MISSION STATEMENT

The Academy and its Foundation will support its members through advocacy and education to ensure a patient-centered physician-coordinated medical home and quality health care for every Pennsylvanian.

PENNSYLVANIA ACADEMY OF FAMILY PHYSICIANS

12 Noon     Lunch

12:30 pm    Call to Order     William Sonnenberg, MD, Board Chair

12:35 pm    President’s Report     Doug Spotts, MD, President

12:45 pm    EVP Report     John S. Jordan, CAE, EVP
1. Primary Healthcare Consultants

1:30 pm     Consent Agenda     William Sonnenberg, MD, Board Chair
1. Minutes of the March 6 & 8 BOD Meetings*
2. Correspondence*
3. Status of March 6 & 8 BOD Actions*

1:35 pm    Old/New Business
1. Bylaws Amendments (Chapter XI Component Assemblies Section 4)*
2. Strategic Leadership for the Future     Doug Spotts, MD, President
Nicole Davis, MD, President-Elect
Rob Rodak, DO, Vice President

3. Wanda Filer’s Campaign
Russ Breish, MD, AAFP Delegate
Dennis Gingrich, MD

4. AAFP COD Resolutions*
Russ Breish, MD, AAFP Delegate

2:40 pm    Adjourn the PAFP Academy Meeting/Convene the PAFP Foundation BOT

PENNSYLVANIA ACADEMY OF FAMILY PHYSICIANS FOUNDATION

2:45 pm    Call to Order     Rob Rodak, DO, President

2:50 pm    Foundation Agenda
1. Education
   CME Live – November 7-9, Marriott City Center, Pittsburgh

2. Corporate Fund Raising
3. Grants

3:15 pm Adjourn the PAFP Foundation Meeting/Convene the PAFP Academy BOD

3:20 pm Adjournment
Next Board Meeting – Saturday, November 22, 8:00 am – 4:00 pm
Sheraton Harrisburg/Hershey Hotel

- Supporting documentation*
- Bold print indicates board action
CALL TO ORDER – 6:30 pm

The meeting was called to order by Board Chair Kevin Wong, MD with the following Board members in attendance:

Doug Spotts, President-Elect
Nicole Davis, MD, Vice President
Ed Zurad, MD, Director At-Large
Chris Lupold, MD, Director South Central
James Joseph, MD, Director North Central
V Hema Kumar, MD, Director South West
Laura McIntosh, MD, Director North West
Mary Stock Keister, MD, Director North East
Russ Breish, MD, AAFP Senior Delegate
Jeanne Spencer, MD, Representative, Program Directors & Medical School Chairs
Allison Walton, Chair, Student Assembly
Dawn McCabe, Corporate Representative

Guests: Brad Fox, MD
   Dennis Gingrich, MD
   D. Scott McCracken, MD
   Tiffany Leonard, MD
   Drew Keister, MD
   Madalyn Schaefgen, MD
   Brad Gray, DO
   Wanda Filer, MD
   Reid Blackwelder, MD
   David O’Gurek, MD
   Andy Lutzkanin, MD

Staff: John S. Jordan, CAE, Executive Vice President
   Karen Runyeon, VP Finance and Administration
   Brent Ennis, Vice President Government Affairs
   Janine Owen, Vice President, Education & Academia
   Molly Talley, Director of Student & Resident Initiatives
   Jerry Miller, Director of Health Information
   Tract Koval, Director of Practice Advocacy
   Debra Hammaker, Director, PA REACH East Project
   Michael Zigmund, Director of Communications
Consent Agenda

Dr. Wong asked if a board member would like to extract items from the agenda for further discussion.

**Motion:** There was a motion to accept the consent agenda. Motion carried.

EVP Report – Mr. John S. Jordan, CAE

Mr. Jordan provided an update regarding PAFP bylaws, Contractor Advisory Committee, member expense forms, conflict of interest statements, and the 2014 AAFP ALF/NCSC meeting in May.

Mr. Jordan presented the results of the market research study conducted by the Lepson/Polk Market Research group of York. There was a quantitative and qualitative study to inquire if a medical practice is interested seeking consulting services in establishing a patient-centered medical home (PCMH) from the PAFP. A summary was provided of the results which indicated strong support for consulting services. Mr. Jordan indicated the actual cost of the research study was approximately $9,000. The budget was $55,000 which was approved by the board in November 2013. The significant difference was due to the elimination of the focus groups and the survey being conducted in-house. The board discussed the pros and cons of establishing a consulting company.

Prior to the board meeting, the study was presented to the Finance Commission for consideration. Brad Fox, MD, Vice Chair, Finance Commission presented a motion to the board to support the proposal.

**Motion:** There was a motion from Brad Fox, MD, Vice Chair, Finance Commission to accept the market research study and pursue the establishment of a new consulting company, Keystone Healthcare Consultants. The board will appoint three representatives to oversee the implementation and start-up of the new company and review the financials after nine months. Motion carried.

Old/New Business

2014 Ten State Meeting
Dr. Spotts provided an overview of the Ten State Meeting which was held in Hershey at the Hotel Hershey. The evaluations were excellent. He indicated the speakers were non-physicians presenting their leadership experiences.

Strategic Leadership for the Future
Dr. Spotts presented a review of the last phone conferences with Cygnet Strategy, Marybeth Fidler and Cate Bower. There will be a planned summit next year along with surveys, focus groups and individual interviews.
Commission Reports

Practice Advocacy
Dr. Scott McCracken provided an overview of the Commission meeting. Issues that were discussed include Medicaid parity, pharma visits, e-prescribing, use of the PAFP community, e-cigarettes, and the colon rectal grant initiative. He stated there is a bi-monthly newsletter outlining current practice advocacy issues.

Education
Dr. Drew Keister announced the DOT course will be available by audio. There will be a charge for the audio. The CME needs assessment is now complete and waiting for the results. The 2015 summer CME will most likely be out of state.

Legal & Government Affairs
Dr. David O’Gurek discussed several pieces of legislation including scope of practice, naturopathic licensure, medical marijuana and pharmacists providing immunization shots to minors.

Resident & Student Affairs
Dr. Tiffany Leonard announced the Commission conducted a phone conference. The Commission discussed the on-line community, milestone initiative and Research Day. The residents and students enjoyed the Ten State Meeting that was held at the Hotel Hershey.

Member Services
Dr. Russ Breish reported the Commission conducted its meeting by using the on-line community. The PAFP continues to be the third largest chapter according to the membership statistics. The retention rate is 95% while the market share is 77%. After completing residency the percentage of residents maintaining their membership as active members is approximately 77%. Tar Wars posters are due by April 15.

Motion: There was a motion to recess the Academy Board Meeting and call the Academy Foundation meeting to order. Motion carried.

ACADEMY FOUNDATION

Dr. Nicole Davis, President, called the meeting to order.

Dr. Davis summarized the upcoming education events in 2014. She also provided an update of the most recent grants. The silent auction will be held in conjunction with the President’s Gala. The on-line auction will be held April 15–30. Dr. Davis encouraged board members to talk to local pharma representatives for the upcoming CME events in 2014. The cruise to Bermuda is scheduled for June 20-27 and the CME Live event will be held in Pittsburgh on November 7-9 at the Marriott City Center. PMSLIC was
recognized at the Ten State Meeting for their generous contribution for the reception at the Hershey Automobile Antique Museum.

**Motion:** Having concluded the business of the Foundation, there was a motion to adjourn the Foundation Board Meeting and reconvene the Academy Board of Directors. Motion carried.

**Adjournment**

With no further business the meeting adjourned at 8:30 pm.

Respectively submitted,
John S. Jordan, CAE
Executive Vice President/CEO
Call to Order – 7:30 am

The meeting was called to order by President Doug Spotts, MD at 7:30 am with the following persons in attendance:
Nicole Davis, MD, President-Elect
Chris Lupold, MD, Treasurer
Ed Zurad, Director At-Large
Mary-Stock Keister, MD, Director North East
James Joseph, MD, Director North Central
V. Hema Kumar, MD, Director South West
Russ Breish, MD, AAFP Senior Delegate
David Berkson, MD, Director South East (participated by phone)
Laura McIntosh, MD, Director North West
Sabesan Karuppiah, MD, New Physician
Chaney Stewman, MD, Resident Representative
Allison Walton, Student Representative

Guests: Tiffany Leonard, MD; Tom Weida, MD; Jane Weida, MD; Brad Fox, MD; David O’Gurek, MD

Staff: John S. Jordan, CAE, Executive Vice President

The Board reviewed the Commission/Committee list.

Motion: There was a motion to accept the 2014/15 Commissions/Committees and approve the following new Commission Members (Drs. Kevin Shaffer (Finance), Mary Stock Keister (Finance), and Jeff Zlotnick (Education)). Motion carried.

Motion: There was a motion to recess the Pennsylvania Academy of Family Physicians and convene the PAFP Foundation. Motion carried.

Dr. Nicole Davis called the Academy Foundation Board to order.

Motion: There was a motion to nominate Dr. Rob Rodak as President of the Foundation. Motion to close nominations. Motion carried. By acclamation Dr. Rodak was elected as President of the Foundation.
Motion: There was a motion to nominate Dr. Mary Stock Keister as Vice President of the Foundation. Motion to close nominations. Motion carried. By acclamation Dr. Keister was elected as Vice President of the Foundation.

Motion: There was a motion to nominate Dr. Chris Lupold as Treasurer of the Foundation. Motion to close nominations. Motion carried. By acclamation Dr. Lupold was elected as Treasurer of the Foundation.

Motion: Having concluded the business of the Foundation, there was a motion and a second to adjourn the Foundation Board Meeting and reconvene the PAFP Board of Directors. Motion Carried.

Dr. Spotts called the Academy Board back into session.

New Business
Mr. Jordan announced there will be a new board member orientation on September 5 and 6 at the PAFP headquarters.

Dr. Spotts opened discussion regarding the 2015 Annual Meeting. The Board discussed new ideas for 2015. It was agreed for the Executive Committee to meet and discuss ideas to be implemented next year as part of the Annual Meeting.

The Board requested legal counsel to review the bylaws to determine if the Board can submit resolutions at any time to the AAFP.

With no further business to come before the board at this time, Dr. Spotts adjourned the meeting at 8:30 am.

Prepared by:

John S. Jordan, CAE
Executive Vice President/CEO
July 29, 2014

Ms. Rebecca Janssen
American Academy of Family Physicians
11400 Tomahawk Creek Parkway
Leawood, KS 66211-2672

Dear Ms. Janssen:

It is with pleasure that the Officers and Board of Directors of the Pennsylvania Academy of Family Physicians (PAFP) endorse D. Michael Baxter, MD, for Chair, Commission on Governmental Advocacy.

Dr. Baxter has served as President and Chair of the PAFP Board of Directors. He is currently serving as Chair of the PAFP PAC Board of Directors. As a long dedicated member of the Academy, Dr. Baxter served as the Chair of the Health Care Policy Commission and Assembly of the Program Directors and Medical School Department of Family Medicine Chairs. He authored the PAFP policy on Health Care Reform and is a regular participant in the annual congressional conference. Dr. Baxter served as the Residency Director and active as a faculty member for residents and students for over 20 years at the Reading Hospital and Medical Center.

Dr. Baxter is a bright and energetic physician, a great leader and spokesperson. He is a dedicated family physician practicing in Reading.

We wholeheartedly and enthusiastically endorse Dr. Baxter’s appointment as Chair of the Commission on Governmental Advocacy of the AAFP. Enclosed are his nomination form and passport photo.

Sincerely,

Douglas A. Spotts, MD
President

Cc: PAFP Board of Directors
    John S. Jordan, CAE, EVP & CEO
July 16, 2014

Dennis Gingrich, MD
Penn State University Medical Center
500 University Drive
Hershey, Pennsylvania
17033-2360

Dear Dennis:

On behalf of the Officers and Board of Directors and Staff at the Pennsylvania Academy of Family Physicians and Foundation, I would like to congratulate you on your recent accolade as the American Academy of Family Physicians 2014 Exemplary Teacher Year Award.

You have certainly earned this award from mentoring medical students and residents and spearheading the Primary Care Scholars Program at the Penn State College of Medicine as well serving in several capacities with the AAFP and the PAFP.

We are certainly proud of your many achievements and hard work ethic as a family physician and I am sure you will continue as a role model for future family physicians. As you know, there are many challenges facing medical students entering family medicine, but as a mentor it is very comforting to know you will always be there.

I appreciate the role of mentor you have played in my professional development and, of course, your friendship. Once again, congratulations!

Best regards,

Doug Spotts, MD
President

Cc:  PAFP Board of Directors
     Mr. John S. Jordan, CAE, Executive Vice President & CEO
John Jordan - Executive Vice President, CEO

From: Geraci, MD, Gaspere <ggeraci@pamedsoc.org>
Sent: Thursday, April 24, 2014 9:59 AM
To: jd@pa-acp.org; John Jordan - Executive Vice President, CEO; syunghans@paaap.org
Subject: Joint statement
Attachments: ama-principles-for-physician-employment.pdf

John, John, and Suzanne,

I recently spoke at a PA-ACP function and the idea was raised of a joint statement from our respective groups stating some “Principles for Employed Physicians.” I attached the AMA version. It would be a great idea, I agreed, for our professional organizations to stand up for Pennsylvania employed physicians with a PA joint statement.

The idea of also having some kind of way for employed physicians to be able to report quality concerns came out of that discussion, as employed physicians have some fears of “retaliation by firing.”

If you are all three planning to come to the next PAMED Board Meeting, I thought we might seize a few minutes together to at least decide if it’s an appropriate idea, and set next steps. Your thoughts? Otherwise, I can try to put together a phone call.

Gus

Gaspere (Gus) C. Geraci, MD
FAAFP, FAIHQ, CHCQM, CPE, FABQURP
Chief Medical Officer
Pennsylvania Medical Society
Direct Work Line: 717-558-7806
Office: 717-558-7750
Cell: 717-903-1100
Fax: 717-558-7848

The Pennsylvania Medical Society (PAMED) must position physicians to lead and shape health care delivery to assure that the evolving system provides quality and value to patients and the community.

Don’t be scammed by pill shoppers. Find out more about PAMED’s “Pills for Ills, Not Thrills” campaign and join our grassroots network.

Read my blog.
Or follow me on Twitter.

View my profile on LinkedIn

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AMA Principles for Physician Employment

The following “AMA Principles for Physician Employment” are intended to help physicians, those who employ physicians, and their respective advisors identify and address some of the unique challenges to professionalism and the practice of medicine arising in the face of physician employment. These principles are not intended to serve as a comprehensive listing of the professional and ethical obligations of employed physicians; such obligations—which are the same for all physicians, regardless of employment status—are more fully delineated in the AMA Code of Medical Ethics. Nor are these principles a comprehensive treatment of contractual matters such as work hours, compensation models, employee benefits, and other issues typically the subject of negotiation between physicians and employers; such issues are addressed elsewhere in the body of AMA policy and in the American Medical Association’s model employment agreements. Rather, it is hoped that the “AMA Principles for Physician Employment,” in addressing select, potentially problematic aspects of the employer-employee relationship, will provide broad guidance for employed physicians and their employers as they collaborate to provide safe, high-quality, and cost-effective patient care.

