to the AMAM.

Additionally, one Student and one Resident member of the CAFP Board also serve as Delegates to the AMAM, bringing the formal representative total to ten students and residents. Many local chapters sponsor students and residents to attend the meeting, occasionally naming them in special (non-voting) roles to represent the chapter. Board and Council Student and Resident Delegates are provided appropriate orientation and support, via special trainings and materials.

All members are invited to attend AMAM Orientation trainings in advance of the meeting and a meeting handbook with instructions for Delegates and attendees is published and made widely available in advance of the meeting. Finally, the CAFP Foundation provides scholarships to all attending Council representatives and the CAFP Board members attendance is also funded. Many local chapters provide scholarships and stipends to their Delegates and/or a limited number of student and resident members. CAFP also offers financial assistance waivers to offset the need for registration assistance.

Speaker's Fiscal Notes: There is a significant fiscal impact to the CAFP and CAFP Foundation, already covered by existing policy and practice. Making changes to who can serve as delegates would likely have minimal fiscal impact but could require some limited staff time and resources to make changes to applicable governance documents and records. In addition, if significant numbers of residents become delegates, more resources may be required for increased training for these delegates related to resolutions process and AMAM procedures.

The registration fee for AMAM does not cover the cost of per person food and beverage expenses. As such, if changes resulted in increased AMAM participation, additional cost would be incurred.

Committee Recommendation on Resolution A-16-26

2026 Report of the CAFP Governance Committee

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the CAFP Governance Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-16-26: Increasing Family Medicine Physician Representation as Delegates at the CAFP All Member Advocacy Meeting (AMAM)

RESOLVED: That the California Academy of Family Physicians (CAFP) establish designated positions for family medicine resident physicians to be selected and/or serve as chapter delegates at the annual All Member Advocacy Meeting (AMAM); and be it further

RESOLVED: That CAFP ensure participating resident delegates receive appropriate mentorship, orientation, and support to contribute effectively to policy deliberation and representation ; and be it further

RESOLVED: That CAFP explore mechanisms including but not limited to collaboration with residency programs, structured time-off advocacy policies, or available scholarships—to ensure equitable resident participation regardless of financial or scheduling barriers.

Committee Recommendation: NOT ADOPT THE FIRST RESOLVED, AFFIRM AS EXISTING POLICY THE SECOND RESOLVED, REFER TO CALIFORNIA RESIDENCY NETWORK FOR FURTHER STUDY THE THIRD RESOLVED.

Committee Discussion: The Governance Committee enthusiastically supports Resident (and Student) participation in AMAM, and deeply values their contributions to family medicine, patient care, organized medicine and this specific meeting.

Regarding the first resolved statement: Residents (and Students) are already represented as Delegates. As referenced in the Speaker's notes, CAFP has already granted formal Delegate status to Residents at the All Member Advocacy Meeting. Resident Delegates are selected by the Student and Resident Council, as outlined in CAFP's governing bylaws, and participate with full Delegate rights and responsibilities. These numbers exactly mirror the numbers elected as Delegates to AAFP Congress of Delegates (a much larger body than CAFP), whereby two Delegates and two Alternates from the AAFP's family medicine resident constituency are elected by the National Conference of Family Medicine Residents (NCFMR) to serve as official representatives to the COD. Because of these considerations the committee recommended to not adopt the first resolved statement.

Regarding the second resolved statement: CAFP and the CAFP Foundation already offer participating Resident Delegates mentorship, orientation, and support to contribute effectively to policy deliberation and representation. As a result of this, the committee recommended to affirm this resolved statement as existing policy.

Regarding the third resolved statement: The CAFP Foundation and CAFP already offer stipends and scholarship to offset any financial barriers. However, because the resolution includes language to explore additional mechanisms including but not limited to collaboration with residency programs, and structured time-off advocacy policies, this resolved requires additional study. The committee recommends referring this to the CRN.

Committee Report – Justice, Equity, Diversity and Inclusion (JEDI) Committee

2026 Report of the CAFP Justice, Equity, Diversity and Inclusion (JEDI) Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP JEDI Committee has considered the following resolution referred to it and submits the following report.

- A-17-26: Defend and Uphold Provision of Gender Affirming Care
- A-18-26: CAFP Policy on Intellectual and/or Developmental Disability Care in Primary Care Setting
- A-19-26: JEDI in Politics
- A-20-26: Health Care Rights of Patients Who are Detained by ICE
- A-21-26: Protect Confidentiality and Access to Care for Immigrant Patients
- A-22-26: Protecting Health Care as a Human Right Regardless of Immigration Status

(Original) Resolution # A-17-26: Defend and Uphold Provision of Gender Affirming Care

RESOLVED: That the CAFP opposes federal actions that prohibit funding for gender affirming care services for all age groups, and federal government actions to stop funding hospitals and facilities that provide gender affirming care at their facilities; and

RESOLVED: That the CAFP opposes the federal or state government excluding coverage of gender affirming care from its benefit offerings; and

RESOLVED: That the CAFP supports protections for physicians who provide evidence-based gender-affirming care in California and opposes criminal, civil, or licensure actions against them.

Committee Recommendation: ADOPT

RESOLVED: That the CAFP supports protections for physicians who provide evidence-based gender-affirming care in California and opposes criminal, civil, or licensure actions against them.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP opposes actions that prohibit funding for gender affirming care services for any age groups, and government actions to stop funding hospitals and facilities that provide gender affirming care at their facilities; and

RESOLVED: That the CAFP opposes the exclusion of insurance coverage of gender affirming care for any age groups.

Committee Discussion: The JEDI Committee offers strong support for this resolution, as it is well-aligned with existing policy supporting access to gender affirming care. The committee recommends Adopting as Amended the first resolved. Managing federal actions is outside the scope of the state chapter, and we propose removing the word “federal.”

The committee recommends Adopting as Amended the second resolved. The proposed amended language is more expansive in opposing exclusion of gender affirming care in any type of insurance coverage. The committee also propose adding the reference to “any age groups” included in the first resolved.

The committee recommends to Adopt the third resolved.

(Original) Resolution # A-18-26: CAFP Policy on Intellectual and/or Developmental Disability Care in Primary Care Setting

RESOLVED: That the California Academy of Family Physicians promote inclusive, team-based clinical care for the Intellectual and/or Developmental Disability community by updating existing policy to affirm the role of family physicians in not just acknowledging but also addressing disparities faced by individuals living with developmental disabilities.

RESOLVED: That the California Academy of Family Physicians engage with statewide disability organizations and encourage regional chapters to amplify and disseminate existing resources in disability medicine for family physicians.

RESOLVED: That the California Academy of Family Physicians encourage intellectual and developmental disability training within residency and fellowship programs through posting Disability Medicine fellowship opportunities in the CAFP Career Center website.

Committee Recommendation: NOT ADOPT

Committee Discussion:

The JEDI Committee strongly supports the underlying spirit of this resolution, and it aligns with CAFP strategic objectives to promote health equity. However, the committee perspective is that the first resolved is covered by existing CAFP policy. Since resolutions are meant to introduce new policy, the committee recommends not adopting. The Committee recommends to Not Adopt the second and third resolved clauses, as resolutions are designed to amend and create policy and not meant to guide specific CAFP activities, such as posting specific content on the CAFP website or directing staff to engage with specific organizations.

(Original) Resolution # A-19-26: JEDI in Politics

RESOLVED: That the CAFP will welcome and encourage doctors of all political parties and points of view to share their views freely and openly without fear of being mocked, labeled, punished, pushed out, bullied, shouted down, overlooked, excluded, attacked, interrogated, alienated, slandered, or maligned in any way,

RESOLVED: That resolutions which reflect a strong political bias be considered carefully; the board should first decide whether this is an issue that specifically behooves the CAFP to take a particular political position, whether the position of the CAFP will significantly change the political conversation among lawmakers, whether it is reasonable for family doctors of diverse views to have a separate or opposite perspective on the issue, whether the CAFP's stance would unnecessarily promote distrust among large numbers of patients and doctors, and finally the board should question whether the resolution will unnecessarily alienate CAFP members with a different political point of view regarding the issue; and after carefully weighing the risks and benefits of all of these, the board should make their decision.

Committee Recommendation: NOT ADOPT

Committee Discussion: The JEDI Committee remains firmly committed to inclusivity, nondiscrimination, and respectful professional discourse, principles that are already well established in CAFP's existing policies and governance practices. The Committee determined that the issues

raised are substantively addressed through current policy and that no clear policy gap requiring additional formal action was identified. The Committee also felt that the proposed language was more reflective of individual concerns about tone and experience than of a discrete policy gap requiring formal action.

(Original) Resolution # A-20-26: Health Care Rights of Patients Who are Detained by ICE

RESOLVED: That the California Academy of Family Physicians (CAFP) supports policies that affirm patients who are detained by ICE have the right to private medical interviews and exams, have access to legal resources, and allow medical providers to communicate with patients' emergency contacts.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the California Academy of Family Physicians (CAFP) supports policies that affirm that people who are detained by immigration authorities have the right to appropriate, evidence-based medical care led by a physician, within a timely manner; allow medical providers to communicate with patients' and their family/loved ones in their preferred language and also have access to legal resources and a copy of their medical record.

Committee Discussion: This resolution is in alignment with existing CAFP policy that health care is a human right and that every person, regardless of immigration status, has the right to timely health services. It proposes new CAFP policy supporting rights of people who are detained by immigration authorities. The committee recommends Adopting as Amended. Managing federal action is outside the scope of the state chapter and we propose removing the word "ICE." The proposed amended language on "appropriate care..." is less prescriptive about the specific type of care needed. Policies are meant to be evergreen. Similarly, we propose more expansive language for with whom and how medical providers communicate with patients/patient contacts. This is consistent with CAFP policy supporting access to culturally competent care. The committee also proposes including a copy of medical record as important part of legal resources.

(Original) Resolution # A-21-26: Protect Confidentiality and Access to Care for Immigrant Patients

RESOLVED: That the CAFP strongly opposes the federal government sharing Medicaid enrollees' personal information with government entities outside of the Department of Health and Human Services (HHS) for the purpose of immigration enforcement; and

RESOLVED: That the CAFP supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients; and

RESOLVED: That the CAFP opposes law enforcement stirring fear in immigrant communities and raiding clinics, hospitals, physicians' offices, or other locations that provide medical care causing patients and family members to not seek care or have routine check-ups, vaccinations, refill medications, procedures and surgeries; these actions undermine the physician-patient relationship and erode trust in our health care system; and

RESOLVED: That the CAFP supports designating healthcare facilities and associated property (including but not limited to parking structures, sidewalks, entrances, patient drop-off zones, and any facility-owned or leased adjacent buildings used for patient care) as protective access zones, defined as locations where immigration enforcement activities (including surveillance, arrests, or detentions of individuals seeking care) are prohibited, in order to ensure patients and visitors can safely access medical services without fear; and

RESOLVED: That the CAFP opposes the presence of Immigration and Customs Enforcement (ICE) at healthcare facilities and associated property (including parking structures); and

RESOLVED: That the CAFP opposes any requirements for physicians and healthcare systems to ask for immigration status or to report undocumented individuals (9)

Committee Recommendation: ADOPT

RESOLVED: That the CAFP opposes any requirements for physicians and healthcare systems to ask for immigration status or to report undocumented individuals

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP supports protections that prohibit sharing or utilizing information from medical records or insurance enrollee information with immigration or other law enforcement agencies to pursue immigration enforcement actions against patients

RESOLVED: That the CAFP opposes the presence of immigration authorities at healthcare settings and associated property (including parking structures) unless they are there to bring an individual to seek medical care.

Committee Discussion: The JEDI Committee is in general strong support of this resolution. It is aligned with current policy and practice and introduces new policy on a timely issue. The committee felt the first two resolved statements could be effectively combined into one statement and propose to Adopt as Amended above. The committee also removed references to federal agencies, as that is outside the scope of the state chapter.

The committee understood the sentiment of the third and fourth resolved statements, though finds them overly directive. The committee believes these two statements can be effectively covered in the proposed Amended language for the fifth resolved statement, as above. The committee again removed references to federal agencies, propose expanding healthcare facilities to “settings” (to accommodate street medicine units, etc.) and add exceptions for an individual being brought in for care.

(Original) Resolution # A-22-26: Protecting Health Care as a Human Right Regardless of Immigration Status

RESOLVED: That the California Academy of Family Physicians reaffirm that health care is a human right for all people, regardless of immigration status, and oppose any legislation, regulations, or budget proposals that restrict access to health insurance coverage or medically necessary health services based on immigration status, and advocate for the protection and expansion of Medi-Cal and other publicly funded health programs for all Californians, regardless of immigration status.

Committee Recommendation: AFFIRM AS EXISTING POLICY

Committee Discussion: The JEDI Committee affirmed that this is a significant and timely issue for family medicine but that it is already covered by existing CAFP policy, as noted in the Speaker Notes. As such, the committee recommends affirming as existing policy.

Resolution A-17-26

Proposed Policy Title: Defend and Uphold Provision of Gender Affirming Care

Author: Ian Kim, MD

Co-Authors: None

Endorsed by: None

Whereas, California anti-discrimination law recognizes gender identity as a protected class (1); and

Whereas, all major medical associations including the American Medical Association, the American College of Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians (AAFP) affirm the importance of evidence based gender affirming care for the health and safety of gender non-conforming patients; and

Whereas, existing CAFPP policy upholds gender affirming care as medically necessary; and

Whereas, the policy proposed here was adopted at the California Medical Association 154th Annual Session Actions of 2025 House of Delegates (10/28/25) (2); and

Whereas, recent federal policy change attempts to make gender affirming care less accessible and attempts to threaten physicians providing gender affirming care with legal and professional punishments;

RESOLVED: That the CAFPP opposes federal actions that prohibit funding for gender affirming care services for all age groups, and federal government actions to stop funding hospitals and facilities that provide gender affirming care at their facilities; and

RESOLVED: That the CAFPP opposes the federal or state government excluding coverage of gender affirming care from its benefit offerings; and

RESOLVED: That the CAFPP supports protections for physicians who provide evidence-based gender-affirming care in California and opposes criminal, civil, or licensure actions against them.

Equity Impact Score: 7/9

Problem Statement: Recent federal policy change attempts to make gender affirming care less accessible and attempts to threaten physicians providing gender affirming care with legal and professional punishments.

Problem Universe: Countless family physicians in California are already providing gender affirming care.

Patients seeking gender affirming care may potentially be treated by any practicing family physician in California.

Specific Solution: Opposes federal actions that prohibit funding for gender affirming care services for all age groups, and federal government actions to stop funding hospitals and facilities that provide gender affirming care at their facilities; and

Opposes the federal or state government excluding coverage of gender affirming care from its benefit offerings; and

Supports protections for physicians who provide evidence-based gender-affirming care in California and opposes criminal, civil, or licensure actions against them.

Evidence:**Citations:**

1. Transgender Law Center – FAQ: The Gender Nondiscrimination Act
<https://transgenderlawcenter.org/resources/employment/know-your-rights/faq-the-gender-nondiscrimination-act/>

Speaker's Notes: This resolution asks CAFP to oppose federal actions that restrict or penalize provision of gender-affirming care and to defend clinicians and institutions providing such care. This aligns with existing CAFP policy supporting access to gender-affirming care; feasibility considerations include CAFP's capabilities as a state chapter (primary levers are state advocacy, amicus/letters, and advocacy within AAFP on federal issues).

CAFP has existing policy supporting gender-affirming care and supports gender-affirming care as an essential benefit. CAFP policy opposes denial of coverage based on gender identity and supports coverage for medically appropriate transition services as determined by best practice standards, the patient, and physician. CAFP policy supports malpractice coverage for clinicians offering gender-affirming services under California's shield laws and expansion of transgender medical education for all provider levels. AAFP similarly recognizes diversity in gender identity and expression and supports access to gender-affirming care for all age groups as part of comprehensive primary care, endorses an informed consent model for adults and emancipated minors, and affirms that the full spectrum of gender-affirming care should be legal. AAFP also supports education on gender diversity at all levels of medical education (reaffirmed September 2024).

CAFP presented sessions on gender expansive care at POP in 2023 and committed to revisiting the topic annually.

Speaker's Fiscal Notes: There would be minimal to moderate costs associated with the activities outlined in this resolution, depending on the level of engagement CAFP undertakes.

CAFP typically engages in state-level advocacy, direct federal advocacy is outside CAFP's usual scope. Actions involving federal policy would likely be limited to referral to AAFP for national advocacy, which would incur minimal cost. Drafting statements or letters expressing CAFP's position on state-level or supportive federal policy matters would also result in minimal costs, unless accompanied by a broader communications strategy.

Costs could rise if CAFP is expected to take a more active role in coalition-building, providing expert testimony, or monitoring federal or state policy actions affecting gender-affirming care. Engagement on complex legal or regulatory issues may require additional staff time, research, or external expertise, particularly if the Academy is asked to track, analyze, and respond to multiple potential actions or legal challenges.

Committee Recommendation on Resolution A-17-26

2026 Report of the CAFP Justice, Equity, Diversity and Inclusion (JEDI) Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP JEDI Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-17-26: Defend and Uphold Provision of Gender Affirming Care

RESOLVED: That the CAFP opposes federal actions that prohibit funding for gender affirming care services for all age groups, and federal government actions to stop funding hospitals and facilities that provide gender affirming care at their facilities; and

RESOLVED: That the CAFP opposes the federal or state government excluding coverage of gender affirming care from its benefit offerings; and

RESOLVED: That the CAFP supports protections for physicians who provide evidence-based gender-affirming care in California and opposes criminal, civil, or licensure actions against them.

Committee Recommendation: ADOPT

RESOLVED: That the CAFP supports protections for physicians who provide evidence-based gender-affirming care in California and opposes criminal, civil, or licensure actions against them.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP opposes actions that prohibit funding for gender affirming care services for any age groups, and government actions to stop funding hospitals and facilities that provide gender affirming care at their facilities; and

RESOLVED: That the CAFP opposes the exclusion of insurance coverage of gender affirming care for any age groups.

Committee Discussion: The JEDI Committee offers strong support for this resolution, as it is well-aligned with existing policy supporting access to gender affirming care. The committee recommends Adopting as Amended the first resolved. Managing federal actions is outside the scope of the state chapter, and we propose removing the word "federal."

The committee recommends Adopting as Amended the second resolved. The proposed amended language is more expansive in opposing exclusion of gender affirming care in any type of insurance coverage. The committee also propose adding the reference to "any age groups" included in the first resolved.

The committee recommends to Adopt the third resolved.

Resolution A-18-26

Proposed Policy Title: CAFP Policy on Intellectual and/ or Developmental Disability Care in Primary Care Setting

Author: Mai Nojima, MD

Co-Authors: Caryssa Lim, MD; Jonathan Raymundo, MD; Justin Siu, MD

Endorsed by: None

Whereas, Over 10 million people in the US have an intellectual and/or developmental disability (IDD), with over 600,000 of people with IDD estimated to be living in California

Whereas, People with IDD face significant health disparities, including higher rates of mental health concerns, chronic conditions and preventable deaths; they are less likely to receive preventative care and be up to date on cancer screenings

Whereas, Stigma as well as lack of formal physician training in medical school and residency contribute to health disparities among people with intellectual and/or developmental disability, and deter patients from receiving healthcare services

Whereas, There is an insufficient number of experienced physicians who feel comfortable to care for patients with intellectual and/or developmental disability, especially as patients transition to adult care

Whereas, The California Academy of Family Physicians maintains current resolution to encourage federal designation of individuals with intellectual and developmental disabilities as a medically underserved population (Res A-08-17)

RESOLVED: That the California Academy of Family Physicians promote inclusive, team- based clinical care for the Intellectual and/or Developmental Disability community by updating existing policy to affirm the role of family physicians in not just acknowledging but also addressing disparities faced by individuals living with developmental disabilities.

RESOLVED: That the California Academy of Family Physicians engage with statewide disability organizations and encourage regional chapters to amplify and disseminate existing resources in disability medicine for family physicians.

RESOLVED: That the California Academy of Family Physicians encourage intellectual and developmental disability training within residency and fellowship programs through posting Disability Medicine fellowship opportunities in the CAFP Career Center website.

Equity Impact Score: 7/9

Problem Statement: People with IDD face significant health disparities, which is exacerbated by physicians' lack of comfortability and confidence caring for this population.

Problem Universe: As noted above over 600,000 people with IDD live in California, with about 500,000 people utilizing Regional Center Services. Given the wide spectrum of what constitutes an intellectual and or developmental disability, there is difficulty collecting accurate health data on this community as well, which is what a previous CAFP resolution aimed to tackle by asking to designate this community as a medically underserved population.

Specific Solution: We wish for CAFP to not only acknowledge this community as a medically underserved population, but take active steps to engage with the community. We believe that

amplifying this community's voices is critical to be able to co-create sustainable plans for family medicine physicians to be able to provide a more welcoming and equitable healthcare environment.

Evidence:

Citations:

1. Pham HH, Benevides TW, Andresen ML, et al. Advancing Health Policy and Outcomes for People With Intellectual or Developmental Disabilities: A Community-Led Agenda. *JAMA Health Forum*. 2024;5(8):e242201. doi:10.1001/jamahealthforum.2024.2201
2. Health Disparities of People with IDD. Center for Inclusive Health. Accessed December 5, 2025. <https://inclusivehealth.specialolympics.org/about/health-disparities>
3. Ervin DA, Hennen B, Merrick J, Morad M. Healthcare for Persons with Intellectual and Developmental Disability in the Community. *Front Public Health*. 2014;2:83. doi:10.3389/fpubh.2014.00083
4. Chandan P, Noonan EJ, Brody KD, Feller C, Lauer E. Innovation in Medical Education on Intellectual/Developmental Disabilities. *Med Care*. 2025;63(1 Suppl 1):S25-S30. doi:10.1097/MLR.0000000000002079

Speaker's Notes: The resolution seeks CAFPP policy updates and advocacy to improve primary care for individuals with intellectual and/or developmental disabilities (I/DD). This aligns with the CAFPP strategic objective to prioritize advocacy activities that improve health equity. Depending on the scope of proposed activities, the resource impact on the Academy could be significant. Particularly, convening multi-stakeholder partnerships would be an activity that could require a substantial reallocation of CAFPP's resources away from other priorities.

The California Academy of Family Physicians (CAFP) has policy related to clinical care for people with intellectual and/or developmental disabilities. CAFPP policy includes broader commitments to supporting people living with disabilities, including advocating for least restrictive settings, self-determination, supported decision-making, and inclusion of people with disabilities in advisory roles. CAFPP also recognizes the significant health disparities experienced by individuals with intellectual and developmental disabilities and supports their designation as a medically underserved population at the state and federal levels.

Encouraging intellectual and developmental disability training aligns well with CAFPP's strategic goals of championing health equity and developing and diversifying the family medicine workforce. Expanding and highlighting training of this nature encourages full spectrum care and acknowledges the diversity of patient populations that family physicians are trained and equipped to care for.

AAFP does not have official policy related to clinical care for individuals with intellectual and developmental disabilities but does maintain official clinical guidance and care standards for these populations. AAFP's models of care focus on neurodiversity and social models of disability, with guidance covering the entire lifespan, from pediatric developmental screening to adult focus clinical care. The resources from AAFP also include approaches to communication and supported decision making. AAFP has actively engaged with CMS on Medicare Payment Schedule updates that influence how physicians are reimbursed for extra time required for complex care management including supporting care for patients with intellectual or developmental disabilities.

Speaker's Fiscal Notes: The various resolved statements could have varying fiscal impacts depending on the level of staff time and involvement. There would be limited fiscal impact of updating existing policy to affirm the role of family physicians in addressing disparities faced by

individuals living with developmental disabilities. However, there could be more significant costs if further action is required.

Posting Disability Medicine fellowship opportunities in the CAFP Career Center website would likely require minimal resources because it fits within already established activities and responsibilities of the CAFP staff. However, if further resources or time is required in order to network with residency programs, do further research or enhance communication channels, further resources may be required. In addition, further activities to encourage intellectual and developmental disability training may require additional staff resources if it requires the development of any kind of advocacy strategy that promotes an increase in Disability Medicine training opportunities statewide.

Resolutions are designed to amend and create CAFP Policy. They are not meant to guide CAFP activities. The CAFP Board (elected representatives of each District and some constituencies) develops a three-year strategic plan. The Board carefully weighs issues in relation to resources, clinical information, CAFP priorities and policy and political environment. CAFP's professional staff utilizes their expertise in organizational resources, policy, politics, education, membership development and communications to operationalize those priorities by developing strategies and activities. This resolution includes a specific resolved statement that directs CAFP to engage with statewide disability organizations to disseminate resources in disability medicine. This would require significant time and staff resources to determine the applicable organizations, network with external organizations, and potentially develop new educational materials related to disability medicine.

Committee Recommendation on Resolution A-18-26

2026 Report of the CAFP Justice, Equity, Diversity and Inclusion (JEDI) Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP JEDI Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-18-26: CAFP Policy on Intellectual and/or Developmental Disability Care in Primary Care Setting

RESOLVED: That the California Academy of Family Physicians promote inclusive, team-based clinical care for the Intellectual and/or Developmental Disability community by updating existing policy to affirm the role of family physicians in not just acknowledging but also addressing disparities faced by individuals living with developmental disabilities.

RESOLVED: That the California Academy of Family Physicians engage with statewide disability organizations and encourage regional chapters to amplify and disseminate existing resources in disability medicine for family physicians.

RESOLVED: That the California Academy of Family Physicians encourage intellectual and developmental disability training within residency and fellowship programs through posting Disability Medicine fellowship opportunities in the CAFP Career Center website.

Committee Recommendation: NOT ADOPT

Committee Discussion:

The JEDI Committee strongly supports the underlying spirit of this resolution, and it aligns with CAFP strategic objectives to promote health equity. However, the committee perspective is that the first resolved is covered by existing CAFP policy. Since resolutions are meant to introduce new policy, the committee recommends not adopting. The Committee recommends to Not Adopt the second and third resolved clauses, as resolutions are designed to amend and create policy and not meant to guide specific CAFP activities, such as posting specific content on the CAFP website or directing staff to engage with specific organizations.

Resolution A-19-26

Proposed Policy Title: JEDI in Politics

Author: Angela Bymaster, MD

Co-Authors: None

Endorsed by: None

Whereas it is beneficial for FM doctors to reflect the diversity of patients in the population, and

Whereas the best ideas, plans, and policies come from collaboration among people of different perspectives, and

Whereas the mission of the CAFP is to empower, educate, and connect family physicians to improve the health of all Californians, and

Whereas the non-discrimination policy of the CAFP states, "The California Academy of Family Physicians supports the principle that membership in the organization, service on the organization's governing bodies, committees and task forces, participation in Academy programs and activities, and Academy collaboration and cooperation with outside entities will be without regard to age, gender, race, ethnicity, sexual orientation, disability, national origin, political affiliation or religious belief" (8/96 BoD), and

Whereas fewer than half of Californians who are registered to vote are registered Democrats, and the remaining voters are Republicans, Third Party, "Other", and Unaffiliated, and

Whereas a majority of voters of color in California identify as either "moderate" or "conservative" in their political ideology, and

Whereas the CAFP holds the values of Diversity, Inclusion, Equity, and Justice to be important, and

Whereas it is not in the best interests of the CAFP to be politically partisan, and

Whereas in the past 20 years, the vast majority (>95%) of the political CAFP and AAFP resolutions which have been adopted have endorsed partisan positions aligned with liberal views, and

Whereas the exclusion of specific political points of view (in this case, conservative) leads to mistrust among a large percentage of the population,

RESOLVED: That the CAFP will welcome and encourage doctors of all political parties and points of view to share their views freely and openly without fear of being mocked, labeled, punished, pushed out, bullied, shouted down, overlooked, excluded, attacked, interrogated, alienated, slandered, or maligned in any way,

RESOLVED: That resolutions which reflect a strong political bias be considered carefully; the board should first decide whether this is an issue that specifically behooves the CAFP to take a particular political position, whether the position of the CAFP will significantly change the political conversation among lawmakers, whether it is reasonable for family doctors of diverse views to have a separate or opposite perspective on the issue, whether the CAFP's stance would unnecessarily promote distrust among large numbers of patients and doctors, and finally the board should question whether the resolution will unnecessarily alienate CAFP members with a different political point of view regarding the issue; and after carefully weighing the risks and benefits of all of these, the board should make their decision.

