THE THIRD SESSION of the Congress of Delegates of the American Academy of Family Physicians convened at 1:00 p.m., on Tuesday, September 16, with Vice Speaker Mabry presiding.

Dr. Anne Cather of Morgantown, West Virginia, chair of the Credentials Committee, reported that 64 delegates were registered for the third session. Delegates for the third session remained the same as those for the first session, except for alternate delegates temporarily seated as delegates.

JOHN G. WALSH AWARD FOR LIFETIME CONTRIBUTIONS TO FAMILY MEDICINE

President King presented the John G. Walsh Award for Lifetime Contributions to Family Medicine to Dr. Jeannette South-Paul of Pittsburgh, Pennsylvania. Dr. King addressed the delegates as follows:

> The 2008 John G. Walsh Award goes to Dr. Jeannette E. South-Paul. Dr. South-Paul is Professor of Family Medicine and the Chair of the Department of Family Medicine at the University of Pittsburgh in Pittsburgh, Pennsylvania. As an educator, author, clinician and professional leader for more than two decades, Dr. South-Paul has made significant contributions to the family medicine education and to improvement of health of the public. Previously, she was a Professor of Family Medicine and Chair of the Department of Family Medicine in the Uniformed Services University of the Health Sciences. Dr. South-Paul also serves active duty in the U.S. Army Medical Corps.
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> A member of the AAFP since 1980, Dr. South-Paul currently serves as senior advisor to the Quality Care for Diverse Populations Project and is an AAFP representative to the Health, Mental health and Safety in School Projects which is developing national guidelines for school health programs. She has also served as representative to the USDA School Nutrition Task Force. She is a Past President of the Uniformed Services Academy of Family Physicians and past, present and current Board member of the Society of Teachers of Family Medicine. Dr. South-Paul has written and lectured extensively on clinical topics, medical education, cultural diversity, and public health. She has received numerous awards including the AAFP Exemplary Teaching Award, Uniformed Services University of Health Sciences Distinguished Service Medal, and the University of Pittsburgh Distinguished Alumni Award.
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> Dr. South-Paul, for your immeasurable contribution to the advancement of family medicine and for a lifetime of service to your country, your patients, and your students, it is my honor to present to you the AAFP's John G. Walsh Award.
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> Congratulations, Reg.

Dr. South-Paul expressed her appreciation to the delegates amid a standing ovation and addressed them as follows:

Thank you so very much. I'm really humbled by this recognition. A recognition from my colleagues and from my friends for a career that I think has just begun as opposed to ending. I'm doing what I absolutely love to do, which is caring for patients and helping to train the next generation of family physicians, such as you and I who will continue to provide the best quality of care. It is also a joy to be considered a leader because I have considered that a very important part of my goal. It is wonderful for me to see colleagues and friends that I have known many years, such as Lori Heim and Ted Epperly, and folks that have been right there partnering with me, so it is again the humility and thanks that I appreciate this award and hope to continue to do things for our families and our communities. Thank you.

President King presented the Humanitarian Award to Dr. Stoney Abercrombie of Anderson, South Carolina. Dr. King addressed the delegates as follows:

HUMANITARIAN AWARD

Today we recognize Dr. Stoney Abercrombie for his selfless and extraordinary humanitarian efforts within and beyond the borders of the United States. From Anderson, South Carolina to Ho Chi Min City, Vietnam, Dr. Abercrombie has provided quality, compassionate medical care to patients on five different continents. Dr. Abercrombie is currently Director of Medical Education, Associate Dean and Professor at the Medical University of South Carolina in Anderson.

In 1986, Dr. Abercrombie founded the Volunteers in Medical Missions, an organization dedicated to taking American goodwill and free medical care to poverty stricken nations. To date, Dr. Abercrombie volunteers have completed more than 200 Mission Trips to 300 countries at an estimated contribution of more than 20 million dollars.

Dr. Abercrombie has also been an active volunteer and leader in South Carolina. He served as a volunteer physician at the free clinics, organized a group of medical professionals to perform free physicals at the local orphanage, and established rural residency programs to address health care shortages in rural areas.

Dr. Abercrombie has been active in the South Carolina Academy of Family Physicians for more than 20 years, serving as President, Board Chair and Delegate to the AAFP Congress of Delegates. On the national level, he has served on the AAFP Publications Committee and is Chair of the Commission on Continuing Professional Development.

Dr. Abercrombie, on behalf of our 93,000 members, it is my honor to present to you the 2008 AAFP Humanitarian Award. Congratulations.

Dr. Abercrombie expressed his appreciation to the delegates amid a standing ovation and addressed them as follows:

Wow! What an honor! I want to thank the South Carolina Academy and our Executive Vice President, Paquita Turner, for nominating me and the AAFP for selecting me. I am happy that my wife, Donna, and my daughter, Christina, could be here to share this with me today. I accept this recognition of honor in memory of the many humanitarian services that our family medicine colleagues perform daily so often unrecognized. In rural areas, in dangerous underserved inner-cities of America, in mission fields worldwide, and in academic attempts to teach family medicine principles so desperately in need of our services, family physicians boldly go where no one has gone before. Yes, I am a Trekkie.

A humanitarian is what my parent's taught me as a child. Treat every other person as you would want to be treated. Whether the needs of my patients were physical, emotional or spiritual, I have attempted to treat them all with respect, dignity, and in still some sense of hope, in difficulty situations.

I would like all family doctors here today to look around. Look at your colleagues. You are looking at the true humanitarians of modern medicine. I accept this award on behalf of all of you and our many colleagues who give daily to our patients in spite of bureaucratic and political decisions that handicap us. I might even feel worthy to receive this award as a symbol of our great humanitarian efforts if you would join me in applauding me and all of our family medicine colleagues who are the true humanitarians of America. Thank you, all.

EXEMPLARY TEACHING AWARD

Dr. Mabry announced the presentation of the Exemplary Teaching Award for Lifetime Contribution of Family Medicine to Dr. Reid Blackwelder of Kingsport, Tennessee (Full/Part-Time Faculty) and Dr. Cathy Woodring of Wichita, Kansas (Volunteer Faculty). Dr. King addressed the delegates as follows:

Full/Part-Time Faculty, Dr. Reid Blackwelder

This year's full-time faculty teaching award goes to Dr. Reid Blackwelder. Dr. Blackwelder is Professor of Family Medicine and Director of the residency program at East Tennessee State University in Kingsport, Tennessee. Dr. Blackwelder has

long been a proponent of family medicine. He has served as a Board member and Past President of the Tennessee Academy of Family Physicians and is currently state delegate to the AAFP Congress of Delegates. At the national level, Dr. Blackwelder serves on the AAFP Commission on Continuing Professional Development and is a liaison to the American Board of Family Medicine. He is also a member of the AAFP Home Study Advisory Board. As an educator, author, clinician and professional leader, Dr. Blackwelder is recognized and honored by those he has mentored at the East Tennessee State University. He is a recipient of numerous awards including the Outstanding Preceptor of the Year, and the Dean's Distinguished Teaching Award in Clinical Sciences.

Today, I am honored to recognize Dr. Blackwelder's devoted service to the specialty of family medicine, the institution in which he works, and the students he mentors, and the community in which he lives.

Congratulations, Dr. Blackwelder.

Volunteer Faculty, Cathy Woodring, M.D.

I am honored to present this year's Volunteer Faculty Teaching Award to Dr. Cathy Woodring, a Clinical Assistant Professor in the Department of Family Medicine and Community Medicine at the University of Kansas School of Medicine in Wichita. Dr. Woodring has been actively involved in medical education at the University of Kansas since 1985. In addition to her teaching duties, she was a preceptor of residents at what is now the Family Medicine Residency in both hospital and outpatient settings. Last year, due to a staff shortage in the Wesley Family Medicine Program, Dr. Woodring began supervising residents there.

Dr. Woodring has been actively involved in medical education at the University of Kansas since 1985. In addition to her teaching duties, she was a preceptor of residents at what is now the Via Christi Family Medicine Residency in both hospital and outpatient settings. Last year, due to a staff shortage in the Wesley Family Medicine Residency Program, Dr. Woodring began supervising residents there and has become a highly respected preceptor of Wesley residents. Dr. Woodring's infectious enthusiasm and commitment are noted by peers and students alike.

In the words of one of her students, "Besides being an articulate teacher, Dr. Woodring treated me like a peer and helped me feel like a member of the team." And from a colleague, "Above all, Dr. Woodring is an advocate of patient education. After we have developed a plan, she asks how we are going to help the patient be successful."

I am honored to have the opportunity today to recognize Dr. Woodring for her dedication to students and to our specialty.

Congratulations, Dr. Woodring.

Dr. Woodring expressed her appreciation to the delegates amid a standing ovation and addressed them as follows:

Thank you. It is an honor to me to represent all of you who each in his or her own way keep the faith. What we do despite the pressures and changes in our profession is very important and is worth passing on to the next generations. I grew up in a family of teachers. I was thinking I would be a teacher until I discovered the discipline, the passion, the joy to be found in medicine. So, thanks Mom and Dad for all those dinner time conversations about education. I guess some of it sunk in.

While we are on the subject of thanks, I was informed by my nurse of more than 18 years that I needed to credit her for teaching me everything I know. Of course, it is true, we would all be helpless without our staffs. So, thank you, Lori, for all the camaraderie and the good patient care we have learned to deliver together.

I have been teaching residents and students for more than 25 years, but a couple of years ago, I made a major change in my practice which has allowed me to do much more of the teaching that I love so much. So, this award is very special for me because it is sort of a validation of that decision. I might not have been able to make that leap of faith without the support and encouragement of my darling husband. Thank you for your belief in me, which helped me to see that medicine and life offer many different paths which are exciting and fulfilling, especially when we walk them together.

For those of us who have been doing this job for a long time, teaching is a very good thing because the students and residents are always asking why. That makes me re-examine my knowledge and my decision-making. You know, because it is the way we have always done it is just not a good enough answer. That means that evidence-based data and keeping up to date takes on a real life meaning.

A heartfelt thank you to all the students and residents who have kept me honest and have allowed me to share some of what I have learned in nearly 30 years of practice. And a particular thank you to all my colleagues and fellow teachers who are doing a

really good job of teaching family medicine in Kansas. Those at the University of Kansas School of Medicine in Wichita, at Wesley and St. Francis Via Christi Family Medicine Residencies. You have made me feel appreciated and very welcome. Thank you.

Dr. Blackwelder expressed his appreciation to the delegates amid a standing ovation and addressed them as follows:

Wow, what an honor! This is doubly, triply, quadruplely blessed to be able to live my passion, to do what I love to do, and then to be recognized by an amazing group of people, many of you who are my mentors as well as people that I have had a chance to impact.

You don't do this job, family physician or teacher because it makes sense. You do it because you are called to do it and it is what you have to do and you can't talk yourself out of it. What is truly powerful is to be able to do that, to love it, to live it, to move forward to impact people, to have those folks touch you as we heard before unexpectedly; to come up and say, "I just want to let you know you made a difference in my life." To get that from patients and to get that from students and learners, not expecting it, but to be blessed by that is amazing. To be able to be blessed by people I care about and have given a lot of my life to means so much. Thank you very, very much!

All of the winners were given a standing ovation by the delegates.

NOMINATIONS FOR AMERICAN BOARD OF FAMILY MEDICINE DIRECTOR

Speaker Weida assumed chair and called for additional nominations for American Board of Family Medicine Director in addition to the announced nominees of Dr. Diane Kaye Beebe of Jackson, Mississippi; Dr. Alan K. David of Milwaukee, Wisconsin; Dr. Frederick D. Edwards of Scottsdale, Arizona; Dr. Elisabeth Mock of Holden, Maine; Dr. Robert Morrow of Bronx, New York and Dr. Mary Elizabeth Roth of Wilkes Barre, Pennsylvania. There were no additional nominations.

NOMINATIONS FOR ACADEMY OFFICERS

Vice Speaker Mabry assumed the chair and called for additional nominations for the office of President-elect in addition to announced candidates Dr. Bradley Fedderly of Fox Point, Wisconsin; Dr. Lori Heim of Vass, North Carolina; Dr. Robert Pallay of Savannah, Georgia and Dr. Thomas Weida of Lititz, Pennsylvania. There were no additional nominations.

Speaker Weida assumed the chair and called for additional nominations for the office of Speaker of the Congress of Delegates in addition to announced candidate Dr. Leah Raye Mabry of San Antonio, Texas. There were no additional nominations and Speaker Weida declared Dr. Leah Raye Mabry elected as Speaker by acclamation.

Speaker Weida called for additional nominations for the office of Vice Speaker of the Congress of Delegates in addition to announced candidates Dr. Richard Madden of Belen, New Mexico; Dr. John Meigs of Brent, Alabama and Dr. Joseph Zebley of Baltimore, Maryland. There were no additional nominations.

Speaker Weida called for additional nominations for Director in addition to the announced nominees Dr. Jeffrey Cain of Denver, Colorado; Dr. John Darnell, Jr. of Flatwoods, Kentucky; Dr. Thomas Felger of South Bend, Indiana; Dr. George Shannon of Columbus, Georgia; Dr. Timothy

Tobolic of Byron Center, Michigan and Dr. Robert Wergin of Milford, Nebraska. There were no additional nominations.

ELECTION OF NEW PHYSICIAN MEMBER TO THE BOARD OF DIRECTORS

Speaker Weida called for additional nominations for New Physician member to the AAFP Board of Directors in addition to Dr. Jason Dees of New Albany, Mississippi, the name sent forth by the National Conference of Special Constituencies. There were none and Speaker Weida declared Dr. Jason Dees elected by acclamation.

ELECTION OF RESIDENT MEMBER TO THE BOARD OF DIRECTORS

Speaker Weida called for additional nominations for resident member to the AAFP Board of Directors in addition to Dr. Jennifer Bacani of Wichita, Kansas, the name sent forth by the National Conference of Family Medicine Residents. There were none and Speaker Weida declared Dr. Bacani elected by acclamation.

ELECTION OF STUDENT MEMBER TO THE BOARD OF DIRECTORS

Speaker Weida called for additional nominations for student member of the AAFP Board of Directors in addition to Ms. Amy McIntyre of Cranston, Rhode Island, the name sent forth by the National Conference of Student Members. There were none and Speaker Weida declared Ms. McIntyre elected by acclamation.

Speaker Weida then declared nominations closed for ABFM and AAFP offices.

CANDIDATES' FORUM

Vice Speaker Mabry assumed chair and announced that the Candidates Forum would begin and called for the candidates for Vice Speaker to come to the front of the ballroom to be seated at a special table.

Vice Speaker Mabry asked President Jim King to moderate this portion of the candidates' forum. He announced that the speeches of the candidates for the office of Vice Speaker were not to exceed five minutes. The candidates spoke in the following order, which was determined by lot: Dr. Richard Madden of Belen, New Mexico; Dr. John Meigs of Brent, Alabama and Dr. Joseph Zebley of Baltimore, Maryland.

President King introduced the first candidate for Vice Speaker, Dr. Richard Madden, who addressed the delegates as follows:

Dr. King, Officers, Board Members, Delegates, Alternates, Chapter Executives and Guests – I am honored to address you today. Let me begin with a question. When did you first imagine becoming a physician? For me, I was 13 when my dad asked

me, "Have you ever thought about being a doctor?" I liked helping people, I wanted to be part of people's lives and family medicine was clearly the choice for me. I listened to family medicine professors teach our class in the first weeks of medical school that an illness is embedded not only in a person but also within a family, a community, within a biosphere. This awareness led to long-term and rewarding relationships with my patients. Then, in the spring of my junior year, along came a very personal shock. The premature birth of our first child, Jennifer, led us through ten weeks of newborn ICU care. My wife, Molly, and I learned about diaphragmatic hernia repair and ventilators, and feeding tubes. Then we learned about her severe brain damage and her cerebral palsy, and we learned to adapt to the unlucky things that happen in life. No one is prepared for the depth of uncertainty misfortunes bring. But these trials teach us to be better doctors. Hardly a day goes by when I don't think of how Jennifer has helped me be more empathetic, more insightful, and more careful with all my patients. So, we learn, we grow, we adapt, we move on and we give back to others. This is the heart of family medicine, continuous involvement in people's lives and learning as we grow.

Another part of my story comes from changes in the business side of health care in our medical community in 1990. Our 24-bed rural hospital was faced with declining revenues. The community voted against a tax to support the hospital. The hospital closed. This critical community resource was gone. There was no facility to care for the old folks with heart failure. No place to deliver babies, no ER and yet, there was still an expectation in our community that someone, somehow would make it all magically reappear. But we moved on and we started a clinic in that hospital where I continue to practice to this day.

Like our tiny hospital, family medicine is at risk. This is a problem that affects everyone in this room. We have struggled to keep our businesses open every day. Medical students sense that risk and choose other specialties to the detriment of our health care landscape and our nation's health care outcomes. That is why I became involved in our state chapter of the American Academy of Family Physicians. I saw then, and I see even more clearly now, the challenges we face. Our Academy is fighting for fair payment to allow us to continue to do our work in our communities, small or large, rural or urban, extremely well. I see us working together to improve access to the Patient-Centered Medical Home including that all important continuous relationship with a trusted family doctor who serves their needs with the highest ethical principles, safety, quality, and efficiency and compassion.

And that is the work of this Congress of our Academy. I am looking forward to furthering the debate of this Congress to ensure that it achieves these ultimate purposes. I bring skills of listening and organizing and moving ideas along a path to completion, effectively and efficiently. I will help this Congress address the changing demands that confront family medicine and family doctors, all in the pursuit in what is best for our patients in family medicine.

I hope you will look forward with me. I pledge to serve you faithfully and thoughtfully. I am Rick Madden. I humbly ask for your vote tomorrow. Thank you.

President King introduced the second candidate for Vice Speaker, Dr. John Meigs, who addressed the delegates as follows:

Officers, Directors, Delegates, Alternates, Ladies, Gentlemen, Friends and Colleagues, I would like to call this meeting to order. Oh, I would like to call this meeting to order, and with your help, perhaps one day I will. I am John Meigs and I want to be your Vice Speaker.

One of my favorite books begins with a line, "It was the best of times, it was the worst of times." Even though Dickens was talking about late 18th Century Europe, he could have just as easily been talking about the current state of health care in America. Or, more importantly, the state of family medicine. Advances in technology, pharmacology, immunology, minimally invasive surgery, genomics and many other areas and "ologies" make it an exciting time to be a physician. But things are not perfect; we all know the problems. The most expensive health care system in the world, yet one ranked only about 13th in quality; 47 million uninsured; significant health care disparities; too many partialists, not enough doctors. We all know the answer. A system that emphasizes and appropriately compensates for preventive care, chronic disease management, and risk factor modification with an emphasis on a Patient-Centered Medical Home for all patients.

Family physicians are ideally suited and trained for such a system. We have a documented track record of providing quality efficient, cost effective care for our patients. We just have to convince the public, employers, third-party payers, and our Government leaders that they demand such a system.

In 1863, a young Army officer, who was active in his church, was assigned to construct defenses for the Port of New Bedford, Massachusetts. As was his custom, he attended his local church, and while there he was asked, without warning to preside over a business meeting of the church. Even though he was an officer in the Corps of Engineers and had participated in church and civic affairs in every church wherever he had been stationed, he did not know how to preside in a meeting. Embarrassed, feeling that the worst thing he could do would be to decline, he plunged ahead with the meeting hoping the assembly would behave itself. It did not. The officer emerged from that turbulent meeting determined that he would never again be placed in that situation until he knew something about parliamentary procedure. Though various parliamentary manuals were

available, the young officer discovered that there was no generally accepted set of parliamentary rules for voluntary associations and professional organizations, so he set out to write one. That young officer was Henry M. Robert, author of Robert's Rules or Order.

Why do I tell that story? First, I like the story. Second, I don't know any stories on Alice Sturgis. And third, I like the fact that the guy who wrote the book did not know at one time how to manage a meeting. Also, like General Robert, I came to appreciate parliamentary procedure through church business meetings. I have attended church and church business meetings my whole life. Some people dread business meetings, I've always love them.

It has been my privilege to preside over the business meetings of my church since 1994. I have also served in and currently still serve as the Speaker for the Medical Association for the State of Alabama.

What is the role for a presiding officer? Ensure the will of the majority, protect the rights of the minority, conduct business in an orderly fashion, making sure everyone knows what is going on, even mindful that every member has a right to be heard and all members have equal rights, privileges, and responsibilities. In other words, the presiding officer is to be fair and exercise common sense.

The Academy's been working on our behalf. More needs to be done. The Congress of Delegates has a role to play in the issues and problems facing our members, our patients, and the health care system as a whole. This Congress and this Academy are going to help find the solutions. I want to help the Congress of Delegates do its work, and do it's work effectively, efficiently, properly.

Certainly, I have opinions on the issues that face us, but that is not why I am running. I'm not running because I have an agenda. I'm running because I can handle the agenda. I'm John Meigs and I want to be your next Vice Speaker. I really do want this meeting called to order. I need your help. I want your vote. I covet your support. Thank you.

President King introduced the third candidate for Vice Speaker, Dr. Joseph Zebley, who addressed the delegates as follows:

Colleagues, Delegates, Guests, Friends – I come before you today to ask for your vote for Vice Speaker of this Academy. So, you ask, why should we vote for you, Jos, over these other candidates for this important position? Well, first, I have the experience already. I have been the Speaker of my state medical society, my family medicine division share and I also have executive experience having served on the Board of a large integrated regional practice system where I dealt with the bankers, the investors, the hospital executives, and the insurance industry. But in addition to experience, I have opportunity and motive. I am in private practice with a comfortable patient volume, a low overhead, a practice that can support my service to the Academy at this time and that is directly impacted by the work we do here at the Congress, and both my sons are now out of the house.

As to motive, well, now is the time for this Academy, dedicated to education and focus and practice support, to really stand up for the welfare of our patients and our specialty. That is what that rebranding was all about.

As the AAFP AMA Delegate for the past eight years, elected from this Congress, I have witnessed how the House of Medicine, the economy but mostly how the people we care for everyday, or patients, suffer. They suffer from this maldistributed, upside down partialists-centered inequitable medical non-system. And now is the time to change the status quo. We have, at best, a 15-month window to revamp the unsustainably flawed CMS payment system, which too often has become the benchmark for private payers.

The Robert Graham Center data shows that simply changing the SGR does very little to change our (family physicians) situations. Now is the time to work with the Congress to revamp the basic funding premises of Medicare and the current volume, counter procedures payment model to a patient management plus incidental fee-for-service system. And, look, despite our many misgivings, we have got to work right now to try and reform the RUC and work with other primary care groups and work with the Medicare Payment Advisory Commission, the MedPAC, as well as with our legislatures, as the Academy is already doing and as I've been doing in my work with the AMA for this Academy to create new models that will not devolve and to gate keeper schemes because that is a big risk. We must all work together in organized medicine. Because folks, the legislators are not always our friends, no matter what they say, unless they see some greater political interest, because legislators do have other priorities besides the welfare of our practices. Legislators do not want to hear competing arguments and competing versions of what physicians want or need.

So, as much as we often disagree with our subspecialty colleagues, and trust me we really, do, we have got to close ranks right now and bring our family medicine based Patient-Centered Medical Home both to our colleagues in medicine as well as to the Administration in Congress and Washington.

You know family doctors, we work in many settings. That is one of the beauties of our specialty. The problem remains the undervalued nature, and the low financial support for both primary care education and services. Primary care services, be they from nurses, or physician assistants, or physicians. But it is family physicians we need because family doctors provide many years of quality, comprehensive care in all settings. You hear it over and over again. We're rural, urban, multi-provider clinics. We are hospital based. We do indigent care and remain the backbone of the American medical system. We've become dependent on the largest of third party payers and financially strapped unhappy family doctors impede our ability to recruit the new, young, family medicine work force America needs for this primary care based health care system we are trying to build.

I pledge to work on the Board of the guidance of the Congress to continue to help develop new practice structures to break away from the current failed system. Because as we individually reform our practices, and we really must as we've heard for the last three days, this Academy will continue to work to reform the larger system.

