2018 AMAM | March 10-12, 2018
The Citizen Hotel
926 J Street, Sacramento, 95814
Phone 916-447-2700

California Academy of Family Physicians

2018 All Member Advocacy Meeting

2018 Participants' Handbook

CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

We've Got an App for That!

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

The new AMAM App will be live on February 26!

The free app will be available to download February 26. All AMAM registrants will receive an email invitation with a link to download the app.

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

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

- See the full AMAM schedule sorted by day, speaker, track and rate the sessions directly on the app.
- Connect and exchange contact details with other attendees.
- Share your event experiences on Facebook, Twitter and LinkedIn.
- Follow the events on Twitter at #amam2018.
- Find sessions and locations with maps of session rooms.
- Catch notifications about networking opportunities, contests and other breaking event news sent directly to your device.

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

If you have any questions, please contact Shannon Goecke at sgoecke@familydocs.org or 415-345-8667.

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

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

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

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

1. AMAM is not a clinical education opportunity – CAFP's Family Medicine Clinical Forum (April 13-15 in Monterey this year) is the CAFP's primary venue for excellent continuing professional development programming – the AMAM sticks to policy issues affecting the practice of medicine and care of patients, although from time-to-time, a CME opportunity may be piggybacked with the AMAM, as with this morning's Safe Prescribing program. We very much hope to see you in Monterey.
2. AMAM is not a partisan debating society – we are here to help find solutions and make certain CAFP's policies serve our members and their patients well. Opinions differ, of course, but discussion and dialogue are respectful and civil.

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

So, fasten your seatbelts, it's going to be a terrific ride! Mark your calendars now for the <u>2019 AMAM and Family Medicine Lobby Day March 9-11, 2019</u> here at The Citizen Hotel.

Walter Mills, MD, Speaker *David Bazzo, MD, Vice Speaker*

Detailed Schedule of Events

Walter Mills, MD, Speaker and David Bazzo, MD, Vice Speaker

Saturday, March 10, 2018 **Sacramento-El Dorado-Yolo Chapter Free CME Program** **Metropolitan Terrace – 9:00 – 11:00 am** **Opioid Prescribing: Safe Practice, Changing Lives**	
8:15 – 9:15 am	Opioid Prescribing: Safe Practice, Changing Lives Registration
9:00 – 11:00 am	Opioid Prescribing: Safe Practice, Changing Lives Carol Havens, MD faculty
Saturday, March 10, 2018 **Open the Door to Leadership: A Workshop for Medical Students and FM Residents** **YEA Room – 9:30 – 11:30am**	
9:30 – 11:30 am	Open the Door to Leadership Drs. Lance Fuchs, David Bazzo, Lee Ralph and Shelly Rodrigues, CAE
Saturday, March 10, 2018 | Opening Session **Metropolitan Terrace – 11:30 am – 5:00 pm** *The AMAM has been reviewed and approved for up to 7.5 Prescribed credits by the AAFP.*	
11:30 am – 12:30 pm	**All Member Advocacy Meeting (AMAM) Registration – Lunch**
12:45 – 1:00 pm	**Opening Session of the All Member Advocacy Meeting** - Certification of Delegates - Presentation of Election Slate - Nominations from the floor, if any
1:00 – 1:10 pm	**Setting Expectations – What Is the AMAM and What Will We Do in the Next Two Days?** Walter Mills, MD, Speaker
1:10 am – 1:30 pm	**Address of the President** Michelle Quiogue, MD
1:30 – 1:40 pm	**Address of the President-elect** Lisa Ward, MD,
1:40 – 1:45 pm	**Passing of the Gavel** Dr. Quiogue presents Dr. Ward with her gavel and pin.
1:45 – 2:45 pm	**Legislative Briefing on Key CAFP Issues** Carla Kakutani, MD, Adam Francis and Jodi Hicks CAFP Legislative Committee Chair, Staff and Legislative Advocate
2:45 – 3:00 pm	**BREAK**

3:00 – 3:45 pm	**Chapter Development – The Key to Advancing Academy Advocacy** Warren Brandle, MD, President, Sacramento-El Dorado Chapter; Alan Shahtaji, DO, President and Sabrina Bazzo, Executive Director, San Diego Chapter; Rossan Chen, MD, President, Solano Chapter
3:45 – 4:30 pm	**Town Hall Meeting – Running for Office and Telling Your Story** Senator Richard Pan, MD (invited) and Kate Catherall, Co-founder and Partner, The Arena
4:30 – 5:00 pm	**Legislative Staffer Panel – How to Maximize Your Visit with Your Legislator** – Speakers to be announced
5:00 pm	**RECESS**
6:15 pm	**Dine Around Dinners**** Join your fellow delegates and alternates for Dutch treat dining at one of several Sacramento restaurants. Sign-ups are available in the Metropolitan Terrace. Dining groups can be organized by region or practice type or issue area if desired.

Sunday, March 11, 2018 | Closing Session Metropolitan Terrace – 7:15 am – 1:00 pm	
7:30 – 8:30 am	**All Member Advocacy Meeting** **Registration and Continental Breakfast**
8:30 am	**All Member Advocacy Meeting Reconvenes**
8:35 – 8:40 am	**Certification of Delegates/Instructions to Delegates**
8:40 – 8:50 am	**Candidate Speeches** (if any)**/Voting Instructions** (if necessary) Election of Officers, AAFP Delegates and Alternates for 2018-19, New Physician Director 2018-2021, Nominating Committee Member 2017-18 Election of Secretary/Treasurer* Election of Editor* **Elected by the Board of Directors only*
8:50 – 9:05 am	**FP PAC Report** Jay W. Lee, MD, MPH, FP-PAC Chair
9:05 – 9:15 am	**Hero of Family Medicine Award Presentation** Presentation by Michelle Quiogue, MD, President
9:15 – 9:25 am	**Report of the CAFP Foundation** Anthony "Fatch" Chong, MD, or Marianne McKennett, CAFP Foundation
9:25 – 9:35 am	**Review of CAFP Board 2017-18 Policies and Actions on 2017 Resolutions**
9:35 – 10:25 am	**Keynote Address** Lisa Ward, MD, MScPH, MS, Medical Director, Santa Rosa Community Health Centers and Tara Scott, MD, Program Director, Santa Rosa Family Medicine Residency – How Family Medicine and Patient Care Rose from the Ashes of the Sonoma County Conflagration
10:25 – 11:25 am	**Resolutions Hearing – Speaker of the AMAM and CAFP Board of Directors**

	Presentation of testimony to the Board of Directors concerning proposed policies developed by members and chapters. Elections, bylaws changes, dues/special assessment changes and memorial resolutions will be considered and voted on by the Delegates to the All Member Advocacy Meeting. The CAFP Board will hear all other proposals, take action on them over the course of the year, and report back to the AMAM on their disposition at the next meeting. All members are invited to speak. Issues/resolutions may be brought to the CAFP Board at any time during the year. An electronic form for submission is available. - 10:25 – 10:50 am: Discussion on resolution to increase dues – AMAM - 10:50 – 11:25 am: Discussion on resolutions on policy – Board
11:25 am	**Announcement of Election Results** (if necessary) Lee Ralph, MD, Immediate Past President Chair, Nominating Committee
11:30 am	**Adjournment**
11:45 am	**Keynote Speaker and Champion of Family Medicine Awardee** Introduction and Presentation of Award by Michelle Quiogue, MD, President
1:15 – 5:30 pm	**Training Tracks**
Track 1 1:15 – 3:15 pm	**Achieving Health Equity and Diversity – Metropolitan Terrace** Danielle Jones, MPH, Manager, AAFP Center for Diversity and Health Equity Health disparities often arise due to inequitable policies, systems and infrastructures that disproportionately affect marginalized populations. While 75 percent of AAFP members surveyed indicated that FPs should advocate for public policies that address the social disparities of health (SDOH), only a quarter have written to or spoken with elected officials to support SDOH policies and less than 10 percent have provided testimony at a legislative hearing. This interactive workshop offers training on how to identify the potential negative risks of policies to health, communicate those risks to decision makers and act as an advocate for changes to policy to advance health equity. Learners will develop a Health in All Policies (HIAP) plan of action to include: identification of a local/state policy of interest, potential stakeholders and to whom the findings should be communicated to effect change. Learning Objectives: 1. Communicate the Health in All Policies Framework with examples of its application in the U.S.

	2. Identify core partners and resources in their communities to implement the framework. 3. Integrate the process into their clinical/administrative workflow. 4. Communicate findings verbally and in writing to decision makers and stakeholders.
3:15 – 3:30 pm	**BREAK**
Track 2 3:30 – 5:30 pm	**Advocacy – How to Meet with Your Legislator – Metropolitan Terrace** Adam Francis CAFP Director of Government Relations Jodi Hicks, CAFP Legislative Advocate Learn how easy and fun it can be to have a successful meeting with your legislator, whether it's on CAFP's Lobby Day or back home in your district. We'll give you all the tools you need to be a true Family Medicine Revolutionary!
5:30 – 7:00 pm	**Special FP-PAC Donor Reception – Scandal Lounge** Open to all 2018 FP-PAC contributors at no additional cost
7:00 pm	**Evening Free – Dine Around Sacramento** (Meet in the lobby at 7) Share an exciting dining experience with fellow CAFP delegates and alternates. CAFP is *tentatively* holding a reservation for up to 20 guests at 7:15 pm. Staff will accompany dining groups.

Monday, March 12, 2018 | Family Medicine Lobby Day Breakfast and Briefing Metropolitan Terrace – 7:30 – 9:00 am	
7:30 – 9:00 am	**Breakfast and Legislative Issues Orientation** CAFP Director of Government Relations Adam Francis, Director of Health Policy (TBD) and Legislative Advocate Jodi Hicks of DiMare, Brown, Hicks and Kessler.
8:45 am	**Group Photo**
9:00 am – 12:00 pm	**Legislative Visits at the Capitol**
12:00 pm	**Debrief and Adjournment**

Mark Your Calendar!

