California Academy of Family Physicians

POLICY COMPENDIUM

CAFP
California Academy of Family Physicians

HOW CAFP POLICY IS ADOPTED

The California Academy of Family Physicians (CAFP) Policy Compendium includes all current CAFP policies. It is a record of all official actions taken by the Board of Directors, Executive Committee, and Congress of Delegates, beginning in 1986. Each entry is taken from one of three key source documents:

BoD	Minutes of the Board of Directors
EC	Minutes of the Executive Committee
CoD	CAFP Congress of Delegates Transactions

The Congress of Delegates became the All Member Advocacy Meeting (AMAM) in 2014 and now official policy goes through the CAFP Board of Directors (BoD) for final approval. Resolutions can be submitted by CAFP members to the BoD at any time throughout the year by completing the online resolution form available at CAFP's website. Resolutions submitted by the AMAM Deadline, typically in December, are added to the agenda for AMAM, where resolution authors and the BoD have the opportunity to hear testimony from CAFP members. Resolutions submitted during other times of the year are added to the agenda for an upcoming CAFP Board meeting. The BoD may vote to adopt, amend and adopt, not adopt, or refer the resolution to a Committee for further study. Once a resolution is adopted, it becomes official and public CAFP policy and it is added to this Policy Compendium.

HOW TO USE THE CAFP POLICY COMPENDIUM

The Policy Compendium is organized with a numbering system for major subject areas, related subcategories and subtopics as applicable. Topic headings with numbering are listed in both the table of contents and the text of the Compendium.

Each policy can be identified in the text of the Compendium by policy title in bold and black. A citation follows most policies in this Compendium, indicating the body that passed the policy, as well as the month and year of its passage *(e.g. BoD 04/2026)*. For applicable policies a topic tag may be included (e.g. # Topic: privileging, HIPAA) in gray.

From the table of contents, you may click on a topic to go to that section. To search through policies control find (Ctrl+F / Cmd+F) and type in key terms to bring up policies that mention the terms or have the topic tag.

Acronym Key

AAFP	American Academy of Family Physicians
AAFP COD	American Academy of Family Physicians Congress of Delegates
ACOG	American College of Obstetricians and Gynecologists
CMA	California Medical Association
CRN	CAFP Residency Network
CNMs, NPs, PAs	Certified nurse-midwife, Nurse practitioner, Physician assistant

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HEALTH SYSTEM REFORM

This section contains policy about health system reform. This includes Medi-Cal, Medicare, physician drug access, insurance plans, and more. Health system reform is a major topic that impacts family physicians and how care is delivered.

10.01 Alternative Payment Models

Medical Group Insolvencies / Capitation Difficulties
CAFP should continue to oppose unfunded mandates and research and educate Academy members on new models of care delivery that will channel more of the health care dollar into patient care, e.g., the Buyers Health Care Action Group. *(BoD 11/1999)*

Medical Home
CAFP adopt the medical home definition as referenced in the "Joint Principles of the Patient-Centered Medical Home."

CAFP urge the California Medical Association (CMA) to support the definition of "medical home" in state law as those practices certified by the National Committee for Quality Assurance (NCQA) that operate under the "Joint Principles of the Patient-Centered Medical Home."

CAFP urges the State of California to incorporate support of the patient-centered medical home, including appropriate payment for primary care case management, team-based care and coordination, information technology, and other components of the medical home in State-supported health care programs. *(CoD 3/2009*)
Topic: Medi-Cal

10.01a Accountable Care Organizations

Joint Principles for Accountable Care Organizations
An Accountable Care Organization (ACO) is defined as a group of physicians, other healthcare professionals*, hospitals and other healthcare providers that accept a shared responsibility to deliver a broad set of medical services to a defined set of patients across the age spectrum and who are held accountable for the quality and cost of care provided through alignment of incentives. These principles state that primary care should be the foundation of any ACO and that the recognized patient and/or family-centered medical home is the model that all ACOs should adopt for building their primary care base. The goals of an ACO structure are to improve the quality and efficiency of care provided and to demonstrate increased value from health care expenditures. The Medicare Payment Advisory Commission (MedPAC) has called for the testing of this care delivery organizational model and the recently passed healthcare reform legislation allows physicians and other healthcare professionals to organize as ACOs under Medicare beginning in 2012. The same

legislation also establishes a pediatric demonstration project that allows qualified pediatric providers to choose to be recognized and receive payments as ACOs under Medicaid. The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association support the establishment of ACOs within public and private settings that are consistent with the a set of policy principles that can be found here or under the Policy Reference Reports listed on CAFP's website at www.familydocs.org/policy.