I've been a Speaker, I've been an educator, I have executive experience, and I ask for your vote tomorrow for Vice Speaker of the American Academy of Family Physicians. Thank you.

President King moderated the question and answer session which followed the Vice Speaker candidates' speeches.

President King next introduced the candidate for Speaker who was running unopposed to present her five-minute speech. Dr. Leah Raye Mabry addressed the delegates as follows:

Dr. King, Mr. Speaker, Officers, Board of Directors, Members of the Congress of Delegates and Guests – I thank you for giving me the opportunity to be your Speaker of the Congress of Delegates. Use the magic in your uniqueness to influence your organization. This is the statement made at an Annual Leadership Forum, which preceded my beginning as a member of the AAFP Board of Directors and as Vice Speaker of the Congress of Delegates. After my apprenticeship as Vice Speaker, I am ready to become Speaker of the Congress of Delegates of the American Academy of Family Physicians. The Speaker of the Academy's Congress of Delegates is an ex-officio member of the Board of Directors who presides over the meetings of the Congress and appoints members to all reference and special committees of the Congress. The Speaker has the responsibility for transmitting the actions of the Congress of Delegates to the Board of Directors for appropriate action and follow up. Bringing the perspective of the Congress to the Board deliberations, the Speaker also has the responsibility to ensure the proper scheduling and smooth flow of business coming from the Congress.

Over the last four years, the Speakers have made significant changes in advancement within the Congress of Delegates to ensure the perspective of the Congress and the voice of the AAFP membership is heard. Included in these advancements are restructuring the reference committees to focus on the strategic priorities of the Academy, schedule changes within the reference committees to provide for membership input, expanding information technology to include wireless internet for the Delegates and Alternates at the annual session, access to the Congress of Delegates Handbook on the web and on a flash drive, inclusion of a consent calendar for reference committee reports and reaffirmation calendar for acknowledgement of the previously passed resolutions, and increasing the teaching of parliamentary procedure within the leadership track of the Academy. These are changes, just to name a few.

In addition, an additional responsibility of the Speaker is to be a voting member of the Board of Directors. This responsibility enables me to fulfill my passion concerning family medicine. At this point in my speech, I was going to tell you about my passions but hearing the candidates for Vice Speaker, I, too, was reminded that I like stories. That young man that one of your Vice Speaker candidates spoke about who was in the Corps of Engineers in the service, just recently saved thousands of lives in Texas as he was the Corps of Engineer member who came down to Galveston and built a wall around the beach to ensure that never again, as it was in the early 1900's, 8,000 would be killed because the water flooded the city. And to date, we have only lost five, although tragically, but still much better than 8,000. That was your Parliamentarian at work for you.

Alice Sturgis, a young upstart, maybe with a personality similar to mine, wrote a book in 1950 because she was tired of listening to antiquated language that put her to sleep. She heard all about the English and she heard all about the Congress and these long terms and words she didn't want to hear again. So she wrote a book called *Alice Sturgis' Parliamentary Procedure*. Mr. Sturgis and the family did not want to continue publishing this book, so they gave it to the American Institute of Parliamentarians to continue editing it. This Congress of Delegates is so up to date and so well run that last year, unbeknownst to you, one of the editors, Tom Soliday, who is the Speaker of the American Dental Association, came to our Congress just to see how we ran everything. To me, it was a compliment and I appreciate that.

Another candidate spoke of Davis. Davis was a young parliamentarian who took Alice Sturgis' book and somewhat added a few things that she had in it some people said it was plagiarism. He took the information out of this book and developed information for reference committees that you use to this day to do the process of the Congress of Delegates. So instead of telling

you about my passions, I wanted to share with you a few of those stories. In becoming Speaker, I will use this uniqueness to influence the growth of our organization. In order to serve our membership and provide care for our patients, I have the dedication and the passion to represent you. Now, I thank you for allowing me to serve you as your Speaker. Thank you.

President King announced that the Candidates Forum for President-elect would begin and called for the candidates for President-elect to come to the front of the ballroom to be seated at a special table. He announced that the speeches of the candidates for the office of President-elect were not to exceed seven minutes. The candidates spoke in the following order, which was determined by lot: Dr. Bradley Fedderly of Fox Point, Wisconsin; Dr. Lori Heim of Vass, North Carolina; Dr. Robert Pallay Savannah, Georgia and Dr. Thomas Weida of Lititz, Pennsylvania.

President King introduced the first candidate for President-elect, Dr. Bradley Fedderly, who addressed the delegates as follows:

Good afternoon. I am Brad Fedderly. I am a family physician and I ask for your vote to be our next AAFP President-elect. During the last three years on the Board of Directors, I have witnessed and given testimony that our specialty is the key ingredient in the recipe for successful health care in the 21st Century. Three years ago, I stood before you and told you the story about President Harry Truman, the first Medicare beneficiary. You well know the many problems that Medicare has developed since its inception in 1965. While we have much more to do, we have made a difference.

Our advocacy efforts averted a near catastrophe in Medicare physician payment earlier this year. Last November, I testified before the U.S. House of Representatives Small Business Committee. One of our messages to the committee was the need to make electronic medical records more affordable for small practices. I urged Congress to adopt legislation that would award grants or low interest loans to practices so they can implement EMR's. That legislation has been drafted. We are one step closer to reality.

The Patient-Centered Medical Home developed by the AAFP and other primary care physician organizations is gaining traction. The halls of government, organized medicine and the private sector are absolutely abuzz with talk of the Patient-Centered Medical Home. We now have data that demonstrates the improved outcomes and cost savings that can be achieved if every American has a Patient-Centered Medical Home. The medical home includes easy access, electronic records, group visits, chronic care management and a number of other features that promise a more convenient, effective and safe practice.

As family physicians we must be able to deliver on that promise. To achieve this we must upgrade and retool our practices and we must do it now. And yet, we can put all of the features of a medical home together but it is the trusted relationships with our patients that make our practices a medical home. I have worked in the same small South Milwaukee practice for over 20 years., the practice Dr. Overfeld put together 80 years ago. It has been my privilege and my passion to serve multiple generations of the same family. My relationships with those families have had an important impact on their health and have sustained me through the inane rules of a dysfunctional health care system. Take for example, Phyllis and Tom, a couple in their 80's. I've been their family doctor for the last 18 years. Tom has suffered from longstanding chronic heart disease. A massive heart attack left him with a defibrillator and an injection fraction of 25 percent. Nevertheless, he golfed every day until severe hip arthritis finally caught up with him. His orthopedic surgeon refused to operate on him because of his heart disease and Tom decided life had ended. Maximal conservative care just couldn't get Tom back on the course. Phyllis appealed to me as their family doctor to do something. I did. I convened a meeting of Tom's cardiologist and his orthopedic surgeon. We prepared Tom for surgery and we got him a new hip. Tom is back on the golf course but sadly he's now caring for Phyllis who was recently diagnosed with metastatic breast cancer. Despite my constant urging, Phyllis had refused regular mammograms mainly out of fear. Her sister, also a patient of mine, had succumbed to the disease several years earlier. Phyllis was holding her own following chemotherapy and radiation but then one day I received a panicked phone call from tom telling me that she had horrible back pain. She had called her radiation oncologist. His response? There's nothing more I can do for you. Call your regular doctor. My response? I welcomed Phyllis back into her medical home. I diagnosed a lumbar radiculopothy, totally unrelated to cancer. I advocated for her to have epidural injections and I reassured the anesthesiologist that bone cancer has nothing to do with her pain. Six months later, Phyllis remains pain free.

Americans love to chant, "We are number one." But according to the World Health Organization, we are 37. That is not okay with me and it is not okay for our patients. Both Phyllis and tom know very well that the American health care system is broken. But they also know that their personal medical home in their family physician's office is their safe place that advocates for them. We must preserve the wide range of skills that enable us to do all we can for our patients. We may work in large institutions or solo settings, deliver babies or focus solely on outpatient or inpatient care, work in rural or urban settings, we may be many practice realities that separate us but the one thing that unifies us is how we think about our patients, their families, and our communities. We attend to the whole person and know the importance of that trusted relationship.

As the policy makers conspire to create more metrics to measure our performance, we must and we will show them the data that these trusted relationships are the essence of good health care and better health outcomes. Better outcomes for the American people must translate to better incomes for America's family doctors. It is time for our hard work and demonstrated value of that work to be fairly recognized. Putting the patient at the center of the medical home and putting the medical home at the center of American health care, may seem like huge challenges, but we can do this. We can rebuild a new and better health care system. Our training and experience provide us the tools. Our advocacy will provide the new rules. Vision. Advocacy. Relationships. Quality. We can build the new medical home that will shelter every American. I am Brad Fedderly. I am a family physician. I live our model. I ask for your vote as President-elect. Let's get to work.

President King introduced the second candidate for President-elect, Dr. Lori Heim, who addressed the delegates as follows:

Congress and Friends, good afternoon. Three years ago when I stood before you, I was in my blue Air Force Colonel's uniform. Well, now I am rural North Carolina. I work with one other physician. I go to the hospital and I get to wear any color I want to. So, how I stand before you asking you to make me your next AAFP President-elect because we are at a pivotal point in our efforts to improve payment, increase the number of family doctors and provide for health care for all of our people. I want to drive our efforts home for our members and our patients. The AAFP is the only voice for family doctors. And family doctors are the only read hope for bringing affordable, accessible, high quality health care for this country. Bold action is needed now. We no longer have the luxury of time. We need a President-elect that has the leadership experience, the strategic focus, and the tenacity to pull it off. I believe my wealth of experience makes me the best qualified candidate.

The current AAFP financial realities meant that the Board had to make some really tough decisions that you've been hearing about. Instead of a crisis, we created an opportunity; an opportunity to be crystal clear that we would dedicate all of our efforts and all of our resources to you, our members, and to the effort to improve your lives and the lives of your patients.

What are our top priorities? I see three. Priority number one is to transform our Academy. We will do this by aligning our resources with our priorities through strategic collaboration such as the Patient-Centered Medical Home and through partnerships with our chapters. Our role as the AAFP is to lead at the national stage and help chapters leverage power through state legislative gains. We also need to develop our grassroots efforts to more effectively enlist our patients in our cause. After all, it is also our patients who stand to lose if we are not financially viable. Our second priority is to develop and transform our practices. You've heard this morning that businesses and patients are requesting patient-centered care. The motivation to transform begins with a desire to improve quality of care and increase professional satisfaction. Not only will a Patient-Centered Medical Home be more rewarding but in time it will and must be more lucrative. The AAFP must help our members transform their practices to meet this demand and ensure that there is adequate payment for this additional work.

I understand that there are some that have valid concerns about becoming a medical home. That is why the AAFP must step in and help create the financial incentives. As a TransforMED Board member, I have helped develop the future business plans and I am confident that we will have the tools for our members to be successful. The third priority is to transform health care. We need to position family medicine as the cornerstone of our health care system. The next few years are critical. We must act now and act effectively. Policy-makers and the public must understand that family medicine is foundational and that we must increase our number if we are going to provide a family doctor for all Americans.

We know that family doctors deserve better payment. We won't solve our workforce issues and attract enough residents until this improves. We know and must show that family doctors are the first line of defense to repair a health care system that is dysfunctional for us and our patients. I think of a recent comment from my patient, Carmella, who had been admitted for a mastectomy and developed complications. After our visit, she expressed her gratitude for my intervention with all of the various sub-specialists. Carmella said that she needed me because I saw the big picture and I didn't lose track of that. That's what we all do. And that's why we are the cornerstone of health care reform. We bring quality and value.

AAFP represents and serves all family doctors. And we practice in a variety of settings. What do we all want and deserve? To be valued by the system and by our patients. If we are valued, then we will be paid fairly and we will be allowed to practice in all environments matching our training and our experience.

I understand the diversity of family physicians. And I understand that there is far more uniting us than dividing us. I have been there with you in clinics, in academics, in remote locations as a commander and as the chief of hospital staff and now in small private practice. I believe that my extensive organizational and leadership experience in the Air Force and now has given me the skills needed to be your next AAFP President-elect.

Integrity, service before self, and striving for excellence in all I do. These Air Force values have guided my life, my practice and my Academy work. And these are the same values that I will bring to the Office of the President-elect. To transform our

Academy, to transform our practices and to transform our health care. I thank you for all that you do for the Academy, for our supports, your friendship throughout my career and now I ask for your vote tomorrow morning.

President King introduced the third candidate for President-elect, Dr. Robert Pallay, who addressed the delegates as follows:

It's 1970, one man stood alone in the darkness. Apollo 13 had just malfunctioned on its way to the moon. Bringing the astronauts safely home seemed hopeless. But Gene Krantz, Apollo 13 Mission Director, would not accept failure. He knew that he was surrounded by intelligence, creativity and resources to bring the Apollo astronauts back. He believed in his team and was determined to succeed. For Krantz, failure was not an option.

Today, our situation in family medicine may seem hopeless. Our existence hangs by a thread. I am not here to reiterate the critical issues that we all know. I am here to tell you that life Gene Krantz, I believe that failure is not an option. Krantz was Mission Director when Apollo 1 caught fire on the launch pad. He was determined that his team would never again fail. He focused them by saying that space flight would never tolerate carelessness. From that day forward, flight control would be known by two words: tough and competent. Tough, forever accountable, never compromising their responsibilities. And competent, taking nothing for granted and never falling short in their knowledge and skills. Tough and competent was the price of admission to mission control. Now is the time to adopt these words in family medicine. Tough, accountable to each other and our patients. Neither compromising our responsibilities nor allowing others to force us into it. And competent, solving our own problems rather than looking to others for solutions. We will never be found wanting in our skills as physicians or in our resolve to transform our practices for success. Tough and competent is the price of admission to being a family physician today and in the future.

So what's that going to take? Let me explain. First, it is time to get tough within the House of Medicine. We must lay out exactly what we require from the AMA. They must become true advocates for family medicine. We must have increased payment for cognitive care. We must have changes in the medical school admission policies. Why isn't the AMA a member of the Patient Centered Primary Care Collaborative? If the AMA truly believes that fixing the health care system is tied to family medicine and the Patient-Centered Medical Home, then they must stand with us and push the system in that direction. If they are unwilling to support us then we should take immediate steps to disengage from the AMA. We cannot accept the status quo.

Second, it is time to get tough with the RUC. Everyone likes to say we need to be at the table. My friends, we've been at this table for 20 years our income has gone down and our partialist colleagues' income has gone up. That's part of the reason why medical students aren't choosing family medicine. I find this totally unacceptable and know that many of you feel the same. It is time to leave the RUC's table and ask our primary care colleagues to join us so that we an advocate for different and better ways to get paid what we deserve. However, even if they chose not to join us, we need to be tough enough to stand alone. Our resources are too precious and spread too thin to waste any more time and money on the RUC.

Third, medical school admission policies must change. We know that by 2020 America is expected to have 60,000 fewer primary care physicians than it needs. Because they are public institutions, medical schools must respond and change admission policies so that the right mix of students are accepted into medical school. It is imperative for the country that we have enough family physicians over the next two decades. We must be tough and competent in the face of change.

A year ago, the Academy faced a severe budget deficit. As a Board, we took steps to secure the economy's financial stability. Were they right decisions? At the time, they were but we've heard the voices of our members now we need to have the courage to revisit those decisions about how the membership is included in the work of the Academy. The new commission structure must be re-evaluated to ensure that we give full voice to our members. We need to re-examine our decisions and change them if that is the right thing to do. We know that change is coming. No matter whether Obama or McCain wins the Presidential election, we are going to be in the position to manage the change we want in health care rather than have that change forced upon us.

Research shows that the medical home with the family physician and the patient at the center is the change that the system needs. We are not only going to be at the table as the changes occur, we are taking the case right to the American people and to business and industry. However, we must be willing to realize that as good as we are, we are not yet good enough. We need to be willing to transform ourselves and our practices. My friends, we have one chance to make a difference. One change to get it right. If we don't lead the changes in the health care system now, we may never get another chance. We cannot fail our members and more importantly we cannot fail our patients. We've never had a better opportunity to be at the forefront of American health care. Family medicine needs a clear, strong voice and strong leadership willing to be tough and competent to lead us into the future. Let me be that leader for you. I challenge you to be tough and competent. I ask for your vote and your help because failure is not an option.

President King introduced the fourth candidate for President-elect, Dr. Thomas Weida, who addressed the delegates as follows:

Delegates and Alternates – Who believed that you would become a doctor? For me, it was my grandmother. She was a true believer. She believed that she would see me become a doctor. And though she had to survive two strokes to do it, she saw me get my degree. She believed in me and I believed in her.

Many of us here today know what it means to believe in who we are and what we do and then to live like a believer. Let me tell you three things that I believe about this privilege we share as family physicians. First, I believe everyone deserves a Patient-Centered Medical Home. Imagine you are the patient. Your doctor does a fine job treating you. Recently, there's been a change. You can feel the family physician's health care team working for you. You can get an appointment today. You can accomplish lifestyle change through group visits. This isn't just fine treatment, it is fantastic treatment! Is this a dream? Hardly. Two years ago, my practice had an idea. We opened a walk-in clinic; the results? Amazing! 7,000 visits with $100,000 net. Patients actually thanked us and the independent nurse practitioners urgent center up the street closed its doors. No retail health clinic is setting up in my neighborhood. And what could be better than this? The joy of practice returned. We go to do what we love to do, deliver the right care at the right time in the right way. I believe the Patient –Centered Medical Home can transform our practices from fine to fantastic; a belief that can transform the fragmented American health care system from mediocre to magnificent. When I share this picture with medical students, their eyes light up. They tell me they like what they hear. The medical home opens the window of their patient-caring souls. But many faculty members don't see this picture.

During my Presidency years, I'll visit every medical school in the country. I'll open their eyes to the medical home concept. We must teach the teachers and, more importantly, we must teach, excite, and inspire the family physicians of the next generation.

Here's my second belief. Family doctors have a right to get paid for all the work we do. We provide the Patient-Centered Medical Home, pay us for the home. We see patients in our office for sick visits, well visits, and counseling visits. Pay us fairly for all the visits. We get quality results. Pay us for medical success. Second class payment won't relieve the shortage of family physicians. It won't encourage medical students to join our ranks. We are family physicians. It won't encourage medical students to join our ranks. We are specialists of comprehensiveness and we deserve to have parity of payment with the partialists. I believe this and I trust many of you believe this too. However, our U.S. Congress doesn't believe it. The Medicare rate fix as a recent success, however, another Academy call to action had only 600 members responding out of 94,000. We need more than a quartet of voices. We need a talented choir of 94,000 family physicians. Our unified voice of reason may resonate in the corridors of Congress, not a whisper, but a shout. Together we must shake up and wake up our legislators to this reality. Family medicine is the future. We provide quality care without chaotic cost. Health care coverage for all cannot exist without us. I pledge to you today to lead this fight to raise the volume of our voice in Washington. I will contact every Delegate and Alternate and ask them to join me in energizing our Academy of advocates. We must become as comfortable lobbying legislators as we are looking in an ear. When 94,000 family physicians, residents and students get into Congress's collective ears, they will respond. This I believe.

Finally, I believe we are the health care providers of choice. No one else is a family doctor. Many family doctors feel threatened by the expansion of doctors of nurse practitioners, DNPs. I don't believe all doctors are the same and neither do our patients when they experience the unsurpassed quality of family physician total care. A DNP is not an FP. We are diagnostic detectives. We are the medical glue that holds patients' lives together. Who else can deliver a baby, check a child's ear, diagnose diabetes, prevent a heart attack and hold the hand of a dying patient, all in the same day? Our children need to hear this. You are too smart to be just a sub-specialist. You need to be a family doctor. My son, just starting medical school, hears it from me all the time.

The Academy has been my passion for 30 years and will be for 30 years more. I am committed to you, to our Academy and to our patients. With my years of leadership experience as your Speaker and Vice Speaker, I have the necessary skills to serve as your President-elect and President, and I have the leadership vision and meeting skills to serve as your Board Chair.

The time is right. It is our time for family medicine's culture of caring to transform American health care. I believe we'll see the Patient-Centered Medical Home flourish. I believe we'll see our compensation improve. I believe we'll see a more vocal Academy of advocates whose voice will not be denied in the corridors of Congress. And, I believe by our working together we will see the transformation of American health care.

We have many challenges ahead but Weida works and I'll continue to work for you. Thirty years ago, when I attended my first National Conference as a student, I was wowed. I was energized. I was excited about my future. Thirty years later that future is now and Weida is still wowed. I am excited about our future, family medicine's future. I have the desire, the energy, and the vision. I have the support of my chapter, staff, family, and patients. But what I need most is your support. I am asking for your vote. I've told you what I believe now I am asking you to believe in me. Support me in our work together. Let's control our destiny. We are family physicians. We care, we cure, we are the medical solution our country needs. Family medicine.

President King moderated the question and answer session which followed the President-elect candidates' speeches.

At the conclusion of the Candidates' Forum, President King turned the proceedings back over to Vice Speaker Mabry for announcements.

Following a brief break, Speaker Weida called for the next item on the agenda, the report of the Reference Committee on Practice Enhancement. Speaker Weida reminded the delegates that the reference committee reports will be voted on as a consent calendar and therefore as one item. If a delegate wishes to extract an item or items, they may do so and these will then be debated and voted on separately. Dr. Daniel Spogen of Sparks, Nevada, committee chair, began the reading of the reference committee report as follows:

REFERENCE COMMITTEE ON PRACTICE ENHANCEMENT

The Reference Committee on Practice Enhancement has considered each of the item referred to it and submits the following report. The committee's recommendations on each item will be submitted as a consent calendar and vote on in one vote. An item or items may be extracted for debate.

Speaker Weida called for any items to be extracted from the reference committee report.

Delegate Reid Blackwelder of Kingsport, Tennessee moved to extract Item No. 18, Revised policy on "Non-Physician Providers (NPPs) Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants" from the consent calendar which is a recommendation to adopt the revised policy. See Congress debate and action on Pages 339-341.

Speaker Weida declared Item No. 18, Revised policy on "Non-Physician Providers (NPPs) Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants" extracted and placed on the table for consideration.

Seeing no further extractions, Speaker Weida then called for the vote on the rest of the report as recommended by the reference committee on the consent calendar below:

The Reference Committee on Practice Enhancement recommends the following consent calendar for adoption:

Item 1 – Adopt Substitute Resolution No. 302 on "Medicare No Pay Movement" in lieu of Resolution No. 302.

Item 2 – Adopt Substitute Resolution No. 303 on "Medicare Election Period" in lieu of Resolution No. 303.

Item 3 – Not Adopt Resolution No. 304 on "Medicare and Diabetic Care".

Item 4 – Adopt Substitute Resolution No. 305 on "Medicare Preventive Care" in lieu of Resolution No. 305.

Item 5 – Referred to the Board of Directors, First and Second Resolved Clauses, Resolution No. 315 on "Post Payment Reviews Conducted by CMS Subcontractors".

Reaffirm, Third Resolved Clause, Resolution No. 315 on "Post Payment Reviews Conducted by CMS Subcontractors".

Item 6 – Not Adopt Resolution No. 301 on "Physician Ranking By Insurance Companies".

Item 7 – Referred to the Board of Directors Resolution No. 309 on "Medication Prior Authorization Rule Transparency".

Item 8 – Adopt Substitute Resolution No. 314 on "Insurance Card Identification of Date Issued" in lieu of Resolution No. 314.

Item 9 – Adopt Substitute Resolution No. 316 on "HEDIS® Audits" in lieu of Resolution No. 316.

Item 10 – Adopt Substitute Resolution No. 317 on "Payment at Time of Service/Point of Service Payment Systems" in lieu of Resolution Nos. 317 and 318.

Item 11 – Not Adopt Resolution No. 319 on "Billing Health Plans and Pharmacy Benefit Managers for Care Coordination".

Item 12 – Adopt Substitute Resolution No. 306 on "Hospital Bylaws" in lieu of Resolution No. 306.

Item 13 – Adopt Substitute Resolution No. 307 on "Delivering More Than One Service to Patients" in lieu of Resolution Nos. 307 and 308.