2019 All Member Advocacy Meeting

March 9-11, 2019

The Citizen Hotel

Roster of 2018 Delegates and Alternates

County/Chapter	Delegates	Alternates
Alameda/Contra Costa (5)	Brea Bondi-Boyd Christina Chavez-Johnson Suzan Goodman Shani Muhammad Brent Sugimoto	Samantha Malm
Amador (1)		
Butte-Glenn-Tehama (1)		
Fresno-Kings-Madera (1)	Robin Lischeid-Janzen	
Humboldt-Del Norte (1)		
Imperial (1)		
Inyo-Mono-Alpine (1)		
Kern (2)	Frank JR Lang Tiffany Pierce	Shweta Agarwal Shakti Srivastava
Lassen-Plumas-Modoc-Sierra (1)		
Los Angeles (12)	Rebecca Bertin Mark Dressner Monique George Nzinga Graham Po-Yin Samuel Huang Kelly Jones Judy Kim Stacey Ludwig Katrina Miller Scott Nass Selene Velasco	Felix Aguilar Sandra Avila Chris Hiromura Daniel Pio Emma Jane Smith-Hiscocks Shabana Tariq
Mendocino-Lake (1)		
Merced-Mariposa (1)		
Monterey (2)	Abril Arias Christine Zaro	
Napa (1)	Tessa Stecker	Christina Kinnevey
North Bay (3)	Toni Ramirez Tara Scott Melanie Southard	Veronica Jordan Panna Lossy Emily Shaw

County/Chapter	Delegates	Alternates
Orange (5)	Jorge Galdamez Anupam Gupta Karina Melgar Timothy Munzing William Woo	Christina Deckert Sofia Meraz Jenny Tan Angel Yap
Placer-Nevada (2)		
Riverside-San Bernardino (6)	Prasanth Bhat Nadia Khan Hobart Lee Alex McDonald Nazmeen Merfeld (Khan) Juan Najarro	Elizabeth Dumeff Mark Keidel Jeff Kim Edwin Kown Michael Nduati Nadia Sheridan
Sacramento-El Dorado (4)	Bill Eng	
San Diego (6)		
San Francisco (2)	Clarissa Kripke Sunny Pak	Ron Labuguen
San Joaquin-Calavaras-Tuolomne (2)	Asma Jafri	
San Luis Obispo (2)		
San Mateo (2)	Steven Howard Alex Moldanado	
Santa Barbara (2)		
Santa Clara (3)		
Santa Cruz (2)		
Shasta-Trinity (2)		
Siskiyou (1)		
Solano (2)	Helen Lam Vanessa Reyes	Robert Moore Christie Thomas
Stanislaus (2)		
Tulare (1)	Robert Allen	Mylene Rucker
Ventura (2)		
Yolo (2)		
Yuba-Sutter-Colusa (1)		

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

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

CAFP Officers and Board of Directors – 2017-2018	
Michelle Quiogue, MD	President
Lisa Ward, MD, MScPH, MS	President-Elect
Lee Ralph, MD	Immediate Past President
Walter Mills, MD	Speaker
David Bazzo, MD	Vice Speaker
Shannon Connolly, MD	Secretary-Treasurer
Carol Havens, MD	AAFP Delegate
Jeffrey Luther, MD	AAFP Delegate
Jay W. Lee, MD, MPH	AAFP Alternate Delegate**
Lee Ralph, MD	AAFP Alternate Delegate**
Anthony "Fatch" Chong, MD	CAFP-F President
Anthony "Fatch" Chong, MD	District I
William Kurt Armstrong, MD	District II
Kevin Rossi, MD	District III
Arthur Ohannessian, MD	District IV
Lauren Simon, MD	District V
Raul Ayala, MD	District VI
Jeannine Rodems, MD	District VII
Jeremy Fish, MD	District VIII
Ashby Wolfe, MD, MPH, MPP	District IX
Nate Hitzeman, MD	District X
Steve Harrison, MD	Rural Director
Shannon Connolly, MD	Young Physician Director
Nate Hitzeman, MD	*CFP* Editor**
Isabel Chen, MD	Resident Co-Director***
Blair Cushing, DO	Resident Co-Director***
Dev Vashishtha	Student Co-Director***
Kimberly Vu	Student Co-Director***

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

*** Non-voting member*

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

2018 Instructions to Delegates and Alternates
CAFP All Member Advocacy Meeting

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

Introduction:

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

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

Advance Preparation: In this Handbook, you will find the Report of Actions of the 2017 All Member Advocacy Meeting and how to access 2017 reports about the CAFP and the CAFP Foundation. Please read the Report of Actions carefully so you will be familiar with the previous actions of the AMAM, the policies considered.

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

What to Do on Site:

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

2. **Certification of Delegates:** CAFP bylaws require that Delegates to AMAM must be reported to the secretary/treasurer sixty (60) working days prior to AMAM (December 18, 2017). Names of Delegates and Alternates reported after that deadline must be accepted as the first action of the AMAM, by a two-thirds (2/3) vote.

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

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

Standing Rules of the All Member Advocacy Meeting:

When AMAM Convenes: The AMAM will convene at 12:30 pm, Saturday, March 10, 2018 following lunch and again on Sunday, March 11, 2018 at 8:30 am following breakfast at The Citizen Hotel, 926 J Street, Sacramento, CA. The order of business will be as outlined in the Participants' Handbook and may be changed by the Speaker of the AMAM as necessary. Meeting rooms also are subject to change.

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

Submission of Resolutions: Resolutions to be submitted to the AMAM should have been submitted to the Academy or the Speaker of the AMAM at least sixty (60) working days prior to the meeting during which they are to be considered (December 18, 2017). The Board of Directors will accept testimony on all resolutions except those regarding dues increases or special assessments; such resolutions will be considered by the voting Delegates of the AMAM under the direction of the Speaker or Vice Speaker.

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

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

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

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

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

When Does the Board Reference Committee Meet? In 2018, the Delegates of the AMAM will meet first at 10:25 am to consider a resolution related to a dues increase; the Board of Directors will convene at 10:50 am and conclude at 11:25 am on Sunday, March 11.

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

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

Nominating Procedures: The Nominating Committee consists of two members selected by and from the Board of Directors, three members elected by and from the AMAM, and the immediate past president, who serves as chair. The 2017 Committee nominated candidates for the following positions, to be elected by the AMAM:

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

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

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

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

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

Knowledge-Based Decision Making Process

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

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

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

This process poses four questions:

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

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

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

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

Parliamentary Procedure

Sturgis Standard Code of Parliamentary Procedure

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

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

Resolutions and Background Materials

Res. A-01-18 - Food Insecurity Screening in Healthcare Settings as Higher Standard of Health Care
Res. A-02-18 - Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis
Res. A-03-18 - Political Resources to Help Family Physician Champions Win Elections – **to be voted on by Delegates of the AMAM**
Res. A-04-18 - Removing REMS Categorization on Mifepristone
Res. A-05-18 - Increased Percentage of Women's Reproductive Health Topics at AAFP FMX and at the National Conference for Residents and Students
Res. A-06-18 - Reducing the Carbon Footprint of California Hospitals through New Renewable Energy Standards
Res. A-07-18 - Call for Physician Wellness as a Quality Indicator of Health Organizations
Res. A-08-18 - Requiring an Evidence-Based Nutrition Curriculum for US Medical Schools
Res. A-09-18 - One Cent Per Ounce Excise Tax on Sugar-Sweetened Beverages

A-01-18

December 18, 2017

Title: Food Insecurity Screening in Healthcare Settings as Higher Standard of Health Care

Authors: Cynthia Chen-Joea, DO, MPH; Isabel Chen, MD MPH; Michelle Lough, MPH, UCLA Medical School

Endorsements: CAFP Resident and Student Council

WHEREAS, The United States Department of Agriculture (USDA) estimates that around 12.3 percent of American households, or 15.6 million people, were food insecure at some point in 2016[1], and

WHEREAS, studies show the cost burden of hunger is at least $160.7 billion annually in the United States[2], and

WHEREAS, based on analysis of the United States Department of Agriculture Household Food Security Survey, the following two questions were most frequently answered in a positive fashion (if answered sometimes or always true) by food insecure families[3]:

1. Are you worried that your food will run out before you get money to buy more? and
2. Does the food you buy last and, if not, do you have money to get more? and

WHEREAS, the two questions had a 97 percent sensitivity and 83 percent specificity rate indicating high accuracy and validity in determining a food insecure family[3], indicating these two questions can easily be used as a quick screen in medical institutions to identify food insecure families and connect them with appropriate resources, and

WHEREAS, hunger and food insecurity are clearly driving up healthcare costs in a significant way[4], and

WHEREAS, the cost of hunger and hunger-related illnesses may far outweigh the cost of feeding families and promoting a healthy lifestyle, now, therefore be it

RESOLVED, that the California Academy of Family Physicians (CAFP) supports and encourages clinicians to identify children and adults who are food insecure to avoid detrimental development and co-morbidities by asking the following two screening tool questions:

1. Are you worried that your food will run out before you get money to buy more? and
2. Does the food you buy last and, if not, do you have money to get more? and, be it further

RESOLVED, that the California Academy of Family Physicians (CAFP) supports and encourages healthcare centers to screen for food insecurity by using the following two screening tool questions as a higher standard of health care:

1. Are you worried that your food will run out before you get money to buy more? and
2. Does the food you buy last and, if not, do you have money to get more? and, be it further

RESOLVED that the California Academy of Family Physicians (CAFP) support various ways for healthcare centers to connect families that are food insecure with short- and long-term food resources, by, for example, referring positively screened patients to local Calfresh representatives who may connect families with such resources.

Speaker's Notes:

Fiscal Note:

1. **PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this resolution pertains to a proposed new CAFP policy or change of policy, what issues does it seek to address?**
   Nutritious foods are essential to healthy growth and development of the physical body and mind. Food insecurity is associated with higher rates of depression, cardiovascular disease, hypertension, diabetes, cancers, and other physician and mental health conditions[4]. By addressing food insecurity, we may hope to also prevent and/or decrease food associated health problems, illnesses and costs. As the first line protectors of our patients' health, family medicine physicians may offer food insecurity screenings as a higher level of care to address this problem.

2. **PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?**
   All family physicians are responsible in playing a role and identifying contributing factors that may affect their patient's health. There are 15.6 million people who are food insecure in America, many of whom may not identify or look obvious. Food insecurity screenings may offer the confidentiality and respect that the patient deserves to connect them with the appropriate resources available.

3. **WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY, i.e., what action do you wish CAFP to take?**
   We propose that CAFP use its position to urge both the CAFP and AAFP to increase awareness about food insecurity among patients of family medicine physicians. Food insecurity screenings offered as a standard practice may provide a higher level of health care that our patients deserve. By investing in public health and prevention strategies and addressing food insecurity, we may protect and prevent food-related illnesses and healthcare associated costs overall.

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

The growing healthcare costs associated with food insecurity is growing every year. These costs include the direct health-related costs, indirect costs of lost work productivity of the patient and/or patient's families, indirect costs of education and schools, subsequent costs of dropouts. The far-reaching effects of food insecurity may contribute to ever-growing and staggering healthcare costs. A new policy is much needed to address this issue through a cost-efficient and beneficial manner[2].