AMA Principles for Physician Employment

(1) Addressing Conflicts of Interest

(a) A physician’s paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

(b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

(c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

(d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(e) Assuming a title or position that may remove a physician from direct patient-physician relations—such as medical director, vice president for medical affairs, etc.—does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics (ama-assn.org/go/code) for further guidance on conflicts of interest.

(2) Advocacy for Patients and the Profession

(a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

(b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.
(3) Contracting

(a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

(b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

(c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

(d) Termination of an employment or contractual relationship between a physician and an entity employing the physician does not necessarily end the patient-physician relationship between the employed physician and persons under his or her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges.

(f) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(g) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.


(4) Hospital Medical Staff Relations

(a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

(b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

(c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

(d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.
Refer to the "AMA Conflict of Interest Guidelines for the Organized Medical Staff" (ama-assn.org/go/coiguidelines) for further guidance on the relationship between employed physicians and the medical staff organization.

(5) Peer Review and Performance Evaluations

(a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.

(b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.

(c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians – not lay administrators – should be ultimately responsible for all peer review of medical services provided by employed physicians.

(d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician’s independent exercise of medical judgment.

(e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.

(f) Unless specified otherwise in the employment agreement, upon termination of employment with or without cause, an employed physician should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws.

Refer to the "AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations" (http://tinyurl.com/b8ff46z) for further guidance on peer review.

(6) Payment Agreements

(a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

(b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer’s billing for physician services, which violation is not the fault of the employee.

Adopted at the 2012 Interim Meeting of the AMA House of Delegates (Board of Trustees Report 6).

Visit the AMA website to learn more about AMA resources for employed physicians (ama-assn.org/go/employment).
The signatories of this document strongly support the following principles for employed physicians.

- Physicians employed by a hospital/health system must retain independent medical judgment in providing care to patients, and any hospital/health system may not discipline the physician for reasonably advocating for patient care.

- Chief Medical Officer – The hospital/health system should appoint a chief medical officer (CMO) who has been approved by the medical staff. For all matters relating to the practice of medicine, each employed physician must ultimately report to the CMO.

- Policies and procedures – The hospital/health system must adopt, maintain, and enforce policies to ensure that an employed physician is free to exercise the physician’s independent medical judgment in providing care to patients at the hospital.

- Complaint mechanisms – The hospital/health system must implement a complaint mechanism to process and resolve complaints regarding interference or attempted interference with a physician’s independent medical judgment.

- Due process – The termination of a physician’s employment with the hospital/health system may not adversely affect the physician’s clinical privileges at the hospital unless the physician was afforded due process in accordance with the medical staff bylaws.

- Contractual waiver prohibited – The mandated protections in medical staff bylaws may not be voided or waived by contract.

- Department of Health enforcement – A hospital/health system that violates the safeguards or retaliates against a physician for exercising rights afforded by the safeguards should be subject to licensure action under the Health Care Facilities Act.

- Mandatory reporting to the DOH – The CMO should immediately report to the Department of Health any action or event that the CMO reasonably and in good faith believes constitutes a compromise of the independent medical judgment of a physician in caring for a patient.

- Whistleblower action – A physician whose employment is terminated or otherwise subject to retaliation in violation of the safeguards or for exercising rights afforded by the safeguards should have a private cause of action for damages.

- Covenants not to compete – Hospitals and Health systems should not require that a physician sign a restrictive covenant that precludes the physician from competing with the employer. This requirement would not preclude a buyout clause that requires the physician to reimburse the employer for reasonable expenses incurred in recruiting the physician and establishing the physician’s patient base. These expenses should be estimated whenever a covenant not to compete is utilized.

- Loyalty clause – A loyalty clause in a physician employment contract must not be used to override safeguards or other physician rights or protections.
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<th>Motion/Recommendation</th>
<th>Board/Date</th>
<th>Referred to</th>
<th>Status</th>
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<tr>
<td>The Board approved the 2014/15 Commissions and Committees.</td>
<td>PAFP/March 8</td>
<td>Board &amp; Staff</td>
<td>Effective immediately</td>
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<td>The Board approved to accept the market research study and pursue the establishment of a new consulting company, Keystone Healthcare Consultants. The board will appoint three representatives to oversee the implementation and start-up of the new company and review the financials after nine months.</td>
<td>PAFP/March 6</td>
<td>Board/Staff</td>
<td>A meeting with Staff to determine course of action. Drs. James Joseph, Brad Fox and Chris Lupold will oversee the establishment of the new consulting services.</td>
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<td>The Foundation approved the 2014/15 new officers.</td>
<td>PAFP/March 8</td>
<td>Board/Staff</td>
<td>Effective immediately</td>
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<td>Rob Rodak, DO, President</td>
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<td>Mary Stock Keister, MD, Vice President</td>
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<td>Chris Lupold, MD, Treasurer</td>
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CHAPTER I
Name

The name of this organization shall be the Pennsylvania Academy of Family Physicians located at 2704 Commerce Drive, Suite A, Harrisburg, Pennsylvania 17110-9365.

CHAPTER II
Vision, Mission, Purposes and Powers

Vision: The Pennsylvania Academy of Family Physicians and its Foundation will be viewed as (a) the leading influential resource among family physicians and physicians in training in Pennsylvania, (b) the primary voice on health care issues with state legislative and administrative branches of government, media and professional health organizations, (c) a benchmark state on the national level; (d) setting the standard for organized medicine and (e) the leader on health care issues in the community.

Mission: The Academy and its Foundation will support its members through advocacy and education to ensure a patient-centered physician-coordinated medical home and quality health care for every Pennsylvanian.

Section 1. To the end that the people of Pennsylvania may receive excellence in health care, the Academy has for its purposes and powers the following:

a. To maintain an organization of family physicians to promote and maintain high standards of the practice of family medicine.

b. To encourage and assist men and women in preparing, qualifying, establishing and maintaining themselves in family medicine.

c. To preserve the right of the family physician to engage in medical and surgical procedures for which he is qualified by training and experience.

d. To encourage and assist practicing family physicians to participate in postgraduate study.

e. To promote the science and art of family medicine and the betterment of the public health, and to preserve the right of free choice of physician to the patient.

f. To provide responsible advocacy for and education of patients and the public in all health-related matters.

g. To maintain and provide an organization with high standards to fulfill the above purposes and to represent the needs of its members.

Section 2. To accomplish the foregoing purposes, this Academy may grant charters to sectional and county chapters, to be known as component assemblies, in such manner as the Bylaws may from time to time provide. This Academy shall have the power to acquire, own and convey real and personal property; to issue publications and to use any and all means for the attainment of its purposes which from time to time may seem to it desirable.

Section 3. This Academy is not conducted for pecuniary profit and does not contemplate pecuniary gain or profit to the members thereof.

CHAPTER III
Membership

Section 1. All physicians who are members of the American Academy of Family Physicians, and who reside in the Commonwealth of Pennsylvania, shall be eligible to become members of this organization.

Section 2. Membership in this organization shall be classified as follows: (1) Active Members, (2) Resident Members, (3) Inactive Members, (4) Honorary Members, (5) Life Members, (6) Student Members and (7) Supporting Members. Eligibility to a membership classification and election thereto shall be governed by the Bylaws of the American Academy of Family Physicians. (These individual definitions of classes of membership are in accordance with Chapter III, Bylaws, American Academy of Family Physicians).

Section 3. Supporting members, as defined by AAFP bylaws, may hold the floor at the Annual Meeting of the Academy; may be appointed to Academy commissions but may not serve as chair; and, may not hold any Academy office.

CHAPTER IV
Annual Meeting

Section 1. Unless otherwise ordered by the Board of Directors, there shall be an annual meeting of the Pennsylvania Academy of Family Physicians. The time and place of the annual meeting shall be designated by the Board of Directors, and announced at least ninety (90) days before the date so fixed.

Section 2. Resolution. Any Academy Member may submit to the Board of Directors at the Annual Meeting a resolution affecting policies of the Academy. Any
Bylaws

Updated March 7, 2014

Chapter V

Officers

The Officers of the Pennsylvania Academy of Family Physicians shall be a President, President-Elect, Board Chair, Vice President, Treasurer, and Executive Vice President.

Chapter VI

Board of Directors

Section 1. The Board of Directors shall be composed of the President; the President-Elect; the Board Chair, the Treasurer; the Vice President; the Senior Delegate to the American Academy of Family Physicians; the Student Representative elected by the Pennsylvania Assembly of Medical Students, or its successor assembly; the Resident Representative elected by the Pennsylvania Assembly of Family Medicine Residents, or its successor assembly; the Chair of the Assembly of Family Medicine Residency Program Directors and Chairs of Departments of Family Medicine, or its successor assembly; the New Physician; one Director from each of the six state regions defined as follows: North West (Armstrong, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, Lawrence, McKean, Mercer, Venango, Warren, Counties); South West (Allegheny, Beaver, Bedford, Fayette, Greene, Somerset, Washington, Westmoreland Counties); North Central (Blair, Bradford, Cambria, Centre, Clinton, Columbia, Huntingdon, Indiana, Juniata, Lycoming, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Counties); South Central (Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry, York Counties); North East (Carbon, Lackawanna, Lehigh, Luzerne, Monroe, Northampton, Pike, Susquehanna, Wayne, Wyoming Counties); South East (Bucks, Chester, Delaware, Montgomery, Philadelphia Counties). One Director-at-large; and one member of the Corporate Advisory Council, or its successor organization, who will serve as a non-voting, non-Executive Session member.

Section 2. The Board of Directors shall set strategic direction, shall have fiduciary responsibility for the business, property, and funds of the Academy, and shall supervise the Executive Vice President.

Section 3. The Board of Directors may recommend the policy of the Academy in the intervals between meetings of the Board or any appropriate Committee or Commission.

Section 4. The Board of Directors shall be empowered to appoint and employ an Executive Vice President who shall be empowered to appoint or employ such assistants and employees as shall be necessary to conduct the affairs of the Academy.

Section 5. Within the Board of Directors shall be an Executive Committee, consisting of the President, President-Elect, Board Chair, Vice President, Treasurer and Executive Vice President. The function of this committee shall be to direct the work of the Executive Vice President of the Academy, and it shall have authority to act for and on behalf of the Board of Directors, except for the expenditure of unbudgeted monies, whenever business of the Academy demands prompt action between stated meetings of the Board of Directors. Meetings of the Executive Committee shall be held at the call of the President or any two members of the Executive Committee. A written report of its action shall be maintained by the Executive Vice President.

Section 6. The Board of Directors shall meet and organize immediately upon conclusion of the annual meeting. Subsequent meetings shall be held at such time and at such place as the Board shall determine. A majority of voting members of the Board of Directors shall constitute a quorum.

Section 7. If funds permit, members may be reimbursed a reasonable amount for expenses incurred for attendance at Academy related activities.

Section 8. The Board of Directors may recommend that the charter of any duly constituted component assemblies be suspended or revoked; but such action shall require two-thirds vote of the Board of Directors.
Section 9. A Board member or officer of the Pennsylvania Academy of Family Physicians shall not be personally liable for money damages as such for any action taken or failure to take action as a director or officer unless his action constitutes self dealing, willful misconduct or recklessness, or unless liability is imposed pursuant to criminal statute or for payment of taxes. The Board of Directors may provide for indemnification of Board members and officers to the extent allowed by law.

Section 10. Directors Duties and Obligations
(a) Standard of Care. A director of the Academy shall stand in a fiduciary relation to the Academy and shall perform his duties as a director, including his duties as a member of any commission of the Board upon which he may serve, in good faith, in a manner he reasonably believes to be in the best interests of the Academy, and with such care, including reasonable inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances. In performing his duties, a director shall be entitled to rely in good faith on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by any of the following:
(1) One or more officers or employees of the Academy whom the director reasonably believes to be reliable and competent in the matters presented;
(2) Counsel, public accountants or other persons as to matters which the director reasonably believes to be within the professional or expert competence of such person;
(3) A commission of the Board upon which he does not serve, duly designated in accordance with law, as to matters within its designated authority, which commission the director reasonably believes to merit confidence. A director shall not be considered to be acting in good faith if he has knowledge concerning the matter in question that would cause his reliance to be unwarranted.
(b) Consideration of Factors. In discharging the duties of their respective positions, the Board of Directors, commissions of the Board and individual directors may, in considering the best interests of the Academy, consider the effects of any action upon employees, upon suppliers and customers of the Academy and upon communities in which offices or other establishments of the Academy are located, and all other pertinent factors. The consideration of those factors shall not constitute a violation of the standard set forth in subsection (a) above.
(c) Presumption. Absent breach of fiduciary duty, lack of good faith or self-dealing, actions taken as a director or any failure to take any action shall be presumed to be in the best interests of the Academy.

Section 11. Interested Director or Officer Contracts
A contract or transaction between the Academy and any one or more of its directors or officers or between the Academy and another of its directors or officers or between the Academy and another domestic of foreign Academy for profit or not-for-profit, partnership, joint venture, trust or other enterprise in which one or more of the Academy’s directors or officers are directors or officers or have a financial or other interest, shall not be void or voidable solely because (a) of such reason or interest, (b) the director or officer is present at or participates in the meeting of the Board of Directors that authorizes the contract or transaction, or (c) the vote of such director or officer is counted in authorizing the contract or transaction; provided, however, that with respect to each of the foregoing, one or more of the following three conditions are satisfied:
(1) The material facts as to the relationship or interest and as to the contract or transaction are disclosed or are known to the Board of Directors and the Board authorizes the contract or transaction by the affirmative votes of a majority of the disinterested directors even though the disinterested directors are less than a quorum; or
(2) The material facts as to the relationship or interest and as to the contract or transaction are disclosed or are known to the members entitled to vote thereon and the contract or transaction is specifically approved in good faith by vote of those members; or,
(3) The contract or transaction is fair as to the Academy as of the time it is authorized, approved or ratified by the Board of Directors or the members.
Common or interested directors may be counted in determining the presence of a quorum at a meeting of the Board which authorizes a contract or transaction specified above.

Section 12. Limitation of Personal Liability of Director
To the fullest extent that the laws of the Commonwealth of Pennsylvania, as in effect on the date of the adoption of this Section 12, or as such laws are thereafter amended, permit elimination or limitation of the liability of directors, no director of the Academy shall be personally liable as such for monetary damages for the action taken, or any failure to take any action, as a director. Any amendment or repeal of this Section 12 or adoption of any other provision of these bylaws of the Academy’s Articles of Incorporation which has the effect of increasing director liability shall operate prospectively only and shall not have any effect with respect to any action taken, or failure to act, prior to the adoption of such amendment, repeal or other provision.