10.01b Pay for Performance

Pay for Performance (P4) Policy Principles

1. The central purpose of any P4P plan should be to improve the quality of patient care and clinical outcomes.
2. Data must be accurate, fair, reliable, and analyzed using a consistent and scientifically valid methodology. Data should track specific performance measures, chosen to reflect real-world patient care, should have physician involvement in their selection, and allow physicians to review, comment, and appeal the results. There must be suitable mechanisms for physicians to update and correct inaccurate data.
3. Incentives/bonus payments must be financed with new or supplemental funds with no reduction in existing fees paid to physicians; reward relative improvement as well as meeting targets; be sufficient enough both to cover administrative costs and to encourage participation; and incentivize the use of information technology.
4. Any participation requirements should allow for flexibility in implementing health information technology (i.e., choosing open source or proprietary options, using paper-based registries).
5. P4P targets should be consistent with evidence-based standards, use a sound methodology, and have substantial potential for improvement over time.
6. Collaboration with physicians, including direct physician involvement, should occur at every stage of decision-making, implementation, and evaluation including the development, piloting and ongoing utilization of measures; determining data sources used for evaluation; and attribution of patients with multiple care providers.
7. Performance data reporting to physicians should be provided in "real time" and bonus payments should be made quarterly.
8. A defined appeals process must be made available in the case of any disputes. *(BoD 11/2005)*

Physician Reporting – California Physician Practice Information (CPPI)

CAFP will endeavor to form collaborative relationships with organizations seeking to capture and analyze physician level quality data pertaining to Californian family physicians and will work with organizations seeking to capture and analyze physician level quality data pertaining to Californian family physicians to encourage them to use a high level of methodological rigor throughout the design and actuation of all related quality assessment and quality reporting projects; whenever other

organizations publicize physician level quality data, the CAFP will advocate for the inclusion of prominently displayed disclaimers whenever those organizations' statistical methodology precludes valid comparisons between physicians on individual quality measures; CAFP will advocate for health plans to make performance reports publicly available only if they can assure that their data are at least 95 percent accurate; and

CAFP will advocate for other organizations' quality assessment and quality reporting projects to involve collaboration with physicians, including direct physician involvement at every stage of decision-making, implementation, and evaluation (development, piloting and ongoing utilization of measures); determining data sources used for evaluation; and attribution of patients with multiple care providers. *(CoD 3/2010)*

10.02 Insurance Plans / Covered Services

Charging to Prepare Forms

CAFP supports the right of physicians to charge appropriately for their services, including the completion of forms that present a time and staff burden. CAFP suggests that family physicians who wish to implement policies to charge patients for form completion should keep in mind the following:

Physicians who routinely charge for forms completion should obtain an Advance Beneficiary Notice (or similar waiver where applicable) from patients and should post a notice of these charges in their offices so patients can be aware in advance.

Fees for form completion should be determined based upon the actual time needed to fill out forms.

Physicians practicing under capitated payment arrangements should review the applicable contracts carefully to ensure that traditionally un-reimbursed services such as form completion are clearly identified as non-covered services. *(BoD 1/2003)*

Co-Payments

Oppose changes in co-payments without prior contractual consent by contracted health care providers. Educate CAFP members about contractual language in agreements that may affect co-payments during the contractual period. *(CoD 2/1996)*

Topic: out of pocket

Consultants

Health plans, medical groups, and IPAs must make current and accurate lists of plan consultants available on a monthly basis. *(CoD 2/2001)*

Topic: transparency

Explanation of Benefits

Continue to support ongoing legislative and other activities to achieve the goal of holding health insurance capitated plans accountable for explaining covered and non-covered services to patients. *(CoD 2/1997)*

Forms
Encourage the development and use of a universal form such as those used for consultation, ancillary tests/x-rays and pharmaceuticals to be accepted by all insurance, HMO, IPA and other health care agencies. *(BoD 11/2001)*
Topic: administrative burden

Gag Clauses
Declare gag clauses an unethical and unacceptable interference in the patient-physician relationship. *(CoD 2/1996)*

Immunization Policies
Encourage plans to: (1) Clearly specify immunization policies in writing for patients and providers by immunization name and time frame for covered services; and (2) Specify that additional immunizations outside of the contractual series are non-covered services. Educate its members about contractual language in agreements that clearly explain covered and non-covered immunization practices. *(CoD 2/1996)*
Topic: vaccines