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Res. A-02-18

December 13, 2017

Title: Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis

Introduced by: Zachary Nicholas, MHS

Endorsement*:
*Endorsement not required

WHEREAS, the prevalence of heroin dependence increased by 90 percent between the period of 2002-2004 and that of 2011-2013[1]; and

WHEREAS, the number of deaths attributed to heroin injection overdoses have quadrupled nationally since 2010[2,3]; and

WHEREAS, persons who inject drugs (PWID) are more likely to contract infectious diseases like HIV, hepatitis C, and soft tissue infections[4,5]; and

WHEREAS, supervised injection facilities (SIFs) are sites that "allow PWID to inject self-provided drugs within a supervised framework in enhanced aseptic conditions with medical monitoring and no risk of police control"[6]; and

WHEREAS, in areas where they are established, SIFs reduce the number of overdose deaths[7], reduce transmission rates of infectious disease[8,9], increase the number of individuals initiating substance use therapy[10,11], improve access to care for those that would not otherwise access the health care system[6,12,13,14], and to date have had no documented fatalities[11,12,17]; and

WHEREAS, SIFs effectively attract and provide services for PWID who are at greatest risk due to homelessness, daily use, and recent nonfatal overdose[12,17], and it has been shown that youth in high-risk categories are more likely to use SIFs[18,19]; and

WHEREAS, SIFs do not increase overall illicit drug use, encourage drug use, or promote first-time drug experimentation[10,20]; and

WHEREAS North America's only currently existing SIF has created significant healthcare savings due to averted infections and deaths, and cost-benefit projections for potential SIFs in other North American cities have predicted similarly favorable results[21,22,23]; and

WHEREAS, SIFs in other locations have demonstrated social benefits of reducing public injecting, syringe litter, and local crime including vehicle break-ins and thefts[24,25]; and

WHEREAS, multiple state legislatures and localities are currently involved in efforts to create legal frameworks for and facilitate the creation of SIFs or similar facilities to further combat the opioid addiction crisis[26,27,28,29]; and

WHEREAS, CAFP policy is to support increased funding for drug treatment programs and increased number of physicians to deliver medication-assisted treatment; now, therefore be it

RESOLVED, that our CAFP work with state and local health departments to achieve the legalization and implementation of facilities that provide a supervised framework and enhanced aseptic conditions for the injection of self-provided illegal substances with medical monitoring, with legal and liability protections for persons working or volunteering in such facilities and without risk of criminal penalties for recipients of such services.

Speaker's Notes:

Fiscal Note:

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Res. A-03-18 **FOR CONSIDERATION BY THE DELEGATES OF THE ALL MEMBER ADVOCACY MEETING**

December 4, 2017

Title: Political Resources to Help Family Physician Champions Win Elections

Introduced by: CAFP Board of Directors

Endorsement: CAFP Board of Directors

WHEREAS, advocacy is ranked as one of the top priorities for both the American Academy of Family Physicians (AAFP) and state chapters; and

WHEREAS, the California Academy of Family Physicians (CAFP) established the Family Physicians Political Action Committee (FP-PAC) in 2004 to strengthen advocacy efforts in California; and

WHEREAS, a political action committee is critical to building relationships with candidates committed to the issues of importance to family physicians and their patients; and

WHEREAS, many of the key issues for family medicine are greatly affected by state legislation; and

WHEREAS, CAFP and FP-PAC have limited resources to solicit contributions from members; and

WHEREAS, less than three percent of CAFP members carry the full weight of FP-PAC's political activity benefiting ALL California family physicians; and

WHEREAS, FP-PAC currently does not have the financial resources to compete with the political action committees of chiropractors, optometrists, trial lawyers and others vying for the attention of lawmakers; in just the third quarter of 2017, CAFP was ranked 377th out of 500 California organizations in terms of political spending* (see below for others' rankings); and

WHEREAS, electing champions for family medicine to the State Legislature ensures family medicine's voice is heard and action is taken with our specialty's values in mind; now, therefore be it

RESOLVED, that Family Physicians Political Action Committee (FP-PAC) and the California Academy of Family Physicians (CAFP) pursue the inclusion of a $49 per Active member political contribution for FP-PAC in tandem with AAFP/CAFP/local chapter dues collection; and be it further

RESOLVED, that in the pursuit of inclusion of a $49 per member Family Physicians Political Action Committee contribution in tandem with AAFP/CAFP/local chapter dues collection, the following language should be included on the dues invoice:

"Of the $(total amount)* paid in dues, $49 will go toward the Family Physicians Political Action Committee (FP-PAC) of the California Academy of Family Physicians (CAFP). Please contact CAFP (cafp@familydocs.org) if you do not wish this amount to be used for FP-PAC political purposes; that amount will instead go to CAFP's general fund. CAFP assumes that your dues are paid by you individually. If that is not the case, please contact CAFP at cafp@familydocs.org or call (415) 345-8667."

*Total amount of dues among AAFP, CAFP and county chapters.

Speaker's Notes:

Fiscal Note:

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

   The Family Physicians Political Action Committee (FP-PAC) has seen slow, but steady growth in contributions since its creation in 2004, but not in contributors. Less than 250 contributors carry the financial weight of family medicine's campaign activity in California – under three percent of CAFP's total membership. This level of participation, combined with annual contribution totals roughly $60,000, deprive FP-PAC of the resources it needs to be a major player in the political arena. Repeated environmental scans have revealed that the only way to make the leap into a higher echelon of health care political action committees (PACs) is to link contributions to membership dues. The American Academy of Family Physicians (AAFP) has repeatedly rebuffed efforts to accomplish this, mostly on the grounds of increased direct cost and administrative burden.

   CAFP staff recently spoke with the Executive Director of the California Society of Anesthesiologists (CSA), who faced the same issue with CSA's national organization. CSA developed a solution that removed the burden from the national organization by legally adding a designated contribution to its PAC as an increase in its state chapter dues. CAFP staff then followed up with Ashley Titus, an attorney who advised the California Society of Anesthesiologists on this matter, to confirm the legal requirements and obstacles to linking the dues to a PAC contribution. FP-PAC can accomplish this change, with the support of the CAFP Board, the CAFP All Member Advocacy Meeting and the American Academy of Family Physicians (AAFP).

   For FP-PAC to have the resources to compete with other PACs in the health care world, it must expand its donor base and total contributions through more than just face-to-face and email/mail solicitations.

   Most AAFP Large and Extra-Large state chapters have dues $50 - $99 higher than California's at $300: CO $415; FL $350; GA $365; IL $390; IN $365; MD $395; MI $375; MN $325; NY $290; NC $340; OH $399; PA $350; TX $350.

An approximate $50 increase allocated to FP-PAC, for example, would equate to $280,000 in contributions (i.e., $50 x 5,600 members). This amount does not include those who likely would continue to contribute more annually. This could yield annual total contributions of more than $300,000. Such resources would make it possible for FP-PAC to play an extremely active role in state elections, especially in targeted races. FP-PAC also could participate in Independent Expenditures (IEs), something its current resources preclude. For example, FP-PAC could send direct mail to constituents in a family medicine champion candidate's district (estimated cost $15k-$40k) touting the support he or she has from family physicians. Given the stellar reputation of family physicians, FP-PAC would immediately be seen as a political player with the influence to sway votes and elections. In addition, FP-PAC could hold events for the Senate President Pro Tem and Speaker in the homes of family physicians. The contribution for such events typically requires a donation of $20,000 or more, which would take up more than two-thirds of FP-PAC's current budget. With more than $300,000 in its coffers, however, FP-PAC could easily dedicate that level of funding to events for key legislative leaders.

It is important to note that contribution restrictions on support or opposition to ballot measures would still exist for FP-PAC, (limiting contributions to less than five percent of total yearly contributions), but that would be the case even if FP-PAC received more than $1 million in contributions.

2. **PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?**
   All Active members of CAFP would be affected by this proposed policy – approximately 5,300.

3. **WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY, i.e., what action do you wish CAFP to take?**
   CAFP would ask AAFP to put a disclaimer on the dues statement or potentially on the dues insert that says, "Of the $749 (or whatever the total dues amount might be in a given year) you pay in dues, $49 will go toward the Family Physicians Political Action Committee."

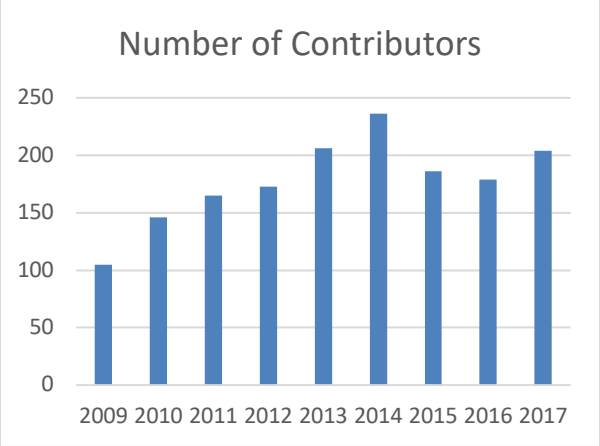
   IT IS NOT REQUIRED, but FP-PAC staff recommends including an opt-out option with the following language: "Please contact CAFP if you do not wish $49 to be used for the FP-PAC and prefer it go instead to CAFP's general fund."

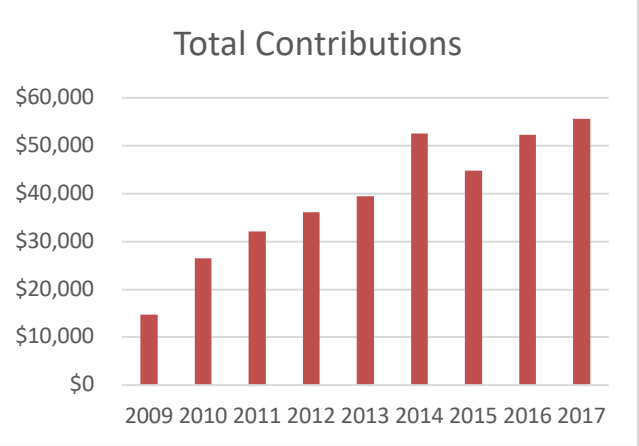
   If a medical group or employer is DIRECTLY paying a member's dues, which is completely legal, FP-PAC only needs to attribute that money to the group or employer (e.g., Hill Physicians) in filing reports. Limits exist on how much a single medical group or employer can contribute to FP-PAC ($7,300), but this will not likely be an issue as we are unaware of any large medical groups or employers that directly pay CAFP membership dues for their family physicians. If the medical group or employer gives the member a stipend that he or she uses to pay membership dues, FP-PAC simply attributes the donation to the physician.

If the dues are paid directly by a public entity (e.g., UC Davis) or a 501(c)(3) (e.g., Mercy Medical), funds cannot be dedicated to FP-PAC. To avoid the additional hassle for AAFP (maybe to CAFP as well) of tracking down the non-member payer of the dues, FP-PAC staff recommends including a disclaimer that reads: "CAFP assumes that your dues are paid by you individually. Contact CAFP if that is not the case."

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

While FP-PAC financial growth has been steady, it has relied on a small number of donors (~200) who disproportionately fund the majority of FP-PAC activities benefiting all CAFP members (9,000+) and family physicians in the state (12,000+).