Item 14 – Referred to the Board of Directors Resolution No. 310 on "Voting in the RUC" and Resolution No. 311 on "CMS Development of Independence RVS Advisory Board".

Item 15 – Referred to the Board of Directors Resolution No. 312 on "Electronic Health Records (EHRs) Data".

Item 16 – Referred to the Board of Directors Resolution No. 313 on "Federal Government Support for Implementing Electronic Health Records (EHR) Systems".

Item 17 – Not Adopt Resolution No. 320 on "Modifiers for Americans with Disabilities Act (ADA) Services".

Item 19 – **Miscellaneous –** Adopt Items A through S.
Information Items for Filing:

- Board Report C, Clinical Data Repository, ALL, (pp. 247-248) except para. 2.
- Board Report E, Patient-Centered Medical Home 2008 Update, ALL, including Appendix A.
- Board Report G, Brief Overview of Private Sector Advocacy, ALL.
- Commission on Practice Enhancement, ALL,, except paras. 11, 31, 38, 39, 40, 88, 92, 94, 96, 98, 101, 103, 105, 106, 109, 111, 113 and Appendices A, B, C & D.
- Commission on Quality, ALL,, except paras. 20 and 21.

The motion carried and the consent calendar of the Reference Committee on Practice Enhancement was adopted as recommended above with the exception of the one extracted item. The detailed report follows with appropriate Congress action noted:

ITEM 1 – MEDICARE NO PAY MOVEMENT

Resolution No. 302 from the Pennsylvania Chapter entitled, "Medicare No Pay Movement," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians Board of Directors study the new Medicare "No Pay" policy and form a response or a policy statement.

The reference committee heard limited testimony on this resolution. All of the testimony was in support of the resolution. The reference committee agreed with the intent of the resolution and believed it would be strengthened by further clarifying the reference to "Medicare 'No Pay' policy" and by further specifying that the impetus for study was the potential implications for future physician payment policy.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 302 which reads as follows be adopted in lieu of Resolution No. 302:*

> *RESOLVED, That the American Academy of Family Physicians Board of Directors study the Medicare hospital "never events" "No Pay" policy as it relates to future Medicare physician payment and form a response or a policy statement.*

The motion carried and Substitute Resolution No. 302 was adopted.

ITEM 2 – MEDICARE ELECTION PERIOD

Resolution No. 303 from the Georgia Chapter entitled, "Medicare Election Period," the resolved portions of which read as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) take the position that physicians be given the option of a bi-annual participation election in Medicare occurring at the end and the middle of the calendar year, and be it further
>
> RESOLVED, That the American Academy of Family Physicians (AAFP) petition the Centers for Medicare and Medicaid Services (CMS) to permit a bi-annual participation election occurring at the end and the middle of the calendar year.

The reference committee heard limited testimony on this resolution. All of the testimony supported the intent of the resolution, and some of the testimony suggested various changes to the language to make that language more consistent with the intent. The reference committee also agreed with the intent of the resolution, and like those who testified, believed the resolution would be strengthened by some changes in the language.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 303 which reads as follows be adopted in lieu of Resolution No. 303:*

> *RESOLVED, That the American Academy of Family Physicians petition the Centers for Medicare and Medicaid Services to modify the Medicare physician participation agreement to permit physicians to change their Medicare participation status with 90 days notice in between each annual election period.*

The motion carried and Substitute Resolution No. 303 was adopted.

ITEM 3 – MEDICARE AND DIABETIC CARE

Resolution No. 304 from the Rhode Island Chapter entitled, "Medicare and Diabetic Care," the resolved portions of which read as printed below:

> RESOLVED, That the Academy of Family Physicians (AAFP) encourage the Centers for Medicare and Medicaid Services (CMS) to cover diabetic supplies, and be it further
>
> RESOLVED, That the Academy of Family Physicians (AAFP) encourage the Centers for Medicare and Medicaid Services (CMS) to investigate the cost of diabetic supply items to our patients and invest in other means to acquire these supplies at bulk or discounted prices.

The reference committee heard limited testimony on this resolution. Testimony from the sponsor of the resolution indicated that Medicare patients cannot afford their diabetic supplies because Medicare will not pay for them or because they fall in the "donut hole" under Medicare Part D. However, testimony from other states questioned this assertion. A review of the Centers for Medicare and Medicaid Services Web site indicates that Medicare does cover diabetic supplies under Part B. Based on the testimony and other available information, the reference committee does not believe that the resolution is factually accurate, and therefore, the reference committee does not believe the Academy should pursue the requested action.

RECOMMENDATION: *The reference committee recommends that Resolution No. 304 not be adopted.*

The motion carried and Resolution No. 304 was not adopted.

ITEM 4 – MEDICARE PREVENTIVE CARE

Resolution No. 305 from the Rhode Island Chapter entitled, "Medicare Preventive Care," the resolved portions of which read as printed below:

> RESOLVED, That the Academy of Family Physicians (AAFP) encourage the Centers for Medicare and Medicaid Services (CMS) to cover all indicated preventive care services designated by the AAFP as standard of care, and be it further
>
> RESOLVED, That the Academy of Family Physicians (AAFP) encourage the Centers for Medicare and Medicaid Services (CMS) to compensate physicians appropriately for the costs of all preventive care services designated by the AAFP as standard of care.

The reference committee heard a moderate amount of testimony on this resolution. In general, the testimony supported the intent of the resolution. However, there were multiple suggested changes to the language of the resolution. For example, some testimony noted that the Academy does not designate certain preventive care services as "standard of care" and suggested that this reference be changed to the United States Preventive Services Task Force. Other testimony noted that CMS is not in a position to change Medicare coverage of preventive services and that only Congress could make such a change. The reference committee further noted that the focus of the whereas clauses in the resolution as well the impetus for the resolution itself, according to testimony, is an issue of Medicare coverage of vaccines. Ultimately, the reference committee also agreed with the intent of the resolution, and like those who testified, believed the resolution would be strengthened by some changes in the language, consistent with the new policy on "Immunizations" included in the annual report of the Commission on Practice Enhancement.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 305 which reads as follows be adopted in lieu of Resolution No. 305:*

> *RESOLVED, That the American Academy of Family Physicians advocate with Congress to include, as a covered Medicare benefit, immunizations recommended by the AAFP, without co-payments or deductibles.*

The motion carried and Substitute Resolution No. 305 was adopted.

ITEM 5 – POST PAYMENT REVIEWS CONDUCTED BY CMS SUBCONTRACTORS

Resolution No. 315 from the North Carolina Chapter entitled, "Post Payment Reviews Conducted by CMS Subcontractors," the resolved portions of which read as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) communicate concerns regarding post payment audits to the Centers for Medicare and Medicaid Service (CMS) and Office of Inspector General (OIG) for further review and appropriate action allowing for the method of post payment audits to be conducted in the manner as outlined by the CMS procedure manual allowing due process for the physician without responding in a "guilty until proven innocent" manner, and be it further
>
> RESOLVED, That the American Academy of Family Physicians (AAFP) present the concerns regarding post payment audits to the American Medical Association (AMA) delegation for review by other subspecialty constituencies who have voiced similar concerns and a desire to work in a concerted manner to resolve this issue on behalf of all physicians, and be it further
>
> RESOLVED, That the American Academy of Family Physicians (AAFP) establish a mechanism of communication allowing physicians to share their experience with post payment audits with other members for the benefit of providing support in the form of potential resources, peer to peer education, and basic professional/colleague support.

The reference committee heard limited testimony on this resolution. In general, that testimony was in support of the resolution. A representative of the Board of Directors testified that the Board had some questions about the intent of the first and second resolved clauses. The Board representative also testified that the Board believes the third resolved clause is already addressed by the fact that the Academy has multiple electronic mail groups (also known as "listservs") that facilitate member-to-member communication, consistent with the third resolved clause. The reference committee agreed that the intent of the first and second resolved clauses was not entirely clear and that the Academy already had established mechanisms of communication that allow members to share their experiences with post payment audits.

RECOMMENDATION: *The reference committee recommends that the first and second resolved clauses of Resolution No. 315 be referred to the Board of Directors.*

The motion carried and the first and second resolved clauses of Resolution No. 315 were referred to the Board of Directors.

RECOMMENDATION: *The reference committee recommends that the third resolved clause of Resolution No. 315 be reaffirmed as already addressed by current Academy efforts.*

The motion carried and the third resolved clause of Resolution No. 315 was reaffirmed as current policy.

ITEM 6 – PHYSICIAN RANKING BY INSURANCE COMPANIES

Resolution No. 301 from the New York State Chapter entitled, "Physician Ranking By Insurance Companies," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians oppose family physician ranking by the insurance industry.

Those testifying expressed a variety of opinions about physician performance measurement and reporting. Most agreed that the state of physician quality and efficiency performance measurement is immature and thus limited in its application for public reporting. Several were of the belief that insurers are incapable of objectively measuring physician performance owing to an inherent financial conflict of interest. Others testified to having worked collaboratively with the insurance industry to develop and implement mutually agreeable quality measurement programs. Some believed that an independent third party should be established to act on behalf of all payers/insurers to collect, analyze and report on standardized physician performance measures using data supplied by the payers/insurers. The idea was also offered that the AAFP should assume this responsibility on behalf of its members. The New York Attorney General's agreement with insurers and the Consumer-Purchaser Disclosure Project's criteria for transparency in physician performance reporting were discussed. The reference committee noted that both of these entities require independent third party review and approval of health insurer physician performance reporting programs and that in both cases the NCQA has been selected as the third party adjudicator.

The reference committee reviewed current relevant Academy policy including Performance Measurement Criteria, Guiding Principles for Physician Profiling, Tiered and Select Physician Networks, Transparency, Data Stewardship and Pay-for-Performance as well as work currently being undertaken by the Commission on Practice Enhancement in response to Referred 2007 COD Resolution No. 322, "Physician Grading and Reporting". This resolution calls on the Academy to formulate and publish a set of "minimum standards" for physician grading and reporting.

The reference committee concluded that it is neither practical nor in the Academy's or its members' best interests to flatly oppose physician performance reporting (tiering, ranking, etc). Rather, it encourages the Academy to continue its ongoing work to consolidate current policy and develop physician grading and reporting minimum standards for use by members, chapters and the AAFP in their interactions with insurers and others. Uses of the minimum standards include both advocacy with public and private payers and collaborative initiatives with other physician organizations and insurers to develop and implement physician measurement and reporting programs in a transparent manner that serve" the needs and best interests of all vested interests: patients, physicians and payers.

RECOMMENDATION: *The reference committee recommends that Resolution No. 301 not be adopted.*

The motion carried and Resolution No. 301 was not adopted.

ITEM 7 – MEDICATION PRIOR AUTHORIZATION RULE TRANSPARENCY

Resolution No. 309 from the Ohio Chapter entitled, "Medication Prior Authorization Rule Transparency," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) work to ensure that when an insurance company requires prior authorization paperwork be filled out, it must include drug-specific information about the criteria that must be met for the drug to be authorized.

Testimony on this resolution was supportive of the resolution and indicated the high degree of member frustration with pharmaceutical prior authorization programs. They interfere with clinical decision-making, cause delays in treatment, create uncompensated administrative expenses and can result in adversarial relationships with patients. Insurance companies and pharmacy benefit management companies do not provide accessible and actionable drug-specific information at the point of care. They do not have physician-friendly communication systems in place. Rather the lack of information and effective communication systems create barriers and result in delays and unnecessary practice expenses.

The reference committee concluded that this is an issue of critical importance to a great many members. The solutions to this problem are complex and not well understood. The committee agrees with the recommendation of the Board representative that it would be best to refer the resolution to the Board for further investigation and follow up by the appropriate entity.

RECOMMENDATION: *The reference committee recommends that Resolution No. 309 be referred to the Board of Directors.*

The motion carried and Resolution No. 309 was referred to the Board of Directors.

ITEM 8 – INSURANCE CARD IDENTIFICATION OF DATE ISSUED

Resolution No. 314 from the Ohio Chapter entitled, "Insurance Card Identification of Date Issued," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) request that insurance companies include the date the insurance card was issued on the insurance card.

Testimony on this resolution was supportive of the resolution. It was suggested by the Board representative that the scope of the resolution be broadened to expand its reach and applicability.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 314 which reads as follows be adopted in lieu of Resolution No. 314:*

> *RESOLVED, That the American Academy of Family Physicians (AAFP) requests that insurance companies, third party administrators, and/or other entities that provide or verify health care coverage for qualified individuals include on the plan card the date the insurance or card was issued.*

The motion carried and Substitute Resolution No. 314 was adopted.

ITEM 9 – HEDIS® AUDITS

Resolution No. 316 from the New Jersey Chapter entitled, "Hedis® Audits," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) bring the matter of the Health Plan Employer Data and Information Set (HEDIS®) audits to national insurers, legislators, regulatory agencies, and other persons and organizations of influence, specifically demanding that either health plan staff perform these audits or that primary care offices are appropriately compensated.

Testimony concerning the author's intent was presented. Health plan contracts with network physicians require their cooperation in conducting quality assurance and improvement activities related to the health plan's HEDIS® reporting requirements. The author reported being required by a contracted Medicare Advantage plan to conduct chart reviews and report the results to the health plan. Others testified to the time and expense related to pulling charts for on-site review by health plan representatives as the more common practice. Others spoke to the lack of surveyor training in extracting quality data from practices' electronic health records and the additional practice time and resources required to assist the surveyor in extracting needed data from the EHR. The bottom line was that practices should be compensated for the time and resources they expend in providing records that solely benefit the health plan. The committee decided to propose a more general statement of policy addressing practices' reporting costs that benefit another entity as suggested by the Board representative.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 316 which reads as follows be adopted in lieu of Resolution No. 316:*

> *RESOLVED, That the American Academy of Family Physicians (AAFP) advocate to health plans that family physicians should be fairly compensated for medical care reporting activities required by the health plan (e.g. HEDIS® audits).*

The motion carried and Substitute Resolution No. 316 was adopted.

ITEM 10 – PAYMENT AT TIME OF SERVICE/POINT OF SERVICE PAYMENT SYSTEMS

Resolution No. 317 from the North Carolina Chapter entitled, "Payment at Time of Service/Point of Service Payment Systems," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) support the development of payment systems such as magnetically activated or bar coded insurance cards that facilitate point of service payment at the time healthcare services are delivered.

Resolution No. 318 from the Rhode Island Chapter entitled, "Billing Assistance by Insurance Companies," the resolved portions of which read as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) work with the insurance companies to develop and implement electronic systems which would provide timely accounts of patient charges, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) work with the insurance companies to provide a payment code for payment of the additional work required when patient balances and charges are not provided at the time of the service, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) work with insurance companies to assist physician offices in billing the insurance company's clients for missed or defaulted payments to the physician office.

Testimony on Resolution No. 317 was in support of the intent. Testimony on Resolution No. 318 was not supportive of the second and third resolves. The actions were not thought to be practical and unlikely to represent a good investment of Academy time and resources. The testimony focused on the importance of real time claims adjudication to resolving multiple problems associated with greater patient financial responsibility for services rendered. The importance of collecting the patient co-pay and deductible amounts were acknowledged but having information at the point of care about a variety of eligibility, coverage and payment issues was deemed to be the key issue. Equally important is that the information is standardized across payers. Concern was expressed that despite the availability of technology to execute real time claims adjudication, that the lack of uniform standards continues to inhibit its wide-spread adoption and implementation by payers and practices. Therefore, it's incumbent upon the Academy to continue to pressure insurers and other entities to support and adopt voluntary operating rules being developed by the Coalition of Affordable Quality Healthcare (CAQH) through its Committee on Operating Rules for Information Exchange (CORE) to streamline healthcare administrative processes.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 317 which reads as follows be adopted in lieu of Resolution Nos. 317 and 318:*

RESOLVED, That the American Academy of Family Physicians (AAFP) support the development of payment systems, such as standardized magnetically activated or bar coded insurance cards, that facilitate point of service claims adjudication.

The motion carried and Substitute Resolution No. 317 was adopted.

ITEM 11 – BILLING HEALTH PLANS AND PHARMACY BENEFIT MANAGERS FOR CARE COORDINATION

Resolution No. 319 from the Indiana Chapter entitled, "Billing Health Plans and Pharmacy Benefit Managers for Care Coordination," the resolved portion of which reads as printed below:

RESOLVED, That the American Academy of Family Physicians (AAFP) seek development of new *Current Procedural Terminology* (CPT) codes that specifically define any mandated care coordination to include actual time involved to complete the task.

The reference committee heard mixed testimony on this resolution. The sponsor of the resolution testified in support of the resolution but expressed a willingness to accept some change in the language, given that there are unknown consequences to seeking development of a code as requested. Other testimony expressed opposition to the resolution, because a time based code would reward inefficient physician practices. Testimony also raised concerns that such a code would require such careful documentation of the time involved that the code would not be worth using. Finally, there was testimony to the fact that a well-compensated patient-centered medical home would otherwise address this issue. The reference committee was persuaded by the testimony that the Academy should not pursue development of a new code as suggested and should, instead, continue to focus on appropriate compensation for care coordination using a care management fee under the patient-centered medical home.

RECOMMENDATION: *The reference committee recommends that Resolution No. 319 not be adopted.*

The motion carried and Resolution No. 319 was not adopted.

ITEM 12 – HOSPITAL BYLAWS

Resolution No. 306 from the Florida Chapter entitled, "Hospital Bylaws," the resolved portion of which reads as printed below:

RESOLVED, That the American Academy of Family Physicians develop a policy statement and model hospital bylaws to address fair methods for physicians resuming inpatient privileges after a period of outpatient–only medical services.

The reference committee heard significant testimony on this resolution. That testimony was generally supportive of the resolution and encouraged the Academy to pursue this issue, even though it will not be an easy one to address. Testimony revealed that the American Medical Association (AMA) has model hospital bylaws that address this issue, and an Academy member who works with the Joint Commission testified that the Joint Commission has new standards that also address this issue. A representative of

the Board of Directors testified that the Board supported the intent of the resolution. However, the Board would recommend that the Academy not develop model hospital bylaws until the Academy has a policy in place and until further investigation of the related AMA and Joint Commission resources can occur. The reference committee agreed that it would be appropriate to approach this issue in a step-wise fashion and develop policy as a precursor to potentially developing model hospital bylaws, rather than doing both simultaneously.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 306 which reads as follows be adopted in lieu of Resolution No. 306:*

RESOLVED, That the American Academy of Family Physicians develop a policy statement to address fair methods for physicians resuming hospital-related privileges after a period of outpatient–only medical services.

The motion carried and Substitute Resolution No. 306 was adopted.

ITEM 13 – DELIVERING MORE THAN ONE SERVICE TO PATIENTS

Resolution No. 307 from the Colorado, Idaho, Indiana, Missouri, Montana, Nebraska, New Mexico, North Dakota, Pennsylvania, Rhode Island, South Carolina and South Dakota Chapters entitled, "Delivering More Than One Service to Patients," the resolved portions of which read as printed below:

RESOLVED, That the American Academy of Family Physicians (AAFP) work to abolish the payment rules amongst all payers that penalize the delivery of more than one service to patients, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) work with all payers to provide incentive payments to encourage the delivery of multiple services to patients at a single encounter.

Resolution No. 308 from the Illinois Chapter entitled, "Delivering More Than One Service to Patients," the resolved portions of which read as printed below:

RESOLVED, That the American Academy of Family Physicians (AAFP) will work to abolish the payment rules amongst all payers that penalize the delivery of more than one service to patients at a single encounter, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) will work with all payers to provide incentive payments to encourage the delivery of multiple services to patients at a single encounter.

The reference committee received testimony jointly on these resolutions, since the language of both was almost identical. The testimony was universally in support of the resolutions, with some suggested language changes to clarify intent. The testimony also noted that the current payment rules that otherwise deny or reduce payment for more than one service provided to a patient on a single day are contrary to open access in the patient-centered medical home. A representative of the Board of Directors further noted that the resolutions are consistent with current policy, which supports efforts to make the current fee-for-service payment system better. The reference committee agrees with the resolution and also agrees with the testimony that the intent of the resolution could be strengthened through some changes in the language.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 307, which reads as follows, be adopted in lieu of Resolution No. 307 and Resolution No. 308:*

RESOLVED, That the American Academy of Family Physicians (AAFP) will work to abolish the payment rules amongst all payers that deny or reduce payment for the delivery of more than one service to a patient in a single day.

The motion carried and Substitute Resolution No. 307 was adopted.

ITEM 14 – RESTRUCTURING RUC

Resolution No. 310 from the Colorado, Indiana, Nebraska, New Mexico, Rhode Island, South Carolina and South Dakota Chapters entitled, "Voting in the RUC," the resolved portions of which read as printed below:

RESOLVED, That the American Academy of Family Physicians (AAFP) work to make the voting in the RUC proportional to the number of physicians that make up the constituent voting entities, and be it further

RESOLVED, That if proportionate representation is not achieved, the American Academy of Family Physicians (AAFP) disengage from the RUC and pursue other means to assign appropriate compensation for physician services.

Resolution No. 311 from the Oregon Chapter entitled, "CMS Development of Independent RVS Advisory Board," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) petition the Centers for Medicare & Medicaid Services (CMS) to develop an independent Relative Value Scale (RVS) Advisory Board with membership representative of the current physician workforce providing care to Medicare recipients or mandate representative restructuring of the Relative Value Scale Update Committee.

The reference committee heard extensive testimony on both of these resolutions. That testimony revealed that the issues involved were complex and that there was no consensus on how to proceed. Some testified in support of both resolutions, noting that it was a waste of effort for the Academy to continue to participate in a forum that did not address the needs of family medicine. Others testified in opposition to both resolutions, arguing that the Academy should continue to advocate for family physicians at the RUC in light of the influence that the RUC has on the value of physician services. Still others supported parts of the resolutions while opposing other parts.

Testimony highlighted that the Commission on Practice Enhancement and the Board of Directors have already grappled with this issue and that the Board of Directors continues to pursue the matter through contact with other primary care specialty societies. In light of this activity, a representative of the Board of Directors testified that the Board recommended referral of both resolutions to the Board. The reference committee was persuaded by the testimony that the issues involved were sufficiently complex and that there was sufficient ongoing Academy activity to merit referral of both resolutions to the Board of Directors.

RECOMMENDATION: *The reference committee recommends that Resolution No. 310 be referred to the Board of Directors.*

The motion carried and Resolution No. 310 was referred to the Board of Directors.

RECOMMENDATION: *The reference committee recommends that Resolution No. 311 be referred to the Board of Directors.*

The motion carried and Resolution No. 311 was referred to the Board of Directors.

ITEM 15 – ELECTRONIC HEALTH RECORDS (EHRS) DATA

Resolution No. 312 from the South Carolina Chapter entitled, "Electronic Health Records (EHRs) Data," the resolved portions of which read as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) assist members in the use of non-identifiable clinical and administrative data derived from physicians' electronic health records (EHRs) by educating them to the value of this data as a potential source of revenue, and be it further
>
> RESOLVED, That the American Academy of Family Physicians (AAFP) identify those health care entities, such as commercial health plans, in need of non-identifiable clinical and administrative data collected for free from physicians' electronic health records (EHRs) and make the names of those companies that sell such information available to members as a possible source of revenue.

Testimony on this resolution focused on perceived or potential economic value of the clinical data stored in family physicians' electronic health records (EHRs) and how to best leverage this data to the financial benefit of individual physicians. The need to educate members on the potential value and to identify potential buyers was explored. Others expressed their belief that the Academy's Clinical Data Repository currently under investigation holds the greatest potential for individual physicians to leverage the value of their electronic clinical data. Insurance companies and other purchasing entities will find aggregated, de-identified data much more appealing than contracting with individual practices. Concerns were also expressed regarding confidentiality of data mining even of de-identified data and with the public relations, ethical and legal implications of selling clinical data. Owing to the complexity of the issue and the ongoing investigation of the Academy establishing its own Clinical Data Repository, the Board representative suggested that the resolution be referred to the Board. The committee concurred.