Incentivizing Continuity and Comprehensive Care to Support Multidisciplinary Clinical Teams
CAFP supports payment models that incentivize and financially support continuity, comprehensive, coordinated care; and be it further

CAFP supports financial models that incentivize person-centered multidisciplinary clinical care teams. *(BoD 7/2024)*

Employer Mandate for Non-HMO Options
CAFP representatives to both the AAFP and CMA House of Delegates propose resolutions urging both of these organizations to support legislation requiring corporations with more than twenty-five (25) employees to offer some non-HMO health insurance option in addition to an HMO. *(CoD 2/1991)*

Stability and Continuity of Care
A health plan must keep the physicians, physician groups and hospitals it advertised when a patient enrolled available to the patient for the duration of the patient's contract. A health plan must keep the medications it advertised when a patient enrolled available for the duration of the patient's contract. *(CoD 2/2001)*

Support Appropriate Medical Care
Oppose any government health or medical care insurance program that limits the right of individuals to purchase appropriate medical care prescribed by physicians. *(CoD 1/1995)*

Truth in Advertising
Encourage the proper state and federal regulatory commissions by whatever means its Board of Directors deems appropriate to ensure that there be "truth in advertising" relative to claims and promises made by managed care health organizations in their sales promotions to patients and employers. CAFP Board of Directors reports its progress to the Congress of Delegates at its 1995 meeting and at more frequent intervals, as indicated. *(CoD 2/1994)*

Infrastructure Improvements
Continue to improve and update CAFP government relations infrastructure: State and Congressional key contacts, Legislator Information Plan, mailing list, areas of expertise, etc. Ensure the availability of prenatal care services. Reduce hassle by administrative bodies. Ensure fair and impartial peer review. Develop member involvement in policy issues via such avenues as presentations to help local chapters on government and medical policy. *(BoD 11/1998)*

10.03 Health Care System Reform

Ban Private Equity Ownership of Medical Practices and Hospitals
CAFP advocates for policies and regulations that promote transparency and accountability in healthcare ownership and operations, ensuring that healthcare decisions are made in the best interest of patient care and community health. *(BoD 7/2024)*

CAFP supports research and data collection on the impact of private equity ownership in the healthcare sector, to inform policymakers, healthcare professionals, and the public about the effects on patient care, healthcare costs, and the healthcare workforce. *(BoD 7/2024)*

Hassle Factor
Endorse the ASIM publication "The Hassle Factor: America's Health Care System Strangling in Red Tape" and incorporate anti-hassle comments into all communications and analyses of health care reform. *(BoD 05/1993)*

Health Care System Reform Policy Principles
The following is a summary of CAFP's Health Care System Reform Principles. For more detailed information, please see our Policy Reference Report on Health Care System Reform here or on CAFP's website at www.familydocs.org/policy.

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

It is the policy of the California Academy of Family Physicians (CAFP) that health care is a human right and every person has a right to comprehensive, high-quality health services delivered in a timely, culturally-competent and economically sustainable

manner regardless of their age, gender identity, sexual orientation, geographic location, income, health status or immigration status. Primary care must be the foundation on which any health care system is built.

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

- **Universal**: providing insurance coverage to every person.
- **Comprehensive**: providing insurance that includes all essential and needed health services.
- **Timely**: providing sufficient workforce and access to the appropriate health care clinician within reasonable time and distance standards.
- **High Quality**: delivering health services according to medically- and culturally-determined standards of practice.
- **Sustainable**: accounting for overall system financing, as well as the financial sustainability of family medicine practices. *(BoD 7/2017)*

Supporting Access to OB Services for All Californians
Access to safe OB services be reframed as a public good in which dedicated and energetic efforts be made to have basic hospital maternity services available within an evidence-based, reasonable time frame of public or vehicular transportation; and be it further

CAFP support an effort to bring stakeholders together to define and enact measures needed to achieve access to obstetrical services in all California communities. *(BoD 7/2024)*

State Revenue Sources
CAFP supports new sources of state revenues to preclude drastic cuts in health care and other programs including an oil severance tax, increasing the tobacco tax, restoring vehicle license fees, and enacting a "nickel-a-drink" tax on alcohol.

Definition of Primary Care
Oppose any effort to weaken the definition of primary care physician as defined in California statute in such a way that it could result in a lower standard of care to patients. *(CoD 1/1995)*

CAFP adopt, but not limit itself to, the