FP-PAC, sometimes in collaboration with other chapter state PACs, pursued several strategies to link PAC contributions to membership dues at the national level; each has failed to increase contributions or was rejected by AAFP for cost and administrative concerns. Our strategies included:

- Adding an insert in the dues package that informs members of FP-PAC's existence and provides a link to the FP-PAC website (which has resulted in ZERO contributions to date).
- Requesting that AAFP offer an "opt-in" contribution on the dues form to allow a member to check a box and contribute to FP-PAC (which AAFP rejected).
- Partnering with other AAFP state chapters with PACs to pass resolutions forcing AAFP to take action to improve state PAC contributions (which FP-PAC rejected).

References:

Third quarter reporting on political spending in California (500 reporting):
Source: http://www.sacbee.com/news/politics-government/capitol-alert/article183131981.html
#27 - Consumer Attorneys of California
#60 - California Optometric Association
#106 - Blue Shield of California
#289 - California Society of Anesthesiologists
#377 - California Academy of Family Physicians

Res. A-04-18

December 13, 2017

Title: Removing REMS Categorization on Mifepristone

Introduced by: Alison D. Block MD, Anastasia J. Coutinho MD, MHS, Emily Guh MD, Chantal Lunderville MD, MPP

Endorsement:

WHEREAS, the Food and Drug Administration (FDA) uses the Risk Evaluation and Mitigation Strategies (REMS) classification to impose restrictions on only the most dangerous drugs with known or suspected serious complications or contraindications,[1, 2] and

WHEREAS, although the current FDA label for mifepristone was modified in 2016 to reflect more evidenced-based dosing and gestational limits,[3,4] the label still includes a REMS classification requiring three provisions to "assure safe use,"[5] including that 1) mifepristone be dispensed in a healthcare setting under supervision from 2) a provider who is registered and has signed a provider agreement with the pharmaceutical distributor, and 3) the patient sign an FDA-approved Patient Agreement Form, and

WHEREAS, the American Academy of Family Physicians (AAFP) "supports a woman's access to reproductive health services and opposes non-evidence-based restrictions on medical care and the provision of such services,"[6] and

WHEREAS, the REMS restrictions on mifepristone are not based on scientific evidence [7,8,9,10,11] and cause significant barriers to accessing abortion care, [12] (such as landlords whose leases don't allow abortions to be done on site, managers who won't allow stocking of mifepristone, and colleagues who object to provision), and

WHEREAS, there are 16 years of data proving an outstanding safety record of mifepristone,[7-11] including a 0.05 percent risk of major complications,[11] and

WHEREAS, other drugs with higher complication rates, such as acetaminophen, aspirin, loratadine, and sildenafil, do not have REMS restrictions [13,14,15,16] and

WHEREAS, the REMS classification contributes to delays in care,[7,17] thereby increasing second-trimester and surgical abortions, both of which have increased complication rates, and

WHEREAS, the REMS classification creates a barrier to safe and effective off-label uses of mifepristone, such as for anti-corticoid treatment of Cushing's disease, term labor induction, and miscarriage management,[18] now, therefore be it

RESOLVED, that the California Academy of Family Physicians (CAFP) endorse the principle that the REMS classification on mifepristone is not based on scientific evidence and limits access to abortion care; and be it further

RESOLVED, that the CAFP engage in advocacy and lobbying efforts to overturn the REMS classification on mifepristone; and be it further

RESOLVED, that the CAFP submit a resolution to the 2018 AAFP Congress of Delegates calling on the AAFP also to endorse the principle that the REMS classification on mifepristone is not based on scientific evidence and limits access to abortion care; and be it further

RESOLVED, that the CAFP submit a resolution to the 2018 AAFP Congress of Delegates calling on the AAFP to engage in advocacy and lobbying efforts to overturn the REMS classification on mifepristone.

SUMMARY of RESOLUTION: Removing REMS Categorization on Mifepristone

1. **PROBLEM STATEMENT:** What specific practice problem does this resolution seek to solve, or, if this resolution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?
   This resolution aims to remove the Risk Evaluation and Mitigation Strategies (REMS) categorization on mifepristone to increase access and availability of medication abortions.

2. **PROBLEM UNIVERSE:** Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?
   As one in three women is known to have an abortion at some point in their lives, all CAFP patients would most likely have a family member, spouse, mother, or friend who would have received an abortion their lifetime. As CAFP physicians would either be caring for these individual women or their families, access and safety of abortion care would affect all member physicians.

3. **WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY,** i.e., what action do you wish CAFP to take?
   Please see RESOLVED statements. We would like the CAFP to recognize that the REMS classification on mifepristone is not based on scientific evidence and limits access to abortion care, and to further engage in advocacy and lobbying efforts to overturn this REMS classification. We would like the CAFP to support these resolutions on a national scale through the AAFP by forwarding or submitting similar resolutions.

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

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Res. A-05-18

December 17, 2017

Title: Increased Percentage of Women's Reproductive Health Topics at AAFP FMX and at the National Conference for Residents and Students

Introduced by: Drs Emily Guh, Sarah McNeil, Nicole Person-Rennell, Anjana Sharma, and Anne Toledo

Endorsement:

WHEREAS, the AAFP affirms it is essential that family physicians be well trained to provide "comprehensive, continuing care of women throughout their lifecycle;"[1] and

WHEREAS, the AAFP "supports a woman's access to reproductive health services and opposes non-evidence based restrictions on medical and the provision of such services;"[2] and

WHEREAS, in order to maintain qualification and a broad scope of practice, family physicians must continue learning throughout their careers so they might provide patients with up-to-date and evidence-based care throughout their lifecycle; and

WHEREAS, for the 2018 Family Medicine Experience FMX, the Curriculum Advisory Panel (CAP) has weighted women's reproductive health topics at four percent; and

WHEREAS, 51 percent of physician visits are to primary care providers and 19.5 percent (the highest proportion) are with family medicine physicians[3]; and

WHEREAS, an estimated 17.9 percent of outpatient visits are by women of reproductive age, with preconception or contraceptive counseling integral aspects of these visits[4]; and

WHEREAS, in order to recruit new members, the AAFP wants to appeal to family residents, 54 percent of whom are female[5] and tend to see majority female patients; and

WHEREAS, funding for Planned Parenthood and Title X clinics is at risk, shifting care to Federally Qualified Health Clinics, which tend to be family physician-led, requiring a well-prepared work force to meet the increased demand of reproductive health needs of patients[6]; and

WHEREAS, while the AAFP does offer a women's health and maternity care conference containing a few reproductive health care updates, it is a burden for members to attend two separate conferences rather than one full spectrum CME activity; and

WHEREAS, at the 2017 FMX there were seven presentations dedicated to women's reproductive health, but 26 slots dedicated to practice management and 11 dedicated to neurology[7]; and

WHEREAS, family medicine residents and students have requested more reproductive health care and women's health care at their national conference, passing resolutions and filling out conference evaluations; now, therefore be it

RESOLVED, That the California Academy of Family Physicians will advocate through the American Academy of Family Physicians to the Family Medicine Experience (FMX) Curriculum Advisory Panel (CAP) to increase the weight of women's reproductive health topics at future FMX events and remove the four percent cap; and be it further

RESOLVED, That the California Academy of Family Physicians via its delegation will submit a resolution to the American Academy of Family Physicians (AAFP) calling on the AAFP to increase the representation of women's reproductive health topics among future AAFP CME events.

Speaker's Notes:

Fiscal Note:

1. **PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this resolution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?**
   As noted above, providing comprehensive women's healthcare throughout a woman's life is an AAFP supported goal. Despite the need for robust training and continuous education in women's reproductive health to meet this goal, women's reproductive health is proportionally underrepresented at CME conferences with one illustration being the weighting of this topic to just 4 percent at the AAFP FMX conference. This weighting at only 4 percent does not represent the volume of visits and health concerns relating to healthcare need of female patients addressed by family medicine physicians.

2. **PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?**
   Narrowly viewed, all CAFP members who attend AAFP CME events would be affected by the expansion of the weight of women's reproductive health topics at future FMX and other AAFP CME events. More broadly applied, increasing inclusion of women's reproductive health topics at future AAFP CME events would potentially impact thousands of current and future CAFP members and feasibly the care of their female patients (55 percent of clinical volume).

3. **WHAT SPECIFIC SOLUTION ARE YOU PROPOSING TO RESOLVE THE PROBLEM OR POLICY (i.e., what action do you wish CAFP to take)?**
   California Academy of Family Physicians will advocate to the Family Medicine Experience (FMX) Curriculum Advisory Panel (CAP) to increase the weight of women's reproductive health topics at future FMX events to be more representative of the percentage of clinical care that involves women's reproductive health topics and to remove the 4% cap; and advocate for increasing representation of women's reproductive health topics at future CME events.

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

Please see "whereas section" and problem statement

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Res. A-06-18

January 11, 2018

Title: Reducing the Carbon Footprint of California Hospitals through New Renewable Energy Standards

Introduced by: Sarah Petrie, DO, Joanna Ingebritsen, MD, Kaitlin Best, DO, Sean Nisam, MD, Deborah Orosz, MD, and Kristina Rodriguez, MD

Endorsement: Napa – Solano CAFP chapters

WHEREAS, hospitals are responsible for roughly eight percent of the U.S.'s greenhouse gas emissions[1]; and

WHEREAS, increasing greenhouse gas emissions affect climate change such that the rates of respiratory, cardiovascular and infectious diseases are increasing, as are famine and direct heat-related deaths[2]; and

WHEREAS, the U.S. health care sector's electricity use contributes to more than $600 million in additional health care costs from increased asthma and other respiratory illness[3]; and

WHEREAS, hospitals have been excluded from the energy efficiency standards applied to other nonresidential buildings set forth by the California Energy Commission since 1982[4]; and

WHEREAS, healthcare represents one-seventh of the US economy and currently spends $5.3 billion on energy each year, thus wielding significant economic clout[5]; and

WHEREAS, investing in renewable energy can result in significant long-term savings, for example, the Cleveland Clinic passed an initiative with the goal of 20 percent energy reduction per square foot and is currently at 12 percent energy reduction per square foot, and saves $6 million/year in energy costs, $3 million of which were from simply switching to LED lightbulbs[1]; and

WHEREAS, 30 percent of hospital energy is used in operating rooms (ORs) where measures such as turning off the air conditioning in ORs when they are not in use and reusing sterilized OR instruments can save hospitals millions of dollars each year[1]; now, therefore be it

RESOLVED, that California Academy of Family Physicians (CAFP) urge the California Department of Public Health's Licensing and Certification Division to adopt stronger regulations regarding the sources of energy for California hospitals and standards for energy efficiency in new hospitals, such that all existing hospitals in California are required to reach a minimum of 30 percent renewable energy by the year 2030 and 50 percent by 2050, and all new hospitals are required to use a minimum of 90 percent renewable energy starting in the year 2020; and be it further

RESOLVED, that in order for hospitals to reach the goals of a minimum of 30 percent renewable energy by the year 2030 and 50 percent by 2050 and all new hospitals using a minimum of 90 percent renewable energy by the year 2020, CAFP should encourage hospitals to install rooftop solar panels, switch to LED light bulbs, maximize insulation within new hospital buildings, shut off air conditioning in

operating rooms that are not in use, use hybrid and electric vehicles in their fleet and for transporting supplies, initiate recycling and compost programs, and re-use sterilized instruments for procedures.