RECOMMENDATION: *The reference committee recommends that Resolution No. 312 be referred to the Board of Directors.*

The motion carried and Resolution No. 312 was referred to the Board of Directors.

ITEM 16 – FEDERAL GOVERNMENT SUPPORT FOR IMPLEMENTING ELECTRONIC HEALTH RECORDS (EHR) SYSTEMS

Resolution No. 313 from the Georgia Chapter entitled, "Federal Government Support for Implementing Electronic Health Record (EHR) Systems," the resolved portions of which read as printed below:

RESOLVED, That the Department of Health and Human Services be petitioned to provide loans of $20,000 per physician to support the implementation of an approved Certification Commission on Healthcare Information Technology (CCHIT) electronic health record (EHR) system to include, but not limited to, hardware procurement, Internet access, staff training, and conversion of current systems, and be it further

RESOLVED, That loans from the Department of Health and Human Services of $20,000 per physician to support the implementation of an approved Certification Commission on Healthcare Information Technology (CCHIT) electronic health record (EHR) system will be forgiven after 12 months if the practice is operationally integrated and the EHR is functional, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) petition the Centers for Medicare and Medicaid Services (CMS) to provide a significant increase in global payments for care to all physician practices incorporating a Certification Commission on Healthcare Information Technology (CCHIT) approved electronic health record (EHR) system.

Testimony was generally supportive of the resolution's intent, federal loan programs and tax credits to support family medicine practices' purchase and implementation of electronic health records and for payment incentives focused on the utilization and outcomes of using the technology. It was also acknowledged that the actions requested could not be implemented by CMS without Congressional action and that the Academy is currently in discussions with Congressional committees to establish a loan program for health information technology. Testimony reflected that reference to "operationally integrated" in the second resolve means "interoperability". The lack of interoperability among disparate systems severely limits the utility and effectiveness of electronic health records in the current environment. Owing to this issue, and many other technical, political and practice considerations, the committee concurred with the Board representative's recommendation that this resolution should be referred to the Board for further study and consideration by the appropriate entity.

RECOMMENDATION: *The reference committee recommends that Resolution No. 313 be referred to the Board of Directors.*

The motion carried and Resolution No. 313 was referred to the Board of Directors.

ITEM 17 – MODIFIERS FOR AMERICANS WITH DISABILITIES ACT (ADA) SERVICES

Resolution No. 320 from the North Carolina Chapter entitled, "Modifiers for Americans with Disabilities Act (ADA) Services," the resolved portion of which reads as printed below:

RESOLVED, That the American Academy of Family Physicians (AAFP) support the creation of ICD-9 code modifiers and increased payment for required services to disabled patients, such as interpreters for the deaf.

There was a modest amount of testimony on this resolution. In general, that testimony supported the resolution, noting that the use of interpreters was a cost to physician practices for which neither payers nor patients were paying. Testimony also noted that, in response to Substitute Resolution No. 507, "Translator Services," as adopted by the 2007 Congress of Delegates, the Commission on Governmental Advocacy recommended and the Board of Directors approved that the Academy advocate for translator services to be paid through Medicare.

The reference committee noted that the existing Academy legislative stance on "Culturally Sensitive Interpretive Services" supports legislation to make funding available for culturally sensitive interpretive services for those who have limited English proficiency, or who are deaf and mute, or who are otherwise language impaired and also requests that the funding be made directly available to the interpreters for culturally sensitive interpretive services. The reference committee also noted that the ICD-9 coding system does not have modifiers and that creation of a code does not guarantee payment. Given this background, the reference committee does not believe that the Academy should pursue a coding solution to the problem identified in Resolution No. 320. Instead, consistent with the current legislative stance, the reference committee believes that the Academy should continue to support legislation that would fund direct payment to interpreters.

RECOMMENDATION: *The reference committee recommends that Resolution No. 320 not be adopted.*

The motion carried and Resolution No. 320 was not adopted.

Speaker Weida called for Dr. Spogen to read the first item extracted from the consent calendar.

ITEM 18 – POLICY ON "NON-PHYSICIAN PROVIDERS (NPPs), GUIDELINES ON THE SUPERVISION OF CERTIFIED NURSE MIDWIVES, NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS"

Paragraph 103 of the annual report of the Commission on Practice Enhancement states that the commission recommended, and the Board of Directors approved, the Academy revise its policy statement on "Non-Physician Providers (NPPs), Guidelines on the Supervision Of Certified Nurse Midwives, Nurse Practitioners And Physician Assistants" to read as shown in Appendix C of the commission's annual report. Testimony to the reference committee noted that in one place in the revised policy there is reference to "a designated alternate" without specifying that this should be either a physician or a physician of the same specialty. The reference committee was persuaded that, in fact, the reference in question should be to another physician. The reference committee did not believe that it was critical for the physician to be of the same specialty, noting, for example, that a general internist could supervise an NPP just as well as a family physician.

RECOMMENDATION: *The reference committee recommends that the policy on "Non-Physician Providers (NPPs), Guidelines on the Supervision Of Certified Nurse Midwives, Nurse Practitioners And Physician Assistants" be revised to read as shown in Appendix A of this report.* – ADOPTED AS AMENDED ON THE FLOOR (SEE APPENDIX A TO THIS REPORT.)

Discussion ensued on the first extracted item from the consent calendar.

Delegate Blackwelder recommended an amendment to the policy statement by inserting "physician of the same specialty" in the section entitled "Remote Supervisor" into the sentence as follows so that it reads: "The supervising physician, or a designated alternate physician of the same specialty must be available…".

The motion was seconded.

Delegate Blackwelder stated that the reason for this recommendation is that while certainly other physicians can supervise nurse practitioners, one of the challenges for family physicians is that the only person who could supervise someone a family physician is supervising has to have the skills in the specialty of family medicine. Internal medicine physicians, for example, really should not be supervising decisions mad about a pediatric case or OB/GYN cases. He further stated that the main issue would be in terms of the relationship of the supervising physician must have the same scope of the patients that are being cared for in that office and the person who is providing that care.

Delegate John Carroll of Carroll, Iowa spoke in favor of the amendment by addition. He stated that from personal experience in his hometown there was a general internist with no pediatric training since his third year of medical school. This general internist hired a family practice nurse practitioner and supervised her practice of pediatrics, which included infants and newborn care without experience. Iowa law did not prohibit him from doing such practice. Delegate Carroll stated that he believes the AAFP should take this very seriously and suggested an emergency room physician or someone similar, a partner, can see these types of patients down through a certain age and who is comfortable doing that so that it can be documented. But here we are talking about supervision of non-physician practitioners and I think we need to be very specific.

Seeing no further debate, Speaker Weida called for a vote on the amendment.

The motion passed and the amendment was adopted.

Speaker Weida called for further debate on the recommendation as amended.

Seeing no debate, Speaker Weida called for a vote on the recommendation as amended.

The motion passed and the recommendation as amended was adopted.

ITEM 19 - MISCELLANEOUS ITEMS

The following items A through S, are presented by the reference committee. All of these items call for action which testimony and discussion resulted in support for the recommendation of the reference committee. At the request of the Congress, any item may be taken off for an individual vote on that item. Otherwise, the reference committee will request approval of all items in a single vote.

(A) Board Report C, Clinical Data Repository, ONLY para. 2.
(B) Annual Report of the Commission on Practice Enhancement, ONLY para. 11.
(C) Annual Report of the Commission on Practice Enhancement, ONLY para. 31 and Appendix A.
(D) Annual Report of the Commission on Practice Enhancement, ONLY para. 38.
(E) Annual Report of the Commission on Practice Enhancement, ONLY para. 39.
(F) Annual Report of the Commission on Practice Enhancement, ONLY para. 40.
(G) Annual Report of the Commission on Practice Enhancement, ONLY para. 88.
(H) Annual Report of the Commission on Practice Enhancement, ONLY para. 92.
(I) Annual Report of the Commission on Practice Enhancement, ONLY para. 94 and Appendix B.
(J) Annual Report of the Commission on Practice Enhancement, ONLY para. 96.
(K) Annual Report of the Commission on Practice Enhancement, ONLY para. 98.
(L) Annual Report of the Commission on Practice Enhancement, ONLY para. 101.
(M) Annual Report of the Commission on Practice Enhancement, ONLY para. 105 and Appendix D.
(N) Annual Report of the Commission on Practice Enhancement, ONLY para. 106.
(O) Annual Report of the Commission on Practice Enhancement, ONLY para. 109.
(P) Annual Report of the Commission on Practice Enhancement, ONLY para. 111.
(Q) Annual Report of the Commission on Practice Enhancement, ONLY para. 113.
(R) Annual Report of the Commission on Quality, ONLY para. 20.
(S) Annual Report of the Commission on Quality, ONLY para. 21.

RECOMMENDATION: *The reference committee recommends adoption of Items A through S above.*

The motion carried and Items A through S above were adopted.

INFORMATIONAL ITEMS

RECOMMENDATION: *The reference committee recommends that the following informational items be filed for reference.*

- Board Report C, Clinical Data Repository, ALL, except para. 2.
- Board Report E, Patient-Centered Medical Home 2008 Update, ALL, including Appendix A.
- Board Report G, Brief Overview of Private Sector Advocacy, ALL.
- Commission on Practice Enhancement, ALL, except paras. 11, 31, 38, 39, 40, 88, 92, 94, 96, 98, 101, 103, 105, 106, 109, 111, 113 and Appendices A, B, C & D.
- Commission on Quality, ALL, except paras. 20 and 21.

The motion carried and the above informational items were filed for reference.

Dr. Spogen concluded the reference committee report by expressing appreciation to those who appeared before the reference committee to offer testimony and to the members of the reference committee for the invaluable assistance in the preparation of the report.

APPENDIX A
Reference Committee on Practice Enhancement Report

"Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants"

(Language to be deleted is indicated by ~~strikeout~~
New Language is indicated by **bold double underscore**.)

Introduction

Many ~~F~~**f**amily physician~~s~~ **practices include non-physician providers (NPPs) such as** ~~have utilized certified nurse midwives, nurse practitioners, and~~ physician assistants**, nurse practitioners and less commonly nurse midwives.** ~~in extending the availability of health care more than any other medical specialty. Approximately thirty percent of family physicians report utilizing at least one of these non-physician providers (NPPs) in their practices.~~ Moreover, family physicians have been at the forefront of innovation in **practicing with** ~~the utilization of~~ NPPs, especially in underserved communities. The Academy has supported a wide variety of efforts by policy makers to improve access to health care services in underserved communities including the innovative utilization of NPPs.

The increasing variety of situations in which NPPs **practice, the emphasis on practice teams,** ~~are utilized~~ and the growing tendency of health policy makers to identify NPPs as a means of improving the availability of health care services raises important issues regarding the appropriate relationship between NPPs and ~~their supervising~~ physicians. Current Academy policy on NPPs stipulates that these providers **should** always function under the "direction and responsible supervision**"** of a practicing, licensed physician **though in many states nurse practitioners have independent practice authority. Academy policy on "Integrated Practice Arrangements" supports practice teams including NPPs.** The Academy, however, believes that practicing physicians**, NPPs** and health policy makers will benefit from a more detailed set of **supervision** guidelines ~~on the supervision of NPPs~~.

These guidelines are intended to serve as a set of general principles with which physicians**, NPPs** and policy makers can assess the role of NPPs in **providing patients a team-based medical home and in** improving access to health care services.

It is important to note that an extremely varied set of laws and regulations defining the legal relationship between physicians and NPPs has been adopted by the federal government and all 50 states. **It's also important to note that there are major differences in state scope of practice statutes among nurse practitioners, nurse midwives and physician assistants. While these guidelines will provide general direction, physicians and NPPs are urged to fully comply with all federal, state and local laws and regulations regarding health care delivery.** Health **insurance** plans and physician practices which **include** non-physician providers should provide information to members/patients regarding the possibility of being seen by a non-physician provider. Such information should be stated in clear terms in plan/practice advertisements and communications, the information should be made known to the patient at the time their appointment is made, and should be clearly stated by the non-physician provider at the time the patient is seen.

Physician Responsibility

The central principle underlying physician supervision of NPPs is that the physician retains ultimate responsibility of the patient care rendered **when so required by state law. In these cases, p**~~P~~hysician supervision means that the NPP only performs medical acts and procedures that have been specifically authorized ~~and directed~~ by the supervising physician.

Generally speaking, i~~I~~t is useful to conceptualize state NPP **supervision** laws as providing physicians with the authority to delegate the performance of certain medical acts to NPPs who meet specified criteria and who function under certain **legal** requirements for supervision. ~~The supervising physician bears both the authority and the responsibility for the delegated acts.~~ Accordingly, the tasks delegated to the NPP should be within the scope of practice of the supervising physician. The physician remains responsible for assuring that all delegated activities are within the scope of the NPP's training and experience. The physician must afford supervision adequate to ensure that the NPP provides care in accordance with accepted medical standards. ~~It is the Academy's position that those services that are delegated to and provided by NPPs are traditional physician services that must be provided with equal quality. To provide services that are substandard quality would establish a second-class system of health care.~~

Supervision ~~Defined~~

~~Supervision means to coordinate, direct, and inspect on an ongoing basis the accomplishments of another, or to oversee, with the power to direct, the implementation of one's own or another's intentions. The supervising physician must have the opportunity and the ability to exercise oversight, control, and direction of the services of a NPP. Accordingly, i~~**I**t is the responsibility of the supervising physician to direct and review the work, records, and practice of the NPP on a continuous basis to ensure that appropriate directions are given and understood and that appropriate treatment is rendered **consistent with applicable state law.** Supervision includes, but is not limited to: (1) the continuous availability of direct communication either in person or by electronic communications between the NPP and supervising physician; ~~(2) the active overview of NPP activities including direct observation of the NPP's ability to take a history and perform a physical examination; (3)~~ **(2)** the personal review of the NPP's practice at regular intervals including an assessment of referrals made or consultations requested by the NPP with other health

professionals; ~~(4)~~ **(3)** regular chart review; ~~(5)~~ **(4)** the delineation of a plan for emergencies; ~~and~~ ~~(6)~~ **(5)** the designation of an alternate physician in the absence of the supervisor~~.~~ **and (6) review plan for narcotic/controlled substance prescribing and formulary compliance.** The circumstance of each practice determines the exact means by which responsible supervision is accomplished.

Direction

It is the responsibility of the physician to ensure that appropriate directions are given, understood, and executed. ~~The physician must provide direction to NPPs in order to specify what medical services should be provided for all types of cases that the NPP is expected to see.~~ These directions may take the form of written protocols, in person, over the phone, or by some other means of electronic communication.

Protocols developed by the supervising physician and NPP should include guidelines describing and delineating NPP functions and responsibilities. ~~From these guidelines, the NPP may provide medical care as an extension of the supervising physician.~~ Protocols should be as specific in their guidance as the physician and NPP require for their particular practice. Many states require that the physician and NPP develop detailed written protocols, and, in some instances, these protocols must be submitted to and approved by the state medical board. As a practical matter, it is not possible to cover all clinical situations in written protocols. Nonetheless, there must be a clear understanding between the physician and NPP regarding the actions that may be undertaken by the NPP in all commonly encountered clinical situations and, especially, under what circumstances physician consultation is to be immediately obtained. The~~ development of adequate protocols, whether written or oral, requires an initial period during which the NPP works under the close supervision of the physician. The degree of supervision should lessen only when the physician can ensure that the NPP will provide care in accordance with directions and accepted medical standards. Furthermore, the~~ physician and NPP must regularly review protocols to ensure their currency in regard to the physician's scope of practice, the range of tasks that have been delegated by the physician and the evolving standards of medical practice. Immediate physician consultation will be indicated for specified clinical situations and in situations falling outside those specified in written and oral protocols. ~~The goal is to err on the side of the NPP seeking physician involvement more often than proves to be necessary.~~

Review

~~Supervision is intended to ensure that directions are implemented properly.~~ The supervising physician must develop and carry out a plan to ensure NPP quality of care. This plan must be in compliance with all applicable laws and regulations. ~~Generally, state laws limit the number of NPPs that a physician may supervise. The plan for supervision should consider: (1) the training and experience of both the supervising physician and NPP; (2) the duties the NPP will or will not perform without first receiving the physician's guidance and permission; (3) the duties of the NPP is not expected to perform except in emergency; (4) communication arrangements in various situations or practice settings; and (5) the availability of back-up supervisors.~~ The supervising physician must regularly review the quality of medical services rendered by the NPP by reviewing medical records to ensure compliance with directions and standard of care~~, and to protect patient welfare~~. The minimum frequency with which such review takes place is, in some instances, specified in federal and state law. In establishing the frequency and extent of record review, the physician may consider the scope of duties that have been delegated to the experience of, and the patient load of the NPP.

~~An NPP should not provide health care services during periods of time when the supervising physician is unavailable unless an alternate supervisor has been designated. Explicit alternate supervising physician requirements are usually set forth in state law.~~

~~Remote~~ Off-site Supervision

In principle, supervision should recognize the diversity of practice settings in which NPPs **practice.** ~~are utilized.~~ As a practical matter, the efficient utilization of a NPP~~,~~ **will at times involve** ~~especially in rural areas, will from time-to-time result in~~ off-site physician supervision. Generally, **off-site supervision** of a NPP involves a physician-NPP team that has **previously** established a working relationship. ~~It is generally presumed that the supervising physician will routinely be present at the location where the NPP practices. However, few states require the supervising physician to be physically present at all times when a NPP is providing care or the supervising physician to be specifically consulted before a delegated task is performed. Several states make explicit provision for NPP practice at sites remote from the supervising physician's primary office, and the federal Medicare statute provides for remote NPP practice in rural health clinics. Where on-site supervision is not provided, the burden is on the physician and the NPP to establish that lack of on-site supervision is reasonable under the circumstances. Some states require explicit approval to utilize a NPP in a remote site. If the NPP is providing services at a remote site, the physician and NPP must ensure that distance does not become an impediment to the regular and adequate review of the NPP's work. No decrement in oversight or quality should result from remote supervision. Generally, the utilization of a NPP at a remote site involves a physician-NPP team that has had sufficient opportunity to establish a close working relationship before the NPP is deployed to the remote site.~~ The supervising physician, **or a designated alternate physician of the same specialty** must be available in person or by electronic communication at all times when the NPP is caring for patients. There should be established clear transportation and

backup procedures for the immediate care of patients needing emergency care and care beyond NPP's scope of practice. As with on-site supervision, the appropriate degree of ~~on-site~~ **off-site** ~~remote~~ supervision includes an overview of NPP's activities **including** a ~~to determine that directions are being followed; immediate availability for necessary consultations; personal and~~ regular review of patient records; and periodic discussion of conditions, protocols, procedures, and patients.

Vice Speaker Mabry assumed the chair and called for the next item on the agenda, the report of the Reference Committee on Organization and Finance. Dr. Alma Littles of Tallahassee, Florida, committee chair, began reading of the reference committee report as follows:

REFERENCE COMMITTEE ON ORGANIZATION AND FINANCE

The Reference Committee on Organization and Finance has considered each of the item referred to it and submits the following report. The committee's recommendations on each item will be submitted as a consent calendar and vote on in one vote. An item or items may be extracted for debate.

Vice Speaker Mabry called for any items to be extracted from the reference committee report.

Delegate Dennis Saver of Vero Beach, Florida moved to extract Item No. 7 – Adopt Substitute Resolution No. 211 in lieu of Resolution No. 211 on "American Academy of Family Physicians (AAFP) Commissions." See Congress debate and action on Pages 348-350.

Delegate Richard Corson of Hillsborough, New Jersey moved to extract Item No. 8, Proposed Amendment No. 4 – Adopted Proposed Amendment No. 4 of the Report of the Bylaws Workgroup, "To Allow AAFP Fellows to Accept their Certificate of Degree of Fellow at Either the AAFP Annual Meeting or a Subsequent Annual Chapter Meeting." See Congress debate and action on Pages 351-353.

Delegate Karen Mitchell of Southfield, Michigan moved to extract Item No. 9 – Adopt first resolved clause of Resolution No. 204 on "Continuation of the National Conference of Special Constituencies." See Congress debate and action on Pages 353-355.

Delegate Jeffrey Weinfeld of Silver Spring, Maryland moved to extract Item No. 10 – Adopt Substitute Resolution No. 210 in lieu of Resolution No. 210 on "Constituent Chapter Support." See Congress debate and action on Pages 355-356.

Vice Speaker Mabry declared Resolution Nos. 204 (first resolved), 210, 211 and Proposed Amendment No. 4 extracted and placed on the table for consideration.

Seeing no further extractions, Vice Speaker Mabry then called for the vote on the rest of the report as recommended by the reference committee on the consent calendar below:

The Reference Committee on Organization and Finance recommends the following consent calendar for adoption:

Item 1 – File for reference Address of the Speaker.

Item 2 – File for reference Address of the President.

Item 3 – File for reference Address of the President-elect, ALL.

Item 4 – File for reference Report of Chair of the Board, ALL, Except Paras. 7, 38, 44 and 65.

Item 5 – File for reference Report of Executive Vice-President, ALL.

Item 6 – Refer to the Board of Directors Resolution No. 207 on "Retail Health Clinics".

Item 9 – Refer to the Board of Directors the second resolved clause of Resolution No. 204 on "Continuation of the National Conference of Special Constituencies".

Item 11 – Adopt Substitute Resolution No. 202 in lieu of Resolution Nos. 201, 202 and 203 on "Repeal the Sunset Clause for Special Constituencies Delegate Seats".

Item 12 – Refer to the Board of Directors Resolution No. 205 on "Dues Check Off for Family Medicine PAC and State Chapter PACs".

File for reference Board Report N on "National and State PAC Dues Check Off."

Item 13 – Adopt Substitute Resolution No. 206 in lieu of Resolution No. 206 on "Support of U.S. Military Reduction of Dues and Waive of Continuing Medical Education (CME) Requirements".

Item 14 – Adopt Substitute Resolution No. 209 in lieu of Resolution Nos. 208, 209 and 212 on "Ban Sale of Tobacco Products and/or By-Products".

Miscellaneous Calendar (Adopted)

(A) Board Report M, ALL, Strategic Plan.
(B) Address of the President-elect, Para. 5.
(C) Board Report B, ONLY paras. 3, 4, 5, 6, 7, 8, and 9, "Policy Statement Review".
(D) Commission on Membership and Member Services, ONLY para. 31, "Policy on Medically Underserved".

Information Items for Filing:

- Commission on Finance and Insurance, ALL.
- Audit Report, ALL.
- Board Report B, ALL except 3, 4, 5, 6, 7, 8, and 9, "Policy Statement Review".
- Board Report F, AAFP Revenue from Pharmaceutical Companies, ALL.
- Commission on Membership and Member Services, ALL except para. 31, "Policy on Medically Underserved".
- Board Report J, Working Group on Rural Health, ALL.
- Board Report L, Using Our Pool of Experience, ALL.
- Board Report H, Organizational Restructuring, ALL.
- AAFP AMA Delegation Report, ALL.

The motion carried and the consent calendar of the Reference Committee on Organization and Finance was adopted as recommended above with the exception of the four extracted items. The detailed report follows with appropriate Congress action noted:

ITEM 1 – ADDRESS OF THE SPEAKER, ALL,

The Reference Committee on Organization and Finance has considered each of the items referred to it and submits the following report. The committee's recommendations on each item will be submitted as a consent calendar and voted on in one vote. Any item or items may be extracted for debate.

The reference committee commends Dr. Weida for his outstanding leadership and commitment as Speaker of the Congress of Delegates.

RECOMMENDATION: *The reference committee recommends that the Address of the Speaker be filed for reference.*

The motion carried and the Address of the Speaker was filed for reference.

ITEM 2 – ADDRESS OF THE PRESIDENT, ALL,

The reference committee wishes to thank Dr. King for his numerous contributions made to the AAFP and its members during his year as President and looks forward to his continued leadership as Board Chair.

RECOMMENDATION: *The reference committee recommends that the Address of the President be filed for reference.*

The motion carried and the Address of the President was filed for reference.