Equity Impact Score: 9/9

Problem Statement: A majority of resolutions accepted by the CAFP reflect a single political position

Problem Universe: 1/4 of California voters are registered Republicans. California Latino voters self-report as 31% "conservative" and 32% "moderate." California African-American voters self-report as 22% "conservative" and 40% "moderate". Rural impoverished populations are very often more conservative than urban populations. It would be good for the CAFP to consider the viewpoints and needs of these important Californians when making resolutions.

Specific Solution: Space should be made for conservative and moderate voices in CAFP discourse, and care should be taken before adopting clearly partisan resolutions. See Resolution.

Evidence: A study was recently performed which looked at policy statements published by 6 professional medical societies, including the AAFP. The results follow:

One-third of policy statements (529/1592, 33.2%) were found to be aligned with a political ideology. Among these 529 statements, 516 (97.5%) were liberal or probably liberal and 13 (2.5%) were conservative or probably conservative. For each organization, among policy statements with a political leaning, the percentage of liberal or probably liberal statements was as follows: 100% (69/69) for the American Academy of Pediatrics, 100% (24/24) for the American College of Obstetricians and Gynecologists, 100% (12/12) for the American College of Surgeons, 99% (72/73) for the American Psychiatric Association, 97% (174/180) for the American Academy of Family Physicians, and 96% (165/171) for the American College of Physicians.

On a personal note, as a doctor in the CAFP who is a registered Republican, I have often heard my views being misunderstood, dismissed, maligned, and mocked at CAFP meetings. I am often afraid to voice my opinions at CAFP events because of strong anti-conservative biases and attitudes, expressed from the stage and from the attendees. I am afraid to speak openly about being a registered Republican, having conservative views, and about specific issues. Examples include the following: I am pro-life, I do not think the COVID vaccine benefits outweigh the risks in pediatric patients, and I believe it is imperative for society to incentivize complete sobriety options for the treatment of substance use disorders.

I do not believe that the CAFP wishes to marginalize anyone, and I hope it is able to correct its course.

I suspect there may be many other current and former CAFP docs who feel the same way, and some may have left the organization because of this.

Citations:

1. Knudsen B, Madkour A, Cholli P, Haslam A, Prasad V
Analysis of the Political Viewpoint of Policy Statements From Professional Medical Organizations Using ChatGPT With GPT-4: Cross-Sectional Study
JMIR Form Res 2025;9:e66204
URL: <https://formative.jmir.org/2025/1/e66204>
DOI: 10.2196/66204
2. <https://independentvoterproject.org/voter-stats/ca>
3. <https://www.ppic.org/publication/race-and-voting-in-california/>

Speaker's Notes: The California Academy of Family Physicians (CAFP) and the American Academy of Family Physicians (AAFP) have policies and practices that reflect inclusivity and awareness of political biases in their policy and advocacy work, noting an emphasis on evidence-based, non-partisan approaches rather than explicit statements about inclusivity of all political views.

CAFP policy emphasizes that medical research and public health policy must be non-partisan, unbiased, and based on scientific evidence. Public health policy should be free from political motivation. In addition, CAFP opposes political interference in medical-decision making. Policy supports free speech rights for medical students, residents, and doctors advocating for humanitarian efforts without repercussion or silencing. CAFP advocates for transparency, evidence-based policy, and opposes prejudice and discrimination in healthcare settings. CAFP also has policy indicating non-discrimination in membership, governance, and collaboration without regard to political affiliation among other factors. CAFP has a political action committee (FP-PAC) that is bipartisan and supports pro-family medicine candidates, indicating engagement with multiple political perspectives to advance family medicine interests.

The CAFP Board of Directors Utilizes a Knowledge-Based Decision-Making Process for its deliberations, and this reminder is included in all Board meeting packets:

This process poses four questions:

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

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

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's 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?

We make collective, rather than individual decisions, encourage diversity of viewpoints, are sensitive to our members' needs and give adequate emphasis to the ethics of each issue.

AAFP encourages political engagement of its members at all levels of government and works with all political parties and candidates to educate them on family medicine's importance.

AAFP has a political action committee (FamMedPAC) that supports candidates based on family medicine priorities, aiming to maintain a consistent voice in legislative matters. AAFP emphasizes evidence-based advocacy and transparency in its policy development.

Speaker's Fiscal Notes: There would be no fiscal impact as this resolution reflects current policies and practices supporting inclusion, non-discrimination, and member representation.

Committee Recommendation on Resolution A-19-26

2026 Report of the CAFP Justice, Equity, Diversity and Inclusion (JEDI) Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP JEDI Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-19-26: JEDI in Politics

RESOLVED: That the CAFP will welcome and encourage doctors of all political parties and points of view to share their views freely and openly without fear of being mocked, labeled, punished, pushed out, bullied, shouted down, overlooked, excluded, attacked, interrogated, alienated, slandered, or maligned in any way,

RESOLVED: That resolutions which reflect a strong political bias be considered carefully; the board should first decide whether this is an issue that specifically behooves the CAFP to take a particular political position, whether the position of the CAFP will significantly change the political conversation among lawmakers, whether it is reasonable for family doctors of diverse views to have a separate or opposite perspective on the issue, whether the CAFP's stance would unnecessarily promote distrust among large numbers of patients and doctors, and finally the board should question whether the resolution will unnecessarily alienate CAFP members with a different political point of view regarding the issue; and after carefully weighing the risks and benefits of all of these, the board should make their decision.

Committee Recommendation: NOT ADOPT

Committee Discussion: The JEDI Committee remains firmly committed to inclusivity, nondiscrimination, and respectful professional discourse, principles that are already well established in CAFP's existing policies and governance practices. The Committee determined that the issues raised are substantively addressed through current policy and that no clear policy gap requiring additional formal action was identified. The Committee also felt that the proposed language was more reflective of individual concerns about tone and experience than of a discrete policy gap requiring formal action.

Resolution A-20-26

Proposed Policy Title: Health Care Rights of Patients Who are Detained by ICE

Author: Cara Smith, MD

Co-Authors: Abdalyz Frias Beltran, MD; Alejandra Rodriguez, MD; Andrew Vo, DO; Dylan Hanami, MD

Endorsed by: None

Whereas, the California Academy of Family Physicians (CAFP) believes patients deserve access to health care regardless of immigration status and rejects policy that requires physicians to report undocumented individuals;

Whereas, HIPAA and the Confidentiality of Medical Information Act apply to all patients with no legal exception for patients detained by ICE;

Whereas, CAFP opposes neglect, mistreatment, or rights violation in detention settings

Whereas, the CAFP supports policies which protect detained and incarcerated patients' rights in hospital and other clinical care settings

Whereas, the CAFP recommends health care teams protect immigrant patient's privacy, prepare for immigration-enforcement encounters, and provide "know your rights" materials, therefore be it

RESOLVED: That the California Academy of Family Physicians (CAFP) supports policies that affirm patients who are detained by ICE have the right to private medical interviews and exams, have access to legal resources, and allow medical providers to communicate with patients' emergency contacts.

Equity Impact Score: 8/9

Problem Statement: This resolution seeks to address the disregard for the rights of patients detained under Immigration Enforcement (ICE) custody to privacy, access to legal assistance, and contact with emergency contacts or family members. Unfortunately, there are active health care facility policies that disregard these rights.

Problem Universe: According to reports from November 2025, there are over 5,700 people in immigration detention in the state of California, which is an 84% increase since the beginning of the year. Further, California has an estimated 1.8 million undocumented immigrants, all of whom are at risk of becoming detained. At this time, most of the immigrants in California who lack documentation do have access to the health care system through primary care, emergency departments, and hospitals - the places where family physicians work. These are our patients.

Specific Solution: Many health care facilities and systems are creating their own policies regarding care for patients in immigration enforcement custody. We propose that the CAFP support those policies that uphold the rights of detained patients to privacy, access to legal assistance, and communication with their emergency contacts.

Evidence: Community members and media outlets are calling out the mistreatment of patients while under ICE custody and seeking health care. The existence of health care facility policies that contradict the rights of detained patients has made it imperative that new CAFP policy is added supporting detained patients' rights and providing guidance for the family physicians working in these institutions to stand up to injustice.

Citations:

1. Boyle Heights Beat. (2025, October). Community demands limits on ICE agents at White Memorial. <https://boyleheightsbeat.com/white-memorial-hospital-immigration-agents-boyle-heights-leaders/>
2. Boyle Heights Beat. (2025, October). White Memorial releases ICE guidelines, but doctors say they fall short. <https://boyleheightsbeat.com/white-memorial-ice-response-doctors-community/>
3. CalMatters (Fry, W., & Kuang, J.). (2025, October 2). California gave counties power to inspect ICE detention centers. They're not using it. <https://calmatters.org/justice/2025/10/ice-detention-center-inspections/>
4. Freedom for Immigrants. (n.d.). Detention statistics. <https://www.freedomforimmigrants.org/detention-statistics/>
5. Institute for Health Policy & Leadership. (2025, September 15). Medi-Cal coverage for undocumented immigrants in California: What will happen to the progress made over the years? <https://ihpl.llu.edu/blog/medi-cal-coverage-undocumented-immigrants-california-what-will-happen-progress-made-over-years>
6. Kaiser Family Foundation. (2023). Health and health care experiences of immigrants: The 2023 KFF/LA Times Survey of Immigrants. <https://www.kff.org/racial-equity-and-health-policy/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/>
7. KFF Health News. (2025). California faces limits as it directs health facilities to push back on immigration raids. <https://kffhealthnews.org/news/article/california-ice-immigrant-protections-hospitals-clinics-agents/>
8. L.A. Public Press. (2025, October). At a Boyle Heights hospital, ICE agents call the shots, doctors say. <https://lapublicpress.org/2025/10/boyle-heights-hospital-ice/>
9. National Nurses United. (2025, October). California nurses condemn ICE presence at California Hospital in Los Angeles. <https://www.nationalnursesunited.org/press/california-nurses-condemn-ice-presence-at-california-hospital-in-los-angeles>
10. Public Policy Institute of California. (2025). Immigrants in California. <https://www.ppic.org/publication/immigrants-in-california/>
11. TRAC Reports. (n.d.). Immigration detention quick facts. <https://tracreports.org/immigration/quickfacts/>

Speaker's Notes: CAFP policy affirms that health care is a human right and that every person, regardless of immigration status, has the right to comprehensive, high-quality, culturally competent, and timely health services. CAFP explicitly opposes policies requiring physicians to report undocumented individuals, emphasizing that communities are safer and healthier when all individuals have access to care without fear. Additionally, CAFP opposes political interference in medical decision-making, which supports the principle that detained patients should have autonomy in their medical care and communication.

AAFP has policy on the Health Impacts of Immigration. The policy includes recommendation for timely access both to healthcare for migrant, asylee and refugee persons in detention facilities and measures to reduce the toxic stress associated with the threat of detention and deportation.

Supporting those detained by ICE with the right to medical care is consistent with CAFP's strategic plan goal of championing public health and health equity. This is consistent with CAFP's emphasis on reducing health disparities and advocating for vulnerable populations, including immigrants and detainees.

CAFP recently published its Healthy Harbors guide, which offers actionable strategies and resources for physicians, clinics, and health care teams to protect patient privacy, prepare for potential

immigration enforcement encounters, and create welcoming clinical environments for all patients, regardless of immigration status.

Speaker's Fiscal Notes: There would be minimal cost for supporting policies that affirm these patient rights. There would be minimal costs associated with drafting letters, releasing statements, or supporting or opposing related legislation or regulation as these activities all fall within established procedures and operations of the CAFP. However, 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. There could also be more significant costs if a communication strategy is required or if active regulatory advocacy efforts are called for.

Committee Recommendation on Resolution A-20-26

2026 Report of the CAFP Justice, Equity, Diversity and Inclusion (JEDI) Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP JEDI Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-20-26: Health Care Rights of Patients Who are Detained by ICE

RESOLVED: That the California Academy of Family Physicians (CAFP) supports policies that affirm patients who are detained by ICE have the right to private medical interviews and exams, have access to legal resources, and allow medical providers to communicate with patients' emergency contacts.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the California Academy of Family Physicians (CAFP) supports policies that affirm that people who are detained by immigration authorities have the right to appropriate, evidence-based medical care led by a physician, within a timely manner; allow medical providers to communicate with patients' and their family/loved ones in their preferred language and also have access to legal resources and a copy of their medical record.

Committee Discussion: This resolution is in alignment with existing CAFP policy that health care is a human right and that every person, regardless of immigration status, has the right to timely health services. It proposes new CAFP policy supporting rights of people who are detained by immigration authorities. The committee recommends Adopting as Amended. Managing federal action is outside the scope of the state chapter and we propose removing the word "ICE." The proposed amended language on "appropriate care..." is less prescriptive about the specific type of care needed. Policies are meant to be evergreen. Similarly, we propose more expansive language for with whom and how medical providers communicate with patients/patient contacts. This is consistent with CAFP policy supporting access to culturally competent care. The committee also proposes including a copy of medical record as important part of legal resources.

Resolution A-21-26

Proposed Policy Title: Protect Confidentiality and Access to Care for Immigrant Patients

Author: Sherrice Law

Co-Authors: Ian Kim, MD

Endorsed by: None

WHEREAS, existing California Academy of Family Physicians (CAFP) policies affirm that health care is a human right and that all Californians deserve access to comprehensive, high-quality health services regardless of immigration status (1); and

WHEREAS, recent policy changes at the federal level have created new and unprecedented challenges to health access for immigrants' access to health care (2,3); and

WHEREAS, the federal government has begun sharing personal information from health programs such as Medicaid with agencies like the Department of Homeland Security (DHS) and Department of Health and Human Services (HHS) in ways that violate long-standing privacy norms and increase risk for immigration enforcement (2); and

WHEREAS, health care facilities have historically been considered safe spaces, free from immigration enforcement actions, but recent narrowing of "sensitive locations" protections by DHS challenge these norms (4,5); and

WHEREAS, immigration enforcement actions at or near health care facilities create fear, discourage patients from seeking care, including routine check-ups, vaccinations, medication refills, prenatal care, or urgent evaluation, and undermine the physician-patient relationship; and

WHEREAS, national survey data show that 31% of immigrants report immigration-related fears negatively affecting their health, with 20% reporting disruptions to eating or sleeping and 31% reporting worsened anxiety (3,6,7); and

WHEREAS, family physicians serve immigrant and refugee communities daily, many of whom struggle with limited or nonexistent insurance coverage, and communities are safer and healthier when all individuals have access to care (8); and

WHEREAS, a policy very similar to that proposed here was adopted at the California Medical Association 154th Annual Session (Actions of 2025 House of Delegates, 10/28/25);

RESOLVED: That the CAFP strongly opposes the federal government sharing Medicaid enrollees' personal information with government entities outside of the Department of Health and Human Services (HHS) for the purpose of immigration enforcement; and

RESOLVED: That the CAFP supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients; and

RESOLVED: That the CAFP opposes law enforcement stirring fear in immigrant communities and raiding clinics, hospitals, physicians' offices, or other locations that provide medical care causing patients and family members to not seek care or have routine check-ups, vaccinations, refill medications, procedures and surgeries; these actions undermine the physician-patient relationship and erode trust in our health care system; and

RESOLVED: That the CAFP supports designating healthcare facilities and associated property

(including but not limited to parking structures, sidewalks, entrances, patient drop-off zones, and any facility-owned or leased adjacent buildings used for patient care) as protective access zones, defined as locations where immigration enforcement activities (including surveillance, arrests, or detentions of individuals seeking care) are prohibited, in order to ensure patients and visitors can safely access medical services without fear; and

RESOLVED: That the CAFP opposes the presence of Immigration and Customs Enforcement (ICE) at healthcare facilities and associated property (including parking structures); and

RESOLVED: That the CAFP opposes any requirements for physicians and healthcare systems to ask for immigration status or to report undocumented individuals (9)

Equity Impact Score: 8/9

Problem Statement: Recent policy changes at the federal level have created new and unprecedented challenges to health access for immigrants' access to health care, and the federal government has begun sharing personal information from health programs such as Medicaid with agencies like the Department of Homeland Security (DHS) and Department of Health and Human Services (HHS) in ways that violate long-standing privacy norms and increase risk for immigration enforcement

Problem Universe: Immigrants who are vulnerable to this discrimination and these attacks can be found at all health care settings where family physicians are practicing.

Specific Solution: Oppose the federal government sharing Medicaid enrollees' personal information with government entities outside of the Department of Health and Human Services (HHS) for the purpose of immigration enforcement;

Support designating healthcare facilities and associated property as protective access zones; and

Oppose any requirements for physicians and healthcare systems to ask for immigration status or to report undocumented individuals.

Evidence:

Citations:

1. Health Care System Reform EXT. California Academy of Family Physicians. Kaiser Family Foundation (KFF). "CMS Plans to Share Data with ICE Could Exacerbate Immigrant Families' Fears About Accessing Health Coverage and Care." Published 11/21/2025. https://www.kff.org/quick-take/cms-plans-to-share-data-with-ice-could-exacerbate-immigrant-families-fears-about-accessing-health-coverage-and-care/?utm_source=chatgpt.com
2. New York Times. "Migrants Are Skipping Medical Care, Fearing ICE, Doctors Say." Published 5/9/2025. <https://www.nytimes.com/2025/05/08/health/migrants-health-care-trump.html>
3. National Immigration Law Center (NILC). "Factsheet: Trump's Rescission of Protected Areas Policies Undermines Safety for All." Published 2/26/2025. <https://www.nilc.org/resources/factsheet-trumps-rescission-of-protected-areas-policies-undermines-safety-for-all/>
4. U.S. Immigration and Customs Enforcement (ICE). "Sensitive Locations Policies and Updates." Last accessed 1/20/2025. <https://www.ice.gov/about-ice/ero/protected-areas>
5. Physicians for Human Rights. "ICE Tactics and Deportation Fears Limit Access to Health Care for Children of Immigrants: Survey." Published 11/19/2025. https://phr.org/news/ice-tactics-and-deportation-fears-limit-access-to-health-care-for-children-of-immigrants-survey/?utm_source=chatgpt.com
6. Medical Care. "Beyond 'Chilling Effects': Latinx and Asian Immigrants' Experiences With Enforcement and Barriers to Health Care." Published 3/20/2023.

https://journals.lww.com/lww-medicalcare/abstract/2023/05000/beyond_chilling_effects_latinx_and_asian.7.aspx

7. Health Policy / General Statement #5/7 Principle. California Academy of Family Physicians.
8. Immigration Issues / ICE INT (7/18 Board of Directors). California Academy of Family Physicians.

Speaker's Notes: The California Academy of Family Physicians (CAFP) has policy 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 immigration status. CAFP policy opposes requirements that physicians report undocumented individuals. CAFP has policy protecting sensitive medical information from inadvertent sharing across state lines.

CAFP recently partnered with other organizations to develop and disseminate the Healthy Harbors guide. *Healthy Harbors* is a practical guide for family physicians, clinics, and health care teams navigating the intersection of immigration policy and patient care. This document offers actionable strategies to protect patient privacy, prepare for enforcement encounters, and create welcoming, informed clinical environments.

AAFP has policy on patient confidentiality, which emphasizes the essential nature of the confidential relationship between physician and patient for effective care. The AAFP policy underscores that medical information is privileged and should remain confidential, with disclosure only permitted with patient and physician authorization or as required by law. The AAFP also highlights the importance of protecting patient privacy to maintain trust and open communication, which is critical for immigrant patients who may fear discrimination or deportation. The AAFP's broader stance on confidentiality supports minimizing documentation of immigration status in medical records to protect patients from potential harm, consistent with ethical principles of beneficence and nonmaleficence.

Speaker's Fiscal Notes: 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.

The cost of advocating on issues outside of CAFP's expertise would be moderate to significant, as it would include significant staff time, research, and potentially utilizing consultants and others external to CAFP. It could also require hiring advocates as it may be outside the parameters of our current lobbying contract.

Committee Recommendation on Resolution A-21-26

2026 Report of the CAFP Justice, Equity, Diversity and Inclusion (JEDI) Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP JEDI Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-21-26: Protect Confidentiality and Access to Care for Immigrant Patients

RESOLVED: That the CAFP strongly opposes the federal government sharing Medicaid enrollees' personal information with government entities outside of the Department of Health and Human Services (HHS) for the purpose of immigration enforcement; and

RESOLVED: That the CAFP supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients; and

RESOLVED: That the CAFP opposes law enforcement stirring fear in immigrant communities and raiding clinics, hospitals, physicians' offices, or other locations that provide medical care causing patients and family members to not seek care or have routine check-ups, vaccinations, refill medications, procedures and surgeries; these actions undermine the physician-patient relationship and erode trust in our health care system; and

RESOLVED: That the CAFP supports designating healthcare facilities and associated property (including but not limited to parking structures, sidewalks, entrances, patient drop-off zones, and any facility-owned or leased adjacent buildings used for patient care) as protective access zones, defined as locations where immigration enforcement activities (including surveillance, arrests, or detentions of individuals seeking care) are prohibited, in order to ensure patients and visitors can safely access medical services without fear; and

RESOLVED: That the CAFP opposes the presence of Immigration and Customs Enforcement (ICE) at healthcare facilities and associated property (including parking structures); and

RESOLVED: That the CAFP opposes any requirements for physicians and healthcare systems to ask for immigration status or to report undocumented individuals (9)

Committee Recommendation: ADOPT

RESOLVED: That the CAFP opposes any requirements for physicians and healthcare systems to ask for immigration status or to report undocumented individuals

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP supports protections that prohibit sharing or utilizing information from medical records or insurance enrollee information with immigration or other law enforcement agencies to pursue immigration enforcement actions against patients

RESOLVED: That the CAFP opposes the presence of immigration authorities at healthcare settings and associated property (including parking structures) unless they are there to bring an individual to seek medical care.

Committee Discussion: The JEDI Committee is in general strong support of this resolution. It is aligned with current policy and practice and introduces new policy on a timely issue. The committee felt the first two resolved statements could be effectively combined into one statement and propose to Adopt as Amended above. The committee also removed references to federal agencies, as that is outside the scope of the state chapter.

The committee understood the sentiment of the third and fourth resolved statements, though finds them overly directive. The committee believes these two statements can be effectively covered in the proposed Amended language for the fifth resolved statement, as above. The committee again removed references to federal agencies, propose expanding healthcare facilities to “settings” (to accommodate street medicine units, etc.) and add exceptions for an individual being brought in for care.

Resolution A-22-26

Proposed Policy Title: Protecting Health Care as a Human Right Regardless of Immigration Status

Author: Michelle Crespo, MD

Co-Authors: None

Endorsed by: None

Whereas, the American Academy of Family Physicians recognizes health care as a basic human right for every person, and the California Academy of Family Physicians (CAFP) has consistently supported universal access to comprehensive, high-quality health care regardless of immigration status; and

Whereas, recent California budget actions freeze or limit full-scope Medi-Cal enrollment for undocumented adults, eliminate selected benefits such as dental services, and introduce new premiums based on immigration status, which restricts access to essential health services for many of our patients; and

Whereas, cuts and barriers to Medi-Cal coverage for undocumented adults will disproportionately harm low-income communities and communities of color, worsen existing health inequities, and shift care from preventive and primary care settings into more costly emergency and inpatient care;

RESOLVED: That the California Academy of Family Physicians reaffirm that health care is a human right for all people, regardless of immigration status, and oppose any legislation, regulations, or budget proposals that restrict access to health insurance coverage or medically necessary health services based on immigration status, and advocate for the protection and expansion of Medi-Cal and other publicly funded health programs for all Californians, regardless of immigration status.

Equity Impact Score: 7/9

Problem Statement: California's current budget and trailer bill changes include freezing new full-scope Medi-Cal enrollment for undocumented adults in 2026 and eliminating certain benefits including dental coverage. These changes conflict with CAFP and AAFP policy that health care is a basic human right regardless of immigration status and will create barriers to essential care for many patients.

Problem Universe: Many CAFP members care for significant numbers of Medi-Cal patients in community settings, a significant proportion of whom are undocumented and recently were included in Medi-Cal access expansion, estimated at around 700,000 adults per one source. Proposed changes to current Medi-Cal eligibility in California therefore will affect hundreds of thousands of current and future patients of CAFP members, especially those in low-income and immigrant communities.

Specific Solution: The resolution asks CAFP to: 1. Reaffirm that health care is a human right for all people, regardless of immigration status; 2. Formally oppose any legislation, regulations, or state budget proposals that restrict access to health insurance or medically necessary services on the basis of immigration status; and 3. Advocate for the protection and expansion of Medi-Cal and other similar programs to ensure that all income-eligible patients can receive comprehensive, affordable care.

Evidence: AAFP policy on the health impacts of immigration states that immigration policies that deny basic human rights limit access to primary care services. Recent Medi-Cal changes that affect undocumented adults are published on the DHCS website which include freezing new Medi-Cal enrollment for undocumented adults, ending dental coverage for adults with unsatisfactory

immigration status, and add monthly premiums in 2027. Updated CAFP policy is needed to explicitly connect CAFP's stance in the right of health care to all to Medi-Cal funding and eligibility decisions based on immigration status, and to give CAFP clear guidance to advocate against laws and budget proposals that restrict coverage for undocumented adults.

Citations:

1. <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/medi-cal-changes.aspx>
2. <https://www.chcf.org/wp-content/uploads/2024/06/MediCalFactsFiguresAlmanac08052024.pdf>
3. <https://apnews.com/article/california-budget-deficit-immigrant-health-care-medicaid-5f45a2bfc47750ec5736f5d326557247>
4. <https://caimmigrant.org/wp-content/uploads/2025/01/H4A-Medi-Cal-Expansion-Report-FINAL.pdf>

Speaker's Notes: CAFP and AAFP both have existing policy affirming the belief that all people deserve access to health care regardless of immigration status. In addition, CAFP has policy that supports the extension of eligibility for full scope Medi-Cal benefits to undocumented immigrants.

Ensuring access to care for all individuals aligns with CAFP's 2025-2027 Strategic Plan, particularly in advancing health equity and supporting comprehensive patient-centered care. CAFP opposes policies requiring physicians to report undocumented individuals, such as measures that conflict with the mission and ethical responsibilities of health care providers.

CAFP has been a strong advocate for expanding access to health care for immigrant communities and has consistently supported legislation aimed at removing barriers to coverage. For example, during the 2023-2024 legislative session, CAFP opposed AB1012, which proposed removing Medi-Cal eligibility for individuals without "satisfactory immigration status".

Speaker's Fiscal Notes: There would be little to no costs associated with affirming a particular policy perspective. Supporting or opposing legislation or regulations that affect access to health care for undocumented immigrants would have minimal costs as it would fall within established procedures for updating and taking positions on proposed policy and legislation. There could be more significant costs if a greater level of engagement is required.

Committee Recommendation on Resolution A-22-26

2026 Report of the CAFP Justice, Equity, Diversity and Inclusion (JEDI) Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP JEDI Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-22-26: Protecting Health Care as a Human Right Regardless of Immigration Status

RESOLVED: That the California Academy of Family Physicians reaffirm that health care is a human right for all people, regardless of immigration status, and oppose any legislation, regulations, or budget proposals that restrict access to health insurance coverage or medically necessary health services based on immigration status, and advocate for the protection and expansion of Medi-Cal and other publicly funded health programs for all Californians, regardless of immigration status.

Committee Recommendation: AFFIRM AS EXISTING POLICY

Committee Discussion: The JEDI Committee affirmed that this is a significant and timely issue for family medicine but that it is already covered by existing CAFP policy, as noted in the Speaker Notes. As such, the committee recommends affirming as existing policy.

Committee Report – Legislative Affairs Committee (LAC)

2026 Report of the CAFP Legislative Affairs Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing **and** subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Legislative Affairs (LAC) Committee has considered the following resolution referred to it and submits the following report.