Speaker's Notes:

Fiscal Note:

References:

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Res. A-07-18

January 11, 2018

Title: Call for Physician Wellness as a Quality Indicator of Health Organizations

Introduced by: Helen Lam, MD; Kaiser Permanente Napa-Solano, CA, Jessica DeJarnette, MD; Kaiser Permanente Napa-Solano, CA

Endorsement: Napa-Solano Chapter of CAFP

WHEREAS, from 2013 to 2017 the overall burnout rate for US physicians has increased from 40 percent to 51 percent based on a survey of more than 14,000 physicians representing 30 different specialties, indicative of a 25 percent increase in more than four years [1]; and

WHEREAS, burnout rates are even higher in other studies, including international studies [2] and young physicians report nearly twice the burnout rate as compared to older colleagues, and is higher still among medical students and resident physicians at an estimated 60-69 percent,[3,4] demonstrating that burnout among physicians is a growing epidemic; and

WHEREAS, burnout is defined as emotional exhaustion, depersonalization, and self-doubt driven primarily by workplace stressors [5,6,7]; or in other words, a long-term negative affective state comprising emotional exhaustion, physical fatigue, and cognitive weariness, resulting from chronic exposure to unresolvable occupational stress; and

WHEREAS, burnout is associated with increased rates of depression, suicidal ideation, and substance abuse; suicide rates in physicians are estimated to be six times higher than in the general population[8,9,10,11]; multiple state board applications deter physicians from seeking help by discriminating against physicians who report substance abuse issues, and/or other psychiatric diagnoses and whether or not physicians see psychiatric providers [12]; and

WHEREAS, up to 65 percent of physicians report concerns about work-life balance, 64 percent feel their workload is too heavy, 8-12 percent of all practicing physicians develop a substance abuse disorder at some point in their careers, and more than 80 percent of general practitioners and hospital doctors report working through illness[13;] and

WHEREAS, ongoing rapid changes to the health care delivery model (increased patient-care demands, remuneration issues, growing bureaucracy with practice, increased conflicts between organizational needs and patient needs) contribute to excessive workloads, chronic work-related stress and restricted autonomy, which all contribute to burnout; and

WHEREAS, as workloads and stress increase, it is expected that turnover rates will rise, increasing the cost to recruit and retain physicians and worsening the projected worldwide shortage of physicians in primary care[14]; and

WHEREAS, patient care suffers and medical errors increase when physicians are unwell; and

WHEREAS, physicians' overall job satisfaction has positive effects on patients' adherence to treatment and actions in managing chronic diseases, in addition to being an important factor in patient satisfaction; and

WHEREAS, indicators of quality patient care and quality within health-care systems do not include any measures of physician wellness; and

WHEREAS, the "Triple Aim" of enhancing patient experience, improving population health and reducing costs that guide health care organization strategies ignores the wellbeing of healthcare providers; now, therefore be it

RESOLVED, that the California Academy of Family Physicians advocate for the Triple Aim to be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of health care providers, and to make Physician Wellness a quality measure for healthcare systems and ask the American Academy of Family Physicians to do the same by working with Congressional leaders.

Speaker's Notes:

Fiscal Note:

1. **PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this resolution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?**
   Physician burnout is an epidemic, with primary care providers exhibiting higher rates of burnout than other specialties. As the American healthcare system has evolved, with fewer small private practices and increasing numbers of physicians employed in healthcare systems, there have been increasing administrative duties, documentation requirements with EMR, coding requirements, and limitations in practice due to insurance reimbursement. All of these factors take away from patient-physician interaction and add to the physician workload. Physicians are working longer hours, dealing with increasing responsibilities, and experiencing burnout, which affects the quality of care provided to the patient, affects patient outcomes, and contributes to increased healthcare costs. The proposed resolution seeks to add a measure of Physician Wellness as a quality indicator to fundamentally address the problem of physician burnout as an organizational responsibility.

2. **PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?**
   All CAFP members and members' patients are potentially affected by the problem of physician burnout as colleagues are suffering and patient care is suffering.

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

   The CAFP should advocate for the AAFP to work with Congressional leaders to expand the quality measures of healthcare systems to include a measure of Physician Wellness and therefore encourage healthcare organizations to seek practical systems-based solutions to burnout.

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

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

References:

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Res. A-08-18

January 7, 2018

Title: Requiring an Evidence-Based Nutrition Curriculum for US Medical Schools

Introduced by: Christie M Thomas, MD, and Kelsey Krigstein, MD

Endorsement: Napa and Solano Chapters

WHEREAS, 36 percent of US adults and 17 percent of US children are obese (BMI greater than or equal to 30) with recent trends showing continued increases[1]; and

WHEREAS, in a recent systematic review and meta-analysis, statistically significant associations with obesity were found with the incidence of type II diabetes, hypertension, coronary artery disease, congestive heart failure, pulmonary embolism, stroke, asthma, gallbladder disease, osteoarthritis, chronic back pain, and cancer, including colorectal, kidney, breast, ovarian, endometrial, and pancreatic[2]; and

WHEREAS, extrapolation from available data suggests that increases in obesity-related diseases are projected to add $48-66 billion a year in additional healthcare costs by 2030[3]; and

WHEREAS, the top contributors to this cost include arthritis, coronary heart disease and diabetes, with half of these projected costs to be incurred by individuals aged 65 and older[3]; and

WHEREAS, the current nutrition instruction guidelines for medical education of 25-30 curricular hours[4], which corresponds to less than one percent of estimated total lecture hours[5], was developed in 1985 when the scope of medically-relevant nutrition knowledge was limited[4]; and

WHEREAS, a survey of 121 US medical schools reported they provided 19 hours on average of nutrition instruction with a standard deviation of 13.7 hours, and 12 schools required no instruction[4]; and

WHEREAS, the majority of the instruction was related to biochemistry and not evidence-based diets or patient counseling[5]; and

WHEREAS, only a small fraction of the instructional hours was during clinical training[4]; and

WHEREAS, one survey of medical residents found that only 14 percent felt prepared to provide competent nutrition recommendations to their patients[6]; and

WHEREAS, one review of patient records found that less than 10 percent of US primary care providers (PCPs) counsel patients on weight loss and 52 percent of that counseling is done by only nine percent of PCPs[7]; now, therefore be it

RESOLVED: that the California Academy of Family Physicians (CAFP) advocate for the American Academy of Family Physicians (AAFP) to work with the Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA) to improve the nutrition curriculum for US medical schools through the following curricular changes:

1. Increase clinical nutrition education from the current 25-30 hours *recommendation* to a *requirement* of 50-60 hours (still less than two percent of estimated total lecture hours);
2. Recommend nutrition instruction in both preclinical *and* clinical settings with a focus on historical nutrition trends and current evidence using an integrated format with lectures, problem-based learning[1], online self-learning modules, and clinical practice;
3. Recommend teaching motivational interviewing and mindfulness training;
4. Consider other creative innovations such as the establishment of teaching kitchens and self-care curriculums with elective laboratory instruction in nutrition and food preparation[5];
5. Consider incorporating healthy diet and weight loss counseling cases in the National Objective Structured Clinical Exam (OSCE); and
6. Require that the United States Medical Licensing Exam (USMLE) evaluate students' knowledge of current evidence-based nutrition.

1. **PROBLEM STATEMENT: What specific practice problem does this resolution seek to solve, or, if this resolution pertains to a proposed new CAFP policy or change of policy, what issue does it seek to address?**
   It is clear from survey data that medical students, residents, and practicing physicians do not feel competent in evidence-based nutrition data nor in counseling patients on diet and weight loss. In fact, one review of patient records[7] found that only 10 percent of PCPs counsel patients on weight loss, yet two-thirds of Americans are overweight and more than one-third are obese[1], and trends show continued increases necessitating that all healthcare professionals are well-versed in evidence-based nutrition and counseling. This resolution seeks to improve nutrition education in medical schools so that we begin to prepare the future generations of physicians for the challenges they will face in treating obesity and obesity-related illness.

2. **PROBLEM UNIVERSE: Approximately how many CAFP members or members' patients are affected by this problem or proposed policy?**
   All physicians nationally are affected by the obesity epidemic in this country as more than one-third of Americans are obese[1].

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

This proposal recommends that the CAFP advocate for the AAFP to work with the LCME and COCA to improve the medical school nutrition curriculum through requiring more dedicated instruction hours in both preclinical and clinical settings with an emphasis on evidence-based nutrition and counseling using integrated and innovative learning tools. It also recommends that nutrition knowledge and counseling be tested on the OSCE and USMLE to ensure mastery of the information.

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

With obesity now defined as an epidemic in the United States it has become one of the most pressing public health issues. A substantial amount of literature predicts continued increases in obesity prevalence, identifying strong associations with multiple medical illnesses, projecting an increased cost burden for these obesity-related illnesses, showing inadequate teaching time in medical school and residency, and noting the perceived lack of competence in evidence-based nutrition and subsequent low counseling rates by PCPs.