Section 13. Standard of Care
Subject to any contrary provision contained in the Academy’s Articles of Incorporation, an officer of the Academy shall perform his duties as an officer in good faith, in a manner he reasonably believes to be in the best interests of the Academy and with such care, including reasonably inquiry, skill and diligence, as a person of ordinary prudence would use under similar circumstances. A person who so performs his duties shall not be liable by reason of having been an officer of the Academy.
Section 14. Indemnification of Directors, Officers and Employees

(a) Right to Indemnification. Except as prohibited by law, every director and officer of the Academy shall be entitled as of right to be indemnified by the Academy against all expenses, liability and loss (including without limitation, attorney's fees, judgments, fines, taxes, penalties and amounts paid in settlement) paid or incurred by such person in connection with any actual or threatened claim, action, suit or proceeding, civil, criminal, administrative, investigation or other, whether brought by or in the right of the Academy or otherwise, in which he may be involved, as a party or otherwise, by reason of such person being or having been a director or officer of the Academy or by reason of the fact such person is or was serving at the request of the Academy as a director, officer, employee, fiduciary or other representative of another domestic or foreign Academy for profit or not-for-profit, partnership, joint venture, trust, employee benefit plan or other entity or enterprise (such claim, action, suit or proceeding hereinafter being referred to as an “Action”); provided, that no such right of indemnification shall exist with respect to an Action brought by an Indemnitee (as hereinafter defined) against the Academy except as provided in the last sentence of this Section 14. Persons who are not directors or officers of the Academy may be similarly indemnified in respect of service to the Academy to the extent the Board of Directors at any time denominates any of such persons as entitled to the benefits of this Section 14. As used in this Section 14, “Indemnitee” shall include each director and officer of the Academy and each other person denominated by the Board of Directors as entitled to the benefits of this Section 14. An Indemnitee shall be entitled to be indemnified pursuant to the Section 14 for expenses incurred in connection with any Action brought by such Indemnitee against the Academy only if the Action is a claim for indemnity or expenses under Section 16 of this Chapter VII or otherwise and either (1) the Indemnitee is successful in whole or in part in the Action for which expenses are claimed or (2) the indemnification for expenses is included in a settlement of the Action or is awarded by a court.

Section 15. Right to Advancement of Expenses
Every Indemnitee shall be entitled as of right to have his expenses in any Action (other than an Action brought by such Indemnitee against the Academy) paid in advance by the Academy prior to final disposition of such Action, subject to any obligation which may be imposed by law or by provision of the Academy’s Article of Incorporation, these bylaws, an agreement or otherwise to reimburse the Academy in certain events.

Section 16. Right of Indemnitee to Initiate Action
If a written claim under Section 14 or Section 15 of this Chapter VII is not paid in full by the Academy within thirty days after such claim has been received by the Academy, the Indemnitee may at any time thereafter initiate an Action against the Academy to recover the unpaid amount of the claim and, if successful in whole or in part, the Indemnitee shall also be entitled to be paid the expenses of prosecuting such Action. It shall be a defense to any Action to recover a claim under Section 14 of this Chapter VII that the Indemnitee’s conduct was such that indemnification is prohibited by law. The only defense to any such of this Chapter VII shall be failure to make an undertaking to reimburse if such an undertaking is required by law or by provision of the Academy’s Articles of Incorporation, these bylaws, an agreement or otherwise.

Section 17. Insurance and Funding
The Academy may purchase and maintain insurance to protect itself and any person eligible to be indemnified hereunder against such expense, liability or loss asserted or incurred by such person in connection with any Action, whether or not the Academy would have the power to indemnify such person against such expense, liability or loss by law or under the provisions of this Chapter VII. The Academy may create a trust fund, grant a security interest, cause a letter of credit to be issued or use other means (whether or not similar to the foregoing) to ensure the payment of such sums as may become necessary to effect indemnification as provided herein.

Section 18. Non-Exclusivity; Nature and Extent of Rights
The rights of indemnification and advancement of expenses provided for in this Chapter VII (1) shall not be deemed exclusive of any other rights, whether now existing or hereafter created, to which any Indemnitee may be entitled under the Academy’s Articles of Incorporation or these bylaws, any agreement, any vote of members or directors or otherwise, (2) shall be deemed to create contractual rights in favor of each Indemnitee, (3) shall continue as to each person who has ceased to have the status pursuant to which he was entitled or was denominated as entitled to indemnification hereunder and shall inure to the benefit of the heirs and legal representatives of each Indemnitee and (4) shall be applicable to Actions commenced after the adoption hereof, whether arising from acts or omissions occurring before or after the adoption hereof. The rights of indemnification provided in this Chapter VII may not be
amended or repealed so as to limit in any way the indemnification or the right to advancement of expenses provided for herein with respect to any acts or omissions occurring prior to the adoption of any such amendment or repeal.

Section 19. Removal from elected position
Any elected member of the Board of Directors may be removed by a two-thirds majority of the total number of the Board of Directors eligible to vote. The motion for removal must be made by a petition of four members of the Board of Directors and state the reason such removal is recommended. The petitioning board members will present the case to the Board and neither the petitioning members nor the accused will be eligible to vote. The motion must be announced in writing to all directors eligible to vote at least thirty days prior to the meeting at which the vote is to take place. The individual whose position is in jeopardy may present a defense at the announced meeting prior to the vote of the Board.

CHAPTER VII
Dues, Assessments and Admission Fees

Section 1. Except when at variance with the Bylaws of the American Academy of Family Physicians, dues and special assessments for the Pennsylvania Academy of Family Physicians shall be set and approved by the Board of Directors, payable to the Treasurer directly or indirectly, at the start of the fiscal year.

CHAPTER VIII
Elections

Section 1. The Board of Directors shall receive nominations from the Academy membership, and shall present to the Annual Meeting a list of one or more nominations for each of the offices of President-Elect, Vice President, Treasurer, Directors as needed to fill the required regional and at-large positions, new physician, one delegate and one alternate delegate to the Congress of Delegates of the American Academy of Family Physicians, of the Pennsylvania Academy of Family Physicians, and such other officers as may be required. Each nominee must be contacted and give his consent to be a candidate for a specific office.

Section 2. Election of opposed candidates shall be made by secret ballot at the Annual Meeting or electronically through a procedure established by the academy and through which the academy general membership is appropriately informed in sufficient time to have the ballots cast prior to the annual meeting. The nominee receiving a majority of votes via hand written and electronic ballots shall be declared elected. If no majority exists on the first ballot, the candidate receiving the least number of votes shall be dropped and the election repeated with members in attendance at the annual meeting voting until a majority is achieved. A final tie shall be decided by lot.

CHAPTER IX
Duties and Term of Office

Section 1. The President or his qualified alternate, shall appoint all standing and special committees and commissions, and shall perform such duties as are usual to that office. The term of office of the President shall begin at his installation at the annual meeting following the one at which he was elected President-Elect, and shall expire at the conclusion of the next annual meeting or when his successor is installed. In the event of the death or resignation of the President during the term of his office or if he shall for any reason be unable or unqualified to serve, the President-Elect shall succeed to the office of President for the unexpired portion of the President’s term. In the event of the death, resignation, or incapacity of the President and the President-Elect, the Board of Directors shall appoint a President for the unexpired portion of the term. The President-Elect shall succeed to the office of President at the conclusion of the first annual meeting following the meeting at which his election occurred.

Section 2. The President-Elect shall serve in this capacity from the conclusion of the annual meeting at which he is elected. He shall perform the duties of the President when the President is absent or unable to perform such duties. He shall succeed to the office of President at the expiration of the President’s term of office as provided in Chapter X, Section 1. In the event of the death, resignation, incapacity, or removal from office of the President-Elect, the Board of Directors shall appoint a President-Elect for the unexpired portion of his term.

Section 3. The Vice President shall serve in this capacity from the conclusion of the annual meeting at which he is elected. He shall oversee the roles of committee members, oversee the attendance of Board members at Board meetings, act as a liaison to the Corporate Advisory Council, and other duties as assigned by the President. He shall perform the duties of the President-Elect when the President-Elect is absent or unable to perform such duties. In the event of the death, resignation, incapacity, or removal from office of the Vice President, the Board of Directors shall appoint a Vice President for the unexpired portion of his term.

Section 4. The Treasurer’s term of office shall begin at the conclusion of the annual meeting at which he is elected, and shall expire at the conclusion of the next annual meeting or when a successor is elected. The Treasurer shall receive all funds from whatever source; and shall dispense funds only within adopted budgetary limits, plus emergency funds by item specification and authorization by the Board of Directors. In the event of the death, resignation, or incapacity of the Treasurer, the
Section 5. The Executive Vice President shall be employed by the Board of Directors with a stipend to be fixed by the Board of Directors. He shall perform such duties as the title of the office ordinarily connotes and such duties of the Treasurer as may be assigned by the Board of Directors. He shall keep or cause to be kept an accurate record of the minutes and transactions of the Board of Directors and the Executive Committee. He shall also serve as Secretary to these bodies. He shall supervise all other employees and agents of the Pennsylvania Academy of Family Physicians and perform such other duties as may be prescribed by the Board of Directors and these Bylaws. He shall not be entitled to vote. The Executive Vice President shall be bonded in an amount fixed by the Board of Directors, with the premium to be paid by the Pennsylvania Academy of Family Physicians.

Section 6. The Immediate Past President upon expiration of his term of office as President, shall serve as Board Chair (hereinafter “Board Chair”) and member of the Board of Directors for a period of one year. He shall be entitled to one vote on the Board of Directors and preside over all meetings of the Board. In his absence, the President shall serve as temporary Chair for that meeting. In the absence of both the Chair and President, the President-Elect shall serve as temporary Chair for that meeting. In the absence of the Chair, President, and the President-Elect a temporary Chair shall be elected by the members present at that meeting. In the event of the death, resignation, or incapacity of the Board Chair, the Board of Directors shall appoint a Board Chair for the unexpired portion of his term.

Section 7. The term of office of the Delegates and Alternate Delegates, to the American Academy of Family Physicians, shall be two years and shall begin at the conclusion of the annual meeting, at which they are elected, and shall expire at the conclusion of the second annual meeting after their election or when their successors are elected. The term of the Delegate to the Congress of Delegates of the American Academy of Family Physicians shall be limited to a total of six years (three, two-year terms). The term of the Alternate Delegate to the Congress of Delegates of the American Academy of Family Physicians shall be limited to a total of six years (three, two-year terms). The limitation of the number of terms to the Congress of Delegates of the American Academy of Family Physicians may be waived at the discretion of the Board of Directors.

Section 8. The term of office of Directors shall be three years and shall begin at the conclusion of the annual meeting at which they are elected and shall expire at the conclusion of the third annual meeting after their election, or when their successors are elected. No Director may serve more than two consecutive three-year terms. If a Director is appointed or elected to serve any portion of an unexpired term, such time spent shall not preclude the Director from subsequently serving two consecutive three-year terms. Vacancies on the Board of Directors, which may occur due to death, resignation, or any other reason, shall be filled by the Board of Directors. Appointees to such vacancies shall serve only until the next meeting of the Annual Meeting.

Section 9. The chair of the Assembly of Family Medicine Residency Program Directors and Chairs of Departments of Family Medicine, or its successor assembly, shall serve a two-year term as defined in the Assembly’s bylaws. The chair of the Assembly will serve as a voting member of the Academy Board of Directors.

Section 10. The term of office of the Resident Representative on the Board of Directors will be for one year and shall begin at the conclusion of the annual meeting of the Resident Assembly and shall expire at the conclusion of the next annual meeting. The Resident Representative will be selected by the Pennsylvania Assembly of Family Medicine Residents, or its successor assembly. No one resident shall serve more than two years in the seat reserved for the Resident Representative. A vacancy in the seat of the Resident Representative shall be filled by the Pennsylvania Assembly of Family Medicine Residents, or its successor assembly. The Resident Representative shall be entitled to a vote on the Board of Directors.

Section 11. The Pennsylvania Assembly of Medical Students, or its successor assembly, will elect a Student Representative to the Board of Directors at their yearly meeting. The term of office of the Student Representative on the Board of Directors will be for one year and shall begin at the conclusion of the yearly meeting of the Pennsylvania Assembly of Medical Students, or its successor assembly. The term shall expire at the conclusion of the next yearly meeting of the Pennsylvania Assembly of Medical Students, or its successor assembly. A student may serve for more than one term on the Board of Directors. The Student Representative shall be entitled to a vote on the Board of Directors.

Section 12. The New Physician member shall be elected every other year, thus serving a two-year term. The New Physician Director may be first eligible for active membership in the PAFP fewer than seven years before being seated by the HOD and is not currently nor have ever served as the Student, Resident or New Physician Board member. The New Physician Director must have become eligible for active membership in the PAFP (graduated from a family medicine residency program). The New Physician shall be entitled to a vote on the Board of Directors.
Section 13. The Corporate Advisory Council Member, or a member of its successor organization, will serve on the Board as a non-voting, non-Executive Session member. He will serve a two-year term and be elected by the Corporate Advisory Council, or its successor organization.

CHAPTER X
Committees and Commissions

Section 1. At the beginning of his term of office, the President shall designate such commissions as the Board of Directors deems necessary to facilitate the business of the Academy. The President shall appoint and the Board of Directors shall approve all Commission appointments. Commission appointees, including chairs, shall serve for a period of one year. Each Commission shall meet a minimum of once yearly and shall submit a written report at the Annual Meeting.

Section 2. Such committees, as are deemed necessary, may be appointed at any time at the Annual Meeting, by the President, Board of Directors or Commission Chairs. Such additional committees shall, unless re-appointed by the incoming President, cease to exist when the new President takes office.

CHAPTER XI
Component Assemblies

Section 1. Component chapters as of July 1, 2008 will be dissolved and reorganized as Component Assemblies.

Section 2. Component Assemblies will not be authorized to collect dues.

Section 3. The PAFP Board of Directors develop a mechanism for the surrender of component chapter funds, future distribution of these funds, and the administration and raising of future component assembly funds.

Section 4. There may be at least one regional meeting per year in each of the six designated regions: North West (Armstrong, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, Lawrence, McKean, Mercer, Venango, Warren, Counties); South West (Allegheny, Beaver, Bedford, Fayette, Greene, Somerset, Washington, Westmoreland Counties); North Central (Blair, Bradford, Cambria, Centre, Clinton, Columbia, Huntingdon, Indiana, Juniata, Lycoming, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Counties); South Central (Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry, York Counties); North East (Carbon, Lackawanna, Lehigh, Luzerne, Monroe, Northampton, Pike, Susquehanna, Wayne, Wyoming Counties); South East (Bucks, Chester, Delaware, Montgomery, Philadelphia Counties).

Section 5. The Assembly of Family Medicine Residency Program Directors and Chairs of Departments of Family Medicine, or its successor assembly, shall meet at least once a year to provide input into the policymaking decisions of the Pennsylvania Academy of Family Physicians. These meetings shall be conducted by a chair elected by the assembly from its membership.

a. A vice chair shall also be elected for a two year term. The vice chair shall assist the chair in all activities, including attendance at required meetings of the chair. The vice chair or designee from the Assembly will be allowed to fulfill the duty of proxy representative to the Board with full voting privilege of the position, in the event that the chair is unable to participate in that particular Board meeting. The vice chair shall assume the office of chair at the conclusion of the chair's term of office at the annual meeting of the Assembly of Family Medicine Residency Program Directors and Chairs of Departments of Family Medicine, and after a vote of confidence by the voting members. Should the vice chair fail to achieve a vote of confidence or decline the position of chair, the office of chair will be filled by the usual election procedures. The combined terms of vice chair and chair shall be limited to four years. In the event of the death, resignation, or incapacity of the chair and/or vice chair, the Assembly shall appoint a chair and/or vice chair for the unexpired portion of his term.