ITEM 3 – ADDRESS OF THE PRESIDENT-ELECT, ALL, Except Paras. 5 and 7

The reference committee commends Dr. Epperly for his dedication and looks forward to a productive year under his leadership as president.

RECOMMENDATION: *The reference committee recommends that the Address of the President-elect, except paras. 5 and 7, be filed for reference.*

The motion carried and the Address of the President-elect was filed for reference.

ITEM 4 – ADDRESS OF THE CHAIR OF THE BOARD, ALL

The reference committee wishes to thank Dr. Kellerman for his devotion to the Academy and the specialty of family medicine, culminating in his years of service as an Officer of the Board of Directors.
RECOMMENDATION: *The reference committee recommends that the Address of the Chair of the Board be filed for reference.*

The motion carried and the Chair of the Board was filed for reference.

ITEM 5 – ADDRESS OF THE EXECUTIVE VICE PRESIDENT, ALL

The reference committee wishes to extend its appreciation and gratitude to Dr. Henley for his leadership, vision, and dedication to ensuring a progressive future for the organization.

RECOMMENDATION: *The reference committee recommends the Address of the Executive Vice President be filed for reference.*

The motion carried and the Address of the Executive Vice President was filed for reference.

ITEM 6 – RETAIL HEALTH CLINICS

Resolution No. 207 from the North Carolina Chapter entitled, "Retail Health Clinics," the resolved portion of which reads as printed below:

RESOLVED, That the American Academy of Family Physicians (AAFP) adopt a policy that retail health clinics meet the following minimum guidelines:

1. Any midlevel provider, whether Nurse Practitioner or Physician Assistant, should be physically located in the same state as the primary practice location of the supervising physician with which they have a collaborative practice agreement;
2. The maximum number of clinical sites (as defined by a specified address or facility location) that would be supervised by a physician should be four; however, academic institutions, prisons and psychiatric institutions and sites in counties defined as medically underserved (HPSA – Health Professional Shortage Areas) would be exempt from these recommended limitations;
3. Facilities should have adequate hand washing opportunities and facilities available within each retail clinic as having a hand washing facility available in the retail store but not within the clinic is considered insufficient;
4. Retail health clinics should adhere to the Health Insurance Portability and Accountability Act (HIPAA), Occupational Safety and Health Administration (OSHA), and other local, state and federal regulations required of outpatient medical offices;
5. The scope of clinical services should be clearly defined and made available widely to the public to ensure that patients do not delay definitive care for certain conditions due to falsely believing they can obtain that service at the retail health clinic, and it should be considered illegal to misrepresent scope of practice in advertising;
6. Clinical services in retail health clinics should be evidence-based with treatment plans that are quality improvement oriented;
7. Supervisory relationships should be with physicians that are readily available for consultation or referral, and whose scope of practice and training is consistent with the patient base served by the retail health clinic;
8. To maintain continuity of comprehensive care, all patients seen at a retail health clinic should be referred back to their current primary care physician. If no primary care relationship exists for a patient seen at a retail health

clinic, then referral should be made to a primary care physician in the local community for follow-up, including private practices, public health clinics or other primary care offices;

9. The name, title, practice address, and phone number of the supervising physician should be posted in a clearly visible location at retail health clinics. That physician should also be available by phone during the hours that the retail health clinic is open for any questions that patients may have that cannot be answered by the mid-level provider at that location. This posting will also indicate all mid-levels that are currently being supervised by the physician along with their practice locations;
10. Efficient and timely referral systems should be in place to refer patients to a physician when the patients' symptoms or condition exceed the scope of practice of the retail health clinic. A discharge summary containing a standard SOAP (Subjective, Objective, Assessment and Plan) Note, and all diagnoses and treatment plans should be forwarded immediately to the patients' primary care physician;
11. Clearly visible notification should be made to patients seen at retail health clinics that they do not have to get prescriptions at the retail pharmacy where care is delivered. This notice should specifically include addresses and phone numbers of other nearby pharmacies where medications might be obtained at a lower price.

Testimony to the reference committee noted that this is a complex issue with many implications at the state level for practicing family physicians. While this resolution imposes many restrictions, the reference committee agrees with the intent of the resolution and the need for on-going review of the Academy's Desired Attributes of Retail Health Clinics. It was also noted during testimony, and the reference committee concurs, that the Academy should encourage retail health clinics to make the specialty of the supervising physician public and the same as the mid-level providers in states where these providers do not have independent practice authority.

RECOMMENDATION: *The reference committee recommends that Resolution No. 207 be referred to the Board of Directors.*

The motion carried and Resolution No. 207 was referred to the Board of Directors.

Vice Speaker Mabry called for Dr. Littles to read the first item extracted from the consent calendar.

ITEM 7- COMMISSION STRUCTURE

Resolution No. 211 from the New Jersey Chapter entitled, "American Academy of Family Physicians (AAFP) Commissions," the resolved portions of which read as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) express its concern to our elected and staff leadership with regard to the potential damage to AAFP culture, effectiveness, and relevance to the membership of the AAFP that the most recent round of governance changes are likely to cause, and be it further
>
> RESOLVED, That the American Academy of Family Physicians (AAFP) direct our elected and staff leadership to restore the number of commissions to the levels that existed prior to the May 2008 reductions, and be it further
>
> RESOLVED, That the American Academy of Family Physicians (AAFP), in recognition of the reduction in efficiencies that will most certainly be the result of the reduction of face-to-face commission meetings, direct our elected and staff leadership to restore the number of cluster meetings to the levels that existed prior to the May 2008 reductions, and be it further

RESOLVED, That future reductions in the Academy's Governance Structure be presented to the Congress prior to implementation. The reference committee heard mixed testimony regarding this proposed resolution. While the changes made by the Board of Directors were necessary in order to achieve a balanced operational budget, there is concern that the changes made in reference to the governance structure of the organization may have made it exceedingly difficult to accomplish the work of the Commissions. In addition, testimony reflected the decreasing opportunities for networking and leadership development. Concerns were also expressed about the timing of a single Cluster. Specifically, the timing of a January Cluster presents challenges for new appointees in terms of travel arrangements. However, other members testified as to the importance of the work of the Board over the past year and asked the reference committee not to micromanage the Board and allow for the Commissions to embrace the new structure and investigate other ways to accomplish their work.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 211 be adopted in lieu of Resolution No. 211:*

RESOLVED, That the Congress of Delegates express its concern to our elected and staff leadership regarding the potential damage to the American Academy of Family Physicians' (AAFLP) culture, effectiveness, and relevance to the membership as a result of the most recent round of governance changes, and be it further

RESOLVED, That the American Academy of Family Physicians Board of Directors consider optimal timing of the one-face-to-face Cluster meeting and solicit recommendations from Commissions if the work of the Commissions warrant additional face-to-face meetings that may be held in conjunction with other Academy meetings in a fiscally responsible manner.

Discussion ensued on the first extracted item from the consent calendar.

Delegate Dennis Saver of Vero Beach, Florida moved to propose an amendment by substitute for Resolution No. 211 as follows:

RESOLVED, That the Congress of Delegates commends the Board of the American Academy of Family Physicians for its stewardship of the AAFP's budget and finance and the accomplishment of the difficult process of achieving a balanced operational budget, and be it further

RESOLVED, That the Congress of Delegates respectfully advises the Board of the AAFP that it wishes to maintain the schedule of two face-to-face meetings each year of AAFP Commissions, and considers that this is a priority which requires adequate budget funding. The Congress understands that this re-alignment of priorities will require a restructure of the budget and reduction of other activities; and, be it further

RESOLVED, That the Board study mechanisms by which the Congress of Delegates can, in the future, advise the Board of its priorities for ordering competing funding projects, and report this to the 2009 Congress of Delegates; and, be it further

RESOLVED, That the American Academy of Family Physicians Board of Directors consider optimal timing of the face-to-face Cluster meeting(s) and solicit recommendations from Commissions if the work of the Commissions allow reduction, or warrant additional face-to-face meetings (that may be held in conjunction with other Academy meetings in a fiscally responsible manner).

The motion was seconded.

Delegate Saver stated that discussion in the reference committee was accurate and illuminating. He stated that he believes that it is the responsibility of the Congress to review the acts of the Board which are undertaken on our behalf when we do not meet and to accept them or to request that they be revised. He further stated that this proposed substitute seeks to revise and reinstitute two meetings of the commissions for the many reasons described. It recognizes that this will not be simple and will require additional work, and it proposes a mechanism which in the future will hopefully provide better communication between the Congress and the Board should such activities be required.

Delegate Lloyd Van Winkle of Castroville, Texas stated that this substitute speaks to his desire to have two face-to-face meetings of the commission of which he is a member. He further stated that he trusts that the opinion of all four Presidential candidates who endorsed the fiscal

conservative positions of our Board and his understanding of how it is to run his home, his practice and other's homes and practices, makes it obvious that during times of a fiscal constraint, sometimes we have to do what is unpleasant and sometimes we have to do some things that we hope to be able to reverse. For that reason, Delegate Van Winkle spoke against the substitute resolution.

Delegate Douglas Parks of Cheyenne, Wyoming spoke in favor of the substitute. He stated that he felt in his time on committees that the face-to-face time was very valuable. He doesn't think that the same work could have been done by teleconference. He further stated that he understood the expense that it has go to be very expensive to set up the cluster meetings. However, he wondered if there might not be some way to find cheaper places to meet, cheaper ways to meet or even the possibility of trying to find out who's interested in belonging to commissions and committees by allowing them to take responsibility for their own expenses to be in attendance. However, he believes that the face-to-face time is very valuable.

Delegate Hugh Taylor of South Hamilton, Massachusetts stated his support for the amendment by substitute. He commends Delegate Saver of Florida for crafting a resolution which he believes walks a fine line. It respects the work of the Board and yet it reflects the feeling, certainly his feeling that trying to reduce the commissions to once a year won't work. Delegate Taylor further stated that he believes the idea that the commissions can accomplish the same thing by telephone conferences is simply going to prove unworkable.

Delegate William Weare of Santa Rita, Guam proposed to remove the second resolved clause of Substitute Resolution No. 211 which reads "RESOLVED, That the Congress of Delegates respectfully advises the Board of the AAFP that it wishes to maintain the schedule of two face-to-face meetings each year of AAFP Commissions, and considers that this is a priority which requires adequate budget funding. The Congress understands that this re-alignment of priorities will require a restructure of the budget and reduction of other activities" to be voted on separately from the rest of the resolved clauses.

Vice Speaker Mabry called for a vote to divide the question and to vote on the second resolved clause separately from the first, third and fourth resolved clauses. The motion passed and the second resolved clause will be voted on separately from the first, third and fourth resolved clauses.

Vice Speaker Mabry called for a vote on the second resolved clause of Substitute Resolution No. 211 which reads as follows:

> *RESOLVED, That the Congress of Delegates respectfully advises the Board of the AAFP that it wishes to maintain the schedule of two face-to-face meetings each year of AAFP Commissions, and considers that this is a priority which requires adequate budget funding. The Congress understands that this re-alignment of priorities will require a restructure of the budget and reduction of other activities; and, be it further (Not Adopted)*

The motion failed and the second resolved clause of Substitute Resolution No. 211 was not adopted.

Vice Speaker Mabry called for further debate on the first, third and fourth resolved clauses of Substitute Resolution No. 211 as follows:

RESOLVED, That the Congress of Delegates commends the Board of the American Academy of Family Physicians for its stewardship of the AAFP's budget and finance and the accomplishment of the difficult process of achieving a balanced operational budget, and be it further

RESOLVED, That the Board study mechanisms by which the Congress of Delegates can, in the future, advise the Board of its priorities for ordering competing funding projects, and report this to the 2009 Congress of Delegates; and, be it further

RESOLVED, That the American Academy of Family Physicians Board of Directors consider optimal timing of the face-to-face Cluster meeting(s) and solicit recommendations from Commissions if the work of the Commissions allow reduction, or warrant additional face-to-face meetings (that may be held in conjunction with other Academy meetings in a fiscally responsible manner).

Seeing no further debate, Vice Speaker Mabry called for a vote on the substituted first, third and fourth resolved clauses of Substitute Resolution No. 211.

The motion passed and the substituted first, third and fourth resolved clauses were adopted as amended.

Vice Speaker Mabry called for further debate on the substitute resolved clauses as amended.

Seeing no further debate, Vice Speaker Mabry called for a vote on the substitute resolved clauses as amended.

The motion passed and first, third and fourth resolved clauses of Substitute Resolution No. 211 as amended were adopted as follows:

RESOLVED, That the Congress of Delegates commends the Board of the American Academy of Family Physicians for its stewardship of the AAFP's budget and finance and the accomplishment of the difficult process of achieving a balanced operational budget, and be it further

RESOLVED, That the Board study mechanisms by which the Congress of Delegates can, in the future, advise the Board of its priorities for ordering competing funding projects, and report this to the 2009 Congress of Delegates; and, be it further

RESOLVED, That the American Academy of Family Physicians Board of Directors consider optimal timing of the face-to-face Cluster meeting(s) and solicit recommendations from Commissions if the work of the Commissions allow reduction, or warrant additional face-to-face meetings (that may be held in conjunction with other Academy meetings in a fiscally responsible manner).

Dr. Littles continued the report and read the second item extracted (Proposed Amendment No. 4) from the consent calendar.

ITEM 8 – PROPOSED BYLAWS AMENDMENTS

Report of Bylaws Workgroup, ALL, (pp. 751-756), Proposed Amendment No. 1

There was no testimony regarding Proposed Amendment No. 1. Your reference committee is supportive of this proposed amendment, as it will allow for appropriate notification to members of unpaid dues while also reducing mailing costs.

RECOMMENDATION: *The reference committee recommends that Proposed Amendment No. 1, to amend the Bylaws to eliminate the use of certified mail as a way to notify members of unpaid dues, be adopted.*

The motion carried and Proposed Amendment No. 1 was adopted.

Report of Bylaws Workgroup, ALL, (pp. 751-756), Proposed Amendment No. 2

No testimony was offered regarding Proposed Amendment No. 2. This proposed amendment would extend eligibility to a growing category of family physicians, without compromising the integrity of the current criteria. The reference committee supports this direction.

RECOMMENDATION: *The reference committee recommends that Proposed Amendment No. 2, to amend the Bylaws to Expand Criteria for AAFP Active Membership to include Family Physicians who are Board-Certified by the American Board of Family Medicine (ABFM) through Reciprocity Agreements between the ABFM and Foreign Colleges of Family Medicine or General Practice, be adopted.*

The motion carried and Proposed Amendment No. 2 was adopted.

Report of Bylaws Workgroup, ALL, (pp. 751-756), Proposed Amendment Nos. 3A and 3B.

Proposed Amendment Nos. 3A and 3B each would increase the maximum amount of dues to be paid by active members; however, Proposed Amendment No. 3A would establish an ongoing automatic adjustment to the ceiling based on inflation in order to minimize the need to further amend the Bylaws. Little testimony was offered on either approach, although sentiment was expressed that a "fixed" ceiling (Proposed Amendment No. 3B) would provide an appropriate check and balance between dues increases authorized by the Board of Directors and broader oversight by the Congress of Delegates. Discussion within the reference committee did not strongly favor one approach over the other, although the historic practice of a fixed ceiling has not been burdensome to the Board's ability to increase dues as appropriate.

RECOMMENDATION: *The reference committee recommends that Proposed Amendment No. 3B, to amend the Bylaws to Increase the Ceiling on Membership Dues to $450.00 (From $350.00) effective January 1, 2009, be adopted.*

The motion carried and Proposed Amendment No. 3B was adopted.

RECOMMENDATION: *The reference committee recommends that Proposed Amendment No. 3A, to amend the Bylaws to Increase the Ceiling on Membership Dues to $450.00 (From $350.00) effective January 1, 2009 (with inflationary adjustment on an ongoing basis), not be adopted.*

The motion carried and Proposed Amendment No. 3A was not adopted.

Report of Bylaws Workgroup, ALL, (pp. 751-756), Proposed Amendment No. 4. -

No testimony was offered regarding Proposed Amendment No. 4. The reference committee is supportive of this proposed amendment, as it may lead to increased visibility and interest for the degree of fellow.

RECOMMENDATION: *The reference committee recommends that Proposed Amendment No. 4, to amend the Bylaws to allow AAFP Fellows to accept their Certificate for the Degree of Fellow at either the AAFP Annual Meeting or a Subsequent Annual Chapter Meeting, be adopted.*

Debate ensued on the second extracted item.

Delegate Richard Corson of Hillsborough, New Jersey moved that Proposed Amendment No. 4 be referred to the Board of Directors.

The motion was seconded.

Delegate Corson stated that attendance at the Annual Scientific Assembly, people come for many reasons and one of them is to receive the Degree of Fellow. If we were to carve out a number of people and remove one of the reasons people might attend, he believes there could be some significant financial impact. Since there was no discussion of this in the reference committee, he believed that referral to the Board for study and analysis of the financial impact would be appropriate before this Congress adopts the proposed amendment.

Delegate Reid Blackwelder of Kingsport, Tennessee spoke in support of the motion to refer to the Board of Directors. He stated that he was Chair of the Commission on Continuing Professional Development and he greatly respects the reference committee's work on discussing aspects of fellowship, which is a real benefit. It obviously affects members as well as chapters and travel to the Scientific Assembly is an important issue. He further stated that we are faced with declining numbers already and he stated his worries that without further discussion, this may create some challenges for what is seen as our flagship CME process.

He further stated that it does affect non-dues revenue, so this is an important decision that probably warrants further discussion at the Board level to ensure that we look at both sides of this and make an informed decision as to which member benefit we are going to support, the Fellowship versus the advantage of the Scientific Assembly.

Delegate John Carroll of Carroll, Iowa stated that he currently sits on the Commission on Membership and Member Services Awards Subcommittee and spoke in opposition to the motion to refer to the Board the proposed amendment. He stated that this subcommittee spent a lot of time looking at demographics, for example, who's going out and getting their fellowship and the declining number of people obtaining that Fellowship and some of the research into why they are not getting that Fellowship. The subcommittee has looked at Fellowship on a regular basis and really spent a lot of time researching and discussing the fellowship and how can we make this attainable. There are a lot of great point systems set up to get the Degree of Fellow but there are geographic reasons for not getting to the meeting, not getting the honor. He further stated that most family doctors don't pat themselves on the back; they think they are a good doctor and don't know that they are a great doctor. This is one of the few opportunities to turn around and pat yourself on the back and say "Look, my colleagues recognize that I've met standards. I am in support of this fine Academy. I am a Fellow of this Academy." He continued by stating then something comes up and they can't make it to that meeting; they've got to wait until the next year they can attend a meeting. They can obtain the certificate via mail but the can't really get the honor. We want to support our state chapters in getting people to the annual state chapter meeting. If they could not get to the national Scientific Assembly, they can get to their state meeting and be honored by their colleagues within their state chapter at that time. We want to encourage that even if they made it t the national Scientific Assembly meeting; we want to encourage state chapters to take time during their meeting to recognize the new Fellows. He further continued by stating that it seemed like the requirement to attend the Scientific Assembly was a road block to congratulating and encouraging our Fellows.

Board Chair Rick Kellerman of Wichita, Kansas spoke for the Board. He stated that the Board would accept a referral back to the Board on this for further study. He stated that he believed the Congress has heard arguments but the Board would appreciate a referral so that it can fully be studied with all of its implications.

Delegate Susan Kinast-Porter of Monroe, Wisconsin asked if a Fellow can be conferred by mail or do they have to attend in person? Vice Speaker Mabry responded that Fellows have to attend the Scientific Assembly to be conferred. She raised a concern about people from Guam or the Virgin Islands being required to attend the annual meeting. She stated that she thought that it could be a bigger hardship for some than others.

Delegate Karen Mitchell of Southfield, Michigan spoke as the Chair of the Bylaws Workgroup for 2008 and spoke against the motion to refer. She stated she wanted to give the perspective of the workgroup which was to adopt Proposed Amendment No. 4. She stated that the Bylaws Workgroup saw the balance between having the Fellowship and really wanting to promote the Fellowship within the AAFP. That balance won over trying to get it to be delivered only at the AAFP Scientific Assembly and that the Fellowship is something worth promoting and therefore having more options for members to be able to receive it including possibly both at a local chapter meeting as well as the AAFP Scientific Assembly.

Seeing no further debate, Vice Speaker Mabry called for a vote on referral of Proposed Amendment No. 4 to the Board of Directors.

The motion passed and Proposed Amendment No. 4 was referred to the Board of Directors.

Dr. Littles continued the report and read the third item extracted from the consent calendar.

ITEM 9 – NCSC

Resolution No. 204 from the Michigan Chapter entitled, "Continuation of the National Conference of Special Constituencies (NCSC)," the resolved portions of which read as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) continue the National Conference of Special Constituencies (NCSC) as a national meeting of the AAFP, and be it further
>
> RESOLVED, That the American Academy of Family Physicians (AAFP) continue to financially support the National Conference of Special Constituencies (NCSC) at a level to ensure adequate participation, specifically, by continuing to provide resources for travel reimbursement for the NCSC delegates.

Testimony was unanimous in support of the importance of the National Conference of Special Constituencies, as well as its benefit to members and the organization itself. Many members who have been active in special constituency activities testified and provided abundant examples of how participation carries forward to ongoing national and chapter involvement, in addition to professional development in general.

Testimony also reflected sensitivity to budgetary concerns and the need to balance NCSC travel funding as a part of organizational resource allocation. Numerous creative ideas were offered in terms of funding alternatives. Suggestions included limiting expense reimbursement to first- or second-time attendees; development of an AAFP grant program; seeking outside foundation grant support; increased expectation of partial chapter support; and restricting support to representatives of chapters with limited financial resources.

The reference committee was extremely impressed with the passion, success stories, thoughtfulness and pragmatism of all who provided testimony. The reference committee trusts that officers and members of the Board of Directors heard the strong testimony on this subject during the reference committee hearing. The reference committee does not believe it would be appropriate for the Congress to mandate the reinstatement of AAFP-funded travel costs at this time. However, in the event

funding is not reinstated for the 2009 NCSC, the consequences of this action should be more fully evaluated and considered, especially once the 2009 NCSC has occurred.

RECOMMENDATION: *The reference committee recommends that the first Resolved clause of Resolution 204 be adopted.*

RECOMMENDATION: *The reference committee recommends that the second Resolved clause of Resolution 204 be referred to the Board of Directors, and that the Board provide a report to the 2009 Congress of Delegates on member participation at the 2009 National Conference of Special Constituencies.*

Debate ensued on the third extracted item.

Delegate Karen Mitchell of Southfield, Michigan spoke in favor of the second recommendation to refer the second resolved clause of Resolution No. 204 to the Board of Directors. She moved to amend the first resolved clause of Resolution No. 204 by inserting "and Annual Leadership Forum (ALF)" and "with similar travel funding policies" and deleting "a" so that it reads "RESOLVED, That the American Academy of Family Physicians (AAFP) continue the National Conference of Special Constituencies (NCSC) and the Annual Leadership Forum (ALF) as ~~a~~ national meetings of the AAFP with similar travel funding policies."

The motion was seconded.

Delegate Mitchell stated that the NCSC is very important to the Academy. It is vital to the Academy. As such, she believed it is vital to continue to look for ways to get people to attend the NCSC. To take away the travel cost will be a significant impediment to getting people to attend the NCSC who really need to participate. She continued by stating that while we are sensitive to fiscal responsibility, she stated her belief that there is a number of different issues and a number of different creative ways that travel funds may be found. In addition, we are aware that ALF has funding for chapter executives and a couple of chapter officers. She proposed that both NCSC and ALF continue to have similar travel funding policies and that the AAFP look for further options within the AAFP to find ways to continue this very vital conference to the AAFP.

Delegate Anne Kittendorf, Special Constituency, of Dexter, Michigan spoke in support of the amendment. She stated her appreciation of the intent of the reference committee and its recommendation to refer this to the Board; however, she strongly believes that NCSC should not be singled out and long with that the comments made previously about the ALF conference.