References:

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Res. A-09-18

January 14, 2018

Title: One Cent Per Ounce Excise Tax on Sugar-Sweetened Beverages*

Introduced by: Rossan Chen, MD MSc, Matt Symkowick, MD

Endorsement: Napa and Solano CAFP chapters

WHEREAS, a 12-ounce can of regular soda has about 40 grams (10 teaspoons) of sugar[1]; and

WHEREAS, an eight-ounce fruit punch has about 30 grams (seven teaspoons) of sugar[2]; and

WHEREAS, sugar-sweetened beverages are the largest contributors of added sugars in American diets[3]; and

WHEREAS, sugar-sweetened beverages are the top source of total calories among American teenagers[4]; and

WHEREAS, unlike sugar from food, sugar from beverages enters the body quickly and overloads the liver and pancreas's ability to process the sugar; and

WHEREAS, sugar raises insulin levels, which is directly and indirectly implicated in insulin resistance, obesity, diabetes, hypertension, hypertriglyceridemia, heart disease, stroke, dementia, and cancer[5]; and

WHEREAS, consuming one to two sugary drinks per day increases the risk of diabetes by 26 percent[6] and two or more sugary drinks per day increases the risk of heart attack by 35 percent[7]; and

WHEREAS, diabetes affects 9.4 percent (30.3 million) of Americans of all ages and pre-diabetes affects 34 percent (84.1 million) of American adults[8]; and

WHEREAS, medical costs for overweight and obesity are estimated to be $147 billion, or 9.1 percent of US health care expenditures, half of which is paid for publicly through Medicare and Medicaid[9]; and

WHEREAS, existing state sales taxes on soft drinks are too low to affect consumption and the revenues are not earmarked for programs related to health[10]; and

WHEREAS, an excise tax of one cent per ounce on sugar-sweetened beverages could prevent 2.4 million diabetes person-years, 30,000 heart attacks, 8,000 strokes, 26,000 premature deaths, and avert more than $17 billion in medical costs over 10 years[11]; and

WHEREAS, Berkeley, San Francisco, Oakland, and Albany, California have already successfully implemented local "soda taxes" of one cent per ounce on sugar-sweetened beverages; and

WHEREAS, a UC Berkeley study showed a 21 percent decrease in sugar-sweetened beverage consumption and a 63 percent increase in bottled and tap water consumption among low-income neighborhoods in Berkeley one year after the soda tax was implemented [12] yet overall consumer spending did not increase[13]; and

WHEREAS, the US Department of Health and Human Services reports that a national one cent per ounce tax on sugar in soda could generate $14.9 billion in the first year alone[14] and California could generate $1.1 billion annually[15]; and

WHEREAS, the tax revenue generated from the excise tax could be used to subsidize the health care costs incurred from consumption of sugar-sweetened beverages, subsidize healthier foods and beverages, nutrition education and/or obesity prevention research; and

WHEREAS, while opponents may argue that a soda tax would be regressive, the tax on sugar-sweetened beverages would disproportionately benefit the poor by improving health, lowering expenditures on beverages, and supporting obesity prevention, health care and/or school nutrition programs; and

WHEREAS, similarly modeled tobacco taxes have been shown to be an effective, non-regressive tool to reduce harmful tobacco use, increase awareness of the adverse health effects of tobacco, fund further research in tobacco harms and successful cessation practices, and reduce tobacco-associated healthcare costs[16]; now, therefore be it

RESOLVED, That the CAFP work with state legislators for a state-wide excise tax of one cent per ounce on sugar-sweetened beverages and advocate for the AAFP to work with Congressional leaders to implement a nation-wide excise tax of one cent per ounce on sugar-sweetened beverages, exempting beverages sweetened with artificial sweeteners, such as aspartame or saccharine given the current lack of strong scientific evidence that they are associated with deleterious health effects, but closely tracking studies to determine whether taxing might be justified in the future; and be it further

RESOLVED: That the revenue generated from a state-wide and/or a nation-wide excise tax of one cent per ounce on sugar-sweetened beverages be earmarked to support childhood nutrition programs, obesity-prevention research, and subsidizing healthier foods and beverages.

** Sugar-sweetened beverages are defined as carbonated and uncarbonated beverages that contain added, naturally derived caloric sweeteners such as sucrose (table sugar), high fructose corn syrup, or fruit-juice concentrates. Examples include non-diet soft drinks, fruit cocktails, fruit drinks, sports drinks, energy drinks, flavored iced teas, and flavored milk and dairy drinks.*

Speaker's Note: Soft Drinks in Schools Policy: that CAFP adopt a policy on Soft Drinks in Schools, similar to that put out by AAP, as follows:

- Family physicians should work to eliminate sweetened drinks in schools. This entails educating school authorities, patients, and patients' parents about the health ramifications of soft drink consumption. Offerings such as real fruit and vegetable juices, water, and low-fat white or flavored milk provide students at all grade levels with healthful alternatives. Family physicians should emphasize the notion that every school in every district shares a responsibility for the nutritional health of its student body.
- Family physicians should advocate for the creation of a school nutrition advisory council comprising parents, community and school officials, food service representatives, physicians, school nurses, dietitians, dentists, and other health care professionals. This group could be one component of a school district's health advisory council. Family physicians should ensure that the health and nutritional interests of students form the foundation of nutritional policies in schools.
- School districts should invite public discussion before making any decision to create a vended food or drink contract.
- If a school district already has a soft drink contract in place, it should be tempered such that it does not promote over-consumption by students.
- Soft drinks should not be sold as part of or in competition with the school lunch program, as stated in regulations of the US Department of Agriculture.
- Vending machines should not be placed within the cafeteria space where lunch is provided. Their location in the school should be chosen by the school district, not the vending company.
- Vending machines with foods of minimal nutritional value, including soft drinks, should be turned off during lunch hours and ideally during school hours.
- Vended soft drinks and fruit-flavored drinks should be eliminated in all elementary schools.
- Incentives based on the amount of soft drinks sold per student should not be included as part of exclusive contracts.
- Within the contract, the number of machines vending sweetened drinks should be limited. Schools should insist that the alternative beverages listed in recommendation 1 be provided in preference over sweetened drinks in school vending machines.
- Schools should preferentially vend drinks that are sugar-free or low in sugar to lessen the risk of excessive weight gain and/or obesity.
- Consumption or advertising of sweetened soft drinks within the classroom should be eliminated.

A-2-04, 4/04 CoD

Fiscal Note: Expense varies based on degree of advocacy – from minimal to $40,000 or more.

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

This resolution seeks to emulate the success of taxes on tobacco and alcohol. Like these existing excise taxes, revenue generated from taxes on sugar-sweetened beverages can improve health outcomes by discouraging consumption, fund research and education in obesity prevention, and defray the health costs of sugar-sweetened beverages.

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

All, or most, CAFP members treat patients with diabetes, obesity, and metabolic syndrome. All patients who drink sugar-sweetened beverages would be affected by such a tax. Future healthcare savings achieved through the funding of research and education would affect all patients.

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

Work with state and national policymakers to implement a 1 cent per ounce excise tax on sugar-sweetened beverages. Sugar-sweetened beverages is defined as carbonated and uncarbonated beverages that contain added, naturally derived caloric sweeteners such as sucrose (table sugar), high fructose corn syrup, or fruit-juice concentrates. Examples include non-diet soft drinks, fruit cocktails, fruit drinks, sports drinks, energy drinks, flavored iced teas, and flavored milk and dairy drinks. Beverages sweetened with artificial sweeteners, such as aspartame or saccharine, would be exempt given the current lack of strong scientific evidence that they are associated with deleterious health effects, however there should be close tracking of studies to determine whether taxing might be justified in the future.

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

The rising rates of diabetes, obesity, and metabolic syndrome are directly attributed to excess sugar and refined carbohydrates. Reducing consumption of sugar and refined carbohydrates has been shown to reduce diabetes, obesity, and metabolic syndrome. Sugar in beverages is particularly dangerous to our health because the rapid consumption of sugar in beverages quickly overwhelms the liver and pancreas.

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Elections

PRESENT: Lee Ralph, MD, Chair, Asma Jafri, Kelly Jones, Jeannine Rodems, Tonatzin Rodriguez; Susan Hogeland, CAFP Staff.
EXCUSED: Liz Leavitt

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1. Call to Order

2. CAFP Open 2018-2019 Positions

1) President-elect 2018-19
2) Speaker 2018-19
3) Vice Speaker 2018-19
4) AAFP Delegate 2018-19
5) AAFP Alternate Delegate 2018-2019
6) New Physician Director, CAFP Board 2018-2021
7) Two Nominating Committee members for 2018-19 from the AMAM (two-year terms)
8) Secretary/Treasurer 2018-2019 (one-year term) – recommendation only to the CAFP Board of Directors
9) Editor 2018-2021 – recommendation only to the CAFP Board of Directors

3. Nominations

Office	Incumbent	Nominee
Elected by Delegates at the All Member Advocacy Meeting		
1) President-elect	Lisa Ward, MD, MScPH, MS (ineligible)	**Walter Mills**
2) Speaker	Walter Mills, MD, MBA (eligible)	**David Bazzo**
3) Vice-Speaker	David Bazzo, MD (eligible)	**Shannon Connolly**
4) AAFP Delegate (2018-19)	Carol Havens, MD (eligible)	**Carol Havens**
5) AAFP Alt. Delegate	Lee Ralph, MD (eligible)	**Lee Ralph**
6) New Physician, CAFP Board (2018-2019)	Shannon Connolly, MD (ineligible)	**Alex McDonald**
7) Nominating Committee (18-19)* (two positions)	Asma Jafri, MD (eligible if Delegate to the 2018 AMAM)	**Asma Jafri**
	Kelly Jones, MD (eligible if Delegate to the 2018 AMAM))	**Monique George**

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

Elected by and from the Board

8) Secretary-Treasurer (2018-19)	Shannon Connolly, MD (ineligible)	**Lauren Simon**
9) Editor (2018-2021)	Nate Hitzeman, MD (ineligible)*	**Brent Sugimoto**

The Secretary/Treasurer must currently serve on the Board.
*Dr. Hitzeman was elected District 10 Director to the Board in March of 2017.

4. Adjournment

Candidates' Statements

For the Office of President-elect – Walter Mills, MD

It was 40 years ago, at UCSD medical school that I first heard about this new specialty of family medicine. I knew right then that that was why I had come to medical school. Being a family physician has been amazing. I've practiced internationally, been a rural FP, delivered babies, worked in emergency rooms, been a hospitalist, studied integrative medicine and geriatrics, taught, learned how to lead….and follow. 106,000 ambulatory care visits and 3,000 hospital visits later, after growing up with our specialty and being blessed so many times with the joys of being a family physician, I am deeply appreciative of the chance to pay it forward, and, if elected, serve as your President-elect.

Walt Mills, MD

For the Office of Speaker – David Bazzo, MD

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

David Bazzo, MD

For the Office of Vice Speaker – Shannon Connolly, MD

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

Shannon Connolly, MD

For the Office of AAFP Delegate 2018-19 – Carol S. Havens, MD

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

Carol S. Havens, MD

For the Office of AAFP Alternate Delegate 2018-19 – Lee Ralph, MD

I am honored to be selected by the Nominating Committee to run for the office of AAFP Alternate Delegate for the CAFP. Health care in our country is under attack on many fronts. Access to care remains suboptimal, cost increases are becoming even more unaffordable, and recognition and payment for the complicated and complex care provided by family physicians is underappreciated. These are just a few of the issues that must be dealt with at the National, State and community levels. I have been privileged to have attended several of the AAFP Congress of Delegates representing CAFP and would like to continue the journey to help fight for those issues most relevant to you, the members of the CAFP.

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

We have a wonderful group of physicians who have represented us well on the national level and I would be honored to continue working with all of them at the AAFP. Finally, as your alternate delegate I promise to be open and available to communications with any CAFP member regardless of their position on specific issues. We remain unified only if we all are heard! Thank you for your consideration.