- A-23-26: The Dementia Gap
- A-24-26: Increasing State Investment to Expand Home and Community Based Alternative Waiver Program
- A-25-26: Advancing Patient Partnership in CAFP Health Policy Development and Advocacy
- A-26-26: Ensuring the availability and affordability of H-1B visas for primary care physicians
- A-27-26: Opposing the Expansion of SNAP Work Requirements
- A-28-26: Oppose work requirements for Medicaid Medi-Cal
- A-29-26: Support Full-scope Medi-Cal access for Californians, regardless of immigration status
- A-30-26: Preserving Continuous Full-Scope Medi-Cal Coverage for All Income-Eligible Adults
- A-31-26: Development of Updated Medical Student Loan Education Resources
- A-32-26: CAFP supports affordable medical education for students from low social economic backgrounds

(Original) Resolution # A-23-26: The Dementia Gap

RESOLVED: That the CAFP advocate for state legislation to create an "Emergency Neuro-Behavioral Stabilization Hold" (distinct from 5150) that authorizes acute care hospitals to detain incapacitated dementia patients with severe behavioral disturbances for up to 96 hours while an expedited Public Guardian investigation occurs; and be it further

RESOLVED: That the CAFP lobby the Department of Health Care Services (DHCS) to incentivize and license "Neuro-Behavioral Skilled Nursing Facilities" in rural and underserved regions, specifically designed to accept involuntary patients with dementia who require secure perimeters but do not meet criteria for acute inpatient psychiatry.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP supports measures that create processes (including involuntary holds) for hospitals and other acute care settings to provide support to patients who lack capacity and are unable to care for themselves due to dementia.

RESOLVED: That the CAFP support incentivizing the establishment of "Neuro-Behavioral Skilled Nursing Facilities" in rural and underserved regions, specifically designed to accept involuntary patients with dementia who require secure perimeters but do not meet criteria for acute inpatient psychiatry.

Committee Discussion: The LAC supports the overall spirit of the resolution. While the Committee acknowledged that current CAFP policy does not directly address this issue, it also noted that policy is not intended to direct organizational activities or generally be too specific. The proposed amendments changed the language in both resolved statements to indicate general support for

concepts and policies instead of directing the CAFP to advocate or lobby for specific legislation or regulatory changes.

(Original) Resolution # A-24-26: Increasing State Investment to Expand Home and Community Based Alternative Waiver Program (HCBA) Capacity and Access

RESOLVED: That the CAFP will actively increase advocacy efforts at the local and national level, including lobbying efforts to expanding HCBA Waiver capacity and ensure timely access for medically complex Californians; and

RESOLVED: That CAFP advocate for policies that strengthen equitable access to HCBS statewide, ensuring that disabled individuals, older adults, and medically fragile patients can safely remain in their homes and communities.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP supports ensuring full access to Home- and Community-Based Services (HCBS) services for Californians at need so disabled individuals, older adults, and medically fragile people can safely remain in their homes and communities and avoid residing in nursing homes when needed.

Committee Discussion: The LAC Committee recognizes the importance of this topic, especially at a time when Medicaid funding is limited due to federal cuts, causing strain on the state budget to fill in critical gaps. The committee agrees that funding for home and community-based services is critical for serving individuals in the least-restrictive environment and helping to alleviate overcrowding in skilled nursing facilities. The Committee also noted that policy is not intended to direct organizational activities but rather convey the CAFP's specific stance on different issues. To address these considerations the Committee recommended combining both resolved statements into one statement with additional amendments to the language to make the resolution less directive and more consistent with other CAFP policy.

(Original) Resolution # A-25-26: Advancing Patient Partnership in CAFP Health Policy Development and Advocacy

RESOLVED: That the California Academy of Family Physicians (CAFP) implement meaningful patient partnership with family physicians in policy development and advocacy for CAFP Lobby Day and related activities such as joint physician-patient visits with legislators, patient-informed message development, or patient testimony.

RESOLVED: That CAFP develop and implement a structured, equitable strategy to recruit, support, and engage patient participants that are reflective of California's diverse population, with intentional outreach to historically underrepresented and marginalized communities, for participation in AMAM advocacy activities.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP explore implementation of meaningful patient partnership with family physicians in policy development and advocacy.

Committee Discussion: The committee appreciated the spirit of the resolution but was concerned that the original resolved statements were too directional about how CAFP conducts advocacy activities. The committee acknowledged the CAFP's existing engagement with patient advocacy groups in its advocacy operations. Committee members acknowledged that the policy compendium includes many issues that directly affect patient issues, and the CAFP staff must consider many factors when determining how to engage with patients depending on the issue. There were also questions about whether it was feasible to include patients in CAFP's Lobby Day because the issues are often focused on non-patient issues. Overall, the committee felt that the

resolved statements were too directional about how CAFP conducts advocacy. The committee decided to amend the resolution to encourage meaningful partnership with patients in policy and advocacy without directing CAFP to specifically engage patients in Lobby Day.

(Original) Resolution # A-26-26: Ensuring the Availability and Affordability of H-1B Visas for Primary Care Physicians

RESOLVED: That the American Academy of Family Physicians (AAFP) opposes financial barriers (including excessive fees) for current and future physicians to obtain an H-1B visa to train in or practice medicine;

RESOLVED: That the American Academy of Family Physicians (AAFP) shall continue to advocate with federal policymakers to remove the new H-1B visa financial fee for foreign-trained physicians, researchers, and trainees, ensuring unfettered access to care nationwide.

Committee Recommendation: AFFIRM AS EXISTING POLICY

Committee Discussion: The committee affirmed that this is a significant issue for family medicine but emphasized that the topic is a federal policy best addressed by AAFP. In addition, the committee acknowledged work that has already been done by AAFP to advocate against the H-1B visa fee. Due to AAFP's existing work on this issue, the committee recommended that this policy be affirmed as existing policy.

(Original) Resolution # A-27-26: Opposing the Expansion of SNAP Work Requirements

RESOLVED: That the California Academy of Family Physicians (CAFP) opposes the expansion of SNAP work requirements that reduce access to food assistance, which will directly affect vulnerable California families; and be it further

RESOLVED: That CAFP support family physicians in addressing food insecurity by promoting validated screening tools, providing centralized resources, and integrating food insecurity screening and referral education into its online education.

RESOLVED: That CAFP update its policy statements to explicitly recognize access to healthy and culturally appropriate food as a core component of health equity, and to support advocacy, clinical practices, and community partnerships that promote reliable access to nutritious food for all patients.

Committee Recommendation: ADOPT:

RESOLVED: That the CAFP opposes the expansion of SNAP work requirements that reduce access to food assistance, which will directly affect vulnerable California families; and be it further

RESOLVED: That the CAFP update its policy statements to explicitly recognize access to healthy and culturally appropriate food as a core component of health equity, and to support advocacy, clinical practices, and community partnerships that promote reliable access to nutritious food for all patients.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP, put forward a resolution to the AAFP to oppose the expansion of SNAP work requirements that reduce access to food assistance, which will directly affect vulnerable California families; and be it further

Committee Discussion: The committee was in support of the general spirit of the resolution. Committee members voted to adopt the first and third resolved but acknowledged that the second resolved was generally already covered by existing CAFP policy on food insecurity screening tools. There were also concerns related to whether or not it was appropriate for policy to direct CAFP to develop specific online education resources. Given that many work requirement policies originate from the federal level, the committee also recommended the amended resolution to refer to AAFP for national action.

(Original) Resolution # A-28-26: Oppose Work Requirements for Medicaid/Medi-Cal

RESOLVED: CAFP opposes work, community service and education requirements for individuals to qualify for Medicaid, as it is a deterrent/roadblock for individuals to access care and may lead to more individuals becoming uninsured.

Committee Recommendation: ADOPT

Committee Discussion: The committee determined that this Resolution was consistent with CAFP policy related to reducing barriers to coverage for patients. The committee acknowledged AAFP and CAFP's existing advocacy efforts on this topic but determined that explicit policy should be adopted to confirm our opposition to Medicaid work requirements.

(Original) Resolution # A-29-26: Support Full-Scope Medi-Cal Access for Californians, Regardless of Immigration Status

RESOLVED: That the CAFP shall support full access to Medi-Cal (including dental coverage) for all income-eligible Californians, regardless of immigration status; and

RESOLVED: That the CAFP shall oppose policies that set different access or cost based on immigration status.

Committee Recommendation: ADOPT

RESOLVED: That the CAFP shall support full access to Medi-Cal (including dental coverage) for all income-eligible Californians, regardless of immigration status.

Committee Discussion: The committee acknowledged that CAFP has existing policy supporting full-scope Medi-Cal access for all Californians, but that our current policy did not explicitly call out dental coverage. The committee recommends adopting the first resolved because of the inclusion of dental, and to affirm the second resolved as existing policy.

(Original) Resolution # A-30-26: Preserving Continuous Full-Scope Medi-Cal Coverage for All Income-Eligible Adults

RESOLVED: That CAFP advocate to the California Legislature for the preservation of continuous full-scope Medi-Cal coverage for all income-eligible adults regardless of immigration status; and be it further

RESOLVED: That CAFP oppose legislative or administrative actions that freeze enrollment, reduce benefits, or otherwise disrupt access to primary, preventive, and chronic disease care for all individuals living in California.

Committee Recommendation: AFFIRM AS EXISTING POLICY

Committee Discussion: The committee determined CAFP has existing policy supporting full-scope Medi-Cal coverage for all income-eligible adults regardless of immigration status. This policy is

already sufficient to direct CAFP to advocate for legislative or administrative actions to expand coverage or oppose enrollment freezes.

(Original) Resolution # A-31-26: Development of Updated Medical Student Loan Education Resources

RESOLVED: That the California Academy of Family Physicians curates and oversees dissemination of updated, accessible educational resources—such as short guides, webpages, or explainer videos—on federal and state medical education loan programs and repayment options to California medical students (via website, student communications, chapter-level outreach, etc.); and be it further

RESOLVED: That the California Academy of Family Physicians establish a process to review and update these educational resources regularly in response to significant federal or state loan policy changes; and be it further

RESOLVED: That the California Academy of Family Physicians collaborate with financial aid specialists, policy experts, or relevant organizations to advocate for reinstating student health professional loan support to the United States Congress.

Committee Recommendation: AFFIRM AS EXISTING POLICY

Committee Discussion: The committee noted that the first and second resolved statements are being addressed through CAFP's current practice of providing and distributing updates to members, including information on student loan repayment. The discussion of the third resolved statement acknowledged that the issue is already addressed by existing AAFP policy. While some concern was raised that the priorities and programs change frequently, and that AAFP policy is specific to federal loans, the committee agreed that the challenge lies in directing members to existing up to date resources rather than creating new policy or duplicative materials.

(Original) Resolution # A-32-26: CAFP Supports Affordable Medical Education for Students from Low Social Economic Backgrounds

RESOLVED: That the California Academy of Family Physicians supports legislation that opposes a federal loan borrowing limit in order to increase the number of medical students who choose primary care specialties and reduce socioeconomic disparities in healthcare.

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

Committee Recommendation: AFFIRM AS EXISTING POLICY

Committee Discussion: The committee noted that AAFP is responsible for federal advocacy. It was also noted that AAFP has already submitted letters consistent with the intent of the resolution. The committee discussed the potential to address state-administered loan programs if the resolved statement were amended accordingly but did not want to move away from the author's intent.

Resolution A-23-26

Proposed Policy Title: The Dementia Gap

Author: Landin Hagge, DO

Co-Authors: None

Endorsed by: None

Whereas, California's Lanterman-Petris-Short (LPS) Act is frequently interpreted by County Behavioral Health departments to exclude "Major Neurocognitive Disorders" (Dementia) from involuntary holds (5150), citing them as non-psychiatric medical conditions; and

Whereas, Acute care hospitals and standard skilled nursing facilities often lack the legal authority, staffing ratios, and physical security (locked perimeters) to safely manage patients exhibiting severe aggression, elopement, or combative behaviors without a conservatorship—a process that often faces critical delays; and

Whereas, Recent legislation (SB 43) expanded the definition of "Gravely Disabled" to include inability to provide for personal safety or medical care, yet failed to allocate funding or create licensing for the specific facilities required to house and treat this population; and

Whereas, This regulatory and infrastructure gap leaves patients with dementia and acute psychosis with no safe disposition, forcing physicians to discharge them to unsafe home environments where they pose an immediate safety risk to themselves and their caregivers

RESOLVED: That the CAFP advocate for state legislation to create an "Emergency Neuro-Behavioral Stabilization Hold" (distinct from 5150) that authorizes acute care hospitals to detain incapacitated dementia patients with severe behavioral disturbances for up to 96 hours while an expedited Public Guardian investigation occurs; and be it further

RESOLVED: That the CAFP lobby the Department of Health Care Services (DHCS) to incentivize and license "Neuro-Behavioral Skilled Nursing Facilities" in rural and underserved regions, specifically designed to accept involuntary patients with dementia who require secure perimeters but do not meet criteria for acute inpatient psychiatry.

Equity Impact Score: Inconclusive

Problem Statement: This resolution seeks to solve the "Dementia Gap" (also known as the LPS Gap)—a systemic failure where patients with Major Neurocognitive Disorders (Dementia) and acute behavioral instability fall between the regulatory silos of Mental Health and Medical Care.

1. The Legal Gap: Despite the expansion of "Gravely Disabled" under SB 43, many County Behavioral Health departments continue to decline 5150 holds for dementia patients, citing their condition as a "medical/organic" diagnosis rather than a primary psychiatric disorder.
2. The Facility Gap: Acute Care Hospitals and standard Skilled Nursing Facilities (SNFs) lack the legal licensure and physical infrastructure (secured perimeters/locked units) to detain patients who are wandering or combative but do not meet criteria for Inpatient Psychiatry.

This results in "placement paralysis," where Family Physicians are liable for patients they cannot legally hold but cannot safely discharge. This resolution addresses the urgent need for a dedicated "Neuro-Behavioral" designation for both legal holds and facility licensing to protect this vulnerable population.

Problem Universe: Direct Impact: This issue affects virtually all 10,000+ CAFP members, particularly those providing emergency, hospital, or long-term care services in safety-net settings.

Patient Impact: In California, there are approximately 720,000 individuals aged 65+ living with Alzheimer's or related dementias (2025 data). Clinical data indicates that 35-50% of these patients (approx. 250,000 - 360,000 individuals) will experience severe behavioral disturbances (agitation, aggression, psychosis) during their disease course.

Systemic Burden: These patients account for disproportionately high emergency department utilization and "administrative boarding" days. In rural counties, where specialized psychiatric resources are scarce, 100% of family physicians functioning as the safety net are impacted by this gap.

Specific Solution: I propose that the CAFP take the following specific actions:

1. **Sponsor State Legislation:** CAFP shall advocate for the creation of a statutory "Emergency Neuro-Behavioral Stabilization Hold" (distinct from Welfare & Institutions Code 5150). This mechanism would authorize acute care hospitals/EDs to detain incapacitated dementia patients who present an imminent danger to self/others for up to 96 hours to allow for medical stabilization and expedited conservatorship investigation.
2. **Advocate for Facility Licensing:** CAFP shall lobby the Department of Health Care Services (DHCS) to create a specific licensure designation and enhanced reimbursement rate for "Neuro-Behavioral Skilled Nursing Facilities." This aims to incentivize the creation of secured-perimeter (locked) beds in rural/underserved areas for patients rejected by standard SNFs.
3. **Establish Liability Protections:** CAFP shall advocate for "Good Faith" legal protections for physicians and hospitals that detain incapacitated, high-risk dementia patients under the proposed hold to ensure they are shielded from liability for false imprisonment when acting to prevent immediate harm.

Evidence:

1. **Legislative Implementation Failure:** While Senate Bill 43 (2023) attempted to expand conservatorship criteria, the California State Association of Counties reports that 56 out of 58 counties deferred implementation until 2026 due to lack of infrastructure.
2. **Clinical Epidemiology:** Studies in JAMA Network Open and the Journal of Alzheimer's Disease indicate that over 90% of dementia patients will experience Behavioral and Psychological Symptoms of Dementia (BPSD), with 30-50% exhibiting severe aggression.
3. **Emergency Department Crisis:** The California Hospital Association documents that patients with behavioral needs wait 10-30 times longer for beds than medical patients.
4. **Rural Disparity:** California Health Care Foundation data shows a near-zero availability of "Geriatric Psych" beds in rural Northern California, leaving family physicians with no safe disposition options.

Citations:

1. **SB 43 Deferral:** California State Association of Counties (CSAC), "SB 43 Implementation Survey Results," Jan 2024. (Noting 56/58 counties delayed).
2. **Prevalence of Aggression:** Kales HC, et al. "Assessment and Management of Behavioral and Psychological Symptoms of Dementia." *BMJ*. 2015;350:h369. (Citing the high prevalence of aggression).
3. **ER Boarding:** "California's Acute Psychiatric Bed Loss." California Hospital Association Center for Behavioral Health, Report 2023.

Speaker's Notes: This resolution highlights a real and growing care gap for patients with dementia who experience severe behavioral symptoms and cycle through EDs, inpatient units, and skilled nursing facilities. The proposed solutions, however, require major new state infrastructure, licensing, and involuntary treatment policy changes and would likely be costly and operationally complex, limiting feasibility for CAFP-led advocacy beyond high-level support and Academy policy positions addressing these issues.

Neither CAFP or AAFP have policy that acknowledges the lack of regulatory and infrastructure support for patients with dementia that are temporarily detained or placed under conservatorship.

AAFP does regularly publish clinical articles for family physicians that include guidance on dementia care and clinical practice guidelines. These educational and clinical resources reflect best practices for family physicians when managing dementia care and coordinating with long term care facilities.

Speaker's Fiscal Notes: There would be minimal cost for supporting legislation sponsored by others that authorized acute care hospitals to detain incapacitated dementia patients. There would 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 and lobbying DHCS would require staff time for research, assessing the policy and political environment, and drafting regulatory comments. Staff may also need to consult other organizations. If engagement goes beyond a written response to include language negotiation, testifying, and stakeholder meetings, costs would increase significantly.

Committee Recommendation on Resolution A-23-26

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RESOLVED: That the CAFP lobby the Department of Health Care Services (DHCS) to incentivize and license "Neuro-Behavioral Skilled Nursing Facilities" in rural and underserved regions, specifically designed to accept involuntary patients with dementia who require secure perimeters but do not meet criteria for acute inpatient psychiatry.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP supports measures that create processes (including involuntary holds) for hospitals and other acute care settings to provide support to patients who lack capacity and are unable to care for themselves due to dementia.

RESOLVED: That the CAFP support incentivizing the establishment of "Neuro-Behavioral Skilled Nursing Facilities" in rural and underserved regions, specifically designed to accept involuntary patients with dementia who require secure perimeters but do not meet criteria for acute inpatient psychiatry.

Committee Discussion: The LAC supports the overall spirit of the resolution. While the Committee acknowledged that current CAFP policy does not directly address this issue, it also noted that policy is not intended to direct organizational activities or generally be too specific. The proposed amendments changed the language in both resolved statements to indicate general support for concepts and policies instead of directing the CAFP to advocate or lobby for specific legislation or regulatory changes.

Resolution A-24-26

Proposed Policy Title: Increasing State Investment to Expand Home- and Community-Based Alternative Waiver Program (HCBA) Capacity and Access

Author: Adrian Garcia, MD

Co-Authors: Diana Howard, MD

Endorsed by: CAFP Fresno-King-Madera Chapter

Whereas, California's Home- and Community-Based Services (HCBS) system provides essential long-term support to a large portion of the state's medically fragile, disabled, and older adult populations, including more than 800,000 individuals receiving personal care through In-Home Supportive Services (IHSS), over 124,000 enrolled in growing Medi-Cal Community Supports programs, and more than 2 million Medi-Cal beneficiaries overall who rely on HCBS and long-term services and supports to remain safely in their homes and communities; (1)

Whereas, Home- and Community-Based Alternative Services (HCBA) programs constitute a critical component of California's long term care system, it allows medically complex, disabled, and chronically ill Californians to sustain living community and avoid premature hospitalization, as July 2025 having 9,593 enrollment and 5,608 persons in the waitlist (1); and

Whereas, inadequate access to preventive, primary, and specialty care leads to avoidable suffering and costs, reflected in more than 240,000 potentially preventable hospitalizations in California in 2022 and over \$3.5 billion in annual spending that could be reduced through stronger outpatient and; (2,3)

Whereas, family physicians play a central role in caring for medically complex patients conducting medical evaluations, developing plans of treatment, coordinating interdisciplinary services, and advocating for access to Home- and Community-Based Services (HCBS), including the HCBA Waiver, but often face systemic barriers when these programs are underfunded, understaffed, or closed to new enrollment; and

Whereas, expanding HCBA capacity aligns with CAFP's strategic priorities to champion health equity, support vulnerable populations, prevent unnecessary hospitalization, and improve access to cost-effective, community-based care;

RESOLVED: That the CAFP will actively increase advocacy efforts at the local and national level, including lobbying efforts to expanding HCBA Waiver capacity and ensure timely access for medically complex Californians; and

RESOLVED: That CAFP advocate for policies that strengthen equitable access to HCBS statewide, ensuring that disabled individuals, older adults, and medically fragile patients can safely remain in their homes and communities.

Equity Impact Score: 7/9

Problem Statement: Many medically complex, disabled, and chronically ill Californians who qualify for home- and community-based long-term care — such as through the Home and Community-Based Alternatives Waiver (HCBA Waiver) — are unable to access needed services because program enrollment is capped and wait-lists are long. As a result, vulnerable patients may remain institutionalized, experience unnecessary hospitalizations, or lack adequate supports to safely remain in their homes. Family physicians and primary-care providers, who frequently coordinate care for these patients, face significant difficulty delivering continuity, safe discharge planning, and home-based care when waiver capacity is limited.

Problem Universe: As of 2024, the HCBA Waiver enrollment cap was 10,774.

- Despite this, as of late 2024, over 5,400 individuals were reportedly waiting for a slot under the waiver due to federal enrollment caps. Assembly Committee on Budget+1
- The waiver reached full capacity and a waiting list was implemented effective July 12, 2023.
- The HCBA Waiver serves medically fragile, often high-need individuals who rely on community-based supports including in-home skilled nursing, personal care, assistive technologies, and care coordination — populations frequently managed by family physicians.
- Given the size of California's Medi-Cal and disabled/elderly populations, this backlog likely affects thousands of Medi-Cal beneficiaries statewide — including a significant portion of patients cared for by family physicians in underserved areas.

Specific Solution: CAFP will actively increase advocacy efforts at the local and national level, including lobbying efforts to expanding HCBA Waiver capacity and ensure timely access for medically complex Californians;

CAFP should advocate for equitable access to HCBS across counties/regions in California, ensuring that socioeconomically disadvantaged, disabled, elderly, and other high-need populations have fair opportunity to enroll.

CAFP should promote increased education and engagement of family physicians about HCBS eligibility, services, and how primary-care teams can support patients through waiver enrollment and care coordination.

Evidence:

1. Wait-list and capacity limitations for HCBA waiver: According to official HCBA Waiver information, new applicants have been placed on a wait-list since July 12, 2023 after the waiver hit maximum capacity.
2. Large number waiting relative to slots available: In 2024, with a cap of 10,774 slots, over 5,400 people were reportedly on the HCBA waiting list — indicating high unmet need.
3. Scope of waiver services and target population The HCBA Waiver provides in-home skilled nursing, personal care, assistive technology, and other supports for individuals at risk of institutionalization — services essential for medically fragile patients to remain at home.
4. Demonstrated benefit of HCBS over institutional care: Research shows that increased HCBS spending is associated with reductions in institutional Medicaid long-term care (LTSS) spending and fewer nursing home residents, indicating cost and care-setting benefits.

Citations:

1. <https://www.chcf.org/wp-content/uploads/2025/01/HomeCommunityBasedAltsWaiverCalAIMCommunitySupports2025.pdf>
2. https://cpehn.org/assets/uploads/2025/05/Preventable_Hospitalizations_Report_042025_UPD_ATED.pdf
3. Volume of home- and community-based Medicaid waiver services and risk of hospital admissions – PubMed

Speaker's Notes: CAFP policy related to HCBS states, “The CAFP opposes any and all attempts to cut federal Medicaid funding, both with respect to the Community First Choice State Plan Option, Medicaid funds to people with disabilities receiving Home and Community-Based Services and the broader Medicaid Program.”

The AAFP does not have policy that specifically relates to Medicaid's Home and Community-Based Services Benefit, but does have policy supporting the development of federal policy for long-term care, including home health care, that includes both public and private financing.

CAFP policy opposes cuts to HCBS and recommends that CAFP advocate for expansion and strengthening of HCBS services at the local and national level. This is consistent with CAFP's general support for policies that expand access to care and sustain funding for Medi-Cal and other programs that support medically fragile or other vulnerable populations.

Expanding access to home and community-based services is consistent with CAFP's strategic goals of advancing health system transformation and championing public health, health equity, and evidence-based medicine.

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

Likewise, supporting regulation through a support letter would likely have minimal fiscal impact. Providing suggested changes or negotiating specific regulatory elements would require a greater investment related to staff time for research, assessing the policy and political environment, drafting regulatory comments and meeting with relevant stakeholders including staff at the Department of Health Care Services and state lawmakers.

Committee Recommendation on Resolution A-24-26

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RESOLVED: That CAFP advocate for policies that strengthen equitable access to HCBS statewide, ensuring that disabled individuals, older adults, and medically fragile patients can safely remain in their homes and communities.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP supports ensuring full access to Home- and Community-Based Services (HCBS) services for Californians at need so disabled individuals, older adults, and medically fragile people can safely remain in their homes and communities and avoid residing in nursing homes when needed.

Committee Discussion: The LAC Committee recognizes the importance of this topic, especially at a time when Medicaid funding is limited due to federal cuts, causing strain on the state budget to fill in critical gaps. The committee agrees that funding for home and community-based services is critical for serving individuals in the least-restrictive environment and helping to alleviate overcrowding in skilled nursing facilities. The Committee also noted that policy is not intended to direct organizational activities but rather convey the CAFP's specific stance on different issues. To address these considerations the Committee recommended combining both resolved statements into one statement with additional amendments to the language to make the resolution less directive and more consistent with other CAFP policy.

Resolution A-25-26

Proposed Policy Title: Advancing Patient Partnership in CAFPP Health Policy Development and Advocacy

Author: Eushavia Bogan

Co-Authors: Kweku Djan, Cristian Aquino, Maxwell Ho, Anthony Diep Rosas, Monica Gutierrez, Zakiyyah Winston, Melissa Ma, Ananya Somasekar, Kavya Nambiar, Summer Khan, Kevin Grumbach, MD

Endorsed by: None

Whereas, family medicine is grounded in longitudinal, trusting, and whole-person relationships, making patients essential partners in identifying policy priorities that meaningfully affect clinical care, community health, and health system performance, (1) and

Whereas, numerous studies demonstrate that patient engagement improves the quality, relevance, and impact of health system decision-making— including evidence that Patient and Family Advisory Councils (PFACs) enhance care quality, safety, satisfaction, and organizational learning,(2-4) and

Whereas, research on active patient participation in the design, delivery, and evaluation of health systems shows that structurally integrating patient partners into governance and decision-making can improve alignment of health priorities with community needs, enhance accountability, and foster positive relationships, (5) and

Whereas, U.S. based primary care practices report that patient advisory councils contribute to improved primary care workflow, communication, care coordination, and patient-centered innovation, (6-7) and

Whereas, these findings collectively support that patient partnership is effective, feasible, and aligned with primary care's core commitments to continuity, equity, community responsiveness, and shared decision-making, and

Whereas, the California Academy of Family Physicians (CAFP) hosts an annual Lobby Day to advocate for policy solutions that strengthen primary care and improve the health of Californians, yet current processes do not include a structured mechanism for direct patient participation or representation, and

Whereas, CAFPP is committed to advancing health equity and patient-centered care, making the formal integration of patient voices a strategic and values-aligned next step in its advocacy evolution, and

Whereas, including patient voices in CAFPP's advocacy and policy development processes would enhance the credibility and community relevance of CAFPP's positions, align with national trends toward co-production in healthcare, and strengthen policy messages by grounding them in lived experience from diverse California communities.

RESOLVED: That the California Academy of Family Physicians (CAFP) implement meaningful patient partnership with family physicians in policy development and advocacy for CAFPP Lobby Day and related activities such as joint physician-patient visits with legislators, patient-informed message development, or patient testimony.

RESOLVED: That CAFPP develop and implement a structured, equitable strategy to recruit, support, and engage patient participants that are reflective of California's diverse population, with intentional

outreach to historically underrepresented and marginalized communities, for participation in AMAM advocacy activities.