Seeing no further debate, Vice Speaker Mabry called for a vote on the amendment to insert in the first resolved clause of Resolution No. 204 "and Annual Leadership Forum (ALF)" and "with similar travel funding policies" and deleting "a" so that it reads "RESOLVED, That the American Academy of Family Physicians (AAFP) continue the National Conference of Special Constituencies (NCSC) and the Annual Leadership Forum (ALF) as ~~a~~ national meetings of the AAFP with similar travel funding policies."

The motion passed and the first resolved clause of Resolution No. 204 was amended as above.

Seeing no further debate, Vice Speaker Mabry called for a vote on the first resolved clause of Resolution No. 204 as amended below:

RESOLVED, That the American Academy of Family Physicians (AAFP) continue the National Conference of Special Constituencies (NCSC) and the Annual Leadership Forum (ALF) as national meetings of the AAFP with similar travel funding policies.

The motion passed and the first resolved clause of Resolution No. 204 as amended above was adopted.

Vice Speaker Mabry then called for debate on the second resolved clause of Resolution No. 204.

Seeing no debate, Vice Speaker Mabry called for a vote to refer the second resolved clause of Resolution No. 204 to the Board of Directors.

The motion passed and the second resolved clause of Resolution No. 204 was referred to the Board of Directors as printed below:

RESOLVED, That the American Academy of Family Physicians (AAFP) continue to financially support the National Conference of Special Constituencies (NCSC) at a level to ensure adequate participation, specifically, by continuing to provide resources for travel reimbursement for the NCSC delegates.

Dr. Littles continued the report and read the fourth item extracted from the consent calendar.

ITEM 10 – CONSTITUENT CHAPTER SUPPORT

Resolution No. 210 from the Rhode island Chapter entitled, "Constituent Chapter Support," the resolved portion of which reads as printed below:

RESOLVED, That the American Academy of Family Physicians (AAFP) develop a study commission to examine the plight of small constituent chapters and investigate ways in which the AAFP could support the important work of small constituent chapters to improve the environment of care in their representative states.

Testimony was offered by members from chapters of varying sizes about the challenges faced by small chapters. The testimony demonstrated that, while many small chapters are encountering difficulties, the problems vary from chapter to chapter. Testimony was also offered to the effect that the Chapter Affairs Subcommittee of the Commission on Membership and Member Services can offer assistance; however, it would be helpful if small chapters could articulate the specific problems being encountered. The reference committee is sensitive to the needs of small chapters and believes that related issues can be addressed without establishment of a specific commission.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 210 which reads as follows be adopted in lieu of Resolution No. 210:*

RESOLVED, That the AAFP examine the challenges faced by small constituent chapters and continue to ensure the viability and success of small constituent chapters.

Discussion ensued on the fourth extracted item.

Delegate Jeff Weinfeld of Silver Spring, Maryland stated his appreciation of the original resolution from Rhode Island. The DC chapter worked very closely with them. He also stated his appreciation of the work of the reference committee but proposes, in conjunction with Rhode Island, an amendment by addition of "and that the results of this examination be reported to the 2009 Congress of Delegates" so that it reads, "RESOLVED, That the AAFP examine the

challenges faced by small constituent chapters and continue to ensure the viability and success of small constituent chapters and that the results of this examination be reported to the 2009 Congress of Delegates."

The motion was seconded.

Delegate Weinfeld stated his appreciation of the recommendations from the reference committee but believes that this without a specific group would be satisfactory but would ask that the results be reported back to the Congress along with a rationale for this is an ongoing issue. There have been changes in the past to greater support the difficulties that face small chapters but since it is an ongoing issue, it is important to officially hear back on what is found out over the year so that further action could be taken, if needed.

Delegate Margaret Sun of Riverside, Rhode Island stated her acceptance as a friendly addition.

Seeing no further debate, Vice Speaker Mabry called for a vote on the amendment by addition as stated above.

The motion passed and the amendment was adopted.

Vice Speaker Mabry then called for a vote on Substitute Resolution No. 210 as amended.

The motion passed and Substitute Resolution No. 210 as amended was adopted as printed below:

RESOLVED, That the AAFP examine the challenges faced by small constituent chapters and continue to ensure the viability and success of small constituent chapters, and that the result of this examination be reported to the 2009 Congress of Delegates.

ITEM 11 – SPECIAL CONSTITUENCY DELEGATE SEATS

Resolution No. 201 from the Joint Constituency entitled, "Repeal the Sunset Clause for Special Constituencies Delegate Seats," the resolved portion of which reads as printed below:

> RESOLVED, That the six delegate and six alternate delegate seats to the American Academy of Family Physicians' Congress of Delegates held by members from the Women, Minority, International Medical Graduate, and Gay, Lesbian, Bisexual & Transgender Constituencies remain in place under the same rules that currently exist in Chapter XI, Section 2 of the Bylaws with no sunset date.

Resolution No. 202 from the Ohio Chapter entitled, "Repeal the Sunset Clause for Special Constituencies Delegate Seats," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) retain the delegate seats for special constituencies that currently exist under Chapter XI Section 2 of the AAFP Bylaws with the addition of a regular review process.

Resolution No. 203 from the Michigan Chapter entitled, "Repeal the Sunset Clause for Special Constituencies Delegate Seats," the resolved portion of which reads as printed below:

> RESOLVED, That the six delegate and six alternate delegate seats to the American Academy of Family Physicians' Congress of Delegates, held by members from the Women, Minority, International Medical Graduate, and Gay, Lesbian,

Bisexual & Transgender constituencies remain in place under the same rules that currently exist in Chapter XI, Section 2 of the Bylaws with no sunset date.

The reference committee heard overwhelming testimony on the success of the leadership development opportunities provided to those who have served as delegates and alternate delegates. Testimony offered suggested that the AAFP leadership may not be representative of the diversity of the membership for the foreseeable future. To sunset the seats at this time could impact the development of a diverse leadership for the AAFP. It was felt, however, that a review of these seats should be in place to ensure that the appropriate constituencies are represented and to evaluate progress made in achieving diversity in the leadership of the AAFP. An extension of the sunset provision would mirror the AAFP's standard of a five- year review period for policies.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 202 which reads as follows be adopted in lieu of Resolution Nos. 201, 202 and 203:*

RESOLVED, That the American Academy of Family Physicians (AAFP) retain the delegate seats for special constituencies that currently exist under Chapter XI Section 2 of the AAFP Bylaws with a new sunset date of 2015.

The motion pass and Substitute Resolution 202 was adopted.

ITEM 12 – POLITICAL ACTION CAMPAIGN DUES

Resolution No. 205 from the Florida, California and Illinois Chapters entitled, "Dues "Check Off" for Family Medicine PAC and State Chapter PACs," the resolved portion of which reads as printed below:

RESOLVED, That the American Academy of Family Physicians (AAFP) add "dues check off" boxes for the national Political Action Committee (PAC) and legal state chapter Political Action Committees (PACs) to the annual AAFP dues statement.

Board Report N entitled, "National and State PAC Dues Check Off".

Testimony heard by the reference committee recognized the significant cost impact of adding a "check off" for national and state PACs to the annual dues statement. However, there was recognition that Advocacy is the number one strategic priority of the AAFP. Concern was expressed about the lack of contributions to both national and chapter PACs and the need to find an easy mechanism for members to contribute. It was noted that in the 2009 dues billing cycle, members who pay online will be given the opportunity to contribute to FamMedPAC, state PACs, and/or state foundations by clicking on links to those sites. The reference committee felt that it would be important for the Board to explore additional alternatives to increase both national and state PAC contributions.

RECOMMENDATION: *The reference committee recommends that Resolution No. 205 be referred to the Board of Directors.*

The motion passed and Resolution No. 205 was referred to the Board of Directors.

RECOMMENDATION: *The reference committee recommends that Board Report N be filed for reference.*

The motion passed and Board Report N was filed for reference.

ITEM 13 – MILITARY DUES REDUCTION/WAIVER OF CME

Resolution No. 206 from the Georgia Chapter entitled, "Support of U.S. Military Reduction of Dues and Waive Continuing Medical Education (CME) Requirements," the resolved portions of which read as printed below:

RESOLVED, That the American Academy of Family Physicians (AAFP) provide family medicine specialists, serving on active deployment, a reduction in their annual dues, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) waive continuing medical education (CME) requirements for family medicine specialists serving on active deployment, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) communicate to sister specialty academies and colleges for their consideration information about our action to reduce annual dues and waive continuing medical education requirements for family medicine specialists serving on active deployment.

The reference committee heard testimony from the Georgia chapter regarding this resolution. After speaking with a number of members of the Uniformed Services, they learned there currently is an AAFP policy allowing for a dues waiver for members serving in the Reserves and National Guard and who are called to active duty. It was also noted that changes to the CME requirement would require a change to the AAFP Bylaws and policies of the American Board of Family Medicine regarding CME requirements. It was also learned that sufficient CME opportunities exist for those on active duty. Several members expressed their appreciation for those who serve in the Uniform Services. A representative of the US-AFP testified that chapter members appreciated the spirit of the resolution and were proud to serve their country as family physicians in uniform. There was additional testimony regarding the need to educate family physicians on the treatment of those who are returning from active duty military service and their families, as well as speaking resources available through the Uniformed Services AFP to meet that need.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 206 which reads as follows be adopted in lieu of Resolution No. 206:*

> *RESOLVED, That the American Academy of Family Physicians (AAFP) provide deployed military AAFP members information on mechanisms for reduction in the annual AAFP dues should they face extreme financial hardship.*

The motion passed and Substitute Resolution No. 206 was adopted

ITEM 14 – SALE OF TOBACCO PRODUCTS ON PREMISES WITH PROVIDERS OF HEALTH CARE

Resolution No. 208 from the Rhode Island Chapter entitled, "Sale of Tobacco Products on Premises with Providers of Health Care," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) policy statement on retail health clinics be amended to add:
>
> - The AAFP recommends that all retail health clinics be located within premises that do not sell cigarettes and other tobacco products.

Resolution No. 209 from the Kansas Chapter entitled, "Prohibition of the Sale of Tobacco Products in Places that Provide Health Services," the resolved portions of which read as printed below:

> RESOLVED, That the American Academy of Family Physicians develop a policy against the sale of tobacco products in facilities that provide health care services, including pharmacies and retail clinics, and be it further
>
> RESOLVED, That the American Academy of Family Physicians urge Congress to pass laws and regulations prohibiting the sale of tobacco products in facilities that provide any health care services or sell medications.

Resolution No. 212 from the Oklahoma Chapter entitled, "Ban Sale of Tobacco Products and/or By-Products," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) advocate for state and federal legislation to ban the sale of tobacco products and/or tobacco by-products in retail outlets housing store-based health clinics.

The reference committee heard testimony regarding the moral and ethical dilemma posed by facilities that provide health care services and also sell tobacco products and/or tobacco by-products. While the resolutions are laudable in their intent, this is a state based issue that may require consideration on a state by state basis. This is currently not a priority in the AAFP's advocacy agenda and would require redirection of limited resources.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 209 which reads as follows be adopted in lieu of Resolution Nos. 208, 209 and 212:*

> *RESOLVED, That the American Academy of Family Physicians develop a policy against the sale of tobacco products in facilities that provide health care services, including pharmacies and retail clinics, and be it further*
>
> *RESOLVED, That the American Academy of Family Physicians (AAFP) advocate for state and federal legislation to ban the sale of tobacco products and/or tobacco by-products in facilities that provide health care services, including pharmacies and retail outlets housing store-based health clinics.*

The motion passed and Substitute Resolution No. 209 was adopted.

MISCELLANEOUS CALENDAR

The following items A through D, are presented by the reference committee. All of these items call for action which testimony and discussion resulted in support of the recommendation of the reference committee. At the request of the Congress, any item may be taken off for an individual vote on that item. Otherwise, the reference committee will request approval of all items in a single vote.

(A) Board Report M, ALL, Strategic Plan.
(B) Address of the President-elect, Para. 5.
(C) Board Report B, ONLY paras. 3, 4, 5, 6, 7, 8, and 9, "Policy Statement Review".
(D) Commission on Membership and Member Services, ONLY para. 31, "Policy on Medically Underserved".

The motion passed and Items A through D above were adopted.

INFORMATIONAL ITEMS

RECOMMENDATION: *The reference committee recommends that the following informational items be filed for reference.*

- Commission on Finance and Insurance, ALL.
- Audit Report, ALL.
- Board Report B, ALL except 3, 4, 5, 6, 7, 8, and 9, "Policy Statement Review".
- Board Report F, AAFP Revenue from Pharmaceutical Companies, ALL.
- Commission on Membership and Member Services, ALL except para. 31, "Policy on Medically Underserved".
- Board Report J, Working Group on Rural Health, ALL.
- Board Report L, Using Our Pool of Experience, ALL.
- Board Report H, Organizational Restructuring, ALL.
- AAFP AMA Delegation Report, ALL.

The motion passed and the above informational items were filed for reference.

Dr. Littles concluded the reference committee report by expressing appreciation to those who appeared before the reference committee to offer testimony and to the members of the reference committee for the invaluable assistance in the preparation of the report.

Speaker Weida assumed the chair and called for the next item on the agenda, the report of the Reference Committee on Advocacy. Dr. Rebecca Jaffe of Wilmington, Delaware, committee chair, began reading of the reference committee report as follows:

REFERENCE COMMITTEE ON ADVOCACY

The Reference Committee on Advocacy has considered each of the items referred to it and submits the following report. The committee's recommendations on each item will be submitted as a consent calendar and voted on in one vote. An item or items may be extracted for debate.

Speaker Weida called for any items to be extracted from the reference committee report.

Delegate John Carroll of Carroll, Iowa moved to extract Item 2 – Resolution No. 502 entitled "Remove Barriers to Contraceptive Access for California Women" from the consent calendar which is a recommendation to adopt a substitute. See Congress debate and action on Pages 361-362.

Delegate Jack Chou of Baldwin Park, California moved to extract Item 3 – Resolution No. 503 entitled "Repeal the Hyde Amendment" from the consent calendar which is a recommendation to not adopt. See Congress debate and action on Pages 363-364.

Speaker Weida declared Resolution Nos. 502 and 503 extracted and placed on the table for consideration.

Seeing no further extractions, Speaker Weida then called for the vote on the rest of the report as recommended by the reference committee on the consent calendar below:

The Reference Committee on Advocacy recommends the following consent calendar for adoption:

Item 1 – Refer to the Board of Directors Resolution No. 501 on "AAFP Endorsement of Single Payor Health Insurance".

Item 4 – Refer to the Board of Directors Resolution No. 504 entitled "Medical/Legal Partnership: Promoting Health Through Preventive Law".

Item 5 – Adopt Substitute Resolution No. 505 entitled "Sustainability of the Robert Graham Center".

Item 6 – Refer to the Board of Directors Resolution No. 506 on "HIPAA Exclusions" with the recommendation that the Board provide a written report of its findings and recommendations to the 2009 Congress of Delegates.

Item 7 – Refer to the Board of Directors Resolution No. 507 entitled "Immunizations".

Item 8 – Refer to the Board of Directors Resolution No. 508 entitled "Capitation Rates and Data".

Miscellaneous Calendar – Adopt Items A and M

INFORMATIONAL ITEMS

RECOMMENDATION: *The reference committee recommends that the following informational items be filed for reference.*

- Board Report D, ALL, except Para. 9 and Appendix A, regarding Health Care for All – Update 2008".
- Board Report K, ALL, including Appendix A & B regarding FamMedPAC – The AAFP's Federal Political Action Committee.

The motion carried and the consent calendar of the Reference Committee on Advocacy was adopted as recommended above with the exception of the two extracted items. The detailed report follows with appropriate Congress action noted:

ITEM 1 – AAFP ENDORSEMENT OF SINGLE PAYOR HEALTH INSURANCE

Resolution No. 501 from the New York State Chapter entitled, "AAFP Endorsement of Single Payor Health Insurance," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians promote, through its lobbyists and through member contact with national legislators, a national single payer health insurance system.

Testimony on this resolution was received from six members, three speaking against the resolution, and three speaking as individuals expressing concern regarding the AAFP supporting one specific payment system. They also expressed concern that advocating for one specific system would limit the ability of the AAFP to respond to changes within the upcoming political environment especially in light of the impending Presidential election.

The reference committee reviewed the testimony in light of the adoption of Board Report D, Health Care for All. The committee believes it is important to reconcile the differences between Board Report D and the intent of the resolution.

RECOMMENDATION: *The reference committee recommends that Resolution No. 501 be referred to the Board of Directors.*

The motion passed and Resolution No. 501 was referred to the Board of Directors.

Speaker Weida called for Dr. Jaffe to read the first item extracted from the consent calendar.

ITEM 2 – REMOVE BARRIERS TO CONTRACEPTIVE ACCESS FOR CALIFORNIA WOMEN

Resolution No. 502 from the California Chapter entitled, "Remove Barriers to Contraceptive Access for California Women," the resolved portions of which read as printed below:

> RESOLVED, That the American Academy of Family Physicians urge all insurers to provide coverage for the full array of available contraceptive methods, including both devices and insertion of IUD and contraceptive implants, and be it further
>
> RESOLVED, That the American Academy of Family Physicians encourage all insurers, including Medicaid, to cover a minimum 12-month supply of the full array of contraceptives at retail pharmacies in one visit, unless there are medical contraindications to doing so, in which case a patient should receive at least a 90-day supply.

Testimony on this resolution was provided by three members, two in support of both resolved clauses and one in support of only the first resolved but against the second.

Committee members were concerned about patients who are partially insured during a calendar period (seasonal workers) or experience a break in insurance coverage (unemployment) resulting in a disruption of access to contraceptive medications. They noted that the "Whereas" section of the resolution cited a study by the California's Family PACT (Planning, Access, Care and Treatment) Program, which showed that dispensing 12 months of contraceptives at one time increases patient compliance and lowers cost compared to receiving one or three months of contraceptives. The committee focused on the value of making sure that patients had access to at least a year's supply of contraceptive medications to assure their success in avoiding unintended pregnancies.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution 502 be adopted in lieu of Resolution No. 502 which reads as printed below:*

> *RESOLVED, The AAFP supports the provision of insurance coverage for the full array of available contraceptive methods; this includes payment for IUDs and contraceptive implants and their insertion, and be it further*
>
> *RESOLVED, The AAFP encourages all payers, including Medicaid, to allow for a single dispensing of a minimum of a one year supply of contraceptives unless there are medical contraindications to doing so, in which case a patient should receive at least a 90-day supply.*

Discussion ensued on the first extracted item from the consent calendar.

Delegate John Carroll of Carroll, Iowa proposed an amendment by replacement in the second resolved clause after the phrase "in which case" to delete "a patient should receive at least a 90-day supply" and inserting "the decision should be made by the physician using clinical judgment considering a patient's situation and needs" so that it reads: "RESOLVED, The AAFP encourages all payers, including Medicaid, to allow for a single dispensing of a minimum of a one year supply of contraceptives unless there are medical contraindications to doing so, in which case the decision should be made by the physician using clinical judgment considering a patient's situation and need."

The motion was seconded.

Delegate Carroll proposed the amendment believing that it strengthens the intent of the second resolved clause. There were discussions in the State of Iowa that there are different needs that people have and as presently stated, there would only be two choices, a 12-month supply dispensed or a 90-day supply. Some physicians have patients who go away for various times to different parts of the world such as a patient of Delegate Carroll's who was deployed to Iraq for a longer period of time. A 90-day or a 12-month supply would not suffice. There are probably other situations that would require an extended period of time away from home and he believes that the amendment would make the resolution stronger.

Delegate Susan Kinast-Porter of Monroe, Wisconsin stated her support of the amendment and proposed a second order amendment by the deletion of the word "a" and the insertion of the word "yearly" so that the resolved clause reads "RESOLVED, The AAFP encourages all payers, including Medicaid, to allow for **~~a~~ yearly** single dispensing of a minimum of yearly one year supply of contraceptives unless there are medical contraindications to doing so, in which case the decision should be made by the physician, using clinical judgment, considering a patient's situation and need."

The motion was seconded.

Delegate Kinast-Porter stated that she proposed the second order amendment because it is unclear in the first line of the second resolved clause when it states "to allow for a single dispensing of a minimum of one year." She stated that it sounds like one time only that the patient receives one year's worth and she believes the intent is to allow for a yearly single dispensing not just once in a lifetime.

Speaker Weida called for further debate. Seeing no further debate, Speaker Weida for a vote on the second order amendment to delete the word "a" and insert the word "yearly" in the first line of the second resolved clause.

The motion passed and the second order amendment was adopted.

Speaker Weida then called for further debate on the first order amendment to delete the words "a patient should receive at least a 90-day supply" and insert the words "the decision should be made by the physician using clinical judgment, considering a patient's situation and needs." Delegate Adebowale Prest of the Special Constitution delegation spoke against the first order amendment because she believes it's given a little bit too much information. She stated that she believes that as clinicians, we know what is medically appropriate and if we are going to start lobbying with a statement that is going to give loopholes for politicians and lawyers, she believes it is going to get us in some hot water.

Seeing no further debate, Speaker Weida called for a vote on the first order amendment.

The motion passed and the first order amendment was adopted.

See no further debate on the substitute resolution as amended twice, Speaker Weida called for a vote on Substitute Resolution No. 502 as amended twice.

The motion passed and Substitute Resolution No. 502 as amended twice was adopted and reads as follows:

> *RESOLVED, The AAFP encourages all payers, including Medicaid, to allow for yearly single dispensing of a minimum of yearly one year supply of contraceptives unless there are medical contraindications to doing so, in which case the decision should be made by the physician, using clinical judgment, considering a patient's situation and need.*

Dr. Jaffe continued the report and read the second item extracted from the consent calendar.

ITEM 3 – REPEAL THE HYDE AMENDMENT

Resolution No. 503 from the California Chapter entitled, "Repeal The Hyde Amendment," the resolved portions of which read as printed below:

> 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.

Testimony on this resolution was heard from five members, one in support and four against. All acknowledged the resolution is an issue that is very divisive among the membership. Those providing testimony on behalf of constituent chapters noted that even among their own boards that votes taken on the issue were divided.

The reference committee reviewed current AAFP policy on this issue, determining it appears to be a carefully written compromise on one of the nation's most divisive domestic issues. The committee members felt that it would be unlikely that the Congress of Delegates could come to an agreement on the resolution.

RECOMMENDATION: *The reference committee recommends that Resolution No. 503 not be adopted.*

Discussion ensued on the second extracted item.

Delegate Jack Chou of Baldwin Park, California stated his appreciation of the interpretation for the testimony that was heard at the reference committee. However, he stated that he speaks in support of this resolution as there may have been a misperception of the testimony. He stated that he is not speaking on the issue of reproductive decisions and the policy on reproductive decisions, which the Congress of Delegates has carefully crafted. He believes that this is a debate on the decision of knowingly discriminating against a socio-economic class and not on the policy on reproductive decisions. He further stated that there is an amendment in the Congress that effectively ended the provision of a service to a group of low income women in the United States through Medicaid programs. On this issue, the AAFP has a clear policy on medically underserved, which urges every single one of its members to become involved personally to improve the health of the people from minority and socio-economically disadvantaged groups. He stated that this is very consistent with the AAFP Medicaid Service policy, as well.

Delegate Chou further stated that the United States has created class by a rule, by amendment, which, unfortunately, the good Representative Hyde is not longer with us. But this creation of a class of folks that has a right without access to these services and that is very unfortunate.

Delegate Margaret Sun of Riverside, Rhode Island proposed to divide the question and to separate the two resolved clauses so that they are voted on separately as she believes one is more divisive than the other.

Speaker Weida called for debate on the first resolved clause.

Delegate Laura Knobel of Walpole, Massachusetts spoke in favor of the first resolved clause. She echoed Dr. Chou's aspects that it looks like discrimination based on sex, economic status, employment and age. She stated that discrimination just isn't appropriate.

Seeing no further debate, Speaker Weida called for a vote on the first resolved clause.

The motion passed and the first resolved clause of Resolution No. 503 was adopted as printed below:

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

Speaker Weida called for debate on the second resolved clause of Resolution No. 503.