Section 6. The Pennsylvania Assembly of Family Medicine Residents shall meet at least once yearly. These meetings shall be conducted by a chair elected by the assembly from its membership. The Pennsylvania Assembly of Family Medicine Residents shall also elect one Resident Representative to the Board of Directors of the Pennsylvania Academy of Family Physicians. The chair of the Pennsylvania Assembly of Family Medicine Residents shall notify the Pennsylvania Academy's Executive Vice President annually of the names and addresses of these delegates, alternate delegates, and the Resident Representative. These delegates, alternate delegates, and the Resident Representative must be Resident members in good standing.

a. A vice chair shall also be elected. The vice chair shall assist the chair in all activities, including attendance at required meetings of the chair. The vice chair or designee from the Assembly will be allowed to fulfill the duty of proxy representative to the Board with full voting privilege of the position, in the event that the chair is unable to participate in that particular Board meeting. The vice chair shall assume the office of chair at the next spring (or annual) meeting of the Pennsylvania Assembly of Family Medicine Residents after a vote of
confidence by the voting members. Should the vice chair fail to achieve a vote of confidence or decline the position of chair, the office of chair will be filled by the usual election procedures. The combined terms of vice chair and chair shall be limited to two years. In the event of the death, resignation, or incapacity of the chair and/or vice chair, the Assembly shall appoint a chair and/or vice chair for the unexpired portion of his term.

Section 7. The Pennsylvania Assembly of Medical Students shall meet at least yearly. These meetings shall be conducted by a chair elected by the Assembly from its membership. The Pennsylvania Assembly of Medical Students shall also elect one Student Representative to the Board of Directors of the Pennsylvania Academy of Family Physicians. The chair of the Pennsylvania Assembly of Medical Students shall notify the Pennsylvania Academy’s Executive Vice President annually of the names and addresses of these delegates, alternate delegates, and the Student Representative. These delegates, alternate delegates, and the Student Representative must be Student members in good standing.

a. A vice chair shall also be elected. The vice chair shall assist the chair in all activities, including attendance at required meetings of the chair. The vice chair or designee from the Assembly will be allowed to fulfill the duty of proxy representative to the Board with full voting privilege of the position, in the event that the chair is unable to participate in that particular Board meeting. The vice chair shall assume the office of chair at the next spring (or annual) meeting of the Pennsylvania Assembly of Medical Students, after a vote of confidence by the voting members. Should the vice chair fail to achieve a vote of confidence or decline the position of chair, the office of chair will be filled by the usual election procedures. The combined terms of vice chair and chair shall be limited to two years. In the event of the death, resignation, or incapacity of the chair and/or vice chair, the Assembly shall appoint a chair and/or vice chair for the unexpired portion of his term.

CHAPTER XII
Ethics

Section 1. The Principles of Medical Ethics of the AAFP, in accordance with Chapter V of the AAFP bylaws, shall be the principles of ethics of the Academy and hereby are made a part of these bylaws. (See Appendix A and B).

CHAPTER XIII
Fiscal Year

The fiscal year of the Pennsylvania Academy of Family Physicians shall coincide with the calendar year.

CHAPTER XIV
Authority

The Current Edition of The Standard Code of Parliamentary Procedure, as revised by the American Institute of Parliamentarians and generally known as "Sturgis Rules of Order," shall control all parliamentary procedures of the annual and special meetings of the Academy, its Board of Directors and Executive Committee except when these Rules are in conflict with the standing rules of the body, the Bylaws of the Pennsylvania Academy of Family Physicians or the American Academy of Family Physicians.

CHAPTER XV
Amendment and Adoption of Bylaws

Section 1. These Bylaws may be adopted, amended or rescinded by affirmative vote of not less than two-thirds of the members of the Board of Directors present and voting at any meeting of the Annual Meeting, provided that notice of the proposed action shall have been given by the Executive Vice President to the members of the Academy by mail or official publication at least thirty (30) days before the meeting at which such action is proposed to be taken.

Section 2. Any five or more members of the Academy may propose amendments to these Bylaws by submitting the same to the Executive Vice President at least sixty (60) days prior to any annual or special meeting of Board of Directors.

Section 3. This Academy adopts as part of its Bylaws, the Bylaws of the American Academy of Family Physicians and any subsequent changes in the latter become a part of these Bylaws.

Section 4. These Bylaws shall take effect immediately upon their adoption.

Section 5. These Bylaws shall be reviewed yearly and updated, as needed.

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Note: The personal pronouns used throughout this document are intended to be generic in nature and are not to be interpreted as indications of gender.
The comments affixed to some bylaw provisions are intended solely as a guide to the reader to summarize the specific terms of the bylaws; the comments shall not be construed to be a part of the bylaws and shall not be construed to affect the terms of the bylaws in any manner whatsoever. (See Appendix C).

**PRINCIPLES OF MEDICAL ETHICS**

*American Medical Association*

**Preamble**

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

**APPENDIX A**

**BYLAWS**

*American Academy of Family Physicians*

**CHAPTER V**

*Ethics*

**Section 1.** By specific action of the Academy's Congress of Delegates on a two-thirds (2/3) vote, this organization may adopt policies or positions relating to ethical issues even though such policies or positions are in addition or contrary to the Principles of Medical Ethics of the American Medical Association. However, absent such specific action by the Congress of Delegates, the Principles of Medical Ethics of the American Medical Association, as they now or hereafter may provide, shall be the principles of ethics of this organization.

**Section 2.** If any member is in good faith believed to have violated the Principles of Medical Ethics or the Bylaws of this Academy, or to be otherwise guilty of conduct justifying censure, suspension, or expulsion from this organization, any member may file charges against him or her. The form of such charges and the rights, responsibilities and obligations of all parties involved in the filing and consideration of such charges shall be as hereinafter set forth in this chapter; provided, however, that to the extent the provisions in this chapter are in conflict with applicable law, the provisions of applicable law shall supersede these Bylaws. All those against whom charges have been filed pursuant to this chapter shall have the right to be represented by counsel at the initial hearing and upon appeal to the Board of Directors of the American Academy of Family Physicians.

Such charges must be in writing and signed by the accuser or accusers and must state the acts or conduct complained of with reasonable particularity.

Such charges must be filed with the secretary of the constituent chapter to which the accused member belongs, if any; otherwise the executive vice president of the American Academy of Family Physicians. At the first meeting of the Board of Directors of the constituent chapter or the American Academy of Family Physicians as the case may be, held after the filing of said charges, said charges must be presented to the Board. The Board shall then or at any adjournment of said meeting, but not more than thirty (30) days thereafter, consider the charges and shall either dismiss them or shall proceed as hereinafter set forth.

If the Board fails to dismiss said charges, it shall within fifteen (15) days thereafter cause a copy of the charges to be served upon the accused by depositing in the United States mail a copy thereof, registered and addressed to the last known address of the accused. The Board shall also and at the same meeting fix a time and place for hearing said charges and the accused shall be notified of the time and place at the same time and in the same manner as provided for the serving of the charges.
The time set for said hearing shall be not less than fifteen (15) days nor more than six (6) months after service of charges.

The accused may answer in writing but need not do so and failure to answer shall not be an admission of truth of the charges or a waiver of the accused’s rights to a hearing.

The Board shall, after having given to the accuser and the accused every opportunity to be heard, including oral arguments and the filing and consideration of any written briefs, conclude the hearing and within thirty (30) days thereafter shall render a decision. The affirmative vote of a majority of the members of the Board present and voting shall constitute the verdict of the said Board which by such vote may exonerate, censure, suspend, or expel the accused member. The decision of the Board shall be expressed in a resolution which shall contain no opinion and shall be signed only by the chairman of the Board and its secretary. No member of the Board not present for the entire time of the hearing shall be entitled to vote.

Censure shall mean a reprimand by the chairman of the Board of Directors administered to the accused in the presence of the said Board. No member shall be suspended for more than one year and at the expiration of the period of suspension shall be reinstated to membership upon his application and the payment of dues accrued during the period of suspension. The decision of the Board of Directors shall be final, except as provided hereafter.

**Section 3.** Any member of a constituent chapter who has been censured, suspended, or expelled by such chapter may appeal such action within six (6) months after notice thereof is given by said chapter to the Board of Directors of the American Academy of Family Physicians. The jurisdiction of the Board shall extend only to matters of procedure and law and not of fact. The Board shall fix a time and place for the hearing of the appeal and, after giving the appellant and representatives of the chapter from whose decision he appeals reasonable opportunity to be heard, shall by a majority vote either sustain or reverse such censure, suspension or expulsion. The decision of the Board shall be final.

**APPENDIX B**

**INTERPRETIVE COMMENTS**

*To Amendments Adopted by the 1992 House of Delegates*

*To the Academy Bylaws*

**Chapter VII**

**Section 9.**
The Academy is a corporation. Directors and officers of corporations have been sued personally for actions taken by the corporate board which have resulted in corporations losing money and shareholders becoming disgruntled. In turn, many capable individuals have become reluctant to serve on Boards of Directors. The legislature believed that the best interests of society would be served by having well qualified and capable individuals serve on Boards. Accordingly, the Business Corporation Law was amended to include numerous protections, including insulation of directors and officers from lawsuits based on what could be considered negligence of the corporation.

Section 9 protects each member of the Board from personal liability for any negligent actions that would harm a member of the Academy. Negligence constitutes a breach of the duty of care the director owes the Academy membership. The duty of care is that action which a reasonable person of reasonable intelligence and experience would undertake in a given circumstance.

This provision also protects the director from "misfeasance" which is essentially negligence for failure to take certain action that a reasonable man of reasonable intelligence should have taken under the circumstances.

The duty of care is defined in Section 10 below as the "standard of care." The Business Corporation Law, and this Section, does not protect the director from actions more serious than negligence which include self-dealing, willful misconduct or recklessness, and criminal liability as listed above. "Self-dealing" occurs when a "trustee" such as a director seeks to consummate a deal wherein his self-interest is opposed to the best interests of the Academy. "Willful misconduct" or "recklessness" is conduct that is either intentional or committed under circumstances exhibiting a reckless disregard for the safety or interests of others; it is an aggravated form of negligence, differing in quality rather than degree from ordinary lack of care. The final two actions are self-explanatory in terms of violating a criminal law or violating a tax law.

If a director is sued for negligence as a result of action taken or any failure to act, the Board may pay the director or officer for the losses suffered as a result of the lawsuit; such restoration or payment is known as "indemnification."

**Section 10.**
This paragraph explains the standard of care or "duty" that a director must follow in order to receive the protections provided by the bylaws. "Fiduciary relation" means the director has been granted the trust and confidence of the Academy membership. This requires scrupulously good faith behavior and candor. The director must act primarily for the benefit of the Academy and its physician members, not himself. The director owes a duty of loyalty to the Academy and its physician members.
The director may not act contrary to or compete with the interests of the Academy. This duty requires the director to devote himself to Academy affairs with a view toward promoting the interests of the Academy.

The director may only avail himself of a corporate opportunity if the corporation itself is financially unable to seize that opportunity. This duty is breached if, as a result of a deal, the director is unjustly enriched to the detriment of the Academy.

The final sentence of Section 10 (a) grants protection to the director if a decision is made based on information he has received by Academy employees, officers, counsel, CPAs or another committee of the Academy. This "good faith reliance" does not apply if the director has knowledge that the information he receives contains errors or is unreliable.

Section 10 (b) permits a director to consider how his action would affect the Academy’s employees, suppliers, or patients of family physicians when making decisions. The director may consider these factors and still act in good faith within the standard of care.

Section 10 (c) creates a presumption. Presumption is a very important procedural issue that affects the type of evidence needed to prove a case against a director. A presumption exists if the courts will treat fact A (the basic fact) as proof of fact B (the presumed fact). Here, a plaintiff bringing a lawsuit could not recover unless he proves the director’s actions were not in the best interests of the Academy. If a director has not breached the fiduciary duty, acted in bad faith, or committed self-dealing as fully described in detail above, every action taken by the director creates a presumption that he acted in the best interests of the Academy. Thus, absent stringent proof of breaching the standard of care, no other actions by the director can result in a recovery of damages. In all likelihood, Pennsylvania courts would require the person suing to overcome the presumption by “clear and convincing evidence,” which is a much higher burden of proof than is required in basic negligence cases.

Section 11.

Individuals often believe that wrongdoing occurs if a company purchases goods or services from another company where a director of the purchasing company has a financial interest in the selling company. For example, if the Academy held its annual convention at the Harrisburg Hilton every year and one of the Academy Board members had a financial interest in the hotel, the tendency would be to believe that the director is exerting influence over the Board and possibly making money at the expense of the Academy.

Section 11 permits such a transaction to occur if one of the three conditions listed are satisfied. Each of these conditions requires the “interested” director to fully disclose his relationship in the selling corporation to the Board. The contract is permissible if either (a) a majority of the disinterested directors approve it; (b) a majority of all directors approves it in good faith; or (c) the contract is simply fair to the Academy in terms of appropriate pricing, etc (i.e., the Hilton convention is billed at fair market value rates). If none of these conditions are met, the contract is void. The last sentence adds a technical provision. The "interested" directors are included in the count to determine if a quorum exists for the meeting. Of course, if a quorum was not present, the contract would be void.

Section 12.

This provision limits the personal liability of a director in the event the Academy is sued and a monetary recovery is obtained. The first clause recognizes the statutory authority of a corporation to limit the liability of its directors. This is important because it changed existing legal principles.

The second clause of the first sentence specifically protects each director from having to pay any money if the Academy loses a lawsuit for any action taken by a director or a director’s failure to take any action. Of course, this is limited to negligence as more fully described in the preceding comments.

The second sentence of Section 12 adds another layer of protection to the Academy director. It is best explained by an example. If the Academy changes the bylaws effective January 1, 1994 to minimize or totally eliminate the liability protection, the loss of protection applies prospectively only, i.e., only to those actions, or any failure to act, that occur on or after January 1, 1994. Full protection would be afforded to all actions taken, or any failure to act, up to that point. For instance, if the Academy perceives an inevitably large lawsuit will be filed based upon the alleged negligence of a few directors, and moves to eliminate the protections afforded to those directors, the directors would still be protected for all actions taken prior to the date the new bylaw was adopted.

Section 13.

This section establishes the standard of care for the Academy’s officers. Section 10 (a) addressed directors only. The comments interpreting the directors’ standard of care apply equally here with respect to the officer.

Section 14.

Section 14 (a) establishes the right to indemnification by the Academy of any director, officer or employee of the Academy. “Indemnification” means to restore a person who has suffered a loss in whole or in part by some form of payment; i.e., to make reimbursement to a person who has already suffered a loss.