Equity Impact Score: 7/9

Problem Statement: This resolution pertains to all efforts by CAFP to influence health policy, with a primary focus on its flagship advocacy events, the All Member Advocacy Meeting and Lobby Day, and the policy recommendations of the CAFP Task Force on Primary Care for All. Success in advancing the Task Force recommendations for bold reforms like unified financing of primary care will require partnering with patients/community members to ensure the policy is responsive to community as well as family physician priorities and to ensure that policymakers recognize that patients and the public support the CAFP policy recommendations. A structured mechanism for patient partnership is currently absent, creating a gap between policy development and the lived experiences of the communities CAFP serves.

Problem Universe: Virtually all CAFP members and their patients would be affected, as policies advocated for by CAFP helps shape the delivery and experience of primary care for millions of Californians.

Specific Solution: The specific action is to include patients in annual AMAM sessions and in partnering with CAFP members in visits to legislators on annual Sacramento lobbying day.

Evidence: The articles cited provide evidence of the benefit of patient engagement for health care improvement activities and policy development. At the national level, the Primary Care Collaborative (PCC) recently collaborated with Patients 4 Primary Care in producing patient storytelling videos that were shown to kick off meetings with Congressional staff, with PCC leaders reporting that the videos were very effective in grounding the subsequent discussion such that Congressional staff had a better sense of patients' valuing of primary care and desiring policies to better support primary care. This model of "grounding policy in lived experience" is directly transferable to CAFP's advocacy in Sacramento. Furthermore, the core values of family medicine and CAFP's own commitment to community-responsive care provide a strong foundational rationale for this evolution in advocacy practice.

Citations:

1. AAFP. The Speciality of Family Medicine. www.aafp.org. Published 2025. <https://www.aafp.org/about/dive-into-family-medicine/family-medicine-speciality.html>
2. Sharma AE, Knox M, Mleczko VL, Olayiwola JN. The impact of patient advisors on healthcare outcomes: a systematic review. BMC Health Serv Res. 2017;17(1):693. Published 2017 Oct 23. doi:10.1186/s12913-017-2630-4
3. Misra-Hebert AD, Rose S, Clayton C, et al. Implementation of Patient and Family Advisory Councils in Primary Care Practices in a Large, Integrated Health System. J Gen Intern Med. 2019;34(2):190-191. doi:10.1007/s11606-018-4660-y
4. Pomey M, Morin E, Neault C, et al. Patient advisors: How to implement a process for involvement at all levels of governance in a healthcare organization. Patient Experience Journal. 2016;3(2):99-112. doi:10.35680/2372-0247.1134
5. Bombard Y, Baker GR, Orlando E, et al. Engaging patients to improve quality of care: a systematic review. Implement Sci. 2018;13(1):98. Published 2018 Jul 26. doi:10.1186/s13012-018-0784-z
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7. Sharma AE, Angel L, Bui Q. Patient advisory councils: giving patients a seat at the table. *Fam Pract Manag.* 2015;22(4):22-27. <https://www.aafp.org/pubs/fpm/issues/2015/0700/p22.html>

Speaker's Notes: This resolution proposes a new CAFP activity—formal patient partnership in CAFP policy development and advocacy (e.g., Lobby Day and AMAM-related advocacy). The concept could help advance CAFP's strategic objective to prioritize advocacy activities that improve health equity but the RESOLVED clauses are relatively operational and the resolution directs specific activities that would first require staff capacity assessment to determine their feasibility and prioritization relative to other Academy strategic priorities.

CAFP has policy agreeing to identify partners to develop a health reform agenda, including those on the California Primary Care Consortium.

CAFP staff regularly engages with various patient advocacy groups and organizations to further advocacy and policy goals. This includes networking with organizations in pursuit of co-sponsors for legislation and collaborating with various coalitions in collaborations on specific regulatory actions or larger advocacy goals. For example, CAFP's sponsored legislation related to screening for social determinants of health and required CAFP to engage with many organizations to build a coalition to support the bill.

In addition to coalition-building, CAFP is actively working to engage its members in grassroots advocacy efforts. Staff is coordinating outreach to Key Contacts and local chapters to organize a virtual lobby day visits focused on sharing patient stories and advancing our sponsored bill.

Speaker's Fiscal Notes: CAFP committees consider the impact on patients when making recommendations to the Board. Developing a process whereby patient aid in policy development would be a complex undertaking that would be a significant shift into the existing CAFP policy development and research activities. Significant staff resources would be needed to conduct research on appropriate patient groups, develop and maintain patient contact lists, write testimony and talking points with patient perspectives, and ensure representative and diverse patient perspectives.

The development of the Lobby Day Schedule with legislators at AMAM is a significant undertaking for CAFP staff with logistical and scheduling complexity. In order to include patients in Lobby Day activities, significant staff resources would be required to accommodate the schedules of additional people, create additional office visits so group visits do not get too large, and ensure adequate training for patients as well as physicians related to lobbying and how to speak to legislators. This creates additional financial uncertainty related to the capacity of AMAM programming to suit non-physician attendees, including costs of meals, and additional guest capacity.

Committee Recommendation on Resolution A-25-26

2026 Report of the CAFP Legislative Affairs Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Legislative Affairs (LAC) Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-25-26: Advancing Patient Partnership in CAFP Health Policy Development and Advocacy

RESOLVED: That the California Academy of Family Physicians (CAFP) implement meaningful patient partnership with family physicians in policy development and advocacy for CAFP Lobby Day and related activities such as joint physician-patient visits with legislators, patient-informed message development, or patient testimony.

RESOLVED: That CAFP develop and implement a structured, equitable strategy to recruit, support, and engage patient participants that are reflective of California's diverse population, with intentional outreach to historically underrepresented and marginalized communities, for participation in AMAM advocacy activities.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP explore implementation of meaningful patient partnership with family physicians in policy development and advocacy.

Committee Discussion: The committee appreciated the spirit of the resolution but was concerned that the original resolved statements were too directional about how CAFP conducts advocacy activities. The committee acknowledged the CAFP's existing engagement with patient advocacy groups in its advocacy operations. Committee members acknowledged that the policy compendium includes many issues that directly affect patient issues, and the CAFP staff must consider many factors when determining how to engage with patients depending on the issue. There were also questions about whether it was feasible to include patients in CAFP's Lobby Day because the issues are often focused on non-patient issues. Overall, the committee felt that the resolved statements were too directional about how CAFP conducts advocacy. The committee decided to amend the resolution to encourage meaningful partnership with patients in policy and advocacy without directing CAFP to specifically engage patients in Lobby Day.

Resolution A-26-26

Proposed Policy Title: Ensuring the Availability and Affordability of H-1B Visas for Primary Care Physicians

Author: Diana Howard, MD

Co-Authors: None

Endorsed by: CAFP Fresno-Kings-Madera Chapter

Whereas, on September 19, 2025, the President issued a proclamation titled Restriction on Entry of Certain Nonimmigrant Workers requiring a \$100,000 fee for new H-1B petitions filed abroad, unless exempted for “national interest” (1) (White House, 2025);

Whereas, the physician workforce includes more than 10,000 H-1b visa holders nationally(2). In California H-1B physicians play a critical role in filling workforce shortages, particularly in underserved and rural areas (3)

Whereas, California faces some of the nation’s most severe physician shortages, especially in family medicine, where 37 of 58 counties fall below the recommended supply of primary care providers (4,5);

Whereas, restrictions on entry and burdensome financial barriers to recruiting qualified health professionals risk worsening physician shortages, delaying access to care, and exacerbating health inequities in California communities;

RESOLVED: That the American Academy of Family Physicians (AAFP) opposes financial barriers (including excessive fees) for current and future physicians to obtain an H-1B visa to train in or practice medicine;

RESOLVED: That the American Academy of Family Physicians (AAFP) shall continue to advocate with federal policymakers to remove the new H-1B visa financial fee for foreign-trained physicians, researchers, and trainees, ensuring unfettered access to care nationwide.

Equity Impact Score: 9/9

Problem Statement: The new federal requirement imposing a \$100,000 fee on H-1B visa petitions filed abroad creates a significant barrier to recruiting and retaining primary care physicians, including family physicians, who rely on H-1B status to train and practice in the United States. California already faces critical primary care shortages, especially in rural and underserved counties. Additional financial and administrative barriers for internationally trained physicians risk further reducing the primary care workforce, delaying patient access, and widening existing health inequities. This resolution seeks to ensure that qualified physicians are not prevented from practicing in California due to excessive visa fees or restrictive entry policies

Problem Universe: This issue affects a substantial portion of California’s primary care workforce and the patients they serve. Nationally, 64% of foreign-trained physicians practice in Medically Underserved Areas (MUAs) or Health Professional Shortage Areas (HPSAs), and 46% practice in rural communities, demonstrating their critical role in filling care gaps. California, where 37 of 58 counties already fall below the recommended primary care supply, relies heavily on these physicians to maintain essential access to care.

With the United States facing a projected shortage of up to 86,000 physicians by 2036 (7), imposing a \$100,000 H-1B fee risks further shrinking an already fragile workforce. This will directly impact thousands of CAFP members who depend on adequate primary care staffing, and millions of

patients, particularly in underserved, rural, and low-income communities, who already face long wait times and limited access.

Specific Solution: This resolution proposes that CAFP advocate through the AAFP to:

Oppose excessive financial barriers, including the new \$100,000 H-1B petition fee, that prevent physicians from obtaining or renewing H-1B visas to train or practice in the United States.

Urge federal policymakers to remove the newly imposed fee for foreign-trained physicians, researchers, and trainees.

The action sought is clear: protect the affordability and accessibility of H-1B visas for primary care physicians to maintain workforce capacity and ensure uninterrupted access to care.

Evidence: Evidence supporting the problem and the need for policy action includes:

On September 19, 2025, the President issued a proclamation requiring a \$100,000 fee for new H-1B petitions filed abroad unless exempted under narrow “national interest” criteria.

The U.S. physician workforce includes over 10,000 H-1B visa holders, demonstrating the widespread reliance on this visa for maintaining clinical capacity.

In California, H-1B physicians are essential in filling primary care shortages in rural and underserved regions, where workforce gaps are most severe.

37 of 58 California counties fall below recommended primary care supply benchmarks, illustrating the fragility of the workforce.

Adding financial and administrative barriers to international physician recruitment risks deepening shortages, delaying access to primary care, and exacerbating health inequities.

This evidence demonstrates a significant threat to California’s healthcare infrastructure and supports the need for CAFP and AAFP advocacy.

Citations:

1. <https://www.whitehouse.gov/presidential-actions/2025/09/restriction-on-entry-of-certain-nonimmigrant-workers/>
2. https://pmc.ncbi.nlm.nih.gov/articles/PMC5815043/?utm_source=chatgpt.com
3. <https://www.americanimmigrationcouncil.org/report/foreign-trained-doctors-are-critical-serving-many-us-communities>
4. <https://www.chcf.org/resource/new-survey-highlights-worsening-shortage-physicians-rural-northern-california/>
5. <https://www.americanimmigrationcouncil.org/blog/healthcare-shortages-foreign-trained-doctors-international-medical-graduates/>
6. <https://www.aafp.org/news/government-medicine/visa-changes-workforce.html>
7. <https://www.ama-assn.org/press-center/ama-press-releases/ama-urges-dhs-exempt-physicians-new-100000-h-1b-visa-fee>

Speaker’s Notes: The substance of this resolution—reducing financial barriers to H-1B visas for physicians—addresses federal immigration policy and aligns with current AAFP advocacy, but the RESOLVED clauses are written as directives to the AAFP rather than actions CAFP can directly implement. As a state chapter, CAFP’s feasible role would typically be to support and elevate the issue through AAFP processes.

California Academy of Family Physicians (CAFP) policy does not explicitly address H-1B visa financial barriers for foreign-trained physicians. However, CAFP policies emphasize the importance of

increasing and maintaining a diverse primary care workforce that reflects the population's needs, including support for recruiting and retaining underrepresented individuals in medical education and training.

The American Academy of Family Physicians (AAFP) has actively opposed the new \$100,000 H-1B visa application fee imposed by the Department of Homeland Security, which creates significant financial barriers for foreign-trained physicians to train and practice in the U.S. The AAFP has urged federal policymakers to exempt physicians, including residents, fellows, researchers, and non-clinical physicians, from this fee, emphasizing that international medical graduates constitute about one in four practicing physicians in the U.S. and are essential to maintaining access to care, especially in rural and underserved areas. The AAFP continues to advocate for policies that support the Conrad 30 program and other pathways to retain foreign-trained physicians in primary care roles.

Removing barriers to H-1B visas for foreign trained physicians aligns with CAFP's strategic plan goal of developing and diversifying the family medicine workforce. Both CAFP and AAFP have recently engaged in advocacy efforts opposing the H-1B visa fee, including letters to the Department of Homeland Security and coalition actions with other medical organizations to protect the pipeline of foreign-trained physicians critical to the U.S. healthcare system.

Speaker's Fiscal Notes: AAFP is primarily responsible for monitoring, reviewing and leading advocacy and response to federal issues. CAFP's resolution process does not directly influence AAFP policy, however, an issue can be referred to AAFP for national action which would have minimal costs to CAFP.

Committee Recommendation on Resolution A-26-26

2026 Report of the CAFP Legislative Affairs Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Legislative Affairs (LAC) Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-26-26: Ensuring the Availability and Affordability of H-1B Visas for Primary Care Physicians

RESOLVED: That the American Academy of Family Physicians (AAFP) opposes financial barriers (including excessive fees) for current and future physicians to obtain an H-1B visa to train in or practice medicine;

RESOLVED: That the American Academy of Family Physicians (AAFP) shall continue to advocate with federal policymakers to remove the new H-1B visa financial fee for foreign-trained physicians, researchers, and trainees, ensuring unfettered access to care nationwide.

Committee Recommendation: AFFIRM AS EXISTING POLICY

Committee Discussion: The committee affirmed that this is a significant issue for family medicine but emphasized that the topic is a federal policy best addressed by AAFP. In addition, the committee acknowledged work that has already been done by AAFP to advocate against the H-1B visa fee. Due to AAFP's existing work on this issue, the committee recommended that this policy be affirmed as existing policy.

Resolution A-27-26

Proposed Policy Title: Opposing the Expansion of SNAP Work Requirements

Author: Israel Garcia, MD

Co-Authors: Israel Garcia, MD, Annie Bicego, Mai Nojima, MD, Bright Zhou, MD

Endorsed by:

Whereas, Food insecurity affects 22% of California households and disproportionately impacts low-income households, minority communities, immigrants, and residents of rural and underserved areas; and

Whereas, CalFresh, California's name for the Supplemental Nutrition Assistance Program (SNAP), provided assistance to access to healthy and nutritious food options for over 3.1 million households in the state in 2024

Whereas, the federal government's proposed work requirement expansion for SNAP will disproportionately affect low-income workers, students, people experiencing homelessness, and individuals with undiagnosed or unrecognized disabilities who do not qualify for exemptions; and

Whereas, protecting SNAP and CalFresh programs aligns with the mission of family physicians to advocate for policies that advance health equity, protect vulnerable communities, and promote evidence-based public health interventions, and CAFP and AAFP have affirmed that food insecurity is a significant determinant of health, as demonstrated by prior resolutions supporting food insecurity screening and the education of Resident Physicians on available nutrition resources

RESOLVED: That the California Academy of Family Physicians (CAFP) opposes the expansion of SNAP work requirements that reduce access to food assistance, which will directly affect vulnerable California families; and be it further

RESOLVED: That CAFP support family physicians in addressing food insecurity by promoting validated screening tools, providing centralized resources, and integrating food insecurity screening and referral education into its online education.

RESOLVED: That CAFP update its policy statements to explicitly recognize access to healthy and culturally appropriate food as a core component of health equity, and to support advocacy, clinical practices, and community partnerships that promote reliable access to nutritious food for all patients.

Equity Impact Score: 8/9

Problem Statement: This resolution seeks to address threats to food access in California resulting from proposed expansions of federal SNAP work requirements. Food insecurity affects 22% of California households and disproportionately impacts low-income families, minority and immigrant communities, and those in rural or underserved areas. CalFresh, California's SNAP program, supports more than 3.1 million households each year and is a critical resource for preventing chronic disease and supporting overall health.

Federal proposals to expand SNAP work requirements would create new barriers to participation, particularly for low-income workers with unstable schedules, students, individuals experiencing homelessness, and people with disabilities. Although the CAFP and AAFP recognize food insecurity as a significant health determinant, many practices lack the resources to screen for and address patients' nutritional needs routinely. This resolution seeks to strengthen CAFP policy by opposing restrictive federal SNAP changes while affirming healthy, culturally appropriate food as a core

component of health equity. It also aims to support family physicians by promoting standardized screening, centralized referral resources, and integration of food insecurity education into CAFP programs. These actions will advance CAFP's commitment to health equity and protect access to nutrition for California's most vulnerable residents.

Problem Universe: As family physicians, most, if not all CAFP members likely provide care for households relying on CalFresh potentially affecting millions of patients statewide.

Specific Solution: That CAFP resolves to oppose the expansion of SNAP work requirements that would restrict food assistance for vulnerable California families, while supporting family physicians in addressing food insecurity through the promotion of validated screening tools, centralized referral resources, and integrated online education. CAFP further resolves to update its policy statements to explicitly recognize access to healthy and culturally appropriate food as a core component of health equity and to strengthen advocacy, clinical practice, and community partnerships that ensure reliable access to nutritious food for all patients.

Evidence:

Citations:

1. American Academy of Family Physicians. (n.d.). Resolution: New York — Protect WIC & SNAP benefits (Res. 1018). Retrieved December 4, 2025, from <https://cp.aafp.org/aafp/states-cod/resolution-new-york-c-protect-wic-snap-benefits-1018>
2. Bauer L, East C. A Primer on SNAP Work Requirements; the Hamilton Project. The Institution; 2025. https://www.brookings.edu/wp-content/uploads/2025/10/20250407_THP_SNAPWorkRequirements_Paper.pdf
3. California Department of Social Services. (n.d.). CFdashboard-PUBLIC: Annual Participation. Tableau Public. Retrieved December 5, 2025, from <https://public.tableau.com/app/profile/california.department.of.social.services/viz/CFdashboard-PUBLIC/AnnualParticipation>
4. California State Assembly, California Assembly Agriculture Committee. (2025, March). Joint oversight hearing background paper V4. <https://agri.assembly.ca.gov/system/files/2025-03/joint-oversight-hearing-background-paper-v4.pdf>
5. Carlson S, Llobrera J. SNAP Is Linked with Improved Health Outcomes and Lower Health Care Costs. Center on Budget and Policy Priorities; 2022. <https://www.cbpp.org/sites/default/files/12-14-22fa.pdf>
6. Cook J, East C. The Disenrollment and Labor Supply Effects of SNAP Work Requirements. SSRN Electronic Journal. 2025; Working Paper 32411. doi:<https://doi.org/10.2139/ssrn.4826048>
7. Kepper M, Walsh-Bailey C, Owens-Jasey C, Gunn R, Gold R. Integrating Social Needs into Health Care: An Implementation Science Perspective. *Annu Rev Public Health*. 2025 Apr;46(1):151-170. doi: 10.1146/annurev-publhealth-071823-111332. Epub 2024 Oct 30. PMID: 39476408; PMCID: PMC12171984.
8. Los Angeles County Department of Public Health. (n.d.). Community Health Profile: County of Los Angeles. Community Health Profiles. Retrieved December 5, 2025, from https://apps.gis.lacounty.gov/static/DPH/community-profiles/?Geo_ID=la_county (apps.gis.lacounty.gov)
9. Seligman HK, Laraia BA, Kushel MB. Food insecurity is associated with chronic disease among low-income NHANES participants. *J Nutr*. 2010 Feb;140(2):304-10. doi: 10.3945/jn.109.112573. Epub 2009 Dec 23. Erratum in: *J Nutr*. 2011 Mar;141(3):542. PMID: 20032485; PMCID: PMC2806885.

Speaker's Notes: CAFP has existing policy supporting food insecurity screening tools and encouraging strengthened follow-up care for patients experiencing food insecurity. CAFP also has policy encouraging the education of family physicians on how to use and interpret validated food insecurity screening tools and ways to identify local resources to refer patients in need.

AAFP has policy that supports sustained funding for SNAP and policies that promote healthy food options that are culturally competent. AAFP's policy emphasizes the important role that family physicians play in counseling patients on nutrition and their unique positions in identifying individuals in need of support.

AAFP has historically supported efforts to protect and support SNAP. For example, in 2018, AAFP wrote a letter to members of Congress opposing proposed work requirements for SNAP included in the Farm Bill. While AAFP does not have explicit policy opposing work requirements for SNAP, they have joined other major physician organizations in opposing work requirements in Medicaid.

SNAP is a federally funded program that is administered locally based on federal guidance. Recently, the federal government has expanded work requirements as a caveat for sustained funding. As such, states are required to implement these requirements to receive funding. CAFP generally does not directly advocate on federal issues but may support AAFP's federal advocacy efforts.

Speaker's Fiscal Notes: There would be minimal costs to adding policy that emphasizes CAFP's support for food insecurity screening tools and acknowledging access to healthy and culturally appropriate food as a core component of health equity. Additionally, there would be minimal cost for supporting or opposing legislation sponsored by others that affects work requirements for SNAP and it 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.

Committee Recommendation on Resolution A-27-26

2026 Report of the CAFP Legislative Affairs Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Legislative Affairs (LAC) Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-27-26: Opposing the Expansion of SNAP Work Requirements

RESOLVED: That the California Academy of Family Physicians (CAFP) opposes the expansion of SNAP work requirements that reduce access to food assistance, which will directly affect vulnerable California families; and be it further

RESOLVED: That CAFP support family physicians in addressing food insecurity by promoting validated screening tools, providing centralized resources, and integrating food insecurity screening and referral education into its online education.

RESOLVED: That CAFP update its policy statements to explicitly recognize access to healthy and culturally appropriate food as a core component of health equity, and to support advocacy, clinical practices, and community partnerships that promote reliable access to nutritious food for all patients.

Committee Recommendation: ADOPT:

RESOLVED: That the CAFP opposes the expansion of SNAP work requirements that reduce access to food assistance, which will directly affect vulnerable California families; and be it further

RESOLVED: That the CAFP update its policy statements to explicitly recognize access to healthy and culturally appropriate food as a core component of health equity, and to support advocacy, clinical practices, and community partnerships that promote reliable access to nutritious food for all patients.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP, put forward a resolution to the AAFP to oppose the expansion of SNAP work requirements that reduce access to food assistance, which will directly affect vulnerable California families; and be it further

Committee Discussion: The committee was in support of the general spirit of the resolution. Committee members voted to adopt the first and third resolved but acknowledged that the second resolved was generally already covered by existing CAFP policy on food insecurity screening tools. There were also concerns related to whether or not it was appropriate for policy to direct CAFP to develop specific online education resources. Given that many work requirement policies originate from the federal level, the committee also recommended the amended resolution to refer to AAFP for national action.

Resolution A-28-26

Proposed Policy Title: Oppose Work Requirements for Medicaid / Medi-Cal

Author: Ian Kim, MD

Co-Authors: Louise Stephan, MD

Endorsed by:

Whereas, it is well established that work requirements for Medicaid do not increase employment, but do significantly decrease Medicaid enrollment, as evidenced by the experiences recently in Georgia (1) and Arkansas (2); and

Whereas, national Medicaid work requirements could put as many as 36 million people—about 44% of all Medicaid enrollees—at risk of having their health insurance terminated according to the Center on Budget and Policy Priorities; and

Whereas, the administrative costs of the Medicaid work requirement program in the state of Georgia exceeded \$54 million over 5 years (October 2020 – March 2025) according to the U.S. Government Accountability Office, (3) suggesting the costs of a similar program in California will be hundreds of millions of dollars over a similar timeframe; and

Whereas, existing CAFP policy supports the right to health care for all Californians; and

Whereas, a policy very similar to that proposed here was adopted at the California Medical Association 154th Annual Session (Actions of 2025 House of Delegates, 10/28/25);

RESOLVED: CAFP opposes work, community service and education requirements for individuals to qualify for Medicaid, as it is a deterrent/roadblock for individuals to access care and may lead to more individuals becoming uninsured.

Equity Impact Score: 9/9

Problem Statement: The federal budget bill H.R.1, passed by Congress and signed by the president in July 2025, sets a national policy for work requirements for Medicaid. It is well established that work requirements for Medicaid do not increase employment, but do significantly decrease Medicaid enrollment. these requirements will be a heavy administrative burden and an enormous waste of taxpayer dollars.

Problem Universe: Nearly all CAFP members see patients with Medi-Cal. Medi-Cal provides insurance coverage for more than a third of all Californians and nearly half of children.

Specific Solution: Oppose work, community service and education requirements for individuals to qualify for Medicaid, as it is a deterrent/roadblock for individuals to access care and may lead to more individuals becoming uninsured.

Evidence: Ample research on state pilot programs of work requirements in Georgia and Arkansas show that work requirements do not increase employment, but do dramatically decrease Medicaid enrollment due to the administrative burden placed on recipients.

Citations:

1. Johnson D Y, Mein S A, Marinacci L X, Liu M, Wadhera R K. Insurance coverage and employment after Medicaid expansion with work requirements: quasi-experimental difference-in-differences study BMJ 2025; 390 :e086792 doi:10.1136/bmj-2025-086792

2. Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model Policy – Took Away Health Coverage, Added Stress and Red Tape to People's Lives (Center on Budget and Policy Priorities, August 8, 2023)
<https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be>
3. Medicaid Demonstrations: Information on Administrative Spending for Georgia Work Requirements (U.S. Government Accountability Office, Sept 3, 2025)
<https://www.gao.gov/products/gao-25-108160>

Speaker's Notes: The California Academy of Family Physicians (CAFP) policy manual emphasizes universal access to care as a core principle, stating that health care is a human right and that every person should have access to comprehensive, timely, and culturally competent health services regardless of factors such as income or immigration status. CAFP policy explicitly supports continuous and universal insurance coverage without barriers such as complex eligibility rules or underwriting that deter access. While the manual does not specifically mention Medicaid work or community service requirements, the emphasis on removing barriers to care and supporting vulnerable populations is clear.

The American Academy of Family Physicians (AAFP) strongly opposes Medicaid work requirements, viewing them as punitive measures that create barriers to care and contradict Medicaid's mission to ensure access to needed health services. The AAFP, along with other frontline physician organizations, has urged the Centers for Medicare and Medicaid Services (CMS) to reject state waiver requests that impose mandatory work, community service, or education requirements as conditions for Medicaid eligibility. The AAFP supports voluntary programs to assist Medicaid enrollees in gaining employment or skills but opposes making these conditions mandatory for coverage eligibility ([AAFP position](#), [AAFP statement](#)).

Opposing Medicaid work requirements aligns with CAFP's policy supporting universal access to care and reducing barriers that deter individuals from obtaining health coverage and services. Recent activity from the AAFP includes public statements and advocacy urging CMS and states to avoid approving Medicaid work requirements that would harm patient access and health outcomes. CAFP's ongoing advocacy for equitable health care access and alignment with AAFP's positions reinforce the importance of opposing such requirements to protect vulnerable populations and maintain continuous coverage.

Medicaid is a joint State-federally funded program. Recently, the federal government has expanded work requirements as a caveat for sustained funding. As such, states are required to implement these requirements to receive funding. CAFP generally does not directly advocate on federal issues but may support AAFP's federal advocacy efforts.

Speaker's Fiscal Notes: This resolution does not call for any specific action by the CAFP but rather establishes an official position on Medicaid work requirements. There would be minimal cost for supporting or opposing legislation sponsored by others that relate to Medicaid work requirements at the state level. This would fall within established procedures for updating and taking positions on proposed legislation and policy. Providing input on related proposed regulations would incur minimal to moderate costs depending on the level of engagement that is required. Drafting a letter or releasing a statement would incur minimal costs unless a larger communication strategy is required.

The AAFP is primarily responsible for monitoring, reviewing and leading advocacy and response to federal issues. AAFP has consistently been opposed to federal Medicaid work requirements. Referring a Resolution for national action to AAFP would be a minimal cost to CAFP.

Committee Recommendation on Resolution A-28-26

2026 Report of the CAFP Legislative Affairs Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Legislative Affairs (LAC) Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-28-26: Oppose Work Requirements for Medicaid/Medi-Cal

RESOLVED: CAFP opposes work, community service and education requirements for individuals to qualify for Medicaid, as it is a deterrent/roadblock for individuals to access care and may lead to more individuals becoming uninsured.