Lee P. Ralph, MD

For the Office of Nominating Committee Member 2018-2019 – Asma Jafri, MD

No statement submitted.

Asma Jafri, MD

For the Office of Nominating Committee Member 2018-2019 – Monique George, MD
I work at Kaiser Permanente Woodland Hills in LA County and enjoy providing both inpatient and outpatient care and teaching as part of faculty with our Family Medicine Residency Program. I have been involved with the LAAFP for the last four years and this is my second year on the executive committee. I enjoy attending AMAM and feel that now is a crucial time for Family Medicine to advocate for ourselves and our patients. I would like to continue that involvement on the Nominating Committee and represent Los Angeles physicians.

Monique George, MD

For the Office of New Physician – 2018-2021 – Alex Mroszczyk-Mcdonald, MD
I am honored to be nominated as the California Academy of Family Physicians New Physician Director. The Board of Directors must continue to demonstrate strong, effective leadership as we continue to reduce barriers, incorporate efficient use of technology, drive growth and raise awareness of the incredible value of family medicine. Multiple issues face family medicine and it is important that we remain focused and act strategically to have the greatest impact and use our resources wisely. I have found my home within the CAFP and have been incredibly engaged and inspired while serving on the Legislative Affairs Committee as well as the new Membership Engagement Committee. The Family Medicine Revolution is alive and well in the state of California. I would be proud and would cherish the opportunity to help lead the charge into the future and ensure continued success as we stand up for patients and family physicians within our state.

Alex Mroszczyk-McDonald, MD

For the Office of Secretary-Treasurer (elected by and of the Board) – Lauren Simon, MD
I am honored by and grateful for your nomination for the office of CAFP Secretary-Treasurer. Inspired by the dedication and passion of the CAFP leadership and its members, I have been intimately involved in the mission and activities of CAFP for the past two decades. Through CAFP I have developed a deeper understanding of the issues that affect us as family physicians and that challenge our patients, communities and medical learners.

During my tenure with CAFP, I have focused on the areas of advocacy, pipeline and medical education. I have served and currently serve on the CAFP Board of Directors (2006-2012,) and 2015 to the present; as Chairperson Medical Student Resident Affairs Committee MSRAC 2011 -2017; CAFP Co-chairperson the Inland Empire Region, (nine residency programs) of the CAFP California Residency Network (CRN) 2014-present; Delegate or Alternate Delegate to the CAFP All Member Advocacy Meeting (AMAM), formerly the Congress of Delegates, 2000-present; and CAFP Alternate Delegate to the California Medical Association House of Delegates 2016.

Participating in lifelong learning initiatives in CAFP and on the CAFP Foundation Board of Trustees has been one of the highlights of my CAFP experience. Developing the clinical research poster competition, presenting lectures and producing written and electronic continuing medical education (CME) for CAFP CME have fueled my joy of, and commitment to, my work as a Family Physician. Working on projects

and programs with CAFP has provided me with an exceptional opportunity to share friendships and goals with others who share a passion for our specialty and the compassionate care we provide for the people in our communities.

It would be a privilege to serve as CAFP Secretary-Treasurer. I pledge to do all that is in my power to work with my colleagues and friends of the CAFP to navigate the challenges that we face, and the opportunities that we can harness in the specialty of Family Medicine. I look forward to the opportunity to serve our Academy and I appreciate your support.

Lauren Simon, MD

For the Office of Editor – Brent K. Sugimoto, MD, MPH
I am honored to be nominated to the position of Editor of *California Family Physician*. I am a family physician at Kaiser Permanente in Oakland, California, practicing primary care and serving those living with HIV. I also work with community HIV providers, government agencies and non-governmental organizations on the steering committee of East Bay Getting to Zero, an initiative to eliminate new HIV infections, HIV-related deaths and HIV stigma in Alameda and Contra Costa counties. Being a part of our Academy supports both my practice and my work in the community, and I am dedicated to helping keep it strong for all California family physicians.

I have served our Academy as alternate delegate and delegate to the AAFP National Conference of Constituency Leaders, where I have been co-convener for the LGBT caucus, as well as alternate delegate and delegate to the AAFP Congress of Delegates. I continue to be active at the national level as a member of the Commission on Membership and Member Services, as well as that commission's representative to the Workgroup on Primary Care and Public Health Integration. Within the California Academy, I am a member of the Membership Engagement Committee. *California Family Physician* has been an effective medium for communication among our membership and I look forward to continuing that tradition. In our dynamic Academy, communication is a vital piece of organized Family Medicine – if elected I will commit myself as Editor to help keep the voice of family medicine in California clear and strong.

I thank you for this opportunity and humbly submit myself for your consideration.

Brent K. Sugimoto, MD, MPH

Organizational Information

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

Report on Actions by the CAFP Board of Directors on Policies Proposed at the 2017 AMAM

The CAFP All Member Advocacy Meeting Delegates have the responsibility of reviewing the Academy's policy and direction implemented by the Board, Executive Committee, and committees of the Board. The Bylaws require that annual activity reports shall be submitted and that the delegates to the AMAM may, at any time by a majority vote, approve a referendum for submission to the members of the Academy on questions affecting the policy or recommendations of the Academy. The annual dues and/or assessments for members shall be recommended by the Board subject to the approval of a majority of the delegates at the AMAM.

The CAFP Board of Directors has taken the following actions on resolutions submitted since the 2017 AMAM:

The CAFP All Member Advocacy Meeting Delegates have the responsibility of reviewing the Academy's policy and direction implemented by the Board, Executive Committee, and committees of the Board. The Bylaws require that annual activity reports shall be submitted and that the delegates to the AMAM may, at any time by a majority vote, approve a referendum for submission to the members of the Academy on questions affecting the policy or recommendations of the Academy. The annual dues and/or assessments for members shall be recommended by the Board subject to the approval of a majority of the delegates at the AMAM.

The CAFP Board of Directors has taken the following actions on resolutions submitted in 2017:

A-01-17 – Repeal the Hyde Amendment

The Board accepted the first two Resolveds of this resolution as current CAFP policy:

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

RESOLVED, that the CAFP urge the AAFP to engage in advocacy and lobbying efforts to overturn the Hyde Amendment, which bans federal funding for abortions; and be it further

The Board approved substitute Resolveds for the third and fourth Resolveds:

RESOLVED, that the CAFP submit a resolution to the 2017 American Academy of Family Physicians (AAFP) Congress of Delegates calling on AAFP to endorse the principle that women receiving health care paid for through health plans funded by state or federal governments and who have coverage for continuing a pregnancy also should have coverage for ending a pregnancy; and be it further

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

ACTION
A resolution seeking to achieve the third and fourth Resolveds was submitted to the American Academy of Family Physicians' 2017 Congress of Delegates. The Congress referred the resolution to the AAFP Board of Directors.

A-02-17 – Call for a Physical Activity Vital Sign in Clinical Practice

The Board adopted the following substitute resolution for A-02-17 at its April 7, 2017 meeting:

RESOLVED, that California Academy of Family Physician (CAFP) encourage family physicians to recommend that adults aged 18–64 do at least 150 minutes of moderate-intensity aerobic physical activity throughout the week or do at least 75 minutes of vigorous-intensity aerobic physical activity throughout the week or an equivalent combination of moderate- and vigorous-intensity activity, and be it further

RESOLVED, that the California Academy of Family Physicians develop policy to encourage family physicians to make a routine, standardized and widespread practice of measuring patients' habitual physical activity, and consider physical activity a "vital sign," be to assessed at clinical visits as appropriate and to engage patients in conversation and preventative counseling to ensure they are aware of and understand the proven connection between regular physical activity and optimal health.

ACTION
The resolution has been shared with the Academy's Committee on Continuing Professional Development. The author was invited to contribute an article to *California Family Physician.* The policy was included in the CAFP Policy Manual.

A-03-17 – Endorse Restriction of Antibiotic Use in Food Animals

The Board adopted the following substitute resolution for A-03-17 at its April 7, 2017 meeting:

RESOLVED, That CAFP urge that non-therapeutic use in animals of antimicrobials that are also used in humans should be terminated or phased out to protect the efficacy of these medications in human medicine and urges that AAFP do the same; and be it further

RESOLVED: That CAFP encourages bulk purchasers of foodstuffs, including restaurant chains, school and hospitals, to adopt policies encouraging procurement of foodstuffs from food animals raised with no medically important antibiotics except when given on a therapeutic basis (on a non-routine basis, or for a diagnosed disease) by a licensed veterinarian with an established veterinarian client-patient relationship and urges AAFP to encourage the same.

ACTION
The Board directed that this policy be included in CAFP's policy manual and that the Legislative Affairs Committee and staff be informed about it. A resolution was submitted to the AAFP's 2017 Congress of Delegates. The resolution was referred to the Board of Directors.

A-04-17 – Acknowledge the Negative Health Impacts of Artificial Food Colors and Endorse Their Elimination from the American Food System

ACTION
The Board voted not to adopt Res. A-04-17 in the absence of additional evidence supporting the negative health effects from artificial food colors/dyes, at its April 7, 2017 meeting. The authors were informed.

A-05-17 – Protect the Integrity of the Affordable Care Act

ACTION
The Board accepted Res. A-05-17 as current policy on April 7, 2017 and the author was informed.

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

RESOLVED: That the California Academy of Family Physicians advocate for the AAFP to work with legislators on preserving the ACA's Contraceptive Mandate, that contraception be covered by health plans as preventative care, without co-pay.

A-06-17 – New Search Options for Specific Residency Characteristics in the Residency Directory on the AAFP Website

The Board adopted the following substitute resolution for Res. A-06-17 at its April 7, 2017 meeting:

RESOLVED: That CAFP will consult with the CAFP Residency Network (CRN) to create a supplemental area in the CAFP online residency directory to allow California residencies to provide information on the wide range of services they provide, including RHEDI programs, palliative medicine, cross cultural care, sports medicine, etc.; and be it further

RESOLVED: That CAFP will ask the CAFP Residency Network (CRN) also to consider the six questions previously developed by the CRN and those in the original Res. A-06-17 for inclusion in the supplemental area in the CAFP online residency directory and to hold such a discussion at the CRN meeting at the September Student-Resident Summit, with a report back to the Board at its November meeting.

ACTION
The CRN met on 9/13/17 and recommended: CAFP include a voluntary question on its annual Residency Directory survey about whether programs provide "an elective and/or training in reproductive health." (CAFP staff updated the survey appropriately, and sent it to programs on September 29, 2017.) Responses will be monitored. The Board adopted this recommendation at its meeting on November 4, 2017; the authors were informed.

ER-01-17 – Studying Single Payer in California

The Board referred the resolution to the Legislative Affairs Committee for a recommendation.