Section 14 (a) requires the Academy to make this type of reimbursement to any director, officer or employee for any loss or expenses paid as a result of a negligence
lawsuit. The phraseology utilized in the first portion of Section 14 (a) is sufficiently extensive to cover all conceivable situations in order to provide indemnification in negligence suits. Indemnification is prohibited, however, in the limited circumstance where a director, officer or employee who is denied indemnification by the Academy brings a separate lawsuit for the Academy’s failure to pay indemnification unless the person is successful in pursuing the claim of indemnification. While this appears to be somewhat circuitous, it does establish the protection for the Academy in the event of a good faith refusal to pay indemnification to a director, officer or employee whose actions were external to the standard of care.

Section 14 (a) also permits the Academy to extend indemnification benefits to persons who are not directors, officers or employees as the Board sees fit.

Section 15.
An “indemnitee” is any director, officer, employee or other person designated by the Board who receives the benefits of indemnification as established in Section 14. Section 15 requires the Board to pay this person’s expenses in advance as the negligence litigation proceeds. This provision does not apply to the situation where the indemnitee sues the Board for failing to indemnify him. The expense advancement provision could be limited by another bylaw or a change in the law.

Section 16.
As discussed briefly under the comment to Section 14, the Academy’s failure to pay indemnification within thirty days after it receives such a claim permits the indemnified person to sue the Academy to recover the unpaid amount of the claim. This is a protection to a director who should be indemnified and is not based on the Academy’s bad faith denial. The Academy has a defense to such a suit to the extent that the person’s conduct was beyond the stated protections in the bylaws (for example, recklessness or intentional conduct rather than negligence). Of course, the Academy has the burden of proving this defense.

In Section 16, it will become clear that it would not be a defense to this type of suit by an indemnitee that the Academy neglected to make a determination of coverage or made a specific determination of coverage. The only defense is that the Academy could not provide reimbursement because of a provision in the articles of incorporation, the bylaws, or some other agreement. Again, this establishes fairness to the director, officer or employee in the event of the Board’s bad faith denial of coverage. The defense is broad enough to include many possible provisions such as recklessness, intentional actions, improper self-dealing, etc.

Section 17.
This section merely permits the Academy to purchase insurance to implement all of the indemnification provisions listed above. It also permits the Academy to create a trust fund or other legal device to ensure payment of indemnification expenses to a director, officer or employee in the event of a negligence suit.

Section 18.
Section 18 discusses the parameters of indemnification. First, the Board may decide to provide additional remedies to a director who has been attacked in a negligence suit. The first clause of Section 18 permits other creative remedies to be established.

Second, the indemnification provision does not create a contract between the Academy and the person being indemnified. If no contractual rights exist, no lawsuit could be filed based on the existence of a contract. This protects the Academy as a whole.

Third, any person being indemnified by the Academy must continue to be indemnified for actions taken while working on behalf of the Academy even after that person’s status changes, e.g., a Director leaves the Board or the Executive Vice President resigns. Indemnification protections also are given to a person’s heirs or legal representatives if the director dies during the pendency of the litigation.

Fourth, the protections outlined apply to all actions of the directors, officers or employees prior to the adoption of these bylaw provisions on June 17, 1992. Thus, if a negligence suit would be filed against the Academy for an act or an omission that occurred prior to the adoption of these bylaw amendments, the directors, officers or employees are still protected. The last sentence prohibits the limitation of any pre-amendment rights that were granted by the Academy in all of the preceding sections.

APPENDIX C
RESOLUTION NO. *** (Colorado A)

AAFP Vaccination Personal Belief Exemption (PBE) Policy

Introduced by the Colorado Chapter

Referred to the Reference Committee on ***

WHEREAS, Personal Belief Exemptions (PBEs) allow children in many states to be exempt from state mandated and the Centers for Disease Control and Prevention (CDC) recommended vaccinations prior to matriculation for education, and

WHEREAS, the goal of the PBE is to allow legal guardians to make informed, competent decisions in the best interest of their children, and

WHEREAS, the PBE is often used as a convenience by parents who would otherwise desire to have their children immunized but were unable to complete the vaccination schedule due to inconvenience, procrastination, and limited access to immunizations, and

WHEREAS, the ease of obtaining PBEs may play a role in the high rates of Vaccine Preventable Disease (VPD), and

WHEREAS, states that permit exemptions easily are associated with higher rates of exemptions in schools, and,

WHEREAS, schools that have higher rates of exemptions may be associated with higher Vaccine Preventable Disease (VPD) rates, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians adopt as its policy that individual states should require students and parents to see a licensed health care provider for education and/or counseling (with evidence-based materials provided by the state) prior to claiming a personal belief exemption, require physician or immunization providing clinician signature for the personal belief exemption, and require annual renewal of the personal belief exemption, and be it further

RESOLVED, That the American Academy of Family Physicians adopt as its policy that individual states should establish joint policy on immunization data collection and sharing, should hold school districts accountable for enforcing immunization policy, and make publically available the rates of immunization and exemption by schools and licensed child care facilities.

(Received 05/21/14)

Fiscal Impact: None
Background

In response to the first resolved clause, the AAFP does not have policy regarding the mandate to require patients to see a licensed health care provider for education and/or counseling prior to claiming a personal belief exemption. In addition, the AAFP does not have a policy that individual states should establish joint policies on immunization data collection and sharing and hold schools accountable for enforcing these policies. While the CDC encourages the use of immunization registries for data sharing, these policies tend to be more of a state level issue.

The AAFP Government Relations Division has encountered legislation relating to immunizations, but Colorado is the only chapter that has contacted Government Relations regarding the personal belief exemption. Earlier this year, the state of Colorado had legislation on this issue, and the Colorado Academy asked for the AAFP's input. Government Relations shared current resources but does not advocate for state legislative proposals. A letter was sent to Colorado's in response to their request for input.

Most vaccine-preventable diseases are spread from person to person. If one person in a community gets an infectious disease, they can spread it to others who are not immune. But a person who is immune to a disease because they have been vaccinated can’t get that disease and can’t spread it to others. The more people who are vaccinated, the fewer opportunities a disease has to spread.

http://www.cdc.gov/vaccines/vac-gen/whatifstop.htm

The Immunization Action Coalition is a non-biased organization with immunization information. Their website provides information regarding personal belief exemptions regarding immunizations: “Personal belief exemptions for vaccination put people at risk. Examine the evidence for yourself.” http://www.immunize.org/catg.d/p2069.pdf

This is an excellent resource regarding the personal belief exemption issue.

Information about documenting refusals to immunize and their implications can be found at:


CDC’s Understanding the Risks and Responsibilities of Not Immunizing:


The resolution also calls for a clinician’s signature to be required for the personal belief exemption and an annual renewal of the personal belief exemption. This would be difficult as it is unclear whether this visit would be paid by insurers.

The second resolved clause recommends that states establish joint policy on immunization data collection and sharing, should hold school districts accountable for enforcing immunization policy, and make publicly available the rates of immunization and exemption by schools and licensed child care facilities. The state immunization registries should serve as a conduit for this information. However, each state is unique and the registries do allow interoperability with other systems which would make it very difficult for this information sharing to occur.
Current Policy

Immunizations
http://www.aafp.org/about/policies/all/immunizations.html

Prior Congress Actions
None

Prior Board Actions
None
RESOLUTION NO. *** (New York State A)

Promote Emergency Contraceptives (EC) that Are Effective Regardless of Weight

Introduced by the New York State Chapter

Referred to the Reference Committee on ***

WHEREAS, Approximately half of all pregnancies are unintended and occur during a month when contraceptives are used, and

WHEREAS, levonorgestrel emergency contraceptives (EC) [such as Plan B, One-Step, and Next Choice] is less efficacious with increasing BMI, such that obese women (BMI ≥30) are at a 4-fold higher risk of pregnancy compared to normal weight women, and

WHEREAS, ulipristal acetate EC (Ella®) is slightly less efficacious with increasing BMI, such that obese women are at a 2-fold higher risk of pregnancy compared to normal weight women, yet unlike levonorgestrel, maintains full efficacy up to five days after unprotected sexual intercourse, and

WHEREAS, a copper intrauterine device (IUD) is the most reliable method of EC regardless of BMI, with over 99% effectiveness if inserted within five days of unprotected sexual intercourse, is safe for the majority of women, and is highly effective and cost effective for ongoing contraception up to 12 years, and

WHEREAS, a study of women interested in EC showed 40% accepted an IUD and were half as likely to be pregnant one year later compared to those choosing oral levonorgestrel, and

WHEREAS, copper IUDs have been safely used as EC since 1976, is approved in the European Union and recommended by the American Congress of Obstetricians and Gynecologists for this indication, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians update www.familydoctor.org section on emergency contraception with accurate evidence-based information, and be it further

RESOLVED, That the American Academy of Family Physicians request the U.S. Food and Drug Administration to include labeling that levonorgestrel and ulipristal acetate are less effective for emergency contraception (EC) with obese women.

(Received 6/25/14)

Fiscal Impact: None

Background
Levonorgestrel, marketed as Plan B® One-Step or Next Choice®, is used to prevent pregnancy after unprotected sexual intercourse. It is in a class of medications called progestins and works by preventing the release of an egg from the ovary or preventing fertilization. It also may work by changing the lining of the uterus to prevent development of a pregnancy. Levonorgestrel, a tablet to take by mouth, is the most widely used emergency contraception regimen.
On June 20, 2013, the U.S. Food and Drug Administration (FDA) approved the use of Plan B One-Step (levonorgestrel) as a nonprescription product for all women of childbearing potential. This action complied with the April 5, 2013 order of the U.S. District Court in New York to make levonorgestrel-containing emergency contraceptives available as an over-the-counter product without age or point-of-sale restrictions.

Ulipristal acetate, a selective progesterone receptor modulator, can be used up to 5 days (120 h) after unprotected sexual intercourse. Ulipristal acetate developed for emergency contraception was approved by the European Medicines Agency in May 2009 and by the FDA in August 2010.

Full prescribing information on emergency contraceptives on the FDA website at http://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022474s000lbl.pdf points out that "ella and other emergency contraceptives may be less effective in women with a body mass index (BMI) > 30 kg/m."

This resolution calls on the AAFP to update www.familydoctor.org section on emergency contraception with accurate evidence-based information. AAFP editorial staff responsible for the content on FamilyDoctor.org will review the current evidence relative to the section on emergency contraception and will work with physician medical editors as appropriate to update this content. The content was last updated in December 2013 and includes information on all three contraceptive methods listed in the resolution, including efficacy concerns related to increasing BMI and some oral emergency contraceptives (levonorgestrel and ulipristal acetate) and information about the effectiveness of the copper intrauterine device.

Current Policy

Contraceptive Advice
http://www.aafp.org/about/policies/all/contraceptive.html

Prior Congress Action
None

Prior Board Action
None
RESOLUTION NO. *** (New York State C)

Promoting Nutritious Food Purchases in the Federal Supplemental Nutrition Assistance Program

Introduced by the New York State Chapter

Referred to the Reference Committee on ***

WHEREAS, The annual medical cost of obesity in the U.S. is now $190 billion, and rises even higher when adding in indirect costs such as income lost from decreased productivity and absenteeism, and

WHEREAS, the Federal Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps) expends about $78 billion annually to provide food stamps to more than 47 million Americans (1 in 7 people), and

WHEREAS, certain non-nutritious foods – soda, high-energy drinks, cookies, candy, potato chips, ice cream, mixes for alcoholic beverages – can be bought with food stamps, contributing to poor health and increased medical costs, and

WHEREAS, the U.S. Department of Agriculture (USDA) already limits food choices in the Women, Infants & Children (WIC) program, which helps about nine million people nationally, and has implemented rules to cut calories and combat childhood obesity in the federal school lunch program, which helps over 30 million children, and

WHEREAS, a coalition of health advocacy organizations (54, including the Center for Science in the Public Interest and American Heart Association) and public health experts are calling on the USDA to approve state and local pilot SNAP programs that would restrict the purchase of soda and unhealthy foods in order to provide USDA with data on how to restrict purchases to healthy foods and beverages, and

WHEREAS, mayors of 18 large cities sent a letter asking Congressional leaders to enact SNAP limits on purchasing soda and other sugar-sweetened beverages, and

WHEREAS, effectively addressing obesity requires a multi-faceted strategy, one of which is ensuring that the Federal Supplemental Nutrition Assistance Program helps recipients purchase only nutritional foods and beverages, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians (AAFP) lobby the U.S. Congress to direct the U.S. Department of Agriculture (USDA) to approve pilot projects with Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) that would restrict the purchase of soda and unhealthy foods and to provide data to the USDA on how to enhance SNAP purchases of healthy foods and beverages, and it further
RESOLVED, That the American Academy of Family Physicians lobby the U.S. Congress to appropriate funds to the U.S. Department of Agriculture (USDA) for pilot projects with Supplemental Nutrition Assistance Program (SNAP) that would restrict the purchase of soda and unhealthy foods and provide data on how to enhance SNAP purchases of healthy foods and beverages.

(Received 6/25/14)

**Fiscal Impact:** $14,248

**Background**

In February 2014, President Obama signed into law the Agricultural Act of 2014, extending for 5-years agricultural programs, including the Supplemental Nutrition Assistance Program (SNAP) program. Spending on SNAP was reduced by $800 million, or approximately 1 percent.

In 2008, 28.2 million Americans were on food stamps, and an additional 19.4 million have been added in the last five years. Today, 47 million Americans are on food stamps.

SNAP’s mission is to help “low-income residents and families buy the food they need for good health.” Those who are eligible can apply for benefits by completing a state application form. Benefits are provided on an electronic card that is used like an ATM card and accepted at most grocery stores.

According to the U.S. Department of Agriculture website, households may use SNAP benefits to buy foods for the household. The Food and Nutrition Act of 2008 (the Act) defines eligible food as “any food or food product for home consumption and also includes seeds and plants which produce food for consumption by SNAP households.” The Act precludes the following items from being purchased with SNAP benefits: alcoholic beverages, tobacco products, hot food, and any food sold for on-premises consumption. Nonfood items such as pet foods, soaps, paper products, medicines and vitamins, household supplies, grooming items, and cosmetics, also are ineligible for purchase with SNAP benefits.

Soft drinks, candy, cookies, snack crackers, and ice cream are food items and are therefore eligible items. Seafood, steak, and bakery cakes are also food items and are therefore eligible items.

Since the current definition of food is a specific part of the Act, any change to this definition would require action by Congress. Several times in the history of SNAP, Congress had considered placing limits on the types of food that could be purchased with program benefits. However, legislators concluded that designating foods as luxury or non-nutritious would be administratively costly and burdensome. Further detailed information about the challenges of restricting the use of SNAP benefits is discussed in a report from the USDA.

**Fiscal Impact**

The estimated cost would be primarily staff time to lobby at the federal level. The estimate is 50 hours of Upper Management time, 50 hours of Managerial staff time and...
75 hours of Professional Staff time, for a projected cost of $14,258.