Committee Recommendation: ADOPT

Committee Discussion: The committee determined that this Resolution was consistent with CAFP policy related to reducing barriers to coverage for patients. The committee acknowledged AAFP and CAFP's existing advocacy efforts on this topic but determined that explicit policy should be adopted to confirm our opposition to Medicaid work requirements.

Resolution A-29-26

Proposed Policy Title: Support Full-Scope Medi-Cal access for Californians, Regardless of Immigration Status

Author: Ian Kim, MD

Co-Authors: Sherrice Law

Endorsed by:

Whereas, in 2025, California achieved a record level of 94% of Californians with health coverage, owing in large part to the expansion of Medi-Cal to all income-eligible adults regardless of immigration status over the past several years; and

Whereas, recent state policy change freezes enrollment in full-scope Medi-Cal for adult Californians with "Unsatisfactory Immigration Status" (UIS) as of Jan 1, 2026 (1); and

Whereas, under this enrollment freeze, "UIS" Californians who lose their full-scope Medi-Cal coverage for any reason cannot later re-enroll (following a brief grace period); and

Whereas, recent state policy change eliminates adult dental coverage for "UIS" Californians as of Jan 1, 2026; and

Whereas, recent state policy change will institute a monthly premium for "UIS" Californians beginning Jan 1, 2027 (2); and

Whereas, CAFP has previously adopted as policy support for health access for all Californians, regardless of immigration status;

RESOLVED: That the CAFP shall support full access to Medi-Cal (including dental coverage) for all income-eligible Californians, regardless of immigration status; and

RESOLVED: That the CAFP shall oppose policies that set different access or cost based on immigration status.

Equity Impact Score: 8/9

Problem Statement: Recent state policy change freezes enrollment in full-scope Medi-Cal for adult Californians with "Unsatisfactory Immigration Status" as of Jan 1, 2026; and eliminates adult dental coverage for "UIS" Californians as of Jan 1, 2026; and will institute a monthly premium for "UIS" Californians beginning Jan 1, 2027.

Problem Universe: All CAFP members may see or treat patients who have "unsatisfactory immigration status." This would directly affect perhaps 10% of members' patients in California; and indirectly affects all of us.

Specific Solution: Support full access to Medi-Cal (including dental coverage) for all income-eligible Californians, regardless of immigration status; and oppose policies that set different access or cost based on immigration status.

Evidence:

Citations:

1. Unsatisfactory Immigration Status includes people who are no documentation status; DACA recipients; those on tourist, student; or temporary work visas; those applying for U visas; those

applying for asylum; those paroled into the U.S. for less than 1 year.

<https://www.dhcs.ca.gov/Medi-Cal/Pages/immigration-status-categories.aspx>

2. DHCS: Medi-Cal Program Changes (2026-2027): What Medi-Cal Members Need to Know

<https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/medi-cal-changes.aspx>

Speaker's Notes: CAFP and AAFP both have existing policy affirming the belief that all people deserve access to health care regardless of immigration status. In addition, CAFP has policy that supports the extension of eligibility for full scope Medi-Cal benefits to undocumented immigrants.

Ensuring access to care for all individuals aligns with CAFP's 2025-2027 Strategic Plan, particularly in advancing health equity and supporting comprehensive patient-centered care. CAFP opposes policies requiring physicians to report undocumented individuals, such as measures that conflict with the mission and ethical responsibilities of health care providers.

CAFP has been a strong advocate for expanding access to health care for immigrant communities and has consistently supported legislation aimed at removing barriers to coverage. For example, during the 2023-2024 legislative session, CAFP opposed AB1012, which proposed removing Medi-Cal eligibility for individuals without "satisfactory immigration status".

Speaker's Fiscal Notes: Advocating for policy to support full access to Medi-Cal for all people regardless of immigration status would incur minimal costs as it already aligns with existing CAFP policy and fits within the existing policy engagement operations and structure. The proposal lies largely within the purview of CAFP's current legislative and regulatory advocacy work.

Committee Recommendation on Resolution A-29-26

2026 Report of the CAFP Legislative Affairs Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Legislative Affairs (LAC) Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-29-26: Support Full-Scope Medi-Cal Access for Californians, Regardless of Immigration Status

RESOLVED: That the CAFP shall support full access to Medi-Cal (including dental coverage) for all income-eligible Californians, regardless of immigration status; and

RESOLVED: That the CAFP shall oppose policies that set different access or cost based on immigration status.

Committee Recommendation: ADOPT

RESOLVED: That the CAFP shall support full access to Medi-Cal (including dental coverage) for all income-eligible Californians, regardless of immigration status.

Committee Discussion: The committee acknowledged that CAFP has existing policy supporting full-scope Medi-Cal access for all Californians, but that our current policy did not explicitly call out dental coverage. The committee recommends adopting the first resolved because of the inclusion of dental, and to affirm the second resolved as existing policy.

Resolution A-30-26

Proposed Policy Title: Preserving Continuous Full-Scope Medi-Cal Coverage for All Income-Eligible Adults

Author: Arthur Bookstein, MPH

Co-Authors: Justine Po, Prianka Deshmukh, Chigozie Ibe, Natalie Bui, Shireen Saxena

Endorsed by:

Whereas, the California Academy of Family Physicians (CAFP) affirmed in 2024 its support for full-scope Medi-Cal eligibility for all income-eligible individuals regardless of immigration status and referred this position to the American Academy of Family Physicians (AAFP) for national action—including a request that AAFP amend its policy language by replacing “Americans” with “people living in the United States” [1], thereby affirming the principle of ensuring equitable access to care; and

Whereas, the 2025-26 California Budget includes a proposal to freeze new enrollment for undocumented adults ages 19 and older, halting coverage expansion and eliminating access to full-scope Medi-Cal for hundreds of thousands of income-eligible Californians [2]; and

Whereas, evidence shows that restricting or interrupting coverage for undocumented adults increases avoidable emergency department use and higher acute-care expenditures, whereas continuous coverage improves chronic disease management, preventive care uptake, and stability of care [3,4]; and

Whereas, limiting access to full-scope Medi-Cal shifts costs to safety-net hospitals and community health centers, increasing uncompensated care burdens and straining statewide access for all patients [4]

RESOLVED: That CAFP advocate to the California Legislature for the preservation of continuous full-scope Medi-Cal coverage for all income-eligible adults regardless of immigration status; and be it further

RESOLVED: That CAFP oppose legislative or administrative actions that freeze enrollment, reduce benefits, or otherwise disrupt access to primary, preventive, and chronic disease care for all individuals living in California.

Equity Impact Score: 7/9

Problem Statement:

Problem Universe:

Specific Solution:

Evidence:

Citations:

1. American Academy of Family Physicians. Medicaid Expansion Position Paper. 2021. <https://www.aafp.org/dam/AAFP/documents/advocacy/coverage/medicaid/BKG-MedicaidExpansion.pdf>

2. American Academy of Family Physicians. Letter to the U.S. House Leadership. 2025. <https://www.aafp.org/dam/AAFP/documents/advocacy/coverage/medicaid/LT-House-AAFPChaptersOpposeMedicaidCuts-022525.pdf>
3. American Academy of Family Physicians. Letter to the U.S. Senate Leadership. 2025.
4. California Academy of Family Physicians. CAFPP Policy Manual Update: Current Version (September 23, 2025). pp. 107–108. https://www.familydocs.org/wp-content/uploads/2025/09/25.ADM_.CAFPPPolicyManualUpdate.9.23.25.Current-Version.pdf

Speaker's Notes:

CAFP has been a strong advocate for expanding access to health care for immigrant communities and has consistently supported legislation aimed at removing barriers to coverage. For example, during the 2023-2024 legislative session, CAFPP opposed AB1012, which proposed removing Medi-Cal eligibility for individuals without “satisfactory immigration status”.

CAFP and AAFP both have existing policy affirming the belief that all people deserve access to health care regardless of immigration status. In addition, CAFPP has policy that supports the extension of eligibility for full scope Medi-Cal benefits to undocumented immigrants. Ensuring access to care for all individuals aligns with CAFPP's 2025-2027 Strategic Plan, particularly in advancing health equity and supporting comprehensive patient-centered care. CAFPP opposes policies requiring physicians to report undocumented individuals, such as measures that conflict with the mission and ethical responsibilities of health care providers.

Speaker's Fiscal Notes: Advocating for preservation of full-scope Medi-Cal access for all individuals and opposing legislation that disrupts Medi-Cal access would incur minimal costs as it already aligns with existing CAFPP policy and fits within the existing policy engagement operations and structure. The proposal largely lies within the purview of CAFPP's current legislative and regulatory advocacy work.

Committee Recommendation on Resolution A-30-26

2026 Report of the CAFP Legislative Affairs Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Legislative Affairs (LAC) Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-30-26: Preserving Continuous Full-Scope Medi-Cal Coverage for All Income-Eligible Adults

RESOLVED: That CAFP advocate to the California Legislature for the preservation of continuous full-scope Medi-Cal coverage for all income-eligible adults regardless of immigration status; and be it further

RESOLVED: That CAFP oppose legislative or administrative actions that freeze enrollment, reduce benefits, or otherwise disrupt access to primary, preventive, and chronic disease care for all individuals living in California.

Committee Recommendation: AFFIRM AS EXISTING POLICY

Committee Discussion: The committee determined CAFP has existing policy supporting full-scope Medi-Cal coverage for all income-eligible adults regardless of immigration status. This policy is already sufficient to direct CAFP to advocate for legislative or administrative actions to expand coverage or oppose enrollment freezes.

Resolution A-31-26

Proposed Policy Title: Development of Updated Medical Student Loan Education Resources

Author: Giovanni Trejos

Co-Authors: Nathan Kim, Vennela Devanaboyina

Endorsed by:

Whereas, medical students in California face rising educational costs and must navigate new federal loan programs with complex borrowing and repayment structures; and

Whereas, recent updates to federal student loan policies, particularly the H.R.1 - One Big Beautiful Bill Act, create confusion among medical students attempting to make informed financial decisions; and

Whereas, early understanding of loan types, repayment plans, and policy changes can support financial planning and reduce long-term burden for future physicians, yet many medical students report limited access to current and accessible educational materials regarding student loan repayment; and

Whereas, the California Academy of Family Physicians (CAFP) serves as a trusted resource for medical trainees and is positioned to distribute and champion educational materials relevant to student financial literacy; now, therefore, be it

RESOLVED: That the California Academy of Family Physicians curates and oversees dissemination of updated, accessible educational resources—such as short guides, webpages, or explainer videos—on federal and state medical education loan programs and repayment options to California medical students (via website, student communications, chapter-level outreach, etc.); and be it further

RESOLVED: That the California Academy of Family Physicians establish a process to review and update these educational resources regularly in response to significant federal or state loan policy changes; and be it further

RESOLVED: That that the California Academy of Family Physicians collaborate with financial aid specialists, policy experts, or relevant organizations to advocate for reinstating student health professional loan support to the United States Congress.

Equity Impact Score: 8/9

Problem Statement: It seeks to help provide clarity on recent government changes to medical student loans and repayment options, as well as reinstating loan support.

Problem Universe: All current CAFP medical students who are not grandfathered into the current federal student loan and repayment options, and all future CAFP medical students who utilize federal student loans.

Specific Solution: We ask that the CAFP provide up-to-date educational resources regarding federal loans and repayment options, and that they work with others to help reinstate the previous federal loan and repayment support for medical students.

Evidence:

- Average Debt (Medical School Only): Around \$200,000-\$217,000 for indebted graduates
- Including Pre-Med Debt: Total debt often rises to approximately \$246,000 or more
- High-Debt Graduates: A significant portion, over 30%, owe more than \$250,000.

- Tuition Costs: Rising significantly faster than general inflation
- Interest Accrual: Debt grows during medical school and residency, with a \$200,000 loan potentially reaching \$240,000-\$250,000 by residency's end
- Impact of H.R. 1: In addition to impacting funding for graduate schools, undergraduate programs that feed into medical schools will be directly impacted as well.
- Financial Literacy Impact on Residents: Low literacy and high debt levels are associated with a negative impact on well-being.
- Desire for increased financial literacy: Residents report low financial literacy and a lack of financial education opportunities despite their interest.

Citations:

1. Hanson, M. (2025). Average medical school debt [2025]: Student loan statistics. Education Data Initiative; EducationData.org. <https://educationdata.org/average-medical-school-debt>
2. Association of American Medical Colleges (AAMC). (2024, March). Examining long-term trends in reported tuition and fees revenues at U.S. medical schools. AAMC. <https://www.aamc.org/data-reports/report/examining-long-term-trends-reported-tuition-and-fees-revenues-us-medical-schools>
3. Scott, G. (2025, September 27). Average medical school debt and monthly payment. PracticeLink Resource Center. <https://www.practicelink.com/resource-center/physician-student-loans/average-medical-school-debt-monthly-payment/>
4. Congress weighs deep cuts to federal student financial aid, Medicaid programs | University of California. (2025, June 23). University of California. <https://www.universityofcalifornia.edu/news/congress-weighs-deep-cuts-federal-student-financial-aid-medicaid-programs>
5. Garrett, C. C., Doonan, R. L., Pyle, C., & Azimov, M. B. (2022). Student loan debt and financial education: a qualitative analysis of resident perceptions and implications for resident well-being. Medical Education Online, 27(1). <https://doi.org/10.1080/10872981.2022.2075303>
6. Ahmad, F. A., White, A. J., Hiller, K. M., Amini, R., & Jeffe, D. B. (2017). An assessment of residents' and fellows' personal finance literacy: an unmet medical education need. International journal of medical education, 8, 192–204. <https://doi.org/10.5116/ijme.5918.ad11>

Speaker's Notes: CAFP policy states, “CAFP supports legislation that encourages *primary care* specialization by reducing the debt burden of past and current medical student borrowers, reducing the interest rate of medical student loans and removing the adjusted gross income cap to qualify for medical student loan interest payment tax deductions” and that “Primary care student loan programs should be expanded and their criteria simplified to encourage increased participation.”

AAFP policy supports efforts that assist in reducing medical student debt burden and specifically calls for expanding funding for federal loan programs targeted to support family medicine and primary care, allowing the deferment of interest and principal payments on medical student loans until after the completion of training. The policy also supports the development of new innovative programs that promote medical training debt relief.

The CAFP recently published its [New Physician Toolkit](#), which is a resource for early career physicians where they can find information on a variety of topics including student loan forgiveness programs. The resource includes links to California's state loan repayment program, the Steven M. Thompson Physician Corps Loan Repayment Program and other programs the state has to offer.

AAFP also has several educational pages and resources for members on medical student loan forgiveness and repayment programs. There is a dedicated page on the AAFP website that can be found here (https://www.aafp.org/students-residents/medical-students/begin-your-medical-education/debt-management/funding-options/forgiveness.html?utm_). This page includes information about programs including the National Loan Forgiveness Program, HRSA primary care loans, and other government loan forgiveness programs. AAFP has also partnered with other organizations to develop resources on the topic like webinars and loan calculator tools.

AAFP and CAFP have also both been very active in advocating for policies and programs that preserve and expand medical student loan repayment and forgiveness including the public service loan forgiveness program.

Generally, AAFP takes the lead in advocating for federal issues that fall before the U.S. Congress. CAFP can bring resolutions to AAFP's Congress of Delegates for national action.

Speaker's Fiscal Notes: There would be significant costs associated with establishing short guides, webpages and explainer videos related to state and federal medical education loan programs for California medical students. Significant staff time and resources would be required to allow for the appropriate research and analysis to be done to develop content, as well as time to format, design and publish content on CAFP's website. Processes to regularly review and update these resources would also require significant staff resources especially as program changes happen frequently.

Committee Recommendation on Resolution A-31-26

2026 Report of the CAFP Legislative Affairs Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Legislative Affairs (LAC) Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-31-26: Development of Updated Medical Student Loan Education Resources

RESOLVED: That the California Academy of Family Physicians curates and oversees dissemination of updated, accessible educational resources—such as short guides, webpages, or explainer videos—on federal and state medical education loan programs and repayment options to California medical students (via website, student communications, chapter-level outreach, etc.); and be it further

RESOLVED: That the California Academy of Family Physicians establish a process to review and update these educational resources regularly in response to significant federal or state loan policy changes; and be it further

RESOLVED: That the California Academy of Family Physicians collaborate with financial aid specialists, policy experts, or relevant organizations to advocate for reinstating student health professional loan support to the United States Congress.

Committee Recommendation: AFFIRM AS EXISTING POLICY

Committee Discussion: The committee noted that the first and second resolved statements are being addressed through CAFP's current practice of providing and distributing updates to members, including information on student loan repayment. The discussion of the third resolved statement acknowledged that the issue is already addressed by existing AAFP policy. While some concern was raised that the priorities and programs change frequently, and that AAFP policy is specific to federal loans, the committee agreed that the challenge lies in directing members to existing up to date resources rather than creating new policy or duplicative materials.

Resolution A-32-26

Proposed Policy Title: CAFP Supports Affordable Medical Education for Students from Low Social Economic Backgrounds

Author: Adryanna Corral, DO

Co-Authors: Tanya Thomas, MD; Fernando Serrano, MD

Endorsed by: UC Davis Family and Community Medicine

Whereas, low income medical students are more likely to choose to specialize in primary care, leading to more primary care physicians and alleviating the growing national shortage of primary care physicians

Whereas, borrowers of lower socioeconomic status (SES) tend to be underrepresented in medicine, and have been shown to have better patient satisfaction outcomes in race-concordant patient settings and improve racial and socioeconomic disparities in medicine.

Whereas, policies that limit federal loan borrowing disproportionately burden borrowers of lower SES backgrounds and puts them at greater risk of unfavorable borrowing terms of private lenders and excludes them from present and future federal benefits such as public service loan forgiveness (PSLF).

RESOLVED: That the California Academy of Family Physicians supports legislation that opposes a federal loan borrowing limit in order to increase the number of medical students who choose primary care specialties and reduce socioeconomic disparities in healthcare.

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

Equity Impact Score: 8/9

Problem Statement: This resolution seeks to address the issue of federal loan borrowing limits that will disproportionately affect students from low socioeconomic backgrounds pursuing medical education and ultimately reduce diversity, and the stability of the physician workforce.

Problem Universe: Difficult to assess, but would likely impact thousands to millions of patients.

Specific Solution: Support policies that eliminate and/or oppose federal loan borrowing limits for students from low socioeconomic backgrounds pursuing a medical education.

Evidence: Federal loan dependence among medical students rose significantly over the last two decades as education costs increased. Policies such as the One Big Beautiful Bill will likely disproportionately harm low-income and out-of-state students and ultimately reduce diversity, access to lower paying specialties, and the stability of the physician workforce.

Citations:

1. Ramesh T, Kadakia KT, Liu M, Yu H. Federal Loans Among US Medical Students. JAMA. 2025 Nov 26:e2520905. doi: 10.1001/jama.2025.20905. Epub ahead of print. PMID: 41296366; PMCID: PMC12658764.
2. Jetty A, Jabbarpour Y, Pollack J, Huerto R, Woo S, Petterson S. Patient-Physician Racial Concordance Associated with Improved Healthcare Use and Lower Healthcare Expenditures in Minority Populations. J Racial Ethn Health Disparities. 2022 Feb;9(1):68-81. doi:

10.1007/s40615-020-00930-4. Epub 2021 Jan 5. Erratum in: J Racial Ethn Health Disparities. 2022 Feb;9(1):384. doi: 10.1007/s40615-021-01003-w. PMID: 33403653.

3. Shannon EM, Blegen MB, Orav EJ, et al Patient–surgeon racial and ethnic concordance and outcomes of older adults operated on by California licensed surgeons: an observational study BMJ Open 2025;15:e089900. doi: 10.1136/bmjopen-2024-089900
4. <https://www.aamc.org/news/will-free-medical-school-lead-more-primary-care-physicians>
5. <https://www.nber.org/papers/w30767#:~:text=The%20paper%20finds%20that%20racial%20concordance%20leads,patients%20and%20providers%2C%20particularly%20along%20racial%20lines.>
6. <https://students-residents.aamc.org/financial-aid-resources/federal-vs-private-education-loans>
7. <https://www.aamc.org/news/proposed-changes-federal-student-loans-could-worsen-doctor-shortage>

Speaker's Notes: CAFP policy supports the reduction of medical student debt burden and the expansion of primary care student loan programs with simplified criteria to encourage increased participation. AAFP policy supports efforts that assist in reducing medical student debt burden and specifically calls for expanding funding for federal loan programs targeted to support family medicine and primary care, allowing the deferment of interest and principal payments on medical student loans until after the completion of training. The policy also supports the development of new innovative programs that promote medical training debt relief.

Supporting efforts that prevent federal loan borrowing limits aligns with CAFP's strategic plan goal of developing and diversifying the family medicine workforce by creating greater access to medical education for people from lower socioeconomic backgrounds.

AAFP and CAFP have been very active in advocating for policies and programs that preserve and expand medical student loan repayment and forgiveness including the public service loan forgiveness program. AAFP has called for continued support for programs like the National Health Service Corps, which offers scholarships or loan repayments as incentives for physicians to work in underserved areas.

CAFP generally does not independently advocate at the federal level. AAFP is responsible for federal legislative and regulatory advocacy.

Speaker's Fiscal Notes: There would be very minimal cost for CAFP to support legislation that opposes a federal loan borrowing limit because this would be an issue led by AAFP before Congress. There would be minimal cost for referring this resolution to AAFP for national action.

Committee Recommendation on Resolution A-32-26

2026 Report of the CAFP Legislative Affairs Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Legislative Affairs (LAC) Committee has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-32-26: CAFP Supports Affordable Medical Education for Students from Low Social Economic Backgrounds

RESOLVED: That the California Academy of Family Physicians supports legislation that opposes a federal loan borrowing limit in order to increase the number of medical students who choose primary care specialties and reduce socioeconomic disparities in healthcare.

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

Committee Recommendation: AFFIRM AS EXISTING POLICY

Committee Discussion: The committee noted that AAFP is responsible for federal advocacy. It was also noted that AAFP has already submitted letters consistent with the intent of the resolution. The committee discussed the potential to address state-administered loan programs if the resolved statement were amended accordingly but did not want to move away from the author's intent.

Committee Report – Membership Engagement Committee (MEC)

2026 Report of the CAFP Membership Engagement Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Membership Engagement Committee (MEC) has considered each of the resolutions referred to it and submits the following report.

- A-33-26 – Addressing Health Misinformation Through Physician Education and Community Engagement
- A-34-26 – Ensuring Equitable Representation of Independent and Physician-Led Practice

(Original) Resolution # A-33-26: Addressing Health Misinformation Through Physician Education and Community Engagement

RESOLVED: That the CAFP supports efforts to equip family physicians with tools and resources to identify and combat health misinformation through education and training opportunities; and be it further

RESOLVED: That the CAFP support the promotion of accurate, evidence-based health information and counter medically harmful misinformation on social media; and be it further

RESOLVED: That the CAFP supports family physicians as leaders and experts in combatting and debunking medical misinformation from social media or other sources that can be harmful to patient and public health in clinical settings, in their communities, and within their own social media networks; and be it further

RESOLVED: That the CAFP recognizes the importance of thoughtful and responsible engagement by family physicians when disseminating health information on social media and other public platforms.

Committee Recommendation: ADOPT

RESOLVED: That the CAFP supports efforts to equip family physicians with tools and resources to identify and combat health misinformation through education and training opportunities; and be it further

RESOLVED: That the CAFP recognizes the importance of thoughtful and responsible engagement by family physicians when disseminating health information on social media and other public platforms.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP support the promotion of accurate, evidence-based health information; and be it further

RESOLVED: That the CAFP supports family physicians as leaders and experts in combatting and debunking medical misinformation from social media or other sources.

Committee Discussion:

The MEC appreciates the authors' thoughtful work on this resolution and recognizes its strong relevance to current issues facing family medicine and aligns with current CAFP strategic goals. The MEC recommends an amendment to the second resolution to avoid limiting the policy exclusively to social media and instead frame it in a manner that is more enduring over time.

In the same spirit, the MEC recommends an amendment to the third resolution to keep the policy language broad rather than limiting it to specific contexts or scenarios. Maintaining flexibility in the language would allow CAFP to apply the policy thoughtfully and effectively across a variety of settings as circumstances evolve.

(Original) Resolution # A-34-26: Ensuring Equitable Representation of Independent and Physician-Led Practice

RESOLVED: That CAFP develop and implement a distinct "Independent & Physician-Led Practice Job Portal" category in its Career Center and email job feeds, separate from paid promotional listings, available to CAFP members at no or nominal cost; and

RESOLVED: That CAFP ensure career-center newsletters include a clearly visible section highlighting physician-owned, independent, and community-based practice opportunities; and

RESOLVED: That CAFP create an annual "Independent Practice Spotlight" initiative across newsletters, resident outreach, and social media to raise awareness of viable non-corporate practice models; and

RESOLVED: That CAFP collaborate with AAFP and other state chapters to develop model policy ensuring equitable representation of all practice models in workforce communications; and

RESOLVED: That CAFP report annually to the Congress of Delegates on progress toward achieving balanced representation of all practice opportunities; and

RESOLVED: That CAFP affirm the essential role of independent, physician-led practices in the future of family medicine, especially in rural and underserved regions.

Committee Recommendation: DO NOT ADOPT THE FIRST FIVE RESOLVED STATEMENTS, AFFIRM AS EXISTING POLICY THE SIXTH RESOLVED STATEMENT.**Committee Discussion:**

The MEC values the author's intent in highlighting important practice models for physicians and appreciates the spirit and thoughtfulness underlying this resolution. The committee encourages continued dialogue around the broader themes presented, as they raise meaningful considerations for CAFP and its members.

With that in mind, the MEC recommends not adopting resolved statements 1-5 at this time, primarily due to the prescriptive nature of the language and the associated high fiscal note. The committee believes additional discussion may allow these concepts to be explored in ways that preserve flexibility while remaining mindful of their overall impact on resources.

The MEC further recommends that CAFP affirm resolved statement 6 as existing policy, as it aligns with current CAFP policy.

The committee would welcome a future resubmission that incorporates some of these considerations and looks forward to continued collaboration on this important topic.

Resolution A-33-26

Proposed Policy Title: Addressing Health Misinformation Through Physician Education and Community Engagement

Author: Valerie Otti, MD

Co-Authors: 2025 Student & Resident Council Members

Endorsed by: Student & Resident Council

Whereas, “health misinformation” may be defined as any health-related claim of fact that is false based on current scientific consensus (1); and

Whereas, a systematic review found that the prevalence of health-related misinformation on social media ranged from 0.2% to 28.8% across platforms such as Twitter, YouTube, and Facebook (2), and the Kaiser Family Foundation reports that one in six (15%) social media users say they regularly get health information and advice from social media influencers (4); and

Whereas, vaccine skepticism and misinformation propagated on social media during the COVID-19 pandemic was found to causally lower vaccine intentions (5); and

Whereas, a Kaiser Family Foundation survey shows that most patients (85%) trust their own doctor for medical information, emphasizing the necessity for physicians to leverage that trust in combatting medical misinformation (4); and

Whereas, evidence demonstrates that refutational content directing users to evidence-based information, as well as legislative and organizational efforts to improve health literacy, are effective countermeasures to misinformation (6); and

Whereas, the CAFP already engages in monitoring and policy recommendations related to emerging technologies and is well positioned to review rapidly evolving misinformation trends; and

Whereas, CAFP has repeatedly endorsed education-based solutions—such as vaccine education in schools, tobacco prevention campaigns, and training on emerging technologies—to safeguard public health, and education on misinformation aligns with this long-standing commitment; and

Whereas, the CAFP affirms that health care and public health policy must be evidence-based, transparent, and free from political distortion, and misinformation directly undermines these principles by eroding trust in science and impairing clinical decision-making; and

Whereas, CAFP members already use social media platforms to provide evidence-based explanations and counter false claims, demonstrating both leadership and the ongoing need for institutional support in these efforts; and

Whereas, other medical organizations including ACOG and the AMA have adopted policies addressing health misinformation and disinformation (7,8); now, therefore, be it

RESOLVED: That the CAFP supports efforts to equip family physicians with tools and resources to identify and combat health misinformation through education and training opportunities; and be it further

RESOLVED: That the CAFP support the promotion of accurate, evidence-based health information and counter medically harmful misinformation on social media; and be it further

RESOLVED: That the CAFP supports family physicians as leaders and experts in combatting and debunking medical misinformation from social media or other sources that can be harmful to patient and public health in clinical settings, in their communities, and within their own social media networks; and be it further

RESOLVED: That the CAFP recognizes the importance of thoughtful and responsible engagement by family physicians when disseminating health information on social media and other public platforms.