RESOLVED: CAFP will:
1) Make available to the Senate Bill 562 *Californians for a Health California Act's* authors, Senators Ricardo Lara and Toni Atkins, and any other legislators advancing single payer or public option bills, CAFP's principles for reform as endorsed by the Cognitive Coalition; CAFP's February 2017 vision for the Future of Healthcare Reform; as well as other relevant health care reform policy recommendations and the outcome of the 2009 single payer task force report; and

2) Offer to work with Senators Lara and Atkins, and other legislators advancing single payer or public option bills, to craft a bill that CAFP can support; and
3) Publicly support single payer *in concept* while recognizing that the details of the plan are key for support of a specific bill; and

4) Reconvene the single payer task force to help implement the above items, and further guide the CAFP on SB 562, as well as other bills that move California toward a universal healthcare system.

ACTION
At its April 7, 2017 meeting, the Board referred ER-01-17 to the Legislative Affairs Committee for recommendation back to the Board of Directors, noting that SB 562 in its current form was insufficiently developed and the Legislative Affairs Committee had recommended a Close Watch position on this spot bill. The bill subsequently was passed by the State Senate and moved to the Assembly, where it has been removed from consideration by the Speaker because it lacked a funding mechanism, among other provisions. CAFP has prepared a comparison of the bill to the previous single payer bill passed by the Assembly and Senate but vetoed by then Governor Schwarzenegger. The Legislative Affairs Committee reviewed the resolution at its October meeting and a substitute resolution for ER-01-17 which was adopted 11.4.17. The policy has been added to CAFP's policy manual and the authors informed. Articles and presentations will be prepared to address item 2.

Substitute Resolution ER-01-17 Studying Single Payer in California

RESOLVED: CAFP will:

1) Make CAFP's health care system principles available to any legislators advancing single payer or public option bills; and

2) Prioritize education (of members) on health care reform in 2018, including efforts to move California toward universal health care coverage and access.

ER-02-17 – Protecting Medicaid Beneficiaries with Disabilities against Per Capita Caps

ACTION
The CAFP Board accepted Res. ER-02-17 as current policy at its April 7, 2017 meeting and the author was informed:

RESOLVED: That the California Academy of Family Physicians 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.

RESOLVED: That the California Academy of Family Physicians calls upon its national representatives to work expeditiously to oppose any such plans to cut Medicaid funding to the states, emphasizing the uniquely damaging role that such a plan would have on low-income people and people with disabilities.

RESOLVED: That the California Academy of Family Physicians will work to communicate to California's congressional delegation its strong opposition to any such proposal to cut Medicaid funding.

Policy Actions/Resolutions Adopted by the Board on Proposals Submitted in 2017 after the All Member Advocacy Meeting

Res. A-07-17 – Medical Aid-in-Dying Is Not "Assisted Suicide" – Catherine Forest, MD

RESOLVED, That the American Academy of Family Physicians reject the term "assisted suicide" to describe the process whereby terminally ill patients of sound mind ask for and receive prescription medication they may self-administer to hasten death should their suffering become unbearable, and be it further

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

RESOLVED, that the American Academy of Family Physicians submit a resolution to the House of Delegates of the American Medical Association that calls on that organization to: 1) reject use of the term "assisted suicide" when referring to the practice of medical aid-in-dying; and 2) modify its current policy with language that recognizes medical aid-in-dying as an ethical end-of-life option when practiced where authorized and according to prescribed law.

ACTION

The Board adopted the resolution at its July 15, 2017 meeting and the policy was included in the CAFP Policy Manual. The resolution was submitted to the 2017 AAFP Congress of Delegates. The Congress referred it to the Board of Directors and the Board referred it to the Commission on Health of the Public and Science. The author was informed.

Res. A-08-17 – Disabled as Medically Underserved

The Board of Directors adopted A-08-17 at its November 4, 2017 meeting.

RESOLVED: That the California Academy of Family Physicians acknowledges the significant health disparities experienced by individuals with intellectual and developmental disabilities and recognizes the benefits that could be realized with federal designation as a medically underserved population; and be it further

RESOLVED: That the California Academy of Family Physicians strongly urges the Governor to designate people with intellectual and developmental disabilities as a medically underserved population in the state of California.

ACTION

A letter has been written to the Governor and the policy has been included in the CAFP Policy Manual. The author was informed.

Policies Adopted by CAFP Board of Directors 2017-18
see resolutions adopted above.

Participate in an ACLU Lawsuit on the REMS on Mifeprex/Mifepristone 4.7.17

Adopt a Consolidated CAFP Health Care System Reform Policy 7.15.17

CAFP Health Care System Policy

California's family physicians are on the front line of health care every day, providing care to millions of men, women and children in communities large and small, rural and urban, wealthy and poor. One in five physician office visits takes place with a family physician and extensive evidence proves that primary care provides exceptional value for health care dollars. Family physicians save costs AND lives.

It is the policy of the California Academy of Family Physicians (CAFP) that health care is a human right and every person has a right to comprehensive, high-quality health services delivered in a timely, culturally-competent and economically sustainable manner regardless of their age, gender identity, sexual orientation, geographic location, income, health status or immigration status. Primary care must be the foundation on which any health care system is built.

CAFP's positions on health care system financing, administration and delivery are guided by five core principles:

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

Universal

- Access to health care insurance should be universal and continuous.
- Individuals should not be denied health care coverage, have their coverage limited or otherwise capped or cancelled based on a current or pre-existing health care condition(s), age, gender identity, sexual orientation, geographic location, income, ethnicity, health status or immigration status.
- Each health insurance issuer must accept every employer and individual applying for coverage or renewing coverage, permitting annual and special open enrollment periods for those with qualifying lifetime events.

- Non-payment of premiums for health insurance coverage should be the only reason an insurer or employer may discontinue or negatively change an enrollee's health plan.
- Patients on publicly-issued insurance plans should not face discontinuation of coverage based on a reduction in eligibility standards unless provisions are made to transfer the individual into a plan with comparable coverage.
- Annual and lifetime caps on benefits should be prohibited in all health insurance products.
- Health insurance must have uniform standards and requirements. Health plans must not use complex eligibility rules, underwriting, billing procedures and regulatory requirements to deter obtaining and utilizing coverage.
- Premium assistance and cost-sharing reduction subsidies aimed at assisting qualifying individuals with the purchase of health care coverage and/or paying their deductibles and co-pays should be utilized if purchase of coverage is required,
- Out-of-pocket payments should be reasonable and standardized, with maximum limits based on an individual or family's income.
- Premiums in the individual and small group markets should vary only by family structure, geography, the actuarial value of the benefit, age and tobacco use (in an actuarially sound ratio to ensure adequate risk pools).

Comprehensive

- Every individual's coverage should include guaranteed access to evidence-based essential benefits that include, but are not limited to:
    - Access to comprehensive primary, preventative and wellness care services, including diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.).
    - Ambulatory, laboratory, emergency and hospitalization services.
    - Health promotion and maintenance.
    - Diagnostic screening, preventive and rehabilitation services, including any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force.
    - Vaccines identified by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices, the Women's Preventive Services Initiative, Bright Futures and other designated evidence-based assessment entities.
    - Prescription drug and medication management services.
    - Appropriate levels patient education and counseling
    - Reproductive and women's health services, including contraception, abortion, maternity health and newborn care services.
    - Mental health services and substance use disorder services, including behavioral health treatment.
    - Disability services, including community-based attendant services and supports.
    - Palliative and hospice care.
- Prescription drug and mental health services must be covered at the actuarial equivalence of physical health services.

- A clear plan and efforts to reduce racial, ethnic, gender and sexual orientation disparities in health care should be in place. Neglect and mistreatment of marginalized communities negatively affects health and must be opposed.

Timely

- Health insurance should be portable; every individual should be able to access essential health care services regardless of where that individual resides or is located at the time of need.
- Every individual should have access to a primary care physician-led Patient Centered Medical Home and an adequate and diverse network of health care providers who can meet his or her health care needs.
- Intentionally restrictive networks should be prohibited.
- Incentives should be created to properly train, attract and deploy a health care workforce to meet a region's actual and projected demand for health services.
- Medical schools, training programs and sponsoring institutions receiving state funding should have a mission to maintain and increase the primary care workforce, producing physicians who train and remain in primary care, particularly family medicine.
- Payers and patients should have accurate provider network data with which to make informed decisions about access to providers by region/community.

High Quality

- Delivery of health services should be performed in accordance with medically- and culturally-determined standards of practice. Future changes to and maintenance of health care and public health policies should be proposed on the basis of evidence. Medical research must be non-partisan, unbiased, and based on the scientific method. Public health policy must be evidence-based and free from political motivation. Health insurers make available information on initiatives and programs that improve health outcomes through the use of care coordination and chronic disease management, prevent hospital readmissions and improve patient safety, and promote wellness and health.
- Wherever possible, care should be delivered via the team-based patient centered medical home care delivery model. In the absence of a medical home, every enrollee should have a designated primary care physician.
- Expansion of clinically inadvisable scope of practice for non-physician clinicians that results in a lower standard of care should be prohibited.
- Insurers should maintain a transparent medical loss ratio of at least 85 percent. Profits and administrative costs that violate this threshold should be refunded to enrollees or reinvested to improve quality and access.
- Clinicians should use medically determined standards of practice to determine when medical tests, treatments or procedures commonly used in their field are unnecessary. Where health information technologies are used, they should seek to avoid imposition of additional administrative burden on physicians.
- Care delivery should be culturally-competent, including language requirements.

Sustainable

- A health system should be supported by financing and revenue provisions sufficient to account for the costs of providing universal, comprehensive, timely and high-quality health care.
- Both public and private health insurance plans should significantly increase their overall investment in primary care to at least match that of other developed nations' health care systems.
- Patients should incur no out-of-pocket or cost-sharing responsibilities for primary and preventive care services.
- The financing of health care must be affordable, not regressive, and not cause disproportionate barriers to health care access among poorer people.
- The health system should address social determinants of health, including but not limited to economic inequality, housing, food security, environment, crime and personal safety.
- Primary care providers should be adequately compensated for the value they provide to the health care system.
- The criteria for students and schools to qualify for primary care loan programs should be eased through shortening payback periods and loosening non-compliance provisions.
- Where purchase of insurance is proposed, mandatory purchase of insurance may be required to ensure soundness of the overall risk pool.
- Physicians should have the ability to opt-out of the dominant health care structure with reasonable practice alternative(s).
- Primary care physicians should have appropriate and majority representation in any group that negotiates payment.
- Any pay-for-performance or reporting components should be structured so that solo and small physician practices can reasonably participate without facing disproportionate time or technology investments.
- Any financing model should ensure that small, solo or low-earning practices are not disproportionately affected.

Join an Amicus Brief in Duncan v. Bacerra on Large Capacity Magazine Limits Established by Proposition 63 7.15.17

Endorse the Shared Principles of Primary Care **of the Patient Centered Primary Care Collaborative** 7.15.17