Current Policy

Healthy Foods
http://www.aafp.org/about/policies/all/healthy-foods.html

Sugar Sweetened Beverages
http://www.aafp.org/about/policies/all/sweetened-beverages.html

Prior Congress Action

Resolution No. 403 to the 2012 COD (Substitute Adopted):
RESOLVED, That the American Academy of Family Physicians support the
development of healthy food supply chains in supplemental nutrition programs so
as to broaden the availability of healthy food to program recipients.
Please see Page 357 in the 2012 Transactions for details.
http://www.aafp.org/content/dam/AAFP/documents/about_us/congress/restricted/2012/2012Transactions.pdf
Please see Page 176 in the 2013 Transactions for follow-up details.
http://www.aafp.org/content/dam/AAFP/documents/about_us/congress/restricted/2013/2013Transactions.pdf

Resolution No. 403 to the 2013 COD (Referred to the Board of Directors):
RESOLVED, That the American Academy of Family Physicians advocate for
federal policies that better align Farm Bill crop supports with the U.S. Department
of Agriculture (USDA) dietary guidelines.
Please see Pages 279-280 in the 2013 Transactions for details.
http://www.aafp.org/content/dam/AAFP/documents/about_us/congress/restricted/2013/2013Transactions.pdf
Please see the AAFP website for follow-up details at:
http://www.aafp.org/about/governance/congress-delegates/2013/resolutions/resolution-403.mem.html

Prior Board Action
Approval of a recommendation from the Commission on Governmental Advocacy
that the AAFP 1) share examples with state chapters on sugary beverages
subjecting them to excise taxes similar to those used for tobacco and alcohol; 2)
support changes to federal programs that would emphasize substituting healthier
drinks for sugary beverages, especially to children; 3) support providing nutritious
foods in school vending machines.
B2010, April 26-29, p. 18.
RESOLUTION NO. *** (New York State D)

Designating Nursing Pumping Rooms in Commercial Transportation Hubs that are Clean, Private, and Not a Restroom Space

Introduced by the New York State Chapter

Referred to the Reference Committee on ***

WHEREAS, The innumerable benefits of breastfeeding for both mothers and children is well documented, and

WHEREAS, breastfeeding rights in New York State includes the right to breastfeed your baby in any public or private place where you have a right to be, and

WHEREAS, according to New York State breastfeeding rights, no one can tell you to breastfeed in a restroom, and

WHEREAS, breastfeeding in public places is for the most part accepted, but little has been addressed about pumping breast milk in a public place, and

WHEREAS, nursing mothers, whose jobs require frequent traveling, need to pump breast milk in public places including airports to either feed their babies, prevent engorgement or keep milk supply, and

WHEREAS, the amount of milk a woman is able to express depends on many factors, and

WHEREAS, pumping breast milk requires a clean private space with a minimum of a chair, table and a sink to set up the equipment and properly hand wash to prevent contamination, including how relaxed or stressed she is, and expressing in a comfortable setting may help them to have a letdown, and

WHEREAS, a restroom is not a pleasant place to feed a baby or manipulate breast milk and carries a high risk of contamination, and

WHEREAS, many airports currently either do not have a designated nursing/pumping room or they are in or part of a restroom, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians lobby the U.S. Congress to require nursing pumping rooms at commercial transportation hubs as defined by the U.S. Department of Transportation in a non-restroom space with a minimum of chairs, counter, sink, and power for equipment use.

(Received 6/25/14)
RESOLUTION NO. *** (New York State E)

Support the Women’s Health Protection Act

Introduced by the New York State Chapter

Referred to the Reference Committee on ***

WHEREAS, The American Academy of Family Physicians (AAFP) states that “Quality health care in family medicine is the achievement of optimal physical and mental health through accessible, safe, cost-effective care that is based on best evidence, responsive to the needs and preferences of patients and populations, and respectful of patients’ families, personal values, and beliefs,” and

WHEREAS, the AAFP “supports the use of evidence-based and explicitly stated clinical practice guidelines that are “developed using rigorous evidence-based methodology,” and

WHEREAS, since the ruling of Roe vs. Wade in 1973, politicians interested in curbing access to abortion have penned and passed legislation that dictates the way in which abortion care can be provided through numerous means without regard to medical evidence, and

WHEREAS, recent legislation sought to control doctor-patient speech through the use of legally mandated scripts, even requiring doctors to provide information to patients that run contrary to best scientific evidence, for instance, five states require physicians to inform patients of a link between abortion and breast cancer (contrary to the finding of the National Cancer Institute), and eight states require patients to be told of the link between abortion and negative mental health outcomes (contrary to the findings of an American Psychological Association task force), and 12 states require women to be counseled on the ability of a fetus to feel pain (at an earlier gestation than suggested by evidence), and

WHEREAS, recent legislation also dictates doctor-patient interaction, for example, 23 states regulate the provision of ultrasound by abortion providers, with three mandating providers to show and describe the ultrasound image, and

WHEREAS, recent legislation has limited providers ability to prescribe medications for abortion, making it so providers must adhere to the U.S. Food and Drug Administration’s outdated protocol which has worse side effects at a higher failure rate than more recent, evidence-based protocols as well as costs more, additionally, these interferences will force more women to obtain surgical abortions, and

WHEREAS, unnecessary requirements decreases overall access to abortions, cutting the number of providers and clinics, increasing travel time, costs, and stress for the patient, and

WHEREAS, decreasing the number of abortion providers and clinics, in turn, delays women from obtaining the actual abortion, which pushes women later into pregnancy when abortion becomes more expensive and associated with a higher risk of complication, and
WHEREAS, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians, and the American College of Surgeons “believe the legislators should abide by principles that put patients’ best interests first” and that “government must avoid regulating the content of individual clinical encounter without a compelling and evidence-based benefit to the patient, and substantial public health justification, or both,” and

WHEREAS, the Women’s Health Protection Act (S 1696/H.R. 3471 http://beta.congress.gov/bill/113th-congress/senate-bill/1696) is a bill “to protect a women’s right to determine whether and when to bear a child or end a pregnancy by limiting restrictions on the provision of abortion services,” which would override and negate most of the restrictive regulation described above, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians publicly support legislation that would protect a woman’s right to determine whether and when to bear a child or end a pregnancy by opposing non evidence-based restrictions on the provision of abortion services, and be it further

RESOLVED, That the American Academy of Family Physicians support legislation such as the Women’s Health Protection Act (S.1696/H.R. 3471) that would protect a woman’s right to determine whether and when to bear a child or end a pregnancy by opposing non-evidence-based restrictions on the provision of abortion services.

(Received 6/25/14)

Fiscal Impact: None

Background

In 1973, the Supreme Court concluded in Roe v. Wade that the Constitution protects a woman’s right to terminate her pregnancy. In the companion Doe v. Bolton decision, the Court found that a state may not unduly burden the exercise of that fundamental right with regulations that prohibit or substantially limit access to the means of effectuating the decision to have an abortion. However, the Court’s rulings since Roe and Doe have continued to generate debate and have precipitated a variety of governmental actions at the national, state, and local levels designed either to nullify the rulings or limit their effect. These governmental regulations have, in turn, spawned further litigation in which resulting judicial refinements in the law have been no more successful in dampening the controversy.

In recent years, the rights enumerated in Roe have been redefined by decisions such as Webster v. Reproductive Health Services, which gave greater leeway to the states to restrict abortion, and Rust v. Sullivan, which narrowed the scope of permissible abortion-related activities that are linked to federal funding. The Court’s decision in Planned Parenthood of Southeastern Pennsylvania v. Casey, which established the “undue burden” standard for determining whether abortion restrictions are permissible, gave Congress additional impetus to move on statutory responses to the abortion issue, such as the Freedom of Choice Act.

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, includes provisions that address the coverage of abortion services by qualified health plans that will be available through health benefit exchanges beginning in 2014.
ACA’s abortion provisions have been controversial, particularly with regard to the use of premium tax credits or cost-sharing subsidies to obtain health coverage that includes coverage for elective or non-therapeutic abortion services. Under ACA, individuals who receive a premium tax credit or cost-sharing subsidy will be permitted to select a qualified health plan that includes coverage for elective abortions, subject to funding segregation requirements that will be imposed on both the plan issuer and the enrollees in such a plan.

The Women’s Health Protection Act (S 1696/HR 3471), introduced in November of 2013, seeks to create federal protections against state restrictions concerning abortion services. It would prohibit the imposition by any government of the following: a requirement that a medical professional perform specific tests or follow specific medical procedures, unless generally required in the case of medically comparable procedures; a limitation on an abortion provider’s ability to delegate tasks, other than one applicable to medically comparable procedures; a limitation on an abortion provider’s ability to prescribe or dispense drugs based on her or his good-faith medical judgment, other than one generally applicable; a limitation on an abortion provider’s ability to provide abortion services via telemedicine, other than one generally applicable; a requirement or limitation concerning the physical plant, equipment, staffing, or hospital transfer arrangements of facilities where abortions are performed, or the credentials, hospital privileges, or status of personnel at such facilities that is not otherwise imposed where medically comparable procedures are performed; a requirement that, prior to obtaining an abortion, a woman make medically unnecessary visits to the provider of abortion services or to any individual or entity that does not provide such services; and a requirement or limitation that prohibits or restricts medical training for abortion procedures, other than one generally applicable to medically comparable procedures.

The Women’s Health Protection Act also proposes to make unlawful a measure or action that restricts the provision of abortion services, or the facilities that provide them, that is similar to any of those described above if it singles out abortion services or make abortion services more difficult to access and does not significantly advance women’s health or the safety of abortion services. Further, the bill provides standards for the making of a prima facie case in a civil action challenging such restrictions and factors to be considered by a court in determining whether a measure or action impedes access to abortion services.

It also makes the following other restrictions on the performance of abortion unlawful and prohibits their imposition or application by any government: a prohibition or ban prior to fetal viability; a prohibition after fetal viability when, in the good-faith medical judgment of the treating physician, continuation of the pregnancy would pose a risk to the woman’s life or health; a restriction that limits a woman’s ability to obtain an immediate abortion when a health care professional believes, based on good-faith medical judgment, that delay would pose a risk to the woman’s health; and a prohibition or restriction on obtaining an abortion prior to fetal viability based on a woman’s reasons or perceived reasons or that requires her to state her reasons before obtaining an abortion prior to fetal viability. It requires courts to liberally construe the provisions of this Act and authorizes the Attorney General or an individual or entity aggrieved by (or a health facility or medical professional adversely affected by) a violation of this Act, to commence a civil action for injunctive relief.
This resolution calls on the AAFP to support the Women’s Health Protection Act (S.1696/HR 3471), legislation which seeks to protect access to abortion services in order to preserve a woman’s right to end a pregnancy. The AAFP policy recognizes that a pregnant woman has the right to make reproductive decisions.

Current Policy

Reproductive Decisions
http://www.aafp.org/about/policies/all/reproductive-decisions.html

Contraceptive Advice
http://www.aafp.org/about/policies/all/contraceptive.html

Prior Congress Action

Resolution No. 503 to the 2008 COD (1st Resolved Adopted and 2nd Resolved Not Adopted):
RESOLVED, That the American Academy of Family Physicians (AAFP) endorse the principle that women receiving healthcare paid for through health plans funded by state or federal governments be provided with access to the full range of reproductive options when facing an unintended pregnancy, and be it further
RESOLVED, That the American Academy of Family Physicians engage in advocacy efforts to overturn the Hyde Amendment, which bans federal funding for abortions.
Please see Pages 363-364 in the 2008 Transactions for details.
http://www.aafp.org/content/dam/AAFP/documents/about_us/congress/restricted/2008/ThirdSession.pdf

Resolution No. 501 to the 2009 COD (Referred to the Board of Directors):
RESOLVED, That the American Academy of Family Physicians engage in advocacy efforts to overturn the Hyde Amendment, which bans federal funding for abortions.
Please see Pages 314-315 in the 2009 Transactions for details.
Please see Pages 162-163 in the 2010 Transactions for follow-up details.

Resolution No. 502 to the 2011 COD:
RESOLVED, That the American Academy of Family Physicians (AAFP) urge federal, state, and local governments to support only the programs that provide medically accurate information to women facing unintended pregnancies and to enforce existing consumer protection laws prohibiting the deceptive practices.
Please see Page 257 in the 2011 Transactions for details.
Please see Page 174 in the 2012 Transactions for follow-up details.
http://www.aafp.org/content/dam/AAFP/documents/about_us/congress/restricted/2012/2012Transactions.pdf
Prior Board Action

Approval of a recommendation from the Commission on Governmental Advocacy that the AAFP write a letter to the Secretary of HHS in support of the provision of medically accurate information to women facing unintended pregnancies and that AAFP urge the enforcement of existing consumer protection laws.

B2012, May 1-3, p. 11.
RESOLUTION NO. *** (New York State F)

Electronic Cigarettes (e-cigarettes) to be Treated the Same as Tobacco Products

Introduced by the New York State Chapter

Referred to the Reference Committee on ***

WHEREAS, Electronic cigarettes (e-cigarettes) were first introduced in China in 2003 as many nations began imposing strict bans on smoking and have been aimed at giving the user a similar sensation to smoking actual cigarettes, and

WHEREAS, e-cigarettes are battery operated devices filled with liquid nicotine (a proven highly addictive chemical) that heats up and turns into a vapor when inhaled (hence the term "vaping" rather than smoking), and

WHEREAS, it is estimated that tens of millions of people worldwide are now using e-cigarettes on a regular basis, which in the U.S. is projected to be a $1.7 billion industry by the end of 2013, and

WHEREAS, manufacturers and distributors of e-cigarettes claim that they are an effective and healthy alternative to tobacco smoking since the user does not inhale harmful tobacco smoke which contains well over 4,000 toxic chemicals, and

WHEREAS, as a means of appealing to the younger generation, many e-cigarettes are now available in different flavors, such as chocolate, mint, cherry, strawberry and, as such, could lead to possible increase nicotine addictions, and

WHEREAS, the marketing of e-cigarettes currently lacks important regulatory factors, such as essential health warnings, proper labeling of ingredients, etc., and

WHEREAS, the U.S. Food and Drug Administration (FDA) website states that e-cigarettes may contain ingredients that are known to be toxic and unsafe, and

WHEREAS, while much is still unknown about the long-term health risks of e-cigarettes, critics like the British Medical Association and the World Health Organizations are concerned about their addictiveness, especially with young adults, and

WHEREAS, according to a study cited by USA Today, half of young adults indicated that they would try e-cigarettes (over regular tobacco cigarettes) if it was offered to them, and

WHEREAS, research published in the American Journal of Public Health indicated that 53% of young adults in the U.S. who have heard of e-cigarettes believe that they are healthier than traditional cigarettes and 45% actually believe that they could help them quit smoking, and
WHEREAS, there is little, if any, evidence to support either of these two claims, and

WHEREAS, the Medical Society of the State of New York (MSSNY) policy 300.971 (Adolescent Tobacco Prevention Act) - calls upon MSSNY to support Governor Mario Cuomo’s 1992 “Message to the Legislature” for increased taxes on tobacco products to be used for educational programs aimed at decreasing tobacco abuse by adolescents, and

WHEREAS, in 2010, the MSSNY adopted resolution 161 supporting the prohibition of the sale of e-cigarettes to children under the age of 18 and that the sale of e-cigarettes be also prohibited in any facility where health care is delivered or where prescriptions are filled, as well as in public places, in accordance with New York State’s Clean Indoor Air Act, and forwarded a similar resolution to the American Medical Association for its consideration at the 2010 HOD, and

WHEREAS, in 2012, Governor Andrew Cuomo signed legislation which took effect as of January 1, 2013, prohibiting the sale of electronic cigarettes to individuals under the age of 18 (A.9044B/S.2926B), stating that they can serve as a pathway to nicotine addiction leading children to start smoking regular cigarettes and other tobacco products, and

WHEREAS, even though nicotine at any level is harmful, some physicians might encourage patients who smoke to consider e-cigarettes as an alternative to regular cigarettes until sufficient time has passed for studies to be conducted on the possible long-term effects of the use of e-cigarettes, and

WHEREAS, due to the lack of quality control and FDA oversight, when an individual is “vaping,” there is no way of knowing the actual quantity of nicotine, fillers and other potentially harmful by products they may be inhaling, and

WHEREAS, when a consumer purchases a pack or carton of cigarettes, federal and state taxes account for a considerable portion of the price, and

WHEREAS, the federal government distributes a portion of the tax money back to the individual states which often helps to fund many social programs, general health education, cancer research, etc., now, therefore, be it

RESOLVED, That the American Academy of Family Physicians lobby U.S. Congress to treat electronic cigarettes (e-cigarettes) the same as tobacco products, and be it further

RESOLVED, That the American Academy of Family Physicians lobby U.S. Congress to have the Department of Health and Human Services conduct research into the possible risks associated with the use of electronic cigarettes (e-cigarettes) on a long term basis, and be it further

RESOLVED, That the American Academy of Family Physicians lobby the U.S. Congress for the strict quality control and oversight as to the actual ingredients, i.e., nicotine, by-products, etc. which are being inhaled and that these ingredients be printed on each electronic cigarette (e-cigarette) package, and be it further
RESOLVED, That the American Academy of Family Physicians lobby the U.S. Congress to include appropriate warning labels on electronic cigarette (e-cigarette) packages that “vaping for an extended period of time may ultimately prove to be harmful.”