Equity Impact Score: 6/9

Problem Statement: This resolution aims to address the negative consequences of health misinformation on clinical outcomes and public health. Misinformation has contributed to increased mental health stress, vaccine hesitancy, and rejection of evidence-based public health recommendations (9). As family physicians serve as trusted sources of health information, it is crucial that they strengthen their skills to recognize and combat health misinformation across social media and other public platforms.

Problem Universe: Health misinformation impacts CAFP members whose patients use social media, online retail sites, and other digital sources. According to the Kaiser Family Foundation, 55% of U.S. adults report seeking health information on social media at least occasionally (4). Thus, this issue affects a majority of family physicians and the patients they serve.

Specific Solution: The proposed solution is for CAFP to adopt policy that strengthens and expands training and support for family physicians to identify and combat health misinformation. This includes promoting evidence-based health information, providing educational resources, and supporting family physicians who use public platforms to correct misinformation.

Evidence: Studies show that posts containing health misinformation on vaccines, smoking, medications, and noncommunicable diseases range widely—reported between 36% to 87% across major social media platforms (9). Evidence further shows that expert refutational content can reduce belief in misinformation, and that directing users to evidence-based sources significantly improves health information accuracy (6).

Citations:

1. U.S. Department of Health and Human Services; Office of the Surgeon General. *Confronting Health Misinformation: The U.S. Surgeon General's Advisory on Building a Healthy Information Environment*. Washington (DC): U.S. DHHS; 2021.
2. Suarez-Lledó V, Alvarez-Gálvez J. Prevalence of Health Misinformation on Social Media: Systematic Review. *J Med Internet Res*. 2021;23(1):e17187. doi:10.2196/17187.
3. Chou WS, Gaysynsky A, Cappella JN. Where We Go From Here: Health Misinformation on Social Media. *Am J Public Health*. 2020;110(S3):S273–S275. doi:10.2105/AJPH.2020.305905.
4. Kaiser Family Foundation. *KFF Health Information and Trust Tracking Poll — January 2025*. San Francisco (CA): KFF; 2025.
5. Allen J, Watts DJ, Rand DG. Quantifying the Impact of Misinformation and Vaccine-skeptical Content on Facebook. *Science*. 2024;384(6699):eadk3451. doi:10.1126/science.adk3451.
6. Borges do Nascimento IJ, et al. Infodemics and Health Misinformation: A Systematic Review of Reviews. *Bull World Health Organ*. 2022;100(9):544–561. doi:10.2471/BLT.21.287654.
7. American Medical Association. *Addressing Health Misinformation and Disinformation*. AMA Policy H-440.859; 2022.

8. American College of Obstetricians and Gynecologists. ACOG Statement on Patient Safety and Medical Misinformation. Washington (DC): ACOG; 2022.
9. Kaakeh R, et al. Health misinformation and social media impacts. Heliyon. 2024. Available via ScienceDirect.

Speaker's Notes: CAFP supports policies that fund research, strengthen safety and informed engagement with social media, and enhance systemic social media literacy for youth, young adults, and adults. Policy also encourages CAFP to engage in efforts to equip family physicians with the tools to help parents and their children model and establish healthy and safe relationships with social media.

AAFP also actively addresses health misinformation, particularly in the context of vaccine hesitancy and public trust in medical science. The AAFP emphasizes the importance of family physicians as trusted sources of accurate health information and supports initiatives to counteract misinformation on social media and other platforms.

Combatting medical misinformation and promoting accurate, evidence-based health information is aligned with CAFP's strategic plan goal of championing public health and evidence-based medicine.

Speaker's Fiscal Notes: There would be minimal costs associated with adopting the proposed resolutions. CAFP is able to support the promotion of evidence-based health information and counter medically harmful misinformation through its existing operations and activities. CAFP is able to support efforts to equip family physicians with tools to combat health misinformation through existing advocacy and educational activities. However, more staff resources and time may be required if a broader advocacy or communication strategy is required. In addition, the cost of establishing new training or educational materials could be significant.

Committee Recommendation on Resolution A-33-26

2026 Report of the CAFP Membership Engagement Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Membership Engagement Committee (MEC) has considered each of the resolutions referred to it and submits the following report.

(Original) Resolution # A-33-26: Addressing Health Misinformation Through Physician Education and Community Engagement

RESOLVED: That the CAFP supports efforts to equip family physicians with tools and resources to identify and combat health misinformation through education and training opportunities; and be it further

RESOLVED: That the CAFP support the promotion of accurate, evidence-based health information and counter medically harmful misinformation on social media; and be it further

RESOLVED: That the CAFP supports family physicians as leaders and experts in combatting and debunking medical misinformation from social media or other sources that can be harmful to patient and public health in clinical settings, in their communities, and within their own social media networks; and be it further

RESOLVED: That the CAFP recognizes the importance of thoughtful and responsible engagement by family physicians when disseminating health information on social media and other public platforms.

Committee Recommendation: ADOPT

RESOLVED: That the CAFP supports efforts to equip family physicians with tools and resources to identify and combat health misinformation through education and training opportunities; and be it further

RESOLVED: That the CAFP recognizes the importance of thoughtful and responsible engagement by family physicians when disseminating health information on social media and other public platforms.

Committee Recommendation: ADOPT AS AMENDED

RESOLVED: That the CAFP support the promotion of accurate, evidence-based health information; and be it further

RESOLVED: That the CAFP supports family physicians as leaders and experts in combatting and debunking medical misinformation from social media or other sources.

Committee Discussion:

The MEC appreciates the authors' thoughtful work on this resolution and recognizes its strong relevance to current issues facing family medicine and aligns with current CAFP strategic goals. The MEC recommends an amendment to the second resolution to avoid limiting the policy exclusively to social media and instead frame it in a manner that is more enduring over time.

In the same spirit, the MEC recommends an amendment to the third resolution to keep the policy language broad rather than limiting it to specific contexts or scenarios. Maintaining flexibility in the language would allow CAFP to apply the policy thoughtfully and effectively across a variety of settings as circumstances evolve.

Resolution A-34-26

Proposed Policy Title: Ensuring Equitable Representation of Independent and Physician-Led Practice

Author: Maryal Concepcion, MD

Co-Authors:

Endorsed by:

Whereas, CAFP is the statewide professional home for all family physicians and is tasked with supporting members at every stage of their careers while promoting Family Medicine as a thriving and sustainable specialty; and

Whereas, California family physicians continue to experience record levels of burnout, with national data showing nearly 63% burnout rates and evidence that a significant percentage of early-career physicians leave traditional employed medicine within 5–10 years; and

Whereas, More than 80% of graduating residents enter employed corporate or hospital-based positions, despite many physicians expressing desire for autonomy, improved work-life balance, and the ability to practice relationship-driven primary care; and

Whereas, Independent, physician-owned, and community-based practices—such as Direct Primary Care and other non-insurance-based models—represent viable and growing career pathways that offer improved continuity, decreased administrative burden, and enhanced long-term sustainability for family physicians, particularly in rural and underserved areas; and

Whereas, The CAFP Career Center emails and job feeds currently feature only paid corporate and institutional job postings, as confirmed by CAFP staff leadership (“The featured positions in the emails...are paid promotional opportunities through the site for the employer. We do not choose the featured positions.” — CAFP Vice President, Membership & Communications, Oct 2025); and

Whereas, This exclusive visibility of paid corporate job listings creates structural inequity, unintentionally reinforcing the narrative that the only viable career path for family physicians is corporate employment — despite the availability and desirability of physician-led practice models; and

Whereas, Small, physician-owned practices typically lack the funding to purchase featured listings, resulting in persistent underrepresentation in CAFP communications, despite their importance to workforce sustainability, especially in underserved regions; and

Whereas, CAFP's current job-promotion structure does not reflect the diversity of practice opportunities it aims to support statewide, and unintentionally privileges corporate systems that already exert outsized financial and structural influence; and

Whereas, A bipartisan, constructive solution is needed to restore balance, support diverse practice pathways, and ensure CAFP communications reflect the full landscape of family medicine jobs—not only paid corporate listings; now,

RESOLVED: That CAFP develop and implement a distinct “Independent & Physician-Led Practice Job Portal” category in its Career Center and email job feeds, separate from paid promotional listings, available to CAFP members at no or nominal cost; and

RESOLVED: That CAFP ensure career-center newsletters include a clearly visible section highlighting physician-owned, independent, and community-based practice opportunities; and

RESOLVED: That CAFP create an annual “Independent Practice Spotlight” initiative across newsletters, resident outreach, and social media to raise awareness of viable non-corporate practice models; and

RESOLVED: That CAFP collaborate with AAFP and other state chapters to develop model policy ensuring equitable representation of all practice models in workforce communications; and

RESOLVED: That CAFP report annually to the Congress of Delegates on progress toward achieving balanced representation of all practice opportunities; and

RESOLVED: That CAFP affirm the essential role of independent, physician-led practices in the future of family medicine, especially in rural and underserved regions.

Equity Impact Score: 8/9

Problem Statement: CAFP’s Career Center and job-distribution emails exclusively feature paid promotional job listings, resulting in a structural imbalance that over-represents corporate and hospital-based employers while under-representing independent, physician-led practices. Because small physician-owned clinics typically lack the financial capacity to purchase promotional placement, the current system unintentionally perpetuates the belief that employment through large systems is the default or preferred career pathway. This is misaligned with CAFP’s mission, contributes to burnout, and suppresses visibility of viable practice models that support physician autonomy and long-term workforce sustainability.

Problem Universe: The affected population includes:

- All 11,000+ CAFP members, especially early-career physicians and residents who rely on these communications to understand available career options.
- All California Family Medicine residents (approximately 1,200 in training) who are disproportionately influenced by institutional messaging.
- Independent and physician-led practices statewide, especially in rural Northern California, the Central Valley, and underserved regions where independent practices serve as essential access points.
- Patients served by these independent practices — particularly those in communities where corporate employers have reduced or removed physician-led primary care services.

Estimated total impact: hundreds of practices and hundreds of thousands of patients.

Specific Solution: This resolution proposes that CAFP:

1. Create a new no-cost or low-cost job-listing category dedicated to independent, physician-led practice opportunities.
2. Place these opportunities in a designated, visible section of all Career Center emails and web listings.
3. Develop annual programming (Spotlight series) to educate members about practice ownership and diverse models.
4. Align with AAFP to ensure equitable job-board representation across chapters.
5. Provide annual reporting to membership on progress and implementation.

These steps correct the structural inequity without reducing revenue from corporate paid listings.

Evidence: Evidence that a problem exists:

- CAFP staff confirmed that all featured job listings are paid promotional placements, not selected based on relevance, geographic need, or alignment with family medicine workforce priorities.

- Corporate systems such as Adventist Health and Kaiser Permanente frequently dominate paid listings, while independent practices rarely appear.
 - In multiple California regions (e.g., rural Northern California), corporate systems have removed family physicians and replaced them with non-physician models, while simultaneously advertising corporate jobs through CAFP.
 - National burnout rates in family physicians remain >60%, with much attributed to lack of autonomy in corporate employment models.
 - 80% of residents enter employed medicine, often unaware of alternative pathways due to lack of visibility and institutional overrepresentation.
- Evidence supporting need for policy change:
- Independent and physician-owned practices consistently show lower administrative burden, better continuity, and higher physician satisfaction.
 - Rural communities disproportionately depend on independent practices for consistent primary care access.
 - Workforce decline is linked to lack of viable pathways outside corporate systems.
 - Expanding visibility of diverse practice models is aligned with CAFP's mission and AAFP policy on workforce sustainability.

Citations:

1. CAFP Staff Email Communication, October 2025. Confirmation that "featured positions" are paid promotional opportunities chosen by YM Careers.
2. Durbye et. al. Burnout Among Health Care Professionals A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care. National Academy of Medicine. July 2017.
3. AAFP Career Benchmark Dashboard. May 2024.
4. State of the Primary Care Workforce, 2024. National Center for Health Workforce Analysis. November 2024.
5. California Health Care Foundation. New Survey Highlights Worsening Shortage of Physicians in Rural Northern California, 2025.
6. Phillips RL et al. The Future Role of the Family Physician in the United States: A Rigorous Exercise in Definition. Ann Fam Med. Vol 12, No. 3 May/June 2014.
7. American Board of Family Medicine. Liaw, et al. Solo and Small Practices: A Vital, Diverse Part of Primary Care. 2016
8. Linzer M, et al. Physician Worklife and the Impact of Autonomy on Burnout. J Gen Intern Med. 2016
9. CAFP Mission and vision Statements
10. Family Physician Burnout, Well-Being, and Professional Satisfaction (Position Paper). AAFP Oct 2023 COD.

Speaker's Notes: This resolution aims to ensure CAFP workforce communications reflect independent and physician-led practice opportunities and to highlight these models annually. The intent aligns with existing CAFP policy supporting independent practice; however, several clauses are highly operational (directing specific products, reports, and collaborations) and could create ongoing staff and fiscal obligations that may be disproportionate relative to impact.

CAFP has established policies that relate to the representation of independent physicians, particularly emphasizing the importance of physician leadership and participation in organizational governance. The CAFP Policy Manual outlines the structure and responsibilities of delegates to the American Academy of Family Physicians (AAFP), including the selection and vetting of candidates for national office, and encourages active turnover and development of future leaders among delegates. This reflects a commitment to ensuring that family physicians, including those in independent practice, have a voice in shaping policies that affect their profession and patient care. The CAFP also supports mechanisms for physician hospital affiliation documentation, which can be relevant for independent physicians in credentialing processes.

At the national level, the AAFP explicitly supports family physicians in independent practice by providing education, resources, and advocacy tailored to their unique needs. The AAFP advocates for public and private payer policies that support family physicians choosing to work in independent

practice environments, recognizing the distinct challenges and contributions of these physicians. This is reflected in their policy statements and ongoing efforts to sustain and strengthen independent family medicine practices [AAFP Independent Practice Policy](#).

Recent activities by both CAFP and AAFP in this policy area include efforts to improve delegate selection processes, leadership development, and advocacy for fair representation in decision-making bodies. The CAFP continues to refine its governance structures to empower members and enhance advocacy effectiveness, while the AAFP has addressed issues related to physician representation in national committees and payment advisory groups, advocating for proportional representation of family physicians in influential bodies such as the Relative Value Scale Update Committee (RUC).

Speaker's Fiscal Notes: There may be significant fiscal impact if the resolution were to be implemented. CAFP uses an outside contractor (same contractor as AAFP and many other state chapters) to run our online career center. If we were to create our own online career center, it would take staff time and budget each year to administer and promote. In addition, creating an annual Independent Practice Spotlight initiative would require significant staff time and resources in order to do research and determine a communication strategy.

Committee Recommendation on Resolution A-34-26

2026 Report of the CAFP Membership Engagement Committee

This report is not policy and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors.

Speaker, The CAFP Membership Engagement Committee (MEC) has considered each of the resolutions referred to it and submits the following report.

(Original) Resolution # A-34-26: Ensuring Equitable Representation of Independent and Physician-Led Practice

RESOLVED: That CAFP develop and implement a distinct “Independent & Physician-Led Practice Job Portal” category in its Career Center and email job feeds, separate from paid promotional listings, available to CAFP members at no or nominal cost; and

RESOLVED: That CAFP ensure career-center newsletters include a clearly visible section highlighting physician-owned, independent, and community-based practice opportunities; and

RESOLVED: That CAFP create an annual “Independent Practice Spotlight” initiative across newsletters, resident outreach, and social media to raise awareness of viable non-corporate practice models; and

RESOLVED: That CAFP collaborate with AAFP and other state chapters to develop model policy ensuring equitable representation of all practice models in workforce communications; and

RESOLVED: That CAFP report annually to the Congress of Delegates on progress toward achieving balanced representation of all practice opportunities; and

RESOLVED: That CAFP affirm the essential role of independent, physician-led practices in the future of family medicine, especially in rural and underserved regions.

Committee Recommendation: DO NOT ADOPT THE FIRST FIVE RESOLVED STATEMENTS, AFFIRM AS EXISTING POLICY THE SIXTH RESOLVED STATEMENT.

Committee Discussion:

The MEC values the author’s intent in highlighting important practice models for physicians and appreciates the spirit and thoughtfulness underlying this resolution. The committee encourages continued dialogue around the broader themes presented, as they raise meaningful considerations for CAFP and its members.

With that in mind, the MEC recommends not adopting resolved statements 1–5 at this time, primarily due to the prescriptive nature of the language and the associated high fiscal note. The committee believes additional discussion may allow these concepts to be explored in ways that preserve flexibility while remaining mindful of their overall impact on resources.

The MEC further recommends that CAFP affirm resolved statement 6 as existing policy, as it aligns with current CAFP policy.

The committee would welcome a future resubmission that incorporates some of these considerations and looks forward to continued collaboration on this important topic.

Committee Report – Medical Practice Affairs Committee (MPAC)

2026 Report of the CAFP Medical Practice Affairs Committee

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the CAFP Medical Practice Affairs Committee (MPAC) has considered the following resolution referred to it and submits the following report.

- A-35-26 Confidential Support Resources for Physicians with Impairing Illnesses
- A-36-26 CAFP Support for Policies Limiting Government Organization Access to HIPAA protected data
- A-37-26 Focusing on Interoperability to Improve Continuity of Care for Unhoused Patients in California
- A-38-26 Equal Compensation
- A-39-26 Payment Equity
- A-40-26 Measure What Matters for Value-Based Payment

(Original) Resolution # A-35-26: Confidential Support Resources for Physicians with Impairing Illnesses

RESOLVED: That the California Academy of Family Physicians (CAFP) advocate for a California Physician Health Program that is confidential and aligned with national best practices; and be it further

RESOLVED: That the California Academy of Family Physicians (CAFP) supports access to front-facing, updated online resources designed to assist physicians experiencing mental health conditions or other potentially impairing illnesses, including guidance on navigating hospital credentialing, medical licensing, and other professional responsibilities while seeking treatment.

Committee Recommendation: ADOPT:

RESOLVED: That the CAFP advocate for a California Physician Health Program that is confidential and aligned with national best practices; and be it further

Committee Recommendation: ADOPT AS AMENDED:

RESOLVED: That the CAFP supports access to online resources designed to assist physicians experiencing mental health conditions or other potentially impairing illnesses, including guidance on navigating hospital credentialing, medical licensing, and other professional responsibilities while seeking treatment.

Committee Discussion: The committee was supportive of the intent of the resolution to support the development of resources for physicians. The committee acknowledged that California is one of the few states that does not have a physician health program. In the second resolved, the committee decided that the term “front-facing” was unclear and potentially too specific for the intention of the resolution. The committee amended the second resolved to remove “front-facing, updated” for clarity and to ensure the resolved statement would remain evergreen in the CAFP policy compendium.

(Original) Resolution # A-36-26 CAFP Support for Policies Limiting Government Organization Access to HIPAA Protected Data

RESOLVED: That the CAFP supports policies that prohibit government organizations from utilizing HIPAA protected healthcare data, including demographic and medical treatment, for taking legal action against individuals.

RESOLVED: That the CAFP supports policies that prohibit government organizations from utilizing HIPAA protected healthcare data, including demographic and medical treatment, in any format besides completely anonymized format.

Committee Recommendation: ADOPT:

RESOLVED: That the CAFP supports policies that prohibit government organizations from utilizing HIPAA protected healthcare data, including demographic and medical treatment, for taking legal action against individuals.

Committee Discussion: The committee was supportive of the spirit of the resolution to protect patient data and prevent HIPAA protected data from being used for immigration enforcement. The committee noted existing CAFP policy to protect patient confidentiality, but not specific policy that data should not be used for legal action so the committee voted to adopt the first resolved statement. The committee was concerned that the second resolved statement was too vague and it was not clear what policy goal the author was intending to achieve, that wasn't already included in the first resolved statement. There was also concern that the term "anonymized" did not fully account for the problem the author is intending to solve. HIPAA data is often already anonymized when it is shared, but that doesn't prevent it from being used for other purposes after it is received by another agency. Because of this lack of clarity, the committee recommended to not adopt the second resolved statement.

(Original) Resolution # A-37-26 Focusing on Interoperability to Improve Continuity of Care for Unhoused Patients in California

RESOLVED: the California Academy of Family Physicians supports policy measures that promote interoperability in electronic health records to provide seamless, continuous care for unhoused populations.

RESOLVED: the California Academy of Family Physicians advocates for policy measures that support the creation and maintenance of a California interoperability repository for data to be shared from electronic health records across California

Committee Recommendation: DO NOT ADOPT

Committee Discussion: The committee understood and appreciated the intention of the author to support continuity of care for unhoused patients. However, there were also concerns about balancing continuity of care with patient confidentiality in a very vulnerable population that may not be in a position to consent to such data-sharing agreements. There was acknowledgement that CAFP has supported data exchange programs in the past, but there have been concerns about certain types of data that are particularly sensitive including reproductive health information and transgender care. The committee discussed different options to amend the resolution to emphasize consent but ultimately decided that these considerations were beyond the scope of the resolution and opened up a broader conversation that needs to be had around the rights and privacy of unhoused people, patient consent and confidentiality. Due to the broader scope of issues that this resolution uncovered, the committee recommended that the resolution not be adopted.

(Original) Resolution # A-38-26 Equal Compensation

RESOLVED: Primary care physicians get equal pay and this will encourage more procedures right at the local area and promote primary care

Committee Recommendation: DO NOT ADOPT

Committee Discussion: The committee appreciated the intention of this resolution but determined that there was a lack of background information and supporting evidence to explain exactly what problem the resolution is trying to address. Because the intent of the author was not clear, the committee recommended to not adopt.

(Original) Resolution # A-39-26 Payment Equity

RESOLVED: That the California Academy of Family Physicians (CAFP) advocate that payors, health systems, and regulatory bodies reimburse procedures and services based on physician training and demonstrated competence rather than specialty designation; and

RESOLVED: That CAFPP advocate for equitable fee schedules and payment policies that apply uniformly across specialties for the same procedures or services when performed by appropriately trained Family Medicine physicians; and

RESOLVED: That CAFPP oppose payment or scope-of-practice restrictions that limit Family Medicine physicians from providing procedures, services, or devices for which they are trained and competent, and that such advocacy prioritize improving patient access, reducing inequities, and strengthening the comprehensive practice of Family Medicine.

Committee Recommendation: ADOPT AS AMENDED:

RESOLVED: That the CAFPP supports that payors, health systems, and regulatory bodies develop policies that reimburse procedures and services based on physician training and demonstrated competence rather than specialty designation.

Committee Discussion: The committee was supportive of the intent of the resolution. They reviewed the resolved statements holistically and found that the first resolved statement, with some minor amendments, covered the overall intention by the author to support equal reimbursement based on physician competence, not specialty. The committee added a slight language change to keep the policy as a general support statement, consistent with the purpose of CAFPP policy, and added language that was applicable to all listed entities including payors, health systems, and regulatory bodies. The second resolved statement was viewed as redundant to the first resolved. The committee also found the third resolved statement to be overlapping with existing CAFPP policy around privileging and scope of practice. For these reasons, the committee voted to not adopt the second and third resolved statements.

(Original) Resolution # A-40-26 Measure What Matters for Value-Based Payment

RESOLVED: CAFPP support and recommend shift in quality value measures in primary care physician settings to measures that matter that towards the Quintuple Aim.

RESOLVED: Update CAFPP's "Pay for Performance" policy, transitioning to measures that support the core 4Cs (first contact access, comprehensiveness, coordination and continuity) with less administrative burden as supported by AAFP's introduction of September 2024 Position Paper on Value-based Payment Models for Primary Care(2); and measures monitoring total cost of care % investment in PC while concurrently monitoring number of PC physicians who provide 4C PC (given the national access shortage).

RESOLVED: When measuring quality or value, business goals should be targets, not percentiles, as the overarching goal is for more individuals to have excellent whole-person care.

Committee Recommendation: ADOPT AS AMENDED THE FIRST AND THIRD RESOLVEDS, REFER TO A COMMITTEE FOR FURTHER STUDY THE SECOND RESOLVED

RESOLVED: That the CAFP supports shifts in quality value measures in primary care settings to “measures that matter” that moves towards the Quintuple Aim.

RESOLVED: That the CAFP supports policies for measuring quality or value, where business goals should be targets, not percentiles

RESOLVED: That the CAFP recommends that AAFP support national bodies, including CMS and NCQA to shift quality and value measures to “measures that matter” and targets (versus percentiles).

Committee Discussion: The committee discussed the importance of focusing on “measures that matter”, particularly in the context of quality metrics and alternative payment work. Members noted that current metric structures and measures are not effectively capturing meaningful outcomes. The discussion emphasized the alignment with the quintuple aim and the need for better measurement of continuity of care and first-touch access.

The committee recommended to adopt as amended the first and third resolved statements. The second resolved statement was recommended for referral back to a committee for further study, to allow additional time to update and align current CAFP policy on “Pay for Performance”. The committee further added an additional resolved statement to refer the “measures that matter” issue to AAFP for national action.

Resolution A-35-26

Proposed Policy Title: Confidential Support Resources for Physicians with Impairing Illnesses

Author: Lee Lam

Co-Authors: Toussaint Mears-Clarke MD, MBA, FAAFP

Endorsed by:

Whereas, 10-12% of physicians are estimated to develop a substance use disorder in their lifetime¹; and

Whereas, a 2025 systematic review estimated rates of depression among physicians between 4.8% and 66.5%²; and

Whereas, up to 40% of physicians may avoid seeking treatment for mental health issues and impairing illness due to stigma, concerns about licensure, confidentiality, and perceived professional consequences³; and

Whereas, according to the Federation of State Physician Health Programs (FSPHP), the national association that governs physician health programs (PHPs), California is one of three states that does not currently have a PHP⁴; and

Whereas, while such programs can be run by state licensing boards or the policy-making board of a state's medical society, many states delegate the management of support programs to independent non-profit organizations⁴; and

Whereas, physicians who participate in PHPs and similar support programs have better treatment outcomes than the general public, with return to employment in over 70% of participants⁵; and

Whereas, the Louna Breen Foundation of Heroes has been a critical advocate for PHPs as "an alternative to negative employment, credentialing, or regulatory action⁶; and

Whereas, confidentiality is frequently cited as one of the most significant considerations for physicians seeking support and treatment for impairing illnesses; and

Whereas, the California Academy of Family Physicians aims to "support member joy in medicine" as part of its strategic plan for 2025-2027⁷; therefore be it

RESOLVED: That the California Academy of Family Physicians (CAFP) advocate for a California Physician Health Program that is confidential and aligned with national best practices; and be it further

RESOLVED: That the California Academy of Family Physicians (CAFP) supports access to front-facing, updated online resources designed to assist physicians experiencing mental health conditions or other potentially impairing illnesses, including guidance on navigating hospital credentialing, medical licensing, and other professional responsibilities while seeking treatment.

Equity Impact Score: 7/9

Problem Statement: California lacks a confidential, evidence-based Physician Health Program (PHP) to support physicians experiencing substance use disorders, mental health conditions, or other impairing illnesses. Despite high rates of impairment and documented barriers to seeking care, physicians currently have no statewide structured pathway for safe, confidential treatment.

This resolution addresses the absence of a California PHP and the need for accessible, updated resources to guide physicians in seeking help while managing professional responsibilities.

Problem Universe: This issue affects all California physicians, including every CAFP member. Research indicates that 10–12% of physicians develop a substance use disorder, and physician depression rates range from 4.8% to 66.5%. Up to 40% of physicians avoid seeking treatment due to concerns about stigma or professional consequences. Given these prevalence estimates, thousands of CAFP members are directly or indirectly impacted by the lack of a confidential statewide support program.

Specific Solution: The resolution proposes that CAFP advocate for the creation of a confidential California Physician Health Program aligned with national best practices. It also requests that CAFP support the development of clear, accessible, front-facing online resources to help physicians understand treatment options and navigate licensing, credentialing, and other professional obligations while receiving care.