Seeing no further debate, Speaker Weida called for a vote on the second resolved clause. Speaker Weida reminded the delegates that the reference committee is recommending that the second resolved clause not be adopted.

The motion passed and the second resolved clause of Resolution No. 503 was not adopted.

ITEM 4 – MEDICAL LEGAL PARTNERSHIP: PROMOTING HEALTH THROUGH PREVENTIVE LAW

Resolution No. 504 from the Arizona Chapter entitled, "Medical Legal Partnership: Promoting Health Through Preventive Law," the resolved portion of which reads as printed below:

RESOLVED, That the American Academy of Family Physicians (AAFP) educate its members about "medical legal partnerships," in which lawyers work with members to identify and resolve legal issues affecting the health and well being of children and adults in America.

Testimony on the intent of this resolution was very positive. However, all those providing testimony were eager for additional information about the program.

The reference committee reviewed the information provided by the chapter introducing the resolution. Because the issues require further research and practical implementation application, the committee strongly hopes the Board of Directors can proceed efficiently and quickly to bring this to our membership.

RECOMMENDATION: *The reference committee recommends that Resolution No. 504 be referred to the Board of Directors.*

The motion passed and Resolution No. 504 was referred to the Board of Directors.

ITEM 5 – SUSTAINABILITY OF THE ROBERT GRAHAM CENTER

Resolution No. 505 from the Georgia Chapter entitled, "Sustainability of the Robert Graham Center," the resolved portions of which read as printed below:

RESOLVED, That the American Academy of Family Physicians (AAFP) recognizes the excellence of the Robert Graham Center, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) sets the goal of securing stable endowment funding to insure the financial viability of the Robert Graham Center so that it would be at a lower risk for fiscal downturns in the future, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) requests the development of a plan for endowment of the Robert Graham Center by referral of this issue to the AAFP Board of Directors to develop such a plan, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) Board of Directors report back to 2009 Congress of Delegates on the plans to endow the Robert Graham Center to insure the Center's longevity and continued good work.

The committee heard testimony from 8 members, all of whom strongly supported the intention of the resolution. One member described the Graham Center as "a jewel of the AAFP" and several members noted the value of the data created by the Graham Center. Several members recounted their experiences in either using the Graham Center data to support their legislative issues or to advocate for family medicine residencies before hospital administrations. Another member noted that Congressional offices use the Center's One-Pagers frequently. When the Health Resources and Services Administration considered changing the definitions of medically underserved areas to the detriment of family physicians, the Graham Center, through the coordination of the Government Relations Division, developed immediate and useful information that convinced the agency to back away from its new definitions. These speakers all supported AAFP finding mechanisms to solidify the funding base for the Graham Center.

The committee members agreed that the Graham Center was a valuable and valued part of the AAFP's research and advocacy program. The committee reviewed the complicated fiscal implications to the whole AAFP organization of devoting some of the operational or reserve funds to an endowment for the Graham Center. Some members expressed concern that an endowment may not be the suitable fiscal mechanism to assure stability and growth for this invaluable function of the AAFP organization. The committee members noted that every witness who spoke emphasized the need for the Graham Center to have a stable and reliable funding source. Thus the committee chose to simplify the resolution to focus on the important underlying issue of long-term funding for the Center.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 505 be adopted in lieu of Resolution, No 505, the resolved portions of which read as follows:*

RESOLVED, That the American Academy of Family Physicians (AAFP) recognizes the excellence of the Robert Graham Center, and be it further

RESOLVED, That the AAFP Board of Directors report back to the 2009 Congress of Delegates on its plans to provide long-term stable funding for the Robert Graham Center.

The motion passed and Substitute Resolution No. 505 was adopted.

ITEM 6 – HIPAA EXCLUSIONS

Resolution No. 506 from the Georgia Chapter entitled, "HIPAA Exclusions," the resolved portions of which read as printed below:

RESOLVED, That the American Academy of Family Physicians (AAFP), through the Robert Graham Center, study the impact of Title I Health Insurance Portability and Accountability Act (HIPAA) exclusions have on access and continuity of care for Americans employed in small businesses, and be it further

RESOLVED, That the American Academy of Family Physicians (AAFP) and Board of Directors provide a report to the 2009 Congress of Delegates on access and continuity of care for the Health Insurance Portability and Accountability Act (HIPAA) Title I effected individuals.

The committee heard testimony that the Georgia Chapter was concerned about individuals who are employed by small businesses that are excluded by HIPAA from some of the prohibitions against benefit restrictions based on pre-existing conditions. The Board representative noted that the Board reviewed this resolution and agreed with its intent but questioned whether the Graham Center was the most appropriate entity to study the issues involved. The representative recommended that the matter be referred to the Board, and the committee agreed. The committee also felt that it was an important issue that called for a formal Board report to the Congress of Delegates.

RECOMMENDATION: *The reference committee recommends that Resolution No. 506 be referred to the Board, with the recommendation that the Board provide a written report of its findings and recommendations to the 2009 Congress of Delegates.*

The motion passed and Resolution No. 506 was referred to the Board of Directors.

ITEM 7 – IMMUNIZATIONS

Resolution No. 507 from the Iowa Chapter entitled, "Immunizations" the resolved portion of which reads as printed below:

RESOLVED, That the American Academy of Family Physicians (AAFP) lobby the U.S. Congress to nationally mandate that physicians and hospitals be reimbursed at a cost basis for essential immunizations and immune globulins.

The committee heard from six members, five of whom were positive in their support for the resolution but had wording changes to recommend. One member, for example, suggested that the resolution delete the term "and hospital" since hospital payment rates

greatly differ from that of family physicians. One member noted that family physicians are so poorly paid for immunization services that they refer patients to the emergency room where the costs are significantly higher. A member questioned the use of the word, "mandate", and another observed that the resolution should make it clear that the underpayment is not just for the vaccine but for all administrative costs. One member noted that the term, "essential immunizations" should be better defined. Finally, another witness noted that the American Academy of Pediatrics has developed a white paper on how to fund vaccine strategies.

The committee noted that the resolution had two significant components: vaccinations and immunoglobulins. Regarding vaccinations, the committee found that the AAFP already has excellent policy addressing these issues. Current policy states that "Where medical practices incur a cost for vaccines, the AAFP calls for adequate payment for the vaccine itself and all associated overhead costs (i.e., acquisition, storage, inventory, insurance, spoilage/wastage, etc.) of all immunizations recommended by the AAFP and their administration with no patient cost-sharing, as well as covering an evaluation and management (E/M) service during the same visit, when a significant and separately identifiable E/M service is provided and documented."

The reference committee agreed that important new issues not covered by existing policy are raised by the resolution relative to coverage for immunoglobulins such as Tetanus and Hepatitis B used to provide passive immunity after exposure. The committee felt additional consideration is needed of this issue and so recommends referral to the Board of Directors and the appropriate commission.

RECOMMENDATION: *The reference committee recommends that Resolution No. 507 be referred to the Board of Directors.*

The motion passed and Resolution No. 507 was referred to the Board of Directors.

ITEM 8 – CAPITATION RATES AND DATA

Resolution No. 508 from the New Jersey Chapter entitled, "Capitation Rates and Data," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) communicate to national insurers, legislators, regulatory agencies, and other persons and organizations of influence, its members' strong opposition to health plans' refusal to share actuarial processes and data by which these insurers determine capitation rates, and be it further
>
> RESOLVED, That the American Academy of Family Physicians (AAFP) communicate to appropriate legislators the unfair business practice of health insurers' refusal to share the actuarial processes and data by which these insurers determine capitation rates, and be it further
>
> RESOLVED, That the American Academy of Family Physicians (AAFP) instruct its Government Relations staff to work with legislators to introduce and pass legislation requiring that health insurers share the actuarial processes and data by which these insurers determine capitation rates.

There were four members who spoke to this resolution, two of whom were in favor. They noted that insurance companies have access to a vast amount of data upon which they base their determination of capitation rates. Family physicians are consequently always at a disadvantage in negotiating payment rates, since they don't have this data. The resolution calls for a means by which the family physicians can receive the actuarial data.

The Board of Directors was generally supportive of the resolution while recommending increased focus on state legislators, noting that insurance regulation is generally a state issue.

The committee members felt that the resolution may not capture a viable option in this complicated insurance issue. The committee was concerned about the practicality and even the legality of trying to secure this information for physicians. As a result, the committee decided to recommend that the resolution be referred to the Board of Directors.

RECOMMENDATION: *The reference committee recommends that Resolution No. 508 be referred to the Board of Directors.*

The motion passed and Resolution No. 508 was referred to the Board of Directors.

MISCELLANEOUS CALENDER

The following items A through M, are presented by the reference committee. All of these items call for action which testimony and discussion resulted in support for the recommendation of the reference committee. At the request of the Congress, any item may

be taken off for an individual vote on that item. Otherwise, the reference committee will request approval of all items in a single vote.

(A) Address of the President - elect, ONLY, Para. 7, regarding recommendation to adopt Board Report D entitled "Health Care Coverage for All-Update 2008".
(B) Board Report D (Revised), ONLY, Para 9 and Appendix A, regarding policy on "Health Care for All: A Framework for Moving to a Primary Care System in the United States".
(C) Commission on Governmental Advocacy, regarding deletion of policy statement on "Drugs, Safety Packaging", Para. 49.
(D) Commission on Governmental Advocacy, regarding revised policy statement on "Good Samaritan Law," Para. 51.
(E) Commission on Governmental Advocacy, regarding revised policy statement on "Legislative Activities," Para. 53.
(F) Commission on Governmental Advocacy, regarding policy statement on "Licensure/Relicensure, Definition" Para. 54.
(G) Commission on Governmental Advocacy regarding policy statement on "Long Term Care," Para. 55.
(H) Commission on Governmental Advocacy, regarding policy statement on "Medicaid Services", Para 56.
(I) Commission on Governmental Advocacy, regarding policy statement on "National Health Service Corps," Para. 57.
(J) Commission on Governmental Advocacy, regarding policy statement on "Political Action," Para. 59.
(K) Commission on Governmental Advocacy, regarding policy on "Specialty Hospitals," Para. 60.
(L) Commission on Governmental Advocacy, regarding deletion of Legislative Stances on various topics, Para 68.
(M) Commission on Governmental Advocacy, regarding Legislative Stances on, "Culturally Sensitive Interpretive Services," Para. 69.

RECOMMENDATION: *The reference committee recommends adoption of items A - M above.*

The motion passed and Items A through M on the Miscellaneous Calendar above were adopted.

INFORMATIONAL ITEMS

RECOMMENDATION: *The reference committee recommends that the following informational items be filed for reference.*

- Revised Board Report D, ALL, except Para. 9 and Appendix A, regarding "Health Care for All – Update 2008."
- Board Report K, ALL, including Appendix A & B, regarding "FamMedPAC" – The AAFP's Federal Political Action Committee."

The motion passed and the above informational items were filed for reference.

Dr. Jaffe concluded the reference committee report by expressing appreciation to those who appeared before the reference committee to offer testimony and to the members of the reference committee for the invaluable assistance in the preparation of the report.

Vice Speaker Mabry assumed the chair and called for the next item on the agenda, the report of the Reference Committee on Health of the Public and Science. Dr. Julie Wood of Kansas City, Missouri, committee chair, began reading of the reference committee report as follows:

REFERENCE COMMITTEE ON HEALTH OF THE PUBLIC AND SCIENCE

The Reference Committee on Health of the Public and Science has considered each of the items referred to it and submits the following report. The committee's recommendations on each item will be submitted as a consent calendar and voted on in one vote. An item or items may be extracted for debate.

Vice Speaker Mabry called for any items to be extracted from the reference committee report.

Vice Speaker Mabry called for any items to be extracted from the reference committee report.

Delegate Lillian Wu from the Special Constituencies delegation moved to extract Item 1 – Resolution No. 401 entitled "Refuse Federal Funding for Abstinence Only Until Marriage Programs"

from the consent calendar which is a recommendation to adopt a substitute. See Congress debate and action on Pages 368-370.

Delegate Lloyd Van Winkle of Castroville, Texas moved to extract Item 2 – Resolution No. 402 entitled "Flu Vaccine" from the consent calendar which is a recommendation to not adopt. See Congress debate and action on Pages 370-371.

Delegate Mark Belfer of Akron, Ohio moved to extract Item 8 – Option 1 from Board Report O on "AAFP Foundation Recommendation on Funding for Tar Wars" from the consent calendar which is a recommendation to adopt a substitute. See Congress debate and action on Pages 373-379.

Vice Speaker Mabry declared Resolution Nos. 401 and 402 and Option 1 from Board Report O extracted and placed on the table for consideration.

Seeing no further extractions, Vice Speaker Mabry then called for the vote on the rest of the report as recommended by the reference committee on the consent calendar below:

The Reference Committee on Health of the Public and Science recommends the following consent calendar for adoption:

Item 3 – Refer to the Board of Directors Resolution No. 403 on "Promotion of Primary Care Research Funding".

Item 4 – Refer to the Board of Directors Resolution No. 404 on "Promotion of Primary Care and Preventive Medicine Research Institute".

Item 5 – Adopted Substitute Resolution No. 405 in lieu of Resolution No. 405 on "Promoting Early Literacy at Health Supervision Visits".

Item 6 – Adopt Substitute Resolution No. 406 in lieu of Resolution No. 406 on "Opposing Unnecessary Direct to Consumer Screening Exams".

Item 7 – Not Adopt Resolution No. 407 on "A Mandate to Develop a Plan to Decrease Tobacco Consumption".

Item 8 – Not Adopt Option 2 from Board Report O on "AAFP Foundation Recommendation on Funding for Tar Wars".

Miscellaneous Calendar – Adopt Items A through X under the Miscellaneous Calendar.

Information Items for Filing:

- Board Report I, ALL, "Tar Wars Program".
- Board Report O, ALL "AAFP Foundation recommendation on Funding for Tar Wars," except para. 12.
- Commission on Science, ALL, except paras. 43, 44, 45, 46 and 47.
- Commission on Health of the Public, ALL, except paras. 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, and 55, Appendix A-B.

The motion carried and the consent calendar of the Reference Committee on Health of the Public and Science was adopted as recommended above. The detailed report follows with appropriate Congress action noted:

Speaker Weida called for Dr. Jaffe to read the first item extracted from the consent calendar.

ITEM 1 – REFUSE-FEDERAL FUNDING FOR ABSTINENCE ONLY UNTIL MARRIAGE PROGRAMS

Resolution No. 401 from the New York Chapter entitled "Refuse-Federal Funding for Abstinence Only Until Marriage," the resolved portion of which reads as printed below:

RESOLVED, That the American Academy of Family Physicians advocate for opposition of federal funding for abstinence-only-until-marriage programs.

After hearing extensive testimony regarding issues related to problems caused by the current federal policy limiting funding to abstinence only programs, the reference committee recommends that all evidence-based pregnancy prevention programs should be equally considered for funding.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 401 be adopted in lieu of Resolution No. 401.*

> *RESOLVED, That the AAFP advocate for the federal government to provide funding for age appropriate education on sexuality and pregnancy prevention programs that are comprehensive and provide medically accurate and evidence-based information.*

Discussion ensued on the second extracted item.

Delegate Lillian Wu from the Special Constituency delegation proposed an amendment by substitution by inserting the words "only for those educational programs" after "funding" in the first line of the resolved clause and then the phrase "for age appropriate education" is deleted with the phrase "age appropriate," added after the word "comprehensive" so that it reads "RESOLVED, That the AAFP advocate for the federal government to provide funding only for those educational programs ~~for age appropriate education~~ on sexuality and pregnancy prevention ~~programs~~ that are age appropriate, comprehensive and provide medically accurate and evidence-based information."

The motion was seconded.

Delegate Wu stated that the Congress of Delegates most recently, in 2006, revisited the policy on sexuality and contraception for adolescent patients which states that "The AAFP believes that an evidence-based comprehensive approach to sexuality education will be effective in reducing unintended pregnancy and sexually transmitted diseases." She stated that the policy goes on to define effective programs as "those using a comprehensive approach to sexuality education that includes medically accurate information on contraception and abstinence. She further stated that basically, the reason for the amendment is simply to align the Academy's advocacy efforts with current AAFP policy because the way the resolution currently is written advocates for the funding of comprehensive programs but does not exclude funding for programs that are not comprehensive and evidence-based. Revising the language would just assure that the Academy is advocating only for those programs which are comprehensive and evidence-based.

Delegate Jun David of Albany, New York accepted the friendly amendment.

Seeing no further debate, Vice Speaker Mabry called for a vote to adopt the amendment.

The motion passed and the amendment to Substitute Resolution No. 401 was adopted.

Seeing no debate on the substitute resolution as amended, Vice Speaker Mabry called for a vote to adopt the substitute resolution as amended.

The motion passed and Substitute Resolution No. 401 was adopted as amended which reads:

RESOLVED, That the AAFP advocate for the federal government to provide funding only for those educational programs on sexuality and pregnancy prevention that are age appropriate, comprehensive and provide medically-accurate and evidence-based information.

Dr. Wood continued the report and read the second item extracted from the consent calendar.

ITEM 2 – FLU VACCINE

Resolution No. 402 from the New York Chapter entitled "Flu Vaccine," the resolved portion of which reads as printed below:

RESOLVED, That the AAFP advocate for legislative or regulatory action to make the federal government the purchaser and distributor of vaccine.

The reference committee heard from many members about the difficulties they faced in prior years regarding the acquisition of and payment for influenza vaccine. Concerns were raised regarding the receipt of this vaccine by sites other than physician offices, hospitals and other medical locations. Some members pointed out that the purchase of large amounts of flu vaccine by corporations prevented them from receiving vaccine in a timely manner. There was also testimony that the prior AAFP Influenza Task Force had investigated the option of federal purchase of vaccine but that this had been determined to not be feasible given the current federal budget while other members expressed concern with the federal government becoming the sole purchaser and distributor. The reference committee heard about how at least one state program in Rhode Island had been successful in forming a public-private program whereby influenza vaccine was purchased and distributed to practices. The reference committee came to the conclusion that a federal program was not appropriate and feels that this is better addressed at a state by state level.

RECOMMENDATION: *The reference committee recommends that the Resolution No. 402 not be adopted.*

Debate ensued on the second item extracted from the report.

Delegate Lloyd Van Winkle of Castroville, Texas proposed a substitute to read "RESOLVED, That the AAFP disseminate to the state chapters the Rhode Island legislation on state purchasing of flu vaccine as potential model legislation. ~~RESOLVED, That the AAFP advocate for legislative or regulatory action to make the federal government the purchaser and distributor of vaccine.~~"

The motion was seconded.

Delegate John Bossian of Wakefield, Rhode Island stated that when the program was started in Rhode Island, we were told we'd never get it done. Delegate Bossian implored the Board to take a look at this. He believes that Rhode Island is certainly positioned to set a precedent that other states can use. He stated that he doesn't know where the body of evidence or the legislative models need to be housed but he believes that the Academy needs to house strong ideas from other chapters and to keep these on file so that other states can proceed in a more timely fashion and not have to go through the whole process all over again and reinvent the wheel. Delegate Bossian spoke in support of the substitute and requested that the Board continue their efforts in getting this federally funded.

Delegate Jun David of Albany, New York stated his support of the substitute and applauded the Texas Academy for bringing this to the Congress' attention. He stated that he actually was discussing this with Academy staff because this is a yearly problem in New York. He knew of other states that have no problems and maybe since Rhode Island is a smaller state, it is easier to get it done. He continued by stating that we are really looking to the Academy for model legislation so physicians can get flu vaccines on time.

Delegate Patricia Lindholm of Fergus Falls, Minnesota spoke in support of the substitution. She stated that this will be easy to bring forward the Rhode Island legislation because the AAFP is a member of the Council of State Governments which can bring to all 50 states at once and propose it and disseminate it as model legislation.

Seeing no further debate, Vice Speaker Mabry called for a vote to adopt the substitute.

The motion passed and the substitute was adopted.

Vice Speaker Mabry called for debate on the resolution as substituted. Seeing no debate, Vice Speaker Mabry called for a vote to adopt the resolution as substituted.

The motion passed and Resolution No. 402 as substituted was adopted as printed below:

RESOLVED, That the AAFP disseminate to the state chapters the Rhode Island legislation on state purchasing of flu vaccine as potential model legislation.

ITEM 3– PROMOTION OF PRIMARY CARE RESEARCH FUNDING

Resolution No. 403 from the Texas Chapter entitled "Promotion of Primary Care Research Funding," which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) work with existing federal research funding agencies, particularly the Agency for Healthcare Research and Quality (AHRQ), to develop new K-type award mechanisms suitable for community-based academic family medicine faculty.

The testimony was generally in favor of the intent of this resolution with speakers pointing out the difficulty faced by the specialty in obtaining K-Type awards to support the professional development of new researchers. It was pointed out that while specialists in other fields have institutes at the National Institutes of Health that provide such support, family medicine did not have such support. The role of the Agency for Healthcare Research and Quality was noted but their K award funding is limited. The Board liaison asked that this resolution be referred to the Board and the reference committee agrees with this request.

RECOMMENDATION: *The reference committee recommends that the Resolution No. 403 be referred to the Board of Directors.*

The motion passed and Resolution No. 403 was referred to the Board of Directors.

ITEM 4 – PROMOTION OF PRIMARY CARE AND PREVENTIVE MEDICINE RESEARCH INSTITUTE

Resolution No. 404 from the Texas Chapter entitled, "Promotion of Primary Care and Preventive Medicine Research Institute," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) promote the creation of a National Institutes of Health (NIH)-level center or institute for primary care and community-based preventive medicine research.

Testimony was limited but it was pointed out that what was asked for in the resolution was consistent with one of the strategies within the Future of Family Medicine report. It is noted that there is significant overlap with the issues raised in Resolution No. 403. The Board liaison asked that this resolution be referred to the Board and the reference committee concurs.

RECOMMENDATION: *The reference committee recommends that the Resolution No. 404 be referred to the Board of Directors.*

The motion passed and Resolution No. 404 was referred to the Board of Directors.

ITEM 5 – PROMOTING EARLY LITERACY AT HEALTH SUPERVISION VISITS

Resolution No. 405 from the Massachusetts Chapter entitled, "Promoting Early Literacy at Health Supervision Visits," the resolved portions of which read as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) recommends that family physicians promote early literacy development as an important evidence-based intervention at health supervision visits for children from six months through six years of age by:
>
> 1) advising all parents about the importance of reading aloud to young children,
> 2) counseling all parents about specific age- and developmentally-appropriate reading activities, and
> 3) providing developmentally appropriate books at for all low-income children, and be it further
>
> RESOLVED, That the American Academy of Family Physicians (AAFP) support federal and state funding for children's books to be provided at health supervision visits of low income children, the incorporation of funding for children's books in managed care and government insurance programs for low-income children, and research about the effects of early literacy promotion on child health and educational outcomes.

After review of the Reach Out and Read program, it was agreed by the reference committee that, while valuable, it was inappropriate to create a strong recommendation but that it was entirely reasonable to support federal and state funding and to encourage it as a good practice for the patient centered medical home.

RECOMMENDATION: *The reference committee recommends that Substitute Resolution No. 405 which reads as follows be adopted in lieu of Resolution No. 405:*

> *RESOLVED, That the American Academy of Family Physicians (AAFP) recommends that family physicians promote early literacy development as an important evidence-based intervention at health supervision visits for children from six months through six years of age by:*
>
> *1) advising parents and caregivers about the importance of reading aloud to young children,*
> *2) counseling parents and caregivers about specific age- and developmentally-appropriate reading activities, and*
> *3) encourage that family physicians participate in early literacy programs when possible, by making information about access to such programs available on the Academy Web site and to support provision of federal and state funding for such programs.*

The motion passed and Substitute Resolution No. 405 was adopted.