(Received 6/25/14)

**Fiscal Impact:** $14,258

**Background**
This resolution calls on the AAFP to lobby Congress to pass legislation to require regulation of e-cigarette ingredients as well as the inclusion of warning labels on e-cigarettes.

The AAFP recently sent a [letter to the FDA](http://www.aafp.org/about/policies/all/e-cigarettes.html) commenting on the “Deeming Tobacco Products To Be Subject to the Federal Food, Drug, and Cosmetic Act, as Amended by the Family Smoking Prevention and Tobacco Control Act; Regulations on the Sale and Distribution of Tobacco Products and Required Warning Statements for Tobacco Products” proposed rule as published in the April 25, 2014, Federal Register. In the letter, AAFP supported the authority of the FDA to regulate e-cigarettes, called for restrictions on sales to youths, and called for rigorous research on e-cigarette ingredients and health impacts. The letter stated that, “the FDA should have authority to regulate the manufacture, sale, labeling, distribution and marketing of tobacco products and nicotine delivery devices.” Once the final rule is promulgated, the FDA will have authority to regulate e-cigarettes in the manner recommended by this Resolution.

Any Congressional action will be in response to regulations put forth by the FDA, either to strengthen or weaken the regulations. AAFP policy on e-cigarettes is clear and will guide any lobbying efforts.

**Fiscal Impact**
The estimated cost would be primarily staff time to lobby at the federal level. The estimate is 50 hours of Upper Management time, 50 hours of Managerial staff time and 75 hours of Professional Staff time, for a projected cost of $14,258.

**Current Policy**

**Electronic Cigarettes**
[http://www.aafp.org/about/policies/all/e-cigarettes.html](http://www.aafp.org/about/policies/all/e-cigarettes.html)

**Prior Congress Actions**
None

**Prior Board Actions**
Approval of a recommendation from the Commission on Health of the Public and Science to adopt a new policy statement on “Electronic Cigarettes.”

American Academy of Family Physicians  
Fiscal Impact of Resolutions to Congress of Delegates  
2013 Form

Resolution No: NY F (please attach complete copy of resolution to this form)

Name of AAFP staff person preparing this form: Mark Cribben

<table>
<thead>
<tr>
<th>Type of Program, Project, Product, Service, Activity</th>
<th>On-going</th>
<th>Starting Date</th>
<th>Ending Date</th>
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<tr>
<td></td>
<td>One-time</td>
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If the fiscal impact is less than $5,000, check this box and do NOT complete the rest of the form.

Estimated Financial Information
For One-time or Time-limited programs, indicate the total revenue and expenses for the project.
For On-going programs, indicate revenue and expenses for a full 12 month time frame.

Revenue Projections (List):

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<th>Description</th>
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<td>Total Revenue</td>
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Expense Projections:

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<td>Fringe Benefits / Payroll Taxes</td>
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<td>Show Detail</td>
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<td></td>
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<tr>
<td>Meeting Costs</td>
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<td></td>
</tr>
<tr>
<td>Postage</td>
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<td></td>
</tr>
<tr>
<td>Production / Development</td>
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<tr>
<td>Professional Services</td>
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</tr>
<tr>
<td>Promotion</td>
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<td></td>
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<tr>
<td>Travel Costs - Non-Staff</td>
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<tr>
<td>Travel Costs - Staff</td>
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<td></td>
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<td>Other (List):</td>
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</tr>
<tr>
<td>General and Administrative (Overhead)</td>
<td>22.20%</td>
<td>2590</td>
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Total Expenses:

Net Fiscal Impact: $ -14258
Fiscal Impact: **$14,258**

**Background**
This resolution calls on the AAFP to lobby Congress to pass legislation to require regulation of e-cigarette ingredients as well as the inclusion of warning labels on e-cigarettes.

The AAFP recently sent a letter to the FDA commenting on the “Deeming Tobacco Products To Be Subject to the Federal Food, Drug, and Cosmetic Act, as Amended by the Family Smoking Prevention and Tobacco Control Act; Regulations on the Sale and Distribution of Tobacco Products and Required Warning Statements for Tobacco Products” proposed rule as published in the April 25, 2014, Federal Register. In the letter, AAFP supported the authority of the FDA to regulate e-cigarettes, called for restrictions on sales to youths, and called for rigorous research on e-cigarette ingredients and health impacts. The letter stated that, “the FDA should have authority to regulate the manufacture, sale, labeling, distribution and marketing of tobacco products and nicotine delivery devices.” Once the final rule is promulgated, the FDA will have authority to regulate e-cigarettes in the manner recommended by this Resolution.

Any Congressional action will be in response to regulations put forth by the FDA, either to strengthen or weaken the regulations. AAFP policy on e-cigarettes is clear and will guide any lobbying efforts.

**Fiscal Impact**
The estimated cost would be primarily staff time to lobby at the federal level. The estimate is 50 hours of Upper Management time, 50 hours of Managerial staff time and 75 hours of Professional Staff time, for a projected cost of $14,258.

**Current Policy**

**Electronic Cigarettes**
The American Academy of Family Physicians (AAFP) recognizes the increased use of electronic cigarettes (i.e., e-cigarettes) especially among youth and those attempting to quit smoking tobacco. Electronic cigarettes are unregulated, battery-operated devices that contain nicotine-filled cartridges. The resulting vapor is inhaled as a mist that contains flavorings and various levels of nicotine and other toxic substances. Although e-cigarettes may be less toxic than smoking combustible tobacco cigarettes, there is no empirical evidence supporting the efficacy of e-cigarettes as a smoking cessation device. However, some physicians and public health groups consider the use of said devices as a viable harm-reduction strategy. Anecdotal accounts of people using e-cigarettes as a cessation device have led some to believe that these products have the potential to help them quit – especially the long-term, highly addicted smoker. Others are concerned that e-cigarettes may contribute to nicotine dependence, promote dual use of both products, and encourage nicotine consumption. E-cigarettes may also introduce children to nicotine and potential addiction.

There are concerns about the lack of any regulatory oversight by the Food and Drug Administration’s Center for Tobacco Products (FDA CTP) on the manufacture, distribution and safety of e-cigarettes. Therefore, the AAFP calls for rigorous research.
in the form of randomized controlled trials of e-cigarettes to assess their safety, quality, and efficacy as a potential cessation device. The AAFP also recommends that the
marketing and advertising of e-cigarettes, especially to children and youth, should cease immediately until e-cigarette’s safety, toxicity, and efficacy are established.

(January 2014 Board Chair)

http://www.aafp.org/about/policies/all/e-cigarettes.html

Prior Congress Actions
None

Prior Board Actions
Approval of a recommendation from the Commission on Health of the Public and Science to adopt a new policy statement on “Electronic Cigarettes.”

American Academy of Family Physicians  
Fiscal Impact of Resolutions to Congress of Delegates  

Resolution No.  **NY F** (please attach complete copy of resolution to this form)  

Name of AAFP staff person preparing this form  **Mark Cribben**  

| Type of Program, Project, Product, Service, Activity | On-going | Starting Date: **October 2014** | Ending Date:  
| --- | --- | --- | --- |

If the fiscal impact is less than $5,000, check this box and do NOT complete the rest of the form.  

Estimated Financial Information  
For One-time or Time-limited programs, indicate the total revenue and expenses for the project.  
For On-going programs, indicate revenue and expenses for a full 12 month time frame.  

<table>
<thead>
<tr>
<th>Revenue Projections (List):</th>
<th>Amount</th>
</tr>
</thead>
</table>
|  | $  

| Total Revenue | $ 0  |

<table>
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<th>Expense Projections:</th>
<th>Hours</th>
<th>Rate</th>
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<td>Administrative Support</td>
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</table>

| Fringe Benefits / Payroll Taxes | 29.64% | 2668 |

| Show Detail |

| Meeting Costs |
| Postage |
| Production / Development |
| Professional Services |
| Promotion |
| Travel Costs - Non-Staff |
| Travel Costs - Staff |
| Other (List): |

| General and Administrative (Overhead) | 22.20% | 2590 |
| Total Expenses | $ 14258 |
| Net Fiscal Impact | $ -14258 |
RESOLUTION NO. *** (New York State G)

Support of Ending Tobacco Sales at Pharmacies

Introduced by the New York State Chapter

Referred to the Reference Committee on ***

WHEREAS, Tobacco products are highly addictive and account for the preventable death of 25,500 New Yorkers each year, and

WHEREAS, the findings of the 2012 Surgeon General’s report indicates that tobacco use is a “pediatric epidemic” and that tobacco marketing increases youth tobacco use, and

WHEREAS, a facility registered in the State of New York as a pharmacy, refers to the preparation and dispensing of drugs, as well as the counseling of patients in the proper use of these drugs, and

WHEREAS, pharmacies should properly reflect professional concern for patient’s health and well-being, and also participate in smoking cessation efforts, and

WHEREAS, it is a contradiction for pharmacies, providers of health promotion aides, medications, and supplies to also profit from the sale of deadly products such as tobacco, known to cause cancer, heart, and pulmonary diseases, and

WHEREAS, tobacco sales in pharmacies raise ethical questions since tobacco is a product, that when used as intended, kills at least one half of its long term users, and

WHEREAS, cigarette product displays in New York State pharmacies average 50-60 square feet, which is about twice the size of displays in convenience stores, and

WHEREAS, in 2008, San Francisco banned the sale of tobacco products in stores with a pharmacy, and

WHEREAS, in 2009, Boston banned the sale of tobacco in pharmacies and since then 67 other municipalities in Massachusetts have adopted regulation, and

WHEREAS, additionally, the Massachusetts Department of Public Health formally endorsed the regulation, and

WHEREAS, in 2009, the Pharmacists Society of the State of New York passed a resolution supporting the effort to ban the sales of tobacco products in pharmacies, and

WHEREAS, in 2014, CVS Pharmacy announced that it would no longer sell tobacco products in its chain of stores stating it “is simply the right thing to do for the good of our customers and our company. The sale of tobacco products is inconsistent with our purpose – helping people on their path to better health,” now, therefore, be it

RESOLVED, The American Academy of Family Physicians support ending the sale of tobacco products in all pharmacies and stores that contain a pharmacy department, and be it further
RESOLVED, That the American Academy of Family Physicians contact and encourage
the Pharmacist Society; the American Pharmacists Association; the American Society
of Consulting Pharmacists; the National Community Pharmacists Association; the
American Association of Colleges of Pharmacy; the American College of Clinical
Pharmacy; the American Society of Health-System Pharmacists; the Board of
Pharmacy Specialties; the National Association of Chain Drug Stores; and the Joint
Commission on the Accreditation of Healthcare Organizations to also support the
prohibition of the sale of tobacco products in pharmacies

(Received 6/25/14)
RESOLUTION NO. *** (New York State H)

Include Vasectomy in the Patient Protection and Affordable Care Act (ACA)

Introduced by the New York State Chapter

Referred to the Reference Committee on ***

WHEREAS, Coverage of male contraceptive services is currently not included in the Patient Protection and Affordable Care Act (ACA) as a preventive service or under the contraceptive mandate, and

WHEREAS, women already assume most of the burden of contraception, with regards to sterilization and other hormonal and non-hormonal methods, and

WHEREAS, 27% of women rely on female sterilization and only 10% rely on their partner’s vasectomy, and

WHEREAS, female sterilization carries greater risk of major operative and post-operative complication rates than vasectomy (1.2% for tubal ligation and 0.04% for vasectomy), and

WHEREAS, vasectomy is less expensive, with an average cost of vasectomy is $708 in 2012, compared to the average cost of tubal ligation methods at $2,912, and

WHEREAS, vasectomy is as, or more effective, than female sterilization at preventing pregnancy, and

WHEREAS, exclusion of coverage for male contraceptive services is not evidence-based, may be discriminatory, and may further hinder male involvement in contraception by increasing cost barriers and decreasing social expectations for men, and

WHEREAS, mandated coverage of vasectomy could aid efforts to increase uptake of this safe and effective form of contraception, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians write a letter to the Secretary of the Department of Health and Human Services (DHHS) requesting that the list of preventive services be amended to include all contraceptive services, including vasectomy and condoms, and be it further

RESOLVED, That the American Academy of Family Physicians write a letter to the Secretary of the Department of Health and Human Services (DHHS) to advise that sterilization procedures are preventive care and should be included within the Essential Health Benefits pursuant to the Affordable Care Act.

(Received 6/25/14)

Fiscal Impact: None
Background
This resolution asks AAFP to request that the U.S. Department of Health and Human Services amend the covered preventive services under the Affordable Care Act to include male contraception, including vasectomy and condoms.

The Affordable Care Act, the health care legislation passed by Congress and signed into law by President Obama on March 23, 2010, requires most health plans to cover recommended preventive services without cost sharing for preventive services recommended by the U.S. Preventive Services Task Force (with an A or B rating), the Advisory Committee on Immunization Practices, and the Bright Futures Guidelines recommended by the American Academy of Pediatrics.

Preventive services that have strong scientific evidence of their health benefits must be covered and plans can no longer charge a patient a copayment, coinsurance or deductible for these services when they are delivered by a network provider.

Health insurance plans generally do not cover over-the-counter products, such as condoms. As a result, individuals are responsible for the cost of these products.