Evidence: Evidence consistently shows that physician impairment is common and under-treated. Studies estimate that 10–12% of physicians experience substance use disorders, and depression prevalence ranges widely, from 4.8% to 66.5%. National data show that up to 40% of physicians avoid seeking treatment due to confidentiality or licensure concerns. California is one of only three states without a Physician Health Program (PHP), despite PHPs in other states demonstrating strong outcomes, showing over 70% of participants returning to practice. Advocacy groups, including the Dr. Lorna Breen Heroes Foundation, emphasize the importance of confidential support models. These findings demonstrate a clear need for both a California PHP and updated, accessible resources for physicians seeking support.

Citations:

1. Bohigian GM, Croughan JL, Sanders K. Substance abuse and dependence in physicians: an overview of the effects of alcohol and drug abuse. *Missouri Med.* 1994;91(5):233–239.
2. Soenksen O, Abo-Balaa M, Abo-Balaa B, et al. Prevalence and correlates of depression, anxiety, and burnout among physicians and postgraduate medical trainees: a scoping review of recent literature. *Front Public Health.* 2025;*. doi:10.3389/fpubh.2025.1537108
3. Kane L. Medscape National Physician Burnout, Depression & Suicide Report 2019. Medscape Web site. Published January 16, 2019. Accessed December 2, 2025. <https://www.medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056>
4. Federation of State Physician Health Programs. State Programs. Accessed December 2, 2025. <https://www.fsphp.org/state-programs#:~:text=Be%20directed%20by%20a%20policy,into%205%20years%20or%20more>
5. Merlo LJ, Greene WM. Physician views regarding substance use-related participation in a state physician health program. *Am J Addict.* 2010;19(6):529–533. doi:10.1111/j.1521-0391.2010.00088.x
6. Breen L. Six actions toward supporting physician mental health: confidential health programs. Accessed December 2, 2025. <https://drlornabreen.org/allinformentalhealth/six-actions/confidential-health-program/>
7. American Academy of Family Physicians. About the Family Doctor. Accessed December 2, 2025. <https://www.familydocs.org/about/>

Speaker's Notes: This resolution seeks CAFP advocacy for confidential, best-practice-aligned support resources for physicians with potentially impairing illnesses (including substance use and mental health conditions). As noted in the resolution, this is in line with a national movement to destigmatize mental health issues amongst physicians, stigma that has been career ending or resulted in physician suicide.

AB 408 (Berman) would establish a PHP, or, in California, a Physician Health and Wellness Program (PHWP), in which the Medical Board would contract with a non-profit administering entity. It has

been made a two-year bill and its status is uncertain. Given the legislative status, this resolution is timely.

CAFP Policy supports member wellness through development of a wellness curriculum toolkit for family medicine residency programs, enacting physician wellness as a quality measure, and supporting the California Public Protection and Physician Health, Inc., which provides assistance to physicians with disruptive behavioral issues, substance abuse, mental and physical health, aging, the effects of stress and burnout.

Policy supporting physicians struggling with mental illness is aligned with CAFP's strategic plan goal of supporting member wellness and joy in medicine.

Speaker's Fiscal Notes: There would be minimal costs to CAFP to adopt policy that generally supports, encourages or advocates for the development of online resources for physician experiencing mental health conditions or other impairing illnesses. However, the costs and resources would be significantly more if CAFP to directly develop, publish or maintain front-facing, updated online resources. Seeking grant funding to develop such resources would require staff time to research and write the proposal, and meet with funders and potential partners. If staff were to work on developing resources directly, there would be a great deal of research and training required to develop tools, which may take away from other strategic priorities and CAFP activities.

Committee Recommendation on Resolution A-35-26

2026 Report of the CAFP Medical Practice Affairs Committee

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the CAFP Medical Practice Affairs Committee (MPAC) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-35-26: Confidential Support Resources for Physicians with Impairing Illnesses

RESOLVED: That the California Academy of Family Physicians (CAFP) advocate for a California Physician Health Program that is confidential and aligned with national best practices; and be it further

RESOLVED: That the California Academy of Family Physicians (CAFP) supports access to front-facing, updated online resources designed to assist physicians experiencing mental health conditions or other potentially impairing illnesses, including guidance on navigating hospital credentialing, medical licensing, and other professional responsibilities while seeking treatment.

Committee Recommendation: ADOPT:

RESOLVED: That the CAFP advocate for a California Physician Health Program that is confidential and aligned with national best practices; and be it further

Committee Recommendation: ADOPT AS AMENDED:

RESOLVED: That the CAFP supports access to online resources designed to assist physicians experiencing mental health conditions or other potentially impairing illnesses, including guidance on navigating hospital credentialing, medical licensing, and other professional responsibilities while seeking treatment.

Committee Discussion: The committee was supportive of the intent of the resolution to support the development of resources for physicians. The committee acknowledged that California is one of the few states that does not have a physician health program. In the second resolved, the committee decided that the term “front-facing” was unclear and potentially too specific for the intention of the resolution. The committee amended the second resolved to remove “front-facing, updated” for clarity and to ensure the resolved statement would remain evergreen in the CAFP policy compendium.

Resolution A-36-26

Proposed Policy Title: CAFP Support for Policies Limiting Government Organization Access to HIPAA Protected Data

Author: Kevin Yu

Co-Authors: John Christopher, Kevin Flores, Quang Pham

Endorsed by:

Whereas: In July 2025, the California Department of Healthcare Services was informed that Centers for Medicare and Medicaid Services signed an agreement in late July 2025 with the Department of Homeland Security that allowed Immigration and Customs Enforcement (ICE) to access Medicaid member information, including name, address, and other personal information (1, 2).

Whereas: ICE access to Medicaid member information opens vulnerable patient populations to targeted violence by ICE and other government organizations (3, 4, 5).

Whereas: Undocumented patients have access to healthcare in California through Medi-Cal and their healthcare records often list sensitive information including: name, country of origin, language, recent travel, BCG vaccination status, and discussions of social stressors (1, 3).

RESOLVED: That the CAFP supports policies that prohibit government organizations from utilizing HIPAA protected healthcare data, including demographic and medical treatment, for taking legal action against individuals.

RESOLVED: That the CAFP supports policies that prohibit government organizations from utilizing HIPAA protected healthcare data, including demographic and medical treatment, in any format besides completely anonymized format.

Equity Impact Score: 6/9

Problem Statement: ICE has been targeting individuals for deportation, often resulting in violence and harm, and recently signed an agreement with the Centers for Medicare and Medicaid Services allowing ICE access to PHI to locate immigrants who may be subject to deportation.

Problem Universe: Nearly 1.7 million undocumented immigrants are estimated to be on Medi-Cal, and comprise roughly 30% of our patients. It is likely that almost every CAFP member who works with immigrant populations will be affected by this problem.

Specific Solution: We ask the CAFP to support policies and legal action (such as the current lawsuit, citation 2) that prohibit government organizations from utilizing HIPAA protected healthcare data for taking legal action against individuals, and from using such information in any way that allows such organizations to identify individuals.

Evidence: Over the past several months, the number of deportations carried out by ICE has been increasing, and while previous focus was on those with criminal records, increasing numbers of individuals are being deported without a history of committing crimes (4, 5). Exactly how ICE is targeting individuals is unclear; however, ICE recently brokered an agreement with CMS that allows the organization to access PHI for the purpose of identifying individuals subject to deportation (1). This introduces significant risk to patient privacy and safety (3), and has been the subject of legal action aimed at preventing the use of PHI against individuals for this purpose (2).

Citations:

1. STATEMENT FROM THE DEPARTMENT OF HEALTH CARE SERVICES ON THE FEDERAL USE OF MEDI-CAL DATA AND MEMBER PRIVACY. Dhcs.ca.gov. (2025, June 13). <https://www.dhcs.ca.gov/formsandpubs/publications/oc/Pages/2025/25-20-Statement-Federal-Use-Medi-Cal-Data-6-13-25.aspx>
2. Improper sharing of Medicaid data with ICE (California v. U.S. Department of Health and Human Services, N.D. Cal., 3:25-cv-05536). Oregon Department of Justice. (2025, November 13). <https://www.doj.state.or.us/oregon-department-of-justice/federal-oversight/federal-litigation-tracker/improper-sharing-of-medicare-data-with-ice-california-v-u-s-department-of-health-and-human-services-n-d-cal/>
3. Custodio, S. (2025, June 20). Orange County warns Residents Medicare & Medicaid data could fuel ice raids. Voice of OC. <https://voiceofoc.org/2025/06/orange-county-warns-residents-medicare-medicare-data-could-fuel-ice-raids/>
4. Ice enforcement and removal operations statistics | ICE. US Immigration and Customs Enforcement. (n.d.). <https://www.ice.gov/statistics>
5. Strickler, L., & Ainsley, J. (2025, December 7). Ice has arrested nearly 75,000 people with no criminal records, Data Shows. NBCNews.com. <https://www.nbcnews.com/politics/immigration/ice-arrested-nearly-75000-people-no-criminal-records-data-shows-rcna247377>

Speaker's Notes: CAFP policy supports maintaining patient confidentiality and supporting technology platforms that are covered by HIPAA. CAFP does not have explicit policy related to government agencies and data sharing. CAFP Policy states, "CAFP rejects policy that requires physicians to report undocumented individuals as it is not consistent with our mission as health care providers". AAFP has a general policy statement about patient physician confidentiality which emphasizes the fundamental right to patient physician confidentiality, the right to access medical records, and that patients must authorize any release of personally identifiable information to external parties.

Protecting HIPAA protected data aligns with CAFP's strategic plan goal of championing public health and health equity by protecting vulnerable patient populations that may be targeted by ICE and other law enforcement agencies.

Speaker's Fiscal Notes: 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. Providing input on proposed regulations could incur minimal to moderate costs depending on the level of engagement that is required. There would be minimal cost for drafting a letter or releasing a statement should that become relevant. There would be more significant costs if a communication strategy is required.

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Speaker, the CAFP Medical Practice Affairs Committee (MPAC) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-36-26 CAFP Support for Policies Limiting Government Organization Access to HIPAA Protected Data

RESOLVED: That the CAFP supports policies that prohibit government organizations from utilizing HIPAA protected healthcare data, including demographic and medical treatment, for taking legal action against individuals.

RESOLVED: That the CAFP supports policies that prohibit government organizations from utilizing HIPAA protected healthcare data, including demographic and medical treatment, in any format besides completely anonymized format.

Committee Recommendation: ADOPT:

RESOLVED: That the CAFP supports policies that prohibit government organizations from utilizing HIPAA protected healthcare data, including demographic and medical treatment, for taking legal action against individuals.

Committee Discussion: The committee was supportive of the spirit of the resolution to protect patient data and prevent HIPAA protected data from being used for immigration enforcement. The committee noted existing CAFP policy to protect patient confidentiality, but not specific policy that data should not be used for legal action so the committee voted to adopt the first resolved statement. The committee was concerned that the second resolved statement was too vague and it was not clear what policy goal the author was intending to achieve, that wasn't already included in the first resolved statement. There was also concern that the term "anonymized" did not fully account for the problem the author is intending to solve. HIPAA data is often already anonymized when it is shared, but that doesn't prevent it from being used for other purposes after it is received by another agency. Because of this lack of clarity, the committee recommended to not adopt the second resolved statement.

Resolution A-37-26

Proposed Policy Title: Focusing on Interoperability to Improve Continuity of Care for Unhoused Patients in California

Author: Alexander Alvarez, MD, PhD

Co-Authors:

Endorsed by:

Whereas, over 171,000 Californians experience homelessness daily, and

Whereas, over 70% of this population are unsheltered, and

Whereas, minoritized populations, including black, indigenous, Latine, and LGBTQAI+ individuals, are overrepresented in this unsheltered unhoused population, and

Whereas, health disparities disproportionately impact unhoused individuals, and

Whereas, continuity of care for individuals experiencing unsheltered homelessness presents unique challenges due to frequent transitions of care into a variety of primary care homes, specialist offices, emergency departments, acute care facilities, post-acute care facilities, and shelters, and

Whereas, interoperability, or the sharing of protected health information with patients and providers via different electronic health records systems is a goal of both CMS and the California DHCS, and

Whereas, sharing of medical records between a variety of providers and healthcare systems will aid in reducing redundant care and ensuring follow-up on important healthcare issues,

RESOLVED: the California Academy of Family Physicians supports policy measures that promote interoperability in electronic health records to provide seamless, continuous care for unhoused populations.

RESOLVED: the California Academy of Family Physicians advocates for policy measures that support the creation and maintenance of a California interoperability repository for data to be shared from electronic health records across California

Equity Impact Score: 7/9

Problem Statement: This resolution focuses on continuity of care for unsheltered, unhoused individuals through the lens of interoperability. Because of the dynamic and transient nature of unhoused individual's physical location due to forced displacement, incarceration, trauma, assault, and a variety of other socioeconomic factors, care is often sought from a variety of primary care providers, street medicine teams, specialist offices, community and academic emergency departments/hospitals, shelters, skilled nursing facilities, and recuperative care locales scattered across counties. This often leads to redundant and potentially dangerous duplicative medical care (e.g., serologies, immunizations, medication management, etc.), confusion for unhoused patients on which recommendations to follow, and care gaps as each team defers to the other to take responsibility for the patient's preventive care needs.

Interoperability is a concept introduced in the HITECH Act of 2009, which provides rewards for electronic health record (EHR) systems that can effectively share information to promote continuity of care for all populations. While a variety of initiatives have attempted to incentivize this, there are still gaping holes in the implementation of interoperability, as a variety of larger medical records

systems (e.g., Epic and Cerner) do not communicate with each other, and the standardization of how information is shared in these interoperable care systems is all but standardized.

Problem Universe: Although the number of CAFP members affected by this problem is uncertain, an estimated 171,000 individuals reside without stable housing on any given night in California. CAFP members regularly treat these patients as part of street medicine teams as well as in brick-and-mortar locations. Additionally, while the intended target population for this policy change is unhoused individuals, the proposed policy change for increased interoperability will benefit the care for every patient in California. Because most patients receive care from a variety of fragmented systems and practices, interoperability will serve to help primary care providers and all CAFP members to better coordinate and amalgamate recommendations for care for their patients.

Specific Solution: CAFP has the opportunity to advocate for policies that incentivize and encourage interoperability among electronic health record companies, private practitioners, medical conglomerates, and other healthcare practitioners. Additionally, CAFP has the opportunity to advocate for a unified repository for medical records, including documentation, laboratory values, imaging results, and special procedure notes to aid with this interoperability. Though the State of California DHCS and CMS both require interoperability, more specific policies and actions can be taken to make sure this is a reality.

Evidence: Evidence is discussed as below in the citations.

Citations:

1. UCSF Benioff Homelessness and Housing Initiative. (2023). *CASPEH executive summary: California Statewide Study of People Experiencing Homelessness*. University of California, San Francisco. (https://homelessness.ucsf.edu/sites/default/files/2023-06/CASPEH_Executive_Summary_62023.pdf)
2. UCSF Benioff Homelessness and Housing Initiative. (2025, March). *Unsheltered homelessness: Findings from the California Statewide Study of People Experiencing Homelessness* (Unsheltered Brief). (https://homelessness.ucsf.edu/sites/default/files/2025-03/09_11_24_Unsheltered%20Brief_FINAL_v2.pdf)
3. U.S. Centers for Medicare & Medicaid Services. (2025). *CMS Interoperability Framework*. (<https://www.cms.gov/health-technology-ecosystem/interoperability-framework>)
4. California Department of Health Care Services. (2022, November 29). *All Plan Letter 22-026: Interoperability and Patient Access Final Rule* (APL 22-026). (<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-026.pdf>)
5. Li E, Clarke J, Ashrafian H, Darzi A, Neves AL. The Impact of Electronic Health Record Interoperability on Safety and Quality of Care in High-Income Countries: Systematic Review. *J Med Internet Res*. 2022 Sep 15;24(9):e38144. doi: 10.2196/38144. PMID: 36107486; PMCID: PMC9523524.
6. Ingram C, MacNamara I, Buggy C, Perrotta C. Priority healthcare needs amongst people experiencing homelessness in Dublin, Ireland: A qualitative evaluation of community expert experiences and opinions. *PLoS One*. 2023 Dec 14;18(12):e0290599. doi: 10.1371/journal.pone.0290599. PMID: 38096316; PMCID: PMC10720995.
7. McCormack F, Parry S, Gidlow C, Meakin A, Cornes M. Homelessness, hospital discharge and challenges in the context of limited resources: A qualitative study of stakeholders' views on how to improve practice in a deprived setting. *Health Soc Care Community*. 2022 Nov;30(6):e4802-e4811. doi: 10.1111/hsc.13887. Epub 2022 Jun 22. PMID: 35730970.
8. Siersbaek R, Ford J, Ní Cheallaigh C, Thomas S, Burke S. How do health system factors (funding and performance) impact on access to healthcare for populations experiencing homelessness: a realist evaluation. *Int J Equity Health*. 2023 Oct 17;22(1):218. doi: 10.1186/s12939-023-02029-8. PMID: 37848878; PMCID: PMC10583475.

Speaker's Notes: CAFP does not have explicit policy related to the interoperability of electronic health records or a statewide interoperability repository. However, CAFP's broader health care

system reform policies emphasize the importance of a coordinated, patient-centered medical home and a health care infrastructure supported by health information technology that does not impose unrealistic economic burdens on physician practices. These principles align with the goals of interoperability to enable seamless, continuous care, especially for vulnerable populations such as the unhoused.

The American Academy of Family Physicians (AAFP) explicitly supports the use of health information technology, including EHRs, to enhance care coordination, continuity, and patient-centeredness. AAFP policy states that every family physician should leverage EHRs and related technologies to support the medical home model, which inherently requires interoperability. The AAFP has actively engaged in advocacy and regulatory comments to promote interoperability standards and reduce administrative burdens, including recent letters to federal agencies on health data, technology, and interoperability proposed rules. This ongoing activity reflects a commitment to advancing interoperable EHR systems that facilitate data sharing across care settings.

For more details on AAFP's policy and advocacy on EHR interoperability, see [AAFP Electronic Health Records Policy](#) and [AAFP Advocacy on EHRs](#). Information on California's interoperability efforts can be found at the [California Mental Health Services Authority EHR page](#).

Speaker's Fiscal Notes: 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. Likewise, supporting regulation through a support letter would have minimal fiscal impact. Providing suggested changes or negotiating specific regulatory elements would require a greater investment related to staff time for research, assessing the policy and political environment, drafting regulatory comments and meeting with policymakers and their staff.

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Speaker, the CAFP Medical Practice Affairs Committee (MPAC) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-37-26 Focusing on Interoperability to Improve Continuity of Care for Unhoused Patients in California

RESOLVED: the California Academy of Family Physicians supports policy measures that promote interoperability in electronic health records to provide seamless, continuous care for unhoused populations.

RESOLVED: the California Academy of Family Physicians advocates for policy measures that support the creation and maintenance of a California interoperability repository for data to be shared from electronic health records across California

Committee Recommendation: DO NOT ADOPT

Committee Discussion: The committee understood and appreciated the intention of the author to support continuity of care for unhoused patients. However, there were also concerns about balancing continuity of care with patient confidentiality in a very vulnerable population that may not be in a position to consent to such data-sharing agreements. There was acknowledgement that CAFP has supported data exchange programs in the past, but there have been concerns about certain types of data that are particularly sensitive including reproductive health information and transgender care. The committee discussed different options to amend the resolution to emphasize consent but ultimately decided that these considerations were beyond the scope of the resolution and opened up a broader conversation that needs to be had around the rights and privacy of unhoused people, patient consent and confidentiality. Due to the broader scope of issues that this resolution uncovered, the committee recommended that the resolution not be adopted.

Resolution A-38-26

Proposed Policy Title: Equal Compensation

Author: Rasmi Narayana, MBBS

Co-Authors:

Endorsed by:

Whereas, most simple procedures are done by primary care in remote areas of the state but get paid less than the specialists

RESOLVED: primary care physicians get equal pay and this will encourage more procedures right at the local area and promote primary care

Equity Impact Score: 4/9

Problem Statement: Mostly we have family practice physicians in the remote areas taking care of all ages. Many of the procedures are done by them

Problem Universe:

Specific Solution: Advocate for equal reimbursement for procedure whether done by primary care or specialist

Evidence:

Citations:

Speaker's Notes: The resolution calls for "equal pay" for primary care physicians, with the rationale that higher primary care compensation would promote access and reduce downstream costs. The intent aligns with the CAFPP strategic goal to advance payment reform, but the RESOLVED clause is very broad and would benefit from clarifying what policy lever CAFPP is being asked to pursue (e.g., Medi-Cal primary care rate improvements, commercial benchmarking, or workforce incentives).

CAFP policy states that the disparity between primary care and subspecialty payment must be dramatically decreased to ensure fairness and recognition of the value of primary care services. CAFPP policy specifically supports equal compensation for family physicians with other physicians for all family planning services. CAFPP policy also states that practice privileges should be granted on the basis of education, experience and demonstrated competence, not solely on specialty, or membership in a specific scientific organization.

AAFP policy endorses "equal pay for equal work" and supports family physicians being paid commensurate with other specialties.

AAFP provides tools such as the Family Medicine Career Benchmark Dashboard to promote transparency and support family physicians in negotiating fair compensation.

Supporting payment equity for family physicians is closely aligned with CAFPP's strategic plan goal of advancing payment reform and system transformation in order to adequately compensate family physicians for services they are qualified to perform.

Speaker's Fiscal Notes: There would be minimal cost for CAFPP to adopt a policy statement that primary care physicians should be paid equally to other specialties.

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Speaker, the CAFP Medical Practice Affairs Committee (MPAC) has considered the following resolution referred to it and submits the following report.

(Original) Resolution # A-38-26 Equal Compensation

RESOLVED: Primary care physicians get equal pay and this will encourage more procedures right at the local area and promote primary care

Committee Recommendation: DO NOT ADOPT

Committee Discussion: The committee appreciated the intention of this resolution but determined that there was a lack of background information and supporting evidence to explain exactly what problem the resolution is trying to address. Because the intent of the author was not clear, the committee recommended to not adopt.

Resolution A-39-26

Proposed Policy Title: Payment Equity

Author: Angela Bymaster MD

Co-Authors:

Endorsed by:

Whereas Family Medicine (FM) physicians are comprehensively trained across the lifespan and in multiple clinical disciplines, which includes competency-based training in a broad range of outpatient procedures, and

Whereas multiple medical specialties may perform the same procedures, and procedure reimbursement should be based on demonstrated training and competence rather than specialty designation, and

Whereas providing a wide scope of procedural care within Family Medicine practices improves access, reduces delays, and decreases barriers for medically underserved, rural, and low-income populations, and

Whereas limiting reimbursement or denying payment to FM physicians for procedures, devices, medications, or services that they are trained and qualified to provide contributes to inequity within the healthcare workforce and restricts patient access to timely, comprehensive primary care, and

Whereas some payors and health systems apply inconsistent or specialty-based restrictions on procedural reimbursement, contrary to the principles of equitable payment, scope-of-practice fairness, and patient-centered care,

RESOLVED: That the California Academy of Family Physicians (CAFP) advocate that payors, health systems, and regulatory bodies reimburse procedures and services based on physician training and demonstrated competence rather than specialty designation; and

RESOLVED: That CAFP advocate for equitable fee schedules and payment policies that apply uniformly across specialties for the same procedures or services when performed by appropriately trained Family Medicine physicians; and

RESOLVED: That CAFP oppose payment or scope-of-practice restrictions that limit Family Medicine physicians from providing procedures, services, or devices for which they are trained and competent, and that such advocacy prioritize improving patient access, reducing inequities, and strengthening the comprehensive practice of Family Medicine.

Equity Impact Score: 9/9

Problem Statement: This seeks to address the common problem of payers refusing to reimburse family medicine physicians for services (example: Well Child Appointments) and procedures (example: skin biopsy), medical devices (example: IUD), and medications (example: Depo-Provera) which are also given by specialists.

Problem Universe: Most CAFP members and patients are affected by this common, unjust practice.

Specific Solution: California lawmakers should write a law making it illegal for payers to exclude Family Medicine (and other primary care) physicians from receiving payment for their work.

Evidence: I have had payment denied by my local managed Medi-Cal organization multiple times for multiple E&M, procedure, medicine, and device codes. The administration of the managed Medi-Cal organization explained that this was because these codes are only billable by specialists. I have an email thread with an Optum executive wherein this issue is discussed and he affirms the problem exists.

Citations: None included

Speaker's Notes: While not directly related to reimbursement, CAFP policy states that practice privileges should be granted on the basis of education, experience and demonstrated competence, not solely on specialty, or membership in a specific scientific organization. CAFP policy supports primary care as the foundation of the healthcare system and advocates for sustainable financing that includes increased investment in primary care to match other developed nations. Policy emphasizes that the disparity between primary care and specialty payment must be dramatically decreased to ensure fairness and recognition of the value of primary care services. CAFP also supports payment models that provide appropriate and majority representation for primary care physicians in payment negotiations and advocates for financing models that do not disproportionately affect small or solo practices. CAFP supports financial models that incentivize continuity, comprehensive, coordinated care, and multidisciplinary clinical teams, which aligns with advocating for equitable payment structures.

AAFP recognizes the widening income gap between generalists and specialists and supports payment reforms that appropriately value primary care. They promote comprehensive compensation models and value-based incentives to ensure equitable pay for family physicians. The AAFP also provides tools such as the Family Medicine Career Benchmark Dashboard to promote transparency and support family physicians in negotiating fair compensation. Additionally, the AAFP supports payment models like Direct Primary Care (DPC), which allow family physicians to provide comprehensive care with simplified revenue structures, reducing administrative burdens and improving practice satisfaction.

Recent activities from both CAFP and AAFP reflect ongoing advocacy for improved primary care compensation and support for practice models that empower primary care physicians. The AAFP continues to advocate for payment reforms with Medicare and private payers to increase non-fee-for-service payments and reduce burdensome payment models. The CAFP has reaffirmed its support for the Direct Primary Care model.

Adequately compensating family physicians for services they are qualified to perform aligns with CAFP's strategic plan goal of advancing payment reform and supporting member joy in medicine if they are able to ensure adequate payment for services in which they are trained for. It should be noted the advocacy is vaguely defined in this resolution, and given the scope of this issue, different intensities of advocacy would encumber increasing Academy resources (as remarked in the Fiscal Note) without likely commensurate impact.

Speaker's 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. There would be minimal cost for drafting a letter and releasing a statement. There could be more significant costs if a communication strategy is required.

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Speaker, the CAFP Medical Practice Affairs Committee (MPAC) has considered each of the resolutions referred to it and submits the following report.

(Original) Resolution # A-39-26 Payment Equity

RESOLVED: That the California Academy of Family Physicians (CAFP) advocate that payors, health systems, and regulatory bodies reimburse procedures and services based on physician training and demonstrated competence rather than specialty designation; and

RESOLVED: That CAFP advocate for equitable fee schedules and payment policies that apply uniformly across specialties for the same procedures or services when performed by appropriately trained Family Medicine physicians; and

RESOLVED: That CAFP oppose payment or scope-of-practice restrictions that limit Family Medicine physicians from providing procedures, services, or devices for which they are trained and competent, and that such advocacy prioritize improving patient access, reducing inequities, and strengthening the comprehensive practice of Family Medicine.

Committee Recommendation: ADOPT AS AMENDED:

RESOLVED: That the CAFP supports that payors, health systems, and regulatory bodies develop policies that reimburse procedures and services based on physician training and demonstrated competence rather than specialty designation.

Committee Discussion: The committee was supportive of the intent of the resolution. They reviewed the resolved statements holistically and found that the first resolved statement, with some minor amendments, covered the overall intention by the author to support equal reimbursement based on physician competence, not specialty. The committee added a slight language change to keep the policy as a general support statement, consistent with the purpose of CAFP policy, and added language that was applicable to all listed entities including payors, health systems, and regulatory bodies. The second resolved statement was viewed as redundant to the first resolved. The committee also found the third resolved statement to be overlapping with existing CAFP policy around privileging and scope of practice. For these reasons, the committee voted to not adopt the second and third resolved statements.