ITEM 6 – OPPOSING UNNECESSARY DIRECT TO CONSUMER SCREENING EXAMS

Resolution No. 406 from the Missouri Chapter entitled, "Opposing Unnecessary Direct-to-Consumer Screening Exams," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians (AAFP) adopt a policy against unnecessary screening exams marketed directly to consumers, and be it further
>
> RESOLVED, That the American Academy of Family Physicians (AAFP) help members advocate for their patients in regard to unnecessary direct-to-consumer screenings by alerting physicians and prominently displaying patient education materials on the AAFP Web site, as well a sample letter to empower local physicians to send an evidence-based, personalized letter to medical entrepreneurs or civic, religious, or other groups who are considering hosting a direct-to-consumer screening program, and be it further
>
> RESOLVED, That the American Academy of Family Physicians (AAFP) work with other organizations such as the American Medical Association (AMA), American Association of Health Plans, American Association of Retired Persons (AARP), and others, to advocate for patients by educating the public about unnecessary health care screening exams marketed directly to patients.

There was extensive testimony from members on this resolution with speaker after speaker providing information on how wide spread this marketing of unnecessary screening exams was and the impact it was having on patients and health care costs. Patients were exposing themselves to expensive tests that were of dubious clinical value and in many cases undergoing additional testing with greater risks. Some speakers reported that well-meaning organizations such as churches were hosting screening events while in other cases vans with screening equipment were being driven into communities on a regular basis with intensive mail and other advertising promoting the screening. Some speakers spoke of the strategies they had used to counter these events and asked that the AAFP address this issue as a national activity. The reference committee agrees with the need to address this concern and recommends adoption of the resolution.

RECOMMENDATION: *The reference committee recommends that Resolution No. 406 be adopted.*

The motion passed and Resolution No. 406 was adopted.

ITEM 7 – A MANDATE TO DEVELOP A PLAN TO DECREASE TOBACCO CONSUMPTION

Resolution No. 407 from the New Hampshire Chapter entitled, "A Mandate to Develop A Plan To Decrease Tobacco Consumption," the resolved portion of which reads as printed below:

> RESOLVED, That the American Academy of Family Physicians develop a long term plan to decrease with the aim at ultimately eliminate non religious or non ceremonial consumption of tobacco products in the United States taking into consideration medical, legislative, judicial, marketing and other means to achieve this goal and to report this plan to the Congress of Delegates.

Limited testimony was presented on this resolution which asked for the AAFP to develop a long term plan to eventually eliminate virtually all tobacco use. The reference committee favors the Academy taking steps to reduce tobacco use and notes the various current activities such as Ask and Act, Tar Wars, educational, policy, advocacy and work with other organizations and coalitions. However, the reference committee believes that the action requested in the resolution would be a major undertaking far beyond the ability of a single organization. In addition, it would divert resources from higher current priorities such as health care reform and helping members implement the patient centered medical home.

RECOMMENDATION: *The reference committee recommends that Resolution No. 407 not be adopted.*

The motion passed and Resolution No. 407 was not adopted.

Dr. Wood continued the report and read the third item extracted from the consent calendar.

ITEM 8 – BOARD REPORT O, AAFP FOUNDATION RECOMMENDATION ON FUNDING FOR TAR WARS

Board Report O ONLY, Para. 12 (p. 308), regarding the recommendation that the following options be presented to the Congress of Delegates for final action as outlined below:

> OPTION 1: That the Congress of Delegates support the AAFP Foundation in contacting private foundations and corporate foundations, consistent with current AAFP policy, in securing a one-time major gift to the AAFP Foundation to create an endowment to be used exclusively to support AAFP programs in tobacco cessation education, research and Tar Wars.
>
> OPTION 2: That the Congress of Delegates allow a one-time exception to the AAFP Tobacco and Smoking policy so that the AAFP Foundation could contact corporations with giving programs funded by tobacco monies to determine if any would be willing to provide a one-time major gift to the AAFP Foundation to create an endowment to be used exclusively to support AAFP programs in tobacco cessation, education, research and Tar Wars.

After review of the current Academy policy, "The AAFP has no direct association with organizations involved in the manufacture of tobacco products and urges its members to avoid such association," the reference committee agreed that the actions in Option 1 were appropriate.

Testimony was fairly evenly divided and passionate. Those in favor felt the tobacco companies should be financially responsible for the damage their products have inflicted. Others felt the benefit of using tobacco monies to help patients justified the means. Some who supported taking tobacco monies were very explicit about the terms of the commitment. Those opposing it felt that accepting these monies would damage our credibility and position us very awkwardly with our colleagues. Others felt it entirely unacceptable under any circumstance and likened it to the "Sunbeam" debacle experienced by the American Medical Association.

The reference committee felt it was premature to allow any exceptions to the current AAFP Tobacco and Smoking policy. All other options for funding should be exhausted before considering obtaining funds directly from tobacco companies. The Congress of Delegates should consider the requested progress reports for 2009 and 2010 before taking any further action.

RECOMMENDATION: *The reference committee recommends that Substitute Option 1 of Board Report O which reads as follows be adopted in lieu of Option 1:*

That American Academy of Family Physicians support the AAFP Foundation's efforts to seek funding for tobacco cessation, education, research and Tar Wars by contacting private foundations and corporate foundations in a manner consistent with current policy to create a one-time endowment, and

That the American Academy of Family Physicians Board present a progress report indicating the amount of available funding for the tobacco control endowment to the Congress of Delegates in 2009 and 2010, and

That the AAFP inform its members of the acute, short-term need for bridging funds to continue Tar Wars until the tobacco control endowment is funded.

RECOMMENDATION: *The reference committee recommends that the American Academy of Family Physicians not adopt Option 2 of Board Report O.* – not adopted.

Discussion ensued on the third extracted item from the consent calendar.

Delegate Mark Belfer of Akron, Ohio spoke against the second recommendation offered by the reference committee.

Vice Speaker Mabry divided the question so that the delegates will speak to Option 2 first and its recommendation from the reference committee that the AAFP not adopt Option 2 of Board Report O, which reads "That the Congress of Delegates allow a one-time exception to the AAFP Tobacco and Smoking policy so that the AAFP Foundation could contact corporations with giving programs funded by tobacco monies to determine if any would be willing to provide a one-time major gift to the AAFP Foundation to create an endowment to be used exclusively to support AAFP programs in tobacco cessation, education, research and Tar Wars."

Delegate Belfer stated that the Vision Statement for the AAFP Strategic Plan says that the "AAFP's vision is to transform health care to achieve optimal health for everyone." The mission statement for the AAFP states that "The mission of the AAFP is to improve the health of patients, families, and communities by serving the needs of members by professionalism and creativity." He stated that he has a vision as well and probably a vision that all share; a vision that no child will ever pick up a cigarette or chew tobacco in the future. He further stated that he has a vision that so many cancers that are due to tobacco use will decrease or stop. He has a vision that tobacco companies will pay for the deaths and illnesses of the people addicted by them. He continued by stating that his mother-in-law and father-in-law both died from tobacco-related illnesses, lung cancer, COPD and laryngio cancer so this has become personal.

He stated that Tar Wars represents a creative way to education children about the problems with tobacco use. This Congress has mandated that the AAFP continue this program and that is wise. He explained that to date, the Academy has asked the Foundation to pay for it. The funds are drying up and when last evaluated, very few members actually donated to the program. The likelihood of obtaining a major gift from private or corporate foundations for this purpose as described in Option 1 is very low based on the Academy's Foundation's knowledge, experience and previous engagement with these entities. The highest likelihood of obtaining support of this sort is to pursue corporate giving programs. He further explained that this is why we now want to be creative as is mentioned in the AAFP's mission. It is unknown if tobacco companies will donate to the Foundation to fund an endowment for Tar Wars, research and education; they already gave up billions to 46 states. He continued by stating that his own State of Ohio has been using this money to fund the fixing of roads. No money is going toward patients, research or prevention, but it tied hands by not allowing us to even try to obtain funding this way.

Delegate Belfer stated the Board is asking for the chance to ask one time for a grant from these corporations. If Option 2 is voted down, the only thing he would request is that of those sitting in the audience commit to funding it in the future. He summarized his comments by stating that he would rather take money from the devil and all the devil's friends than see one more child take up this habit and see one more patient or family members die from tobacco-related illness. If Option 2 passes, all of us will be working to fulfill our mission to improve the health of patients, families and communities. We will be serving the needs of members with professionalism and creativity.

Alternate Delegate Tim Linder of Selmer, Tennessee spoke in favor of the comments made by Delegate Belfer. The main thing he requests other than that, because as someone who is very passionate about Tar Wars and that teaches a number of classes every year, the AAFP needs the funds for the program. Expanded funding is needed for this program and he stated that he does not have a problem with this, but if anyone in this audience has a moral problem with this, the Foundation has envelopes available to donate funds to this cause. He recommends a $1,000 per person donation, which is what he just wrote for the Foundation to cover Tar Wars if Option 2 is not adopted.

Student Alternate Delegate Jacob Bryan from Columbus, Ohio spoke in opposition of the reference committee's recommendation in support of Option 2. He stated that he has used Tar Wars in the past and can testify to its impact. A couple of years ago, he helped train 25 high school students who then implemented a Tar Wars program in a school of 200 middle school students. It has been very successful. He stated that he wants the Congress to understand the Foundation's President's point that, right now, we are faced with two choices; either let the Tar Wars program expire or support it by giving the Foundation and the AAFP Board of Directors the flexibility they need to ensure its financial sustainability in the future.

Delegate Jeff Cain of Denver, Colorado spoke in support of Option 2 as a member of Colorado and also as the Founder of Tar Wars. He stated that many people would say how could a guy that spent two and a half decades fighting the tobacco industry even consider taking what is in essence, blood money from the tobacco industry and in many ways, it has to do with the way that we think about being effective and the kinds of impact the tobacco industry has had and how they can in some ways make some reparations.

He further stated that he'd like to do one small quote, on a variation on what Dr. Belfer had said. "He would take the money from the devil himself if it would help him do the Lord's work." He believes the only way to consider this is with a couple of principles. First, the amount of money that should be considered if this is going to be done and even discuss with the industry the amount of money that would allow the AAFP to create an endowment that would allow a creative and expanded vision for Tar Wars.

Second, it would be considered as long as the AAFP had complete control of the content of the program, the cessation, the prevention and the Tar Wars program. And third, that it be understood that the AAFP have control over the way that the discussion in the media about that relationship would be held publicly. He stated that it is his hope that there are other organizations that been recognized to have done this successfully. The American Legacy Foundation takes

money from the tobacco industry, and has done some very effective anti-tobacco advertisements. Dr. Cain further stated that he believes that the AAFP is also doing this when taking master settlement fund agreements.

He continued by stating that he wanted to reassure the Congress that when the decision was made to sell Tar Wars to the Academy, it was done so with the trust that this is the right place for Tar Wars and the understanding that this Congress has wisdom that sometimes goes in different directions from where the founders originally intended. He summarized by stating that he would support what the Congress ultimately decides.

Alternate Delegate Chris Gaynor of Seattle, Washington spoke to the excellent work of the reference committee in crafting a compromise that would be acceptable to all. They are allowing for the AAFP to ask for money from tobacco company foundations but not from the tobacco companies themselves which he personally would be opposed to as well. But seeing how strongly and passionately individuals feels about finding money by any means possible to sustain Tar Wars, he stated that he is willing to make that allowance and compromise. However, he is opposed to Option 2. He stated that Option 2 is unacceptable and does not support the substitute offered to go back to Option 2.

Delegate Kevin Ferentz of Baltimore, Maryland stated that he is a full-time faculty member at the University of Maryland and has been for the last 20 years. The majority of his academic time has been spent teaching medical students and residents on how to help their patients stop smoking. He believes there is already precedent in using tobacco restitution funds and he spoke in support of Option 2. He continued by stating that, unfortunately, the tobacco restitution funds in many states is not being used to do anything related to tobacco. If so many states in the country have been able to take tobacco money to help people stop smoking, why can't the Academy do the same? Restitution funds are being used appropriately in some states. Some of that is being used in Maryland and reparations, as was mentioned, have been made many times throughout history. The tobacco industry is evil and they are trying in some respects to correct that evil. He believes this is one way that the money can be used to a great benefit and to patient's benefit.

Delegate William Hakkarinen of Cockeysville, Maryland stated that there is obviously a split opinion. He spoke in opposition to going back to Option 2. He stated that he's been through a number of leadership training programs, both within the Academy and in other venues, and one of the things he learned in them is that organizations, when faced with financial difficulties, react in predictable ways. One of the early ways that they react is they re-evaluate and tend to decline in their values and their ethics. He stated his concern about the reaction because we want so badly to keep Tar Wars and will do anything to make that possible. He continued by stating that he does not know if Tar Wars is effective. He questioned if it Is evidence-based? What is the outcome of Tar Wars? Do kids who go through Tar Wars smoke less than kids who don't? He stated that he has not seen that data. If the Academy has that kind of data, it is great public relations material to publish. He summarized by speaking vehemently, and with passion, against taking money from the devil for whatever purpose.

Delegate Steven Strode of Sherwood, Arkansas spoke against Option 2, supporting the reference committee. The point he wanted to make is that we may be very naïve to think that we could work and take funds from the tobacco industry with the legal and public relations expertise

that they utilize. If the Academy ties itself to the tobacco industry and don't continue to find other ways to fund Tar Wars, it may become a regretful decision.

Delegate David Meyers of the DC delegation from Tacoma Park, Maryland spoke in support of the reference committee and urged the Congress to vote no on Option 2. He stated that living in the Washington, DC area, he is familiar with influence. He does not believe that they can be beat at their own game. He believes the restitution funds have addicted states to the continued economic success of the tobacco industry in the United States. It is the best example of this type of marketing ever done and the Academy should not follow that bad example. He continued by stating that the money the tobacco industry is now making is not coming from our children, it is coming from children around the world. By adopting Option 2, he believes we are saying we are willing to kill children in Africa, in China and India so that we can help make our children be safer. He stated that he is not willing to make that deal.

Delegate Carol Johnson of Park City, Kansas spoke in support of the reference committee's opposition to Option 2. She stated that we need to allow the two years they suggested to look for other means of supporting Tar Wars. She stated that she will donate $1,000 to the Foundation but will not give if the Foundation also takes tobacco money donations.

Alternate Delegate Erica Swegler of Keller, Texas spoke as an individual and in opposition to Option 2 in support of the reference committee's original recommendation. She stated that she would not like to repeat some of what has been said as she is one of the biggest anti-tobacco advocates. She stated that there are other means to approach the problem of youth tobacco use and that would include maximizing our advocacy efforts and trying to convince the Federal government not to be one of the major purchasers of tobacco in the United States as well as to consider doing something about Federal subsidies and growing tobacco. She continued by stating that if we focused our advocacy efforts against a problem, that is in fact a major health problem and has major impact on the health care costs of this country, we could have a larger influence because you will tobacco farmers making other decisions, economically, when faced with those two realities.

Delegate Douglas Parks of Cheyenne, Wyoming offered two thoughts and one of them is that settlement money that goes to the states is just that, settlement money. The tobacco companies did not voluntarily give the money because they were good citizens. The second thing he offered is that he does not want to be watching Monday-night football when the ad comes on for Phillip Morris talking about how they are working with the American Academy of Family Physicians to stop smoking.

Alternate Delegate Wanda Filer of York, Pennsylvania spoke in support of the reference committee's recommendation and in opposition to Option 2. She stated that as Past President of the Pennsylvania Commonwealth Division of the American Cancer Society, she believes that we would be playing right into the hands of the tobacco industry. As an 18-year NBC reporter on behalf of family medicine and my patients, if you believe that our leadership has had three phone calls a day from leading media outlets, they are going to love this one. We'll have 10 a day and we won't like any of the coverage that we receive. She believes the AAFP would be walking into the fire and lose track of our advocacy because the Academy would lose every ounce of creditability it has gained.

Delegate George Shannon of Columbus, Georgia spoke in support of the reference committee's recommendation to oppose Option 2. He stated that he heard the comment "control the media discussions." If the AAFP could control the media discussions, then it would be a very powerful organization. He believes that the media will take it and spin it the way they want. He continued by stating that the Academy is spending millions of dollars in logos, ads, articles, things that are engendering interest in family medicine and we could lose it all. It could all be lost with one spot on NBC news or one article in the front page of the *Wall Street Journal*. There is no guarantee that this is going to work and what we are doing is asking to open the door to seek funding. However, he believes, the Academy could become tainted and still not receive the funds. He encouraged the Congress to look for other alternatives. He stated that Columbus, Georgia has a cancer insurance company that sponsors a children's cancer treatment unit at Eagleston Hospital in Atlanta. He stated that the Academy needs to talk with all the other options first before running the risk of losing its reputation and values.

Delegate Mott Blair of Wallace, North Carolina spoke in favor of the reference committee's recommendation and against the adoption of Option 2. He stated that he does not want to repeat his testimony from the reference committee hearing but did want to state that if the Congress adopted Option 2 and took tobacco money, he could see the tobacco executives, behind our backs, saying "Boy, you have come a long way baby."

Delegate Susan Kinast-Porter of Monroe, Wisconsin spoke against Option 2 although she wanted to stated that the Wisconsin delegation was somewhat split. As a compromise she stated that maybe a report could come back to the Congress in one year rather than two years and three years on what has been done at looking for alternate sources of funding. She stated that she would like to see an actual earmark checkmark on the Foundation gift for giving money specifically to Tar Wars.

Vice Speaker Mabry reminded the audience to speak to the recommendation only.

Delegate Kinast-Porter spoke to not adopt Option 2. She stated she agreed with the previous statements about why to not adopt. She indicated that it would sully the Academy's name, would cause bad publicity and undo the work the branding of the logo. The Academy's name would be used in some way to help their image but not the Academy's.

Special Constituency Delegate Adebowale Prest of Berlin, Maryland spoke in favor of the reference committee's recommendation to not adopt Option 2. It's a complicate issue. She stated that she believes that any of the companies would be willing to provide a one time major gift because they would think how lucky they are when this happens. They are spending 41 million dollars a day targeting children and encouraging them to smoke. She further stated she doesn't know what money the Academy would think be enough of an endowment to be able to compete. She also stated that she believes the Academy would leave behind a poor legacy for young family physicians. She thought about how this would sound at the National Conference of Family Medicine Residents and Medical Students and it doesn't leave a good feeling.

Delegate Craig Czarsty of Oakville, Connecticut called the question.

The motion was seconded.

Vice Speaker Mabry stated that it has been moved and seconded to close debate. This requires a two-thirds vote. Vice Speaker Mabry called for the vote to close debate.

The motion passed and debate was closed and to vote immediately.

Vice Speaker Mabry called for a vote on the reference committee recommendation to not adopt Option 2 which states "That the Congress of Delegates allow a one-time exception to the AAFP Tobacco and Smoking policy so that the AAFP Foundation could contact corporations with giving programs funded by tobacco monies to determine if any would be willing to provide a one-time major gift to the AAFP Foundation to create an endowment to be used exclusively to support AAFP programs in tobacco cessation, education, research and Tar Wars."

The motion failed and Option 2 was not adopted.

Vice Speaker Mabry called for debate on Substitute Option 1.

Seeing no debate, Vice Speaker Mabry called for a vote on the reference committee's recommendation to adopt Substitute Option 1.

The motion passed and Substitute Option 1 from Board Report O was adopted as printed below:

That American Academy of Family Physicians support the AAFP Foundation's efforts to seek funding for tobacco cessation, education, research and Tar Wars by contacting private foundations and corporate foundations in a manner consistent with current policy to create a one-time endowment, and

That the American Academy of Family Physicians Board present a progress report indicating the amount of available funding for the tobacco control endowment to the Congress of Delegates in 2009 and 2010, and

That the AAFP inform its members of the acute, short-term need for bridging funds to continue Tar Wars until the tobacco control endowment is funded.

MISCELLANEOUS CALENDAR

The following items A through X are presented by the reference committee. All of these items call for action which testimony and discussion resulted in support for the recommendation of the reference committee. At the request of the Congress, any item may be taken off for an individual vote on that item. Otherwise, the reference committee will request approval of all items in a single vote.

(A) Annual Report of the Commission on Science, Only Para. 43 regarding revised policy statement on "Clinical Practice Guidelines."
(B) Annual Report of the Commission on Science, Only Para. 44 regarding revised policy statement on "Diagnostic Screening."
(C) Annual Report of the Commission on Science, Only Para. 45 regarding revised policy statement on "Screening."
(D) Annual Report of the Commission on Science, Only Para. 46 regarding revised policy statement on "Chelation Therapy."
(E) Annual Report of the Commission on Science, Only Para. 47 regarding revised policy statement on "Autism."

(F) Annual Report of the Commission on Health of the Public, Only Para. 38 regarding revised policy statement on "Ethics, Life Sustaining Treatment and Advance Planning for Health Care Decisions."
(G) Annual Report of the Commission on Health of the Public, Only Para. 39 regarding revised policy statement on " Ethics, Unethical Experimentation."
(H) Annual Report of the Commission on Health of the Public, Only Para. 40 regarding revised policy statement on "Boxing, Sport of."
(I) Annual Report of the Commission on Health of the Public, Only Para. 41 regarding new policy statement on "Ultimate Fighting and Disabling Competitions."
(J) Annual Report of the Commission on Health of the Public, Only Para. 42 regarding revised policy statement on "Child Abuse."
(K) Annual Report of the Commission on Health of the Public, Only Para. 43 regarding revised policy statement on "Hospice, Care."
(L) Annual Report of the Commission on Health of the Public, Only Para. 44 regarding revised policy statement on "Motorized Recreational Vehicles."
(M) Annual Report of the Commission on Health of the Public, Only Para. 45 regarding revised policy statement on "National Minority Health Month."
(N) Annual Report of the Commission on Health of the Public, Only Para. 46 regarding revised policy statement on "Residential Pool Safety."
(O) Annual Report of the Commission on Health of the Public, Only Para. 47 regarding revised policy statement on "Sports Medicine, Counseling About Risk of Contact/Collision Sports."
(P) Annual Report of the Commission on Health of the Public, Only Para. 48 regarding revised policy statement on "Sports Medicine, Disabled Person: Participation In Sports and Physical Activities."
(Q) Annual Report of the Commission on Health of the Public, Only Para. 49 regarding revised policy statement on "Tobacco and Smoking."
(R) Annual Report of the Commission on Health of the Public, Only Para. 50 regarding revised policy statement on "Culturally Competent Health Care."
(S) Annual Report of the Commission on Health of the Public, Only Para. 51 regarding new policy statement on "Linguistically Appropriate Health Care."
(T) Annual Report of the Commission on Health of the Public, Only Para. 52 and Appendix A regarding deleted position paper on "Family Physicians Supporting Breastfeeding."
(U) Annual Report of the Commission on Health of the Public, Only Para. 53 and Appendix B regarding new policy statement on "Principles for Improving Cultural Proficiency and Care to Minority and Medically-Underserved Communities."
(V) Annual Report of the Commission on Health of the Public, Only Para. 55 regarding deletion of the policy statement on "Domestic Partner Health Benefits."
(W) Annual Report of the Commission on Health of the Public, Only Appendix A regarding new position paper on "Family Physicians Supporting Breastfeeding."
(X) Annual Report of the Commission on Health of the Public, Only Appendix B regarding new policy statement on "Principles for Improving Cultural Proficiency and Care to Minority and Medically-Underserved Communities."

RECOMMENDATION: *The reference committee recommends adoption of Items A through X above.*

The motion passed and Items A through X above were adopted.

INFORMATIONAL ITEMS

RECOMMENDATION: *The reference committee recommends that the following informational items be filed for reference.*

- Board Report I, ALL, "Tar Wars Program."
- Board Report O, ALL "AAFP Foundation recommendation on Funding for Tar Wars," except para. 12.
- Commission on Science, ALL, except paras. 43, 44, 45, 46 and 47.
- Commission on Health of the Public, ALL, except paras. 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, and 55, Appendix A-B.

The motion passed and the above informational items were filed for reference.

Dr. Wood concluded the reference committee report by expressing her appreciation to those who appeared before the reference committee to offer testimony and to the members of the reference committee for their invaluable assistance and to commend the headquarters staff for their help in the preparation of this report.

Speaker Weida then declared the third session of the Congress of Delegates recessed at 5:41 p.m., with the fourth session to convene at 8:00 a.m. the following day.