Vasectomy is a medical procedure intended as permanent birth control for men. According to the Centers for Disease Control and Prevention, vasectomy is a safe and highly effective method of birth control. This procedure can prevent pregnancy by blocking the transport of sperm out of the testes. A vasectomy can be done in a medical office or clinic. It is an out-patient procedure, so a man can go home the same day. The procedure is relatively inexpensive and often covered by insurance.

On August 1, 2011, HHS adopted new Guidelines for Women’s Preventive Services (Guidelines) – including well-woman visits, contraception, and domestic violence screening and counseling. These preventive services are required to be covered without cost sharing in most non-grandfathered health plans starting with the first plan or policy year beginning on or after August 1, 2012. Women with reproductive capacity have access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider. There are no similar recommendations for male contraception methods.

Current Policy

Contraceptive Advice
http://www.aafp.org/about/policies/all/contraceptive.html

Prior Congress Actions
None

Prior Board Actions
None
RESOLUTION NO. *** (New York State I)

Oppose Unnecessary Requirements on Clinicians that Perform Abortions

Introduced by the New York State Chapter

Referred to the Reference Committee on ***

WHEREAS, There are currently 27 states that have policies or laws that regulate abortion providers, surpassing what is necessary to ensure patient safety, and

WHEREAS, their policies and laws hold unnecessary requirements for clinicians that provide abortions, including requiring affiliation with a hospital, requiring hospital admitting privileges or an alternative arrangement, requiring the provider to be a board-certified obstetrician-gynecologist or eligible for certification, and

WHEREAS, the American College of Obstetricians and Gynecologists “opposes legislation or other requirements that single out abortion services from other outpatient procedures” such as “laws or other regulations that require abortion providers to have hospital-admitting privileges,” and

WHEREAS, the Texas Hospital Association states, “Requiring a hospital to grant admitting privileges to physicians who do not provide services inside the hospital is time-consuming and expensive for the hospital and does not serve the purpose for which privileges were intended,” and

WHEREAS, there is no evidence that an abortion provider’s lack of admitting privileges has directly led to a negative outcome for an abortion patient, and

WHEREAS, decreasing the number of abortion providers, in turn, delays women from obtaining the actual abortion, which pushes women later into pregnancy when abortion becomes more expensive and associated with a higher risk of complication, and

WHEREAS, abortion is no more dangerous than other outpatient procedures, such as a colonoscopy or dental work for which there are no similar requirements, and

WHEREAS, unnecessary requirements decreases overall access to abortion, cutting the number of providers and clinics, increasing travel time, costs, and stress for the patient, and are only worse for women who fall at or below the poverty line, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians encourage chapters to oppose state level legislation that imposes unnecessary requirements on abortion providers which infringe on the practice of evidence-based medicine, and be it further

RESOLVED, That the American Academy of Family Physicians oppose national legislation that imposes unnecessary requirements on abortion providers, reducing doctors’ ability to provide evidence-based and patient-centered care.

(Received 6/25/14)

Fiscal Impact: None
Background

The resolution calls for the AAFP to encourage chapters to oppose state-level legislation that imposes unnecessary requirements on abortion providers, and to take an official oppositional stance on any national legislation that imposes unnecessary requirements on abortion providers.

The AAFP recently joined a coalition of physician organizations, patient advocate organizations, and issue-specific non-profit organizations called the “Coalition to Protect the Patient/Provider Relationship.” This coalition was formed as a result of the October 2012 publication of the article, “Legislative Interference with the Patient-Physician Relationship” in the New England Journal of Medicine. After months of planning and drafting, the coalition members finally agreed upon a Statement of Principles, closely modeled after the American College of Physician’s policy, “Statement of Principles on the Role of Governments in Regulating the Patient-Physician Relationship.” The goal of the statement of principles document was to make sure that the coalition focused on fighting government interference on all issues in which the legislature or regulatory authority created an unnecessary barrier to how patients interacted with their physicians. The AAFP continues to provide support to chapters when they must fight legislative or regulatory proposals that infringe upon the patient physician relationship. The AAFP monitors the coalition as organizations share information on state-based legislation and passes this information along to our chapters. The coalition members also disseminate resources created by their respective organizations on relevant issues to share with our members.

Current Policy

Infringement on Patient Physician Relationship
http://www.aafp.org/about/policies/all/infringement-relationship.html

Reproductive Decisions
http://www.aafp.org/about/policies/all/reproductive-decisions.html

Contraceptive Advice
http://www.aafp.org/about/policies/all/contraceptive.html

Prior Congress Action

Resolution No. 503 to the 2008 COD (1st Resolved Adopted and 2nd Resolved Not Adopted):
RESOLVED, That the American Academy of Family Physicians (AAFP) endorse the principle that women receiving healthcare paid for through health plans funded by state or federal governments be provided with access to the full range of reproductive options when facing an unintended pregnancy, and be it further
RESOLVED, That the American Academy of Family Physicians engage in advocacy efforts to overturn the Hyde Amendment, which bans federal funding for abortions.

Please see Pages 363-364 in the 2008 Transactions for details.
http://www.aafp.org/content/dam/AAFP/documents/about_us/congress/restricted/2008/ThirdSession.pdf
Resolution No. 501 to the 2009 COD (Referred to the Board of Directors):
RESOLVED, That the American Academy of Family Physicians engage in advocacy efforts to overturn the Hyde Amendment, which bans federal funding for abortions.

Please see Pages 314-315 in the 2009 Transactions for details.

Please see Pages 162-163 in the 2010 Transactions for follow-up details.

Resolution No. 502 to the 2011 COD:
RESOLVED, That the American Academy of Family Physicians (AAFP) urge federal, state, and local governments to support only the programs that provide medically accurate information to women facing unintended pregnancies and to enforce existing consumer protection laws prohibiting the deceptive practices.

Please see Page 257 in the 2011 Transactions for details.

Please see Page 174 in the 2012 Transactions for follow-up details.
http://www.aafp.org/content/dam/AAFP/documents/about_us/congress/restricted/2012/2012Transactions.pdf

Prior Board Action
Approval of a recommendation from the Commission on Governmental Advocacy that the AAFP write a letter to the Secretary of HHS in support of the provision of medically accurate information to women facing unintended pregnancies and that AAFP urge the enforcement of existing consumer protection laws.
B2012, May 1-3, p. 11.
RESOLUTION NO. *** (New York State J)

Support of Miscarriage Management Training in Family Medicine Residencies

Introduced by the New York State Chapter

Referred to the Reference Committee on ***

WHEREAS, Nearly one in four women will experience miscarriage at some point in their lives, and

WHEREAS, the rate of pregnancies which end in miscarriage is approximately 15% with the percentage increasing along with the sensitivity of pregnancy testing to between 20-62%, and

WHEREAS, miscarriage management is an integral part of comprehensive reproductive health care, and

WHEREAS, comprehensive reproductive health care is within the scope of family medicine, making miscarriage management a part of the care family physicians should be able to provide, and

WHEREAS, miscarriage management can be provided through expectant management, medical management with misoprostol, or uterine aspiration (MVA), and

WHEREAS, family physicians are the only providers some patients have access to, particularly in rural areas, and

WHEREAS, current data shows that operating room-based surgery is the most common way of managing miscarriage, despite the three options which can be offered by family physicians being equally as safe, and

WHEREAS, women feel more satisfied with their care when they are an active member of the decision-making process, and has also been associated with better mental health outcomes, and

WHEREAS, there are many benefits to family physicians providing miscarriage management; it is more cost-effective; it is more conducive to continuity of care, enabling follow-up care to process the experience; and helps to avoid overtreatment, and

WHEREAS, family medicine residents are not routinely trained in miscarriage management, and there is a specific gap in opportunities to train in uterine aspiration, and

WHEREAS, by including office-based miscarriage management training in family medicine residency training, more women could access care from their own family physicians, and

WHEREAS, family medicine residents need to have direct, hands-on training during residency in order to be able to provide miscarriage management, now, therefore, be it

CONGRESS OF DELEGATES American Academy of Family Physicians
RESOLVED, That the American Academy of Family Physicians write a letter to the Accreditation Council for Graduate Medical Education Review Committee for Family Medicine requesting the inclusion of miscarriage management within their training requirements, and be it further

RESOLVED, That the American Academy of Family Physicians include miscarriage management within their continuing medical education meetings as a hands-on, skill-building workshop, and be it further

RESOLVED, That the American Academy of Family Physicians support the overall integration of comprehensive miscarriage management training into family medicine residencies.

(Received 6/25/14)

Fiscal Impact: None

Background
The Accreditation Council for Graduate Medical Education (ACGME) Program Requirements for Graduate Medical Education in Family Medicine were revised and became effective July 1, 2014. Program requirements for family medicine, like all specialties, are organized into “core”, “outcome”, and “detail” categories and have been made more generalized in recognition that the requirements will only be updated every 10 years and to allow greater innovation to achieve the outcomes. The ACGME defines “outcomes” as statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education. While the section on maternity care includes several subsections, the current language of the Section IV.A.5.a).(1).(c) related to this topic includes the following language:

"Must demonstrate competence in their ability to provide maternity care, including distinguishing abnormal and normal pregnancies: caring for common medical problems arising from pregnancy or coexisting with pregnancy."

The AAFP CME Curricular Framework, which is used in the needs assessment process related to CME creation is designed to address gaps in knowledge, procedures, skills, and attitudes of CME for family physicians related to the following topics:

a. Abnormal uterine bleeding
b. Bleeding 1st trimester
c. Bleeding 2nd and 3rd trimester
d. Ectopic pregnancy
e. Spontaneous abortion/miscarriage
f. Termination of pregnancy

Recommended Curriculum Guidelines for Family Medicine Residents entitled "Maternity and Gynecologic Care,” AAFP Reprint No. 261 recommends education surrounding first trimester pregnancy loss which includes the following:

a. Diagnosis and differentiation of failed pregnancies (threatened, incomplete, complete, missed abortions) and recognition and referral of ectopic pregnancies
b. Management of uncomplicated spontaneous abortion

c. Referral for surgical intervention when indicated for spontaneous abortion complicated by infection, retained products of conception, or in otherwise high risk situations

d. Counseling regarding grief in event of any first trimester loss whether planned or spontaneous abortion

e. Appropriate medical evaluation for recurrent early pregnancy loss


Recommended Curriculum Guidelines for Family Medicine Residents entitled “Women’s Health,” AAFP Reprint No. 282 currently recommends counseling related to pregnancy options (including adoption, abortion and parenting), pregnancy loss and infertility, contraceptive choices, and various surgical and diagnostic techniques related to gynecologic care which include, in the appropriate setting, training on uterine aspiration for incomplete first trimester abortion.


AAFP policy “Procedural Skills Training, Residency Criteria” indicates appropriate protocol for procedures training in family medicine residency.

http://www.aafp.org/about/policies/all/procedural-skills-training.html

Current Policy
None

Prior Congress Action
None

Prior Board Action
None
RESOLUTION NO. *** (New York State K)

Rescinding of the U.S. Food and Drug Administration (FDA) Approval of Zohydro

Introduced by the New York State Chapter

Referred to the Reference Committee on ***

WHEREAS, Deaths from prescription opioids have quadrupled in ten years, totaling over 16,000 in 2010, and

WHEREAS, the U.S. Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) have announced that death and addiction from prescription painkillers has become a national epidemic, and

WHEREAS, Zohydro, as pure hydrocodone with no abuse deterrent, is likely to be abused at a much greater rate than hydrocodone in combination products, following the experience with oxycodone, and

WHEREAS, the CDC has announced that reducing deaths from prescription painkillers is a primary goal in 2014, and

WHEREAS, the FDA’s own advisory panel recommended against approval, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians write a letter to the U.S. Food and Drug Administration (FDA) requesting the immediate rescinding of approval of Zohydro, and be it further

RESOLVED, That the American Academy of Family Physicians request that the U.S. Food and Drug Administration (FDA) give proper consideration to the unintended consequences of approval of a particular medication in its deliberations regarding future decisions on approval of medications.

(Received 6/25/14)

Fiscal Impact: None

Background

An FDA factsheet dated April 30, 2014 which can be found on the FDA’s website at [www.fda.gov/drugs/drugsafety/informationbydrugclass/ucm395456.htm](http://www.fda.gov/drugs/drugsafety/informationbydrugclass/ucm395456.htm) addressed misperceptions about the potency of Zohydro ER in the press.

A citizen petition from the Center for Lawful Access and Abuse Deterrence calling on the FDA to reject applications for new solid oral dosage form opioid medications lacking abuse-deterrent properties was approved in part and denied in part by the FDA in a nine-page response which can be found on the federal webpage: [http://www.regulations.gov/#/documentDetail;D=FDA-2013-P-0703-0004](http://www.regulations.gov/#/documentDetail;D=FDA-2013-P-0703-0004).

Federal legislators in both parties support legislation which seeks to end the sale and distribution of Zohydro™ ER. The Act to Ban Zohydro (HR 4241 and S. 2134) was introduced on March 13, 2014 by Rep. Stephen Lynch (D-MA) and Sen. Joe Manchin, III (D-WV) respectively. Both would withdraw approval for its new drug application and prohibit the Commissioner of Food and Drugs (FDA) from approving any new drug application for the capsules unless they are formulated to prevent abuse. HR 4241 has 17 bipartisan cosponsors and was referred to the House Committee on Energy and Commerce’s Health Subcommittee. S 2134 has no cosponsors and was referred to the Senate Health, Education, Labor, and Pensions or “HELP” Committee. Neither committee has taken action on the bill, nor has scheduled any consideration of either measure.

**Current Policy**

**Pain Management and Opioid Abuse** (Position Paper)

**Prior Congress Action**

Board Report O to the 2011 COD (Filed for Information):

**Prior Board Action**

Approval of a proposed letter, with minor edits, to be sent to members of Congress regarding our position paper on pain management and opioid abuse. BC1:12012, October 10, p. 1.

Approval of a proposed letter, with minor edits, to be sent to the FDA regarding our position paper on pain management and opioid abuse. BC1:12012, October 10, p. 1.
Resolution of Condolence

To the Congress of Delegates of the American Academy of Family Physicians

George Gremple Hart, MD, FAAFP

Introduced by the New York State Chapter

WHEREAS, The New York State Academy of Family Physicians (NYSAFP) lost a champion for family medicine on May 13, 2014, when George Gremple Hart died quietly at the age of 98, and

WHEREAS, Dr. Hart had been a member of the American Academy of Family Physicians (AAFP) since 1952, and had been President of the New York State Academy of Family Physicians from 1970 to 1971, and

WHEREAS, Dr. Hart was an active and respected leader in the formation and growth of the Academy and the specialty of family medicine, and

WHEREAS, Dr. Hart’s distinguished career in medicine and his extraordinary achievements as a community leader in Lake Placid epitomize the traditional role of the physician and established Dr. Hart as a role model for young physicians, and

WHEREAS, Dr. Hart was memorialized by the NYSAFP Foundation when it created the Dr. George Hart Fund in 2012 to provide scholarships to support residents in family medicine and medical students in New York State who attend NYSAFP and AAFP conferences, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians recognize Dr. Hart’s invaluable contributions to family medicine, and that a copy of this resolution be presented to his family as an expression of appreciation and condolence.