Resolution A-40-26

Proposed Policy Title: Measure What Matters for Value-based Payment

Author: Dominique Quincy, MD

Co-Authors:

Endorsed by:

Whereas, Barbara Starfield showed 30 years ago that first contact, continuity, comprehensiveness and coordination (the 4Cs) lead to better health, increased longevity and decreased total cost of care.

Whereas, Barbara Starfield's findings have been repetitively shown for the last 30 years in this country and other countries and has been expanded to the Quintuple Aim.

Whereas, We now have the ability to measure 2 of the 4Cs: Continuity and Comprehensiveness; and with some work could add first contact.

Whereas, ABFM's Center for Professionalism and Value in Health Care recommends measuring "Measures that Matter"(1) – specifically: Trust, Continuity, Comprehensiveness and Person-Centered Primary Care Measure (PCPCM).

Whereas, Patients and FM physicians are increasingly going to DPC practices (despite the out of pocket cost), which provide a patient-physician relationship that patients trust and provides care that is first contact, continuity and comprehensive.

Whereas, the goal of Pay for Performance Measures and HEDIS measures were to improve quality and decrease cost in medicine, but we have not seen either. And the high administrative burden of how measures have been done, has seen some diverting of funds from frontline care to data inputting and analysis.

Whereas, Spot check HEDIS measures can help identify population or zip code areas that may need a modified model of care and/or resources.

Whereas, Current HEDIS measures can incentivize "cherry picking" "healthier" communities. HEDIS penalizes physicians who care for individuals with more need and/or complex disease.

Whereas, Target goals are patient-centered and resonate with patients and medical teams. Target goals also encourage medical practices to share successful operational changes that align for better outcomes.

Whereas, The goal of measurements was to show excellent care of more individual patients without increased administrative burden. However, measuring percentile goals versus target goals, means only a small % of PC practices can be considered very good, even if all are within a few percentiles of each other and are providing excellent care. This disincentivizes participation, especially of small practices that may not be able to afford the infrastructure staff to track measures, and discourages sharing of best practice system improvements between practices. In addition, percentiles are a mathematical goal that does not resonate with patients and health care teams.

Whereas, Given how healthcare is reimbursed, there are financial disincentives to continuity and comprehensive and coordinated care in many practice settings.

Whereas, AAFP's September 2024 Position Paper: "Value-based Payment Models for Primary Care" introduction says: " (AAFP) believes value-based Payment (VBP) should support collaborative

partnerships between patients and physicians, improve the quality and patient outcomes of care and reduce unnecessary health care spending. To achieve these aims, VBP for primary care must support the four key functions of primary care (i.e., first contact access, comprehensiveness, coordination and continuity), which are essential to meeting the goals of improved quality and reduced spending” (2) However AAFP language on VBP measurements is varied through AAFP policies.

Whereas, Milbank Memorial Fund articles and PC scorecards show the chronic disinvestment in PC and shortage of PC.

RESOLVED: CAFP support and recommend shift in quality value measures in primary care physician settings to measures that matter that towards the Quintuple Aim.

RESOLVED: Update CAFP’s “Pay for Performance” policy, transitioning to measures that support the core 4Cs (first contact access, comprehensiveness, coordination and continuity) with less administrative burden as supported by AAFP’s introduction of September 2024 Position Paper on Value-based Payment Models for Primary Care(2); and measures monitoring total cost of care % investment in PC while concurrently monitoring number of PC physicians who provide 4C PC (given the national access shortage).

RESOLVED: When measuring quality or value, business goals should be targets, not percentiles, as the overarching goal is for more individuals to have excellent whole-person care.

Equity Impact Score: 9/9

Problem Statement: Proposal updating CAFP policy on VBP measures to measures that support and align with the 4Cs of PC and have been shown for 30 yrs to support Quintuple Aim. And are measures that resonate with patients and healthcare teams and have less administrative burden/cost. And change focus in business to best targets vs percentiles to help more individuals.

Problem Universe: Those involved in VBP.

Specific Solution: Measure what Matters focusing on the 4 Cs and the patient-physician relationship which are key to achieving the Quintuple Aim.

Evidence: The problem is the increased cost of measuring many measurements that can identify zip code or population needs but arguably are not the ideal measures for quality of an individual's care. And the development of new better 4 C related measures which 30 yrs of studies have shown strong correlation with the Quintuple Aim.

Citations:

1. [Measures that Matter | The Center for Professionalism and Value in Health Care](#)
2. www.aafp.org/about/policies/all/value-basedpayment.html

Speaker’s Notes: CAFP Policy includes eight Pay for Performance Policy Principles(P4P) outlining various best practices on how P4P programs should work. The principles include ways to incorporate measurement of quality of care, the financing of incentive payments and ensuring physician involvement in the design of payment policies. CAFP Policy affirms that primary care must be the foundation of any health care system, guided by principles of universal access, comprehensive coverage, timely care, high quality, and sustainability. CAFP policy states its support for financing models that increase investment in primary care, reduce disparities, and ensure fair payment structures that support small and solo practices without disproportionate burdens.

The AAFP similarly emphasizes value-based payment (VBP) models that support collaborative partnerships between patients and physicians, improve quality and outcomes, and reduce

unnecessary spending. AAFP's recent position papers highlight the need for VBP models to provide predictable, prospective revenue streams that sustain comprehensive, longitudinal, patient-centered care. They advocate for alignment across payers, reduction of administrative complexity, and increased investment in primary care infrastructure and workforce. Both CAFP and AAFP recognize the challenges of transitioning from fee-for-service to value-based care, including the need for better information sharing, risk adjustment, and equitable distribution of financial rewards.

Reforming value-based care aligns with CAFP's strategic plan goal of advancing payment reform. Recent CAFP activities include supporting value-based care models as a pathway to achieving Health Care for All, advocating for increased primary care investment, and promoting policies that reduce administrative burdens on family physicians. The AAFP continues to advance these goals through policy development, educational initiatives, and engagement with federal programs such as Medicare Shared Savings and the Centers for Medicare & Medicaid Innovation.

Speaker's Fiscal Notes: Updating CAFP's Pay for Performance Principles would result in minimal to moderate costs. 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. Similarly, providing input on proposed regulations could incur minimal to moderate costs depending on the level of engagement that is required. There would be minimal cost for drafting a letter or releasing a statement on this topic. However, there could be more significant costs if a more comprehensive communication strategy is required.

Committee Recommendation on Resolution A-40-26

2026 Report of the CAFP Medical Practice Affairs Committee

This report is not policy, and it will not become policy until completion of the 2026 All Member Advocacy Meeting (AMAM) resolution testimony hearing and subsequent action by the CAFP Board of Directors

Speaker, the CAFP Medical Practice Affairs Committee (MPAC) has considered each of the resolutions referred to it and submits the following report.

(Original) Resolution # A-40-26 Measure What Matters for Value-Based Payment

RESOLVED: CAFP support and recommend shift in quality value measures in primary care physician settings to measures that matter that towards the Quintuple Aim.

RESOLVED: Update CAFP's "Pay for Performance" policy, transitioning to measures that support the core 4Cs (first contact access, comprehensiveness, coordination and continuity) with less administrative burden as supported by AAFP's introduction of September 2024 Position Paper on Value-based Payment Models for Primary Care(2); and measures monitoring total cost of care % investment in PC while concurrently monitoring number of PC physicians who provide 4C PC (given the national access shortage).

RESOLVED: When measuring quality or value, business goals should be targets, not percentiles, as the overarching goal is for more individuals to have excellent whole-person care.

Committee Recommendation: ADOPT AS AMENDED THE FIRST AND THIRD RESOLVEDS, REFER TO A COMMITTEE FOR FURTHER STUDY THE SECOND RESOLVED

RESOLVED: That the CAFP supports shifts in quality value measures in primary care settings to "measures that matter" that moves towards the Quintuple Aim.

RESOLVED: That the CAFP supports policies for measuring quality or value, where business goals should be targets, not percentiles

RESOLVED: That the CAFP recommends that AAFP support national bodies, including CMS and NCQA to shift quality and value measures to "measures that matter" and targets (versus percentiles).

Committee Discussion: The committee discussed the importance of focusing on "measures that matter", particularly in the context of quality metrics and alternative payment work. Members noted that current metric structures and measures are not effectively capturing meaningful outcomes. The discussion emphasized the alignment with the quintuple aim and the need for better measurement of continuity of care and first-touch access.

The committee recommended to adopt as amended the first and third resolved statements. The second resolved statement was recommended for referral back to a committee for further study, to allow additional time to update and align current CAFP policy on "Pay for Performance". The committee further added an additional resolved statement to refer the "measures that matter" issue to AAFP for national action.

Update on Resolution A-15-24: Empowering Delegates for a Stronger Academy

RESOLVED: that the Academy task the Governance Committee, along with the Speaker and Vice Speaker, to propose the structure and bylaws needed to give policy making power to AMAM.

RESOLVED: that the Speaker present the Governance Committee's proposed changes for consideration of approval by AMAM 2026.

Overview

In fall 2024, the Governance Committee met to determine the information and data that would be useful to collect to support their work as charged via Resolution A-15-24. Staff compiled this information into a 32-page background report and shared this and the findings of a governance survey sent to the 15 largest AAFP chapters, at a spring 2025 committee meeting. The spring Governance Committee meeting also featured a presentation on governance best practices by consultants from the Association Management Center. What follows is a high-level summary of the historical background and survey results, work currently underway by the subsequently formed Governance Committee working group, and important questions for Delegate consideration and input. Delegates are requested to review the full summary included here and carefully consider and discuss the questions listed at the end of this report with their local chapter members, in order to best represent the views of their local chapter. One representative Delegate will be invited to submit written feedback to these questions during AMAM, on behalf of the chapter.

Historical Background

CAFP utilized a Congress of Delegates (COD) model of governance until 2014. The COD was historically scheduled as two half day business meetings, consisting primarily of officer elections; resolution reports, Delegate testimony and voting; and a Town Hall discussion. In 2008, the COD was moved to Sacramento and expanded, to incorporate training in media and advocacy. Lobby Day was launched to provide Delegates with an opportunity to meet with their legislators and practice new skills. During the 2011 Congress, only one resolution was submitted, attendance was severely lagging, and attendees rated the value of Congress as a policy-making body as "very low." A Congress Future Task Force was convened to study the issue and in 2012 the Congress approved changing the COD to an All Member Advocacy Meeting (AMAM). The AMAM was to be open to all members and allow them the floor during resolution testimony, a privilege previously reserved for Delegates only. Delegates continued to elect officers, approve bylaws changes and dues increases, and provide testimony on Resolutions for consideration by the Board. In the new model, the CAFP Board voted on the disposition of Resolutions.

Delegate Role and Representation

In both models, Delegates were/are appointed by the leadership of their respective local county chapters. The process through which this occurs varies significantly by chapter. Delegation size is proportional to the number of Active members in each chapter; the largest chapter (LA) has 12 Delegates, while the smallest chapters (Amador, and several others) have 1 Delegate. In large, established chapters Delegates are elected. In the majority of chapters, Delegates are frequently appointed based on whomever is available and willing to serve. These processes lead to significant variance in the experience and expertise of the Delegates. Some possess a good understanding of the resolution process, Academy workings and governance, while for others AMAM is the first CAFP event they have attended. In the circumstance in which a previously named Delegate is no longer able to attend AMAM, the District Directors often assign a new Delegate on site. Twenty-seven (27) percent of CAFP Local Chapters do not have elected leadership and do not send any Delegates to represent them. Additionally, of those chapters who send Delegates, roughly 20 percent make

changes to their representative Delegates after the submission deadline, due to unforeseen changes in schedules. In 2026, local chapters submitted 53, of a possible 89 local chapter Delegates, by the deadline. If not for the inclusion of Board Delegates, this number would be short of the number required (58) to establish a meeting quorum.

Attendance and Resolution Submissions

COD member attendance prior to the 2014 transition to an AMAM generally ranged from 60 to 80 people, topping out at low 100s. Generally, 50-75 delegates (inclusive of 22 Board members) attended COD and anywhere from 1-10 resolutions were typically submitted. Within a couple of years of changing to an AMAM, member attendance more than doubled to 200, and has reached 225 in the last couple of years. Delegate attendance also increased substantially to now average at 95 (inclusive of Board Delegates). Resolutions submissions range from 10-40, with a typical year in the teens or 20s. A large number of submitted resolutions are currently covered by existing CAFP policy, overly directive of CAFP operations and activities, or outside CAFP scope.

CAFP Attendee Surveys

The survey questions and ranking scales have changed significantly across the years, making comparison challenging. Since its introduction, the most popular session has been the Legislative Issues Briefing, and advocacy training is generally seen as “very valuable.” In recent years, attendees have ranked the top reasons to attend AMAM as shown below. Of note, students and resident responses differ slightly and rank advocacy training as the number two reason to attend, alongside networking or feeling inspired:

1. Networking and connection
2. Feeling uplifted and inspired
3. Advocacy Training
4. Keynote and Speaker Sessions
5. Lobby Day Participation
6. Opportunity to Testify on Resolutions
7. Training Track (Sunday afternoon) Sessions

Governance Survey of Other States & Trends in Association Management

In spring 2025, 15 AAFP large and medium state chapters participated in a survey to share governance structures and delegate involvement in policy making. Surveys were completed by the Chapter Executive and President for each of the 15 states. Of these, 27 percent (4/15) of states use a COD or House of Delegates; 73 percent (11/15) have transitioned to a Board-centric or hybrid model. The primary reasons provided for why states shifted away from COD/HOD was declining attendance and quorum issues, high cost and complexity of COD, perception of COD as unrepresentative, inefficient processes, and a desire for more inclusive engagement. Amongst those who shifted away from a COD/HOD, there was no reported decrease in engagement and some reported increased participation. States' top ranked common objectives of governance meetings are member engagement, networking and connection, governance decisions and policy development. When asked about whether their structure advances the governance objectives of their chapters, enhances member engagement and supports the Board in making sound policy, 100 percent of chapters without a traditional COD strongly agree or agree with these statements, while 60-70 percent of those with a traditional COD/HOD strongly agree or agree with these statements. In May 2025, CAFP invited a consultant from the Association Management Center to present on Association Governance Best Practices. The consultant reiterated that the reasons stated above, which are driving AAFP state chapters to shift away from COD/HODs, are reflected in a general trend for member associations to move away from traditional HOD/CODs.

Governance Committee Working Group

The Governance Committee presented an update of their work and posed several questions to better discern Board intentions at the August 2025 Board meeting. Given the complexity of the task, the Board approved extending the timeline to bring a proposal and any necessary bylaws changes to the Delegates by one year, for consideration at the 2027 AMAM. The committee was directed to provide an update to Delegates at the 2026 AMAM. A Governance Committee work group, consisting of current committee members and non-committee members, was formed and tasked with bringing multiple proposals to the Board for consideration at their June 2026 meeting. The Board will vote on one proposal at the June meeting, to be further fleshed out and returned to the Board (along with any necessary accompanying proposed bylaws changes) in late 2026.

Committee Membership: Alex McDonald, MD (Chair), Anthony Chong, MD (Incoming Chair), Lalita Abhyankar, MD, Rebecca Bertin, MD, Maria Carriedo-Ceniceros, MD, Jack Chou, MD, Mary Hanna, MD, Jay Lee, MD and Matthew Mayeda, MD.

Proposal Considerations

The working group is currently working on multiple proposal ideas; the broad strokes of initial concepts include variations of the following. It is important to note these are initial concepts only, not concrete schematics on which we are asking Delegates to select.

CONCEPT 1: A revised process whereby the Speaker reviews all resolutions to determine whether a resolution reflects current policy (in which case it is placed on a reaffirmation calendar) and falls within AMAM's authority or is out of scope and therefore ruled out of order. In-scope resolutions would then be assigned to a reference committee for review, opened for online member testimony, and receive a formal committee recommendation that places them on the AMAM consent calendar. During AMAM, resolutions could be extracted from consent for debate and Delegate vote, while those not extracted are acted on as a group. Final outcomes may include adoption, adoption as amended, referral to the Board, or non-adoption, with referred items proceeding to Board action consistent with the organization's strategic priorities. A strong understanding of Parliamentary Procedure, meeting standing rules, and advanced preparedness would be required of Delegates and Speaker, as well as significantly more time and resources directed to resolutions and the hearing component of the AMAM.

CONCEPT 2: A revised process beginning with resolution submission, followed by an online member feedback forum that allows members to rank all submitted resolutions according to member priority. Member feedback and rankings would then be referred to reference committees for committee recommendation and scoring. Any resolutions deemed current policy would be placed by the committee on a reaffirmation calendar. All other resolutions would be reviewed by the Speaker alone (or possibly by the Speaker and a newly created resolution rank committee) to determine if the resolution is in AMAM scope and its overall priority for members. Out-of-scope items are ruled out of order and authors are provided this feedback, while in-scope items move to the AMAM prioritized agenda or consent calendar. AMAM Delegates may extract resolutions from consent and would debate and vote on extracted resolutions according to their priority ranking within strictly adhered to time limits. Resolutions not voted on due to time constraints go to the Board if time runs out. Final outcomes include adoption, adoption as amended, referral to committee or the Board, or non-adoption, with certain resolutions ultimately requiring Board action, especially when outside AMAM authority as defined by bylaws. As with the first option, a strong understanding of Parliamentary Procedure, meeting standing rules, and advanced preparedness would be required of Delegates and Speaker, as well as significantly more time and resources directed to resolutions and the hearing component of the AMAM.

The primary differences between concepts 1 and 2 are that concept 2 would allow members to rank resolutions by priority, and for resolutions to be referred to committees for recommendations prior to sending them for review by the Speaker (or Speaker together with a new resolution ranking committee). In concept 2, resolutions would be heard and debated at AMAM in rank order and there

would be time constraints on the hearing (ostensibly limiting Delegate debate and vote to something like a “top ten”). Everything else would be sent to the Board.

CONCEPT 3: A process whereby the resolution review process utilized this and last year is codified as policy and procedure for AMAM. The process would be moved earlier in the fall, to provide more time for resolution education, review and feedback to authors. Resolutions are submitted online and staff prepare analysis; Speakers Notes are renamed to reflect this. Resolutions are referred to committees for recommendations, which are added to a consent calendar for Delegates at AMAM. Delegates may extract resolutions for testimony (all members may provide testimony) and may rank order extracted resolutions according to member priority. All resolutions not extracted are sent to the Board as affirmed by the Delegates. Testimony and rank order of extracted resolutions are sent to the Board, to provide the Board with a sense of member priority. The Board determines action on each resolution and may submit some to AAFP for national action as appropriate. The Board can accept resolutions that are not policy in nature and create a searchable compendium. The AMAM process is reevaluated every 2-3 years.

Questions for Delegates

One Delegate per chapter is invited to represent the views of the chapter, via submission of online written comments. The form for submitting comments will be shared during AMAM and must be submitted by March 20, the Friday immediately following AMAM. The representative Chapter Delegate is welcome to comment as they see appropriate. Some questions for consideration include:

Engagement and Information: Should elected CAFP Board Directors or Local Chapter Delegates at AMAM determine CAFP policy? How do we ensure that individuals making the decisions on CAFP policy have the necessary engagement and information to make informed decisions? As AMAM Delegates are proportional to chapter size and not all chapters fully participate in AMAM, what concerns, if any, do you have that Delegate representation would be equitable and able to support your local chapter?

Emphasis and Structure of AMAM: Depending on the reform, it may change the nature of AMAM, including the amount of time dedicated to discussing resolutions. New processes may result in fewer resolutions, thereby shortening the time spent on resolutions. New processes that require formal discussion and approval of specific resolution language may result in an expansion of the time dedicated for resolution discussion and approval. With limited time at AMAM, how would your chapter feel about lengthening, shortening or eliminating the non-resolutions hearing components of AMAM?

Delegate Education and Training: Delegates making final decisions on resolutions would require the use of more formal structures, likely including parliamentary procedure. How well prepared do your Chapter Delegates feel they can be? Does your chapter feel they would be adequately represented in a model requiring advanced training?

Elections

Report of the 2025 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 2026 All Member Advocacy Meeting (AMAM) or Board of Directors meeting. The 2025 committee members are Drs. Rob Assibey, Maria Carriedo-Ceniceros, Jack Chou, Mary Hanna, Sarah McNeil and CAFP Immediate Past President, Dr. Alex McDonald (Chair). The Governance committee met in November 2025 and presented this recommended slate of officers, which was approved by the Board of Directors at its December 2025 meeting.

Elected by Delegates at the All Member Advocacy Meeting

President-elect	Brent Sugimoto, MD, FAAFP	2026-27
Speaker	Jorge Galdamez, MD	2026-27
Vice Speaker	Erika Roshanravan, MD, FAAFP	2026-27
AAFP Delegate	Shannon Connolly, MD, FAAFP	2026-28
AAFP Alternate Delegate	Kim Yu, MD, FAAFP	2026-28
Governance Committee *	Greg Lewis, MD, FAAFP	2026-28
	Juliana Jones, MD	2026-28

Elected or appointed by and from the Board

Governance Committee (from the BOD)	Anna Askari, MD, FAAFP	2026-28
Secretary/Treasurer**	Maria Carriedo-Ceniceros, MD, FAAFP	2026-27

* 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



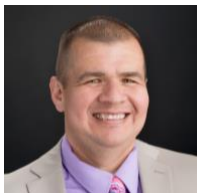
For the Office of President-elect – Brent K. Sugimoto, MD, MPH, FAAFP

I'm grateful for the opportunity to serve you as Speaker. It has been a great privilege to ensure that your voice is not merely reflected in the priorities of CAFP, but that your voice helps shape what we focus on as a specialty. Over the past two years as Vice Speaker and Speaker, I have advanced efforts to make our deliberative processes more open and transparent at AMAM—such as committee-based, informational review of resolutions to provide context for our discussions—because I believe this empowers our specialty. You see this power in the ideas and expertise Family Medicine students, residents, and physicians bring to the floor of this body.

As a candidate for President-Elect, I want to build on this work. At a time when facts, trust, and institutions are under strain, we may feel uncertainty about how best to support our patients and communities—and about the future shape of our practices. In CAFP, we meet that uncertainty by listening to one another and acting with shared purpose.

I will bring that same commitment to transparent, member-driven leadership to the President-Elect role—so we can advance payment reform, strengthen and diversify the workforce, champion evidence-based public health and equity, and support wellness and joy in Family Medicine. Equally important, I will prioritize inclusive pathways into leadership so that the diversity of California's Family Physicians is reflected at all levels of the Academy. If elected, I will faithfully represent you, elevate your voice, and through the Academy, showcase your work to demonstrate how Family Medicine is the way forward.

I humbly ask for your vote. Thank you for your consideration. — *Brent K Sugimoto, MD, MPH, FAAFP*



For the Office of Speaker – Jorge Galdamez, MD, MPH

As a long-term member of the CAFP, I am honored to be nominated for the role of CAFP Speaker for the term 2026-2027. As a family medicine physician, I have had the honor of serving my community over the past 20 years. Having noted that often it is not enough to be the best physician I could be inside the exam room, I became actively involved in CAFP starting in 2013. First, serving as a leader at the local chapter level, I have continued to take on a bigger role through the years. Over the past 6 years, I have happily and wholeheartedly served on the CAFP Board of Directors. The past 2 years I have served as the Secretary-Treasurer and the Vice Speaker. One role vital is in making sure that CAFP as an organization remains financially responsible and viable. The second role in supporting my fellow Speaker in the role of advocacy and ensuring that the voices of our members are heard within our Academy as well as within our healthcare system. Now, I am committed to continue to serve as your CAFP Speaker. In doing so, I hope to continue to lead and ensure that our voices are heard as we continue to be the very best physicians and advocates for our patients and their communities. — *Jorge Galdamez, MD, MPH*

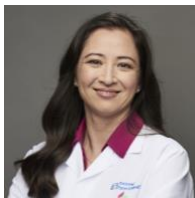


For the Office of Vice Speaker – Erika Roshanravan, MD, FAAFP

It has been a privilege to serve on the CAFP Board of Directors for the past five years, and I would be honored to serve as your Vice Speaker.

We are living in trying times. As family physicians, we directly and deeply experience the threats to safety and well-being in our communities, and the moral injury stemming from a fraught, inequitable healthcare system. In my role as a medical director and lead physician for clinician and staff well-being at a community health center, I face these realities every day. As family physicians, we carry a lot, and we can only do it together. Being connected to this community of family physicians has shown me, time and again, the strength and resilience we find when we band together, support one another, and learn from each other. This room at AMAM brings together the expertise and perspectives of the most brilliant and caring minds in family medicine, and that is our superpower. I am committed to help shape how we strengthen and use our superpower to make our practices more sustainable, our healthcare system more equitable, and to show the world what family physicians can do at the heart of a more accessible, affordable system that centers primary care as a common good.

We need each and every one of us to do this work, and I would be honored to have your support to serve as your Vice Speaker. — *Erika Roshanravan, MD, FAAFP*



For the Office of AAFP Delegate – Shannon Connolly, MD, FAAFP

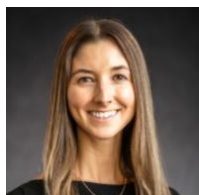
I joined the CAFP as a first-year medical student with a hunch that family medicine might be the right career for the person who gets excited by every aspect of the human experience. At every stage of my career – from med school to residency to new physician to attending and beyond, the CAFP has nurtured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



For the Office of AAFP Alternate Delegate – Kim K. Yu, MD, FAAFP

I am honored to be considered for election as CAFP Alternate Delegate. For the past 26 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 Michigan Academy of Family Physicians serving on its board of directors as President and Board Chair, and as President Elect of California Academy of Family Physicians. 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. I also serve as Liaison to the World Health Organization as a WONCA Executive Committee Board Member. In my work as PRIME National Strategy Consultant for the American Board of Family Medicine and as an urgent care physician at Kaiser Permanente's Urgent Care clinics 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

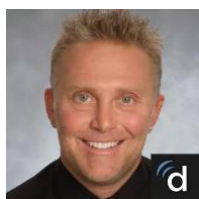
being AAFP social media ambassador, or being a mentor to medical students and residents, or presiding over reference committees and digging into parliamentary procedure (which I love to do!), my hope is to bring joy, excellence, and transparency, so all may understand the essence and heart of Family Medicine. It would truly be an honor to serve as Alternate Delegate, to continue to serve CAFP and all the family physicians in California, to advocate for our specialty, patients and communities. Together with you, I hope to ensure our collective voice in Family Medicine is elevated and the issues that matter to our patients and our specialty are heard and addressed. Thank you again for the opportunity and your kind consideration. — *Kim K. Yu, MD, FAAFP*



For the Office of Governance Committee Member 2026 – 2028 – Juliana Jones, MD

I am seeking the opportunity to serve on the Governance Committee to support the mission of advancing family medicine in California. I completed my residency training in Los Angeles in 2023, where I gained valuable experience caring for a low-socioeconomic status community and addressing a wide range of complex health challenges. These experiences shaped my commitment to patient advocacy, teamwork, and thoughtful systems-based care. I have been actively involved with the California Academy of Family Physicians since medical school, including serving as Student Resident Council Co-Chair, during which I was a member of the CAFP Board of Directors. Through my work on the CAFP Member Engagement Committee, I have collaborated with a diverse group of physicians and trainees to develop innovative strategies to enhance member engagement and retention, fostering community and strengthening relationships across career stages. As an early-career physician, I would bring a perspective to the committee that reflects the experiences and priorities of newer members of the profession.

In my clinical practice, I serve as a mentor and am currently involved in a pilot project to restructure our outpatient clinic, further strengthening my critical thinking, communication, and collaborative leadership skills. I am passionate about patient education and fostering a team-based approach, making me a trusted partner to both patients and colleagues. It would be an honor to serve on the CAFP Governance Committee and contribute to the continued growth and effectiveness of the organization. — *Juliana Jones, MD*



For the Office of Governance Committee Member 2026 – 2028 – Greg Lewis, MD, FAAFP

I am honored to be nominated to serve as a member of the CAFP Governance Committee. As I rotate off the Membership Engagement Committee, where I currently am Co-Chair, I reflected on ways I can continue to contribute to our organization. My career in medicine has provided me with experience in many leadership roles. Having an opportunity to be involved in discussions that identify and nominate individuals to carry out our Strategic Plan would be an incredible privilege. I thank you for your consideration for this important position. — *Greg Lewis, MD, FAAFP*

Organizational Information

CAFP Foundation Annual Report – available on request to cafp@familydocs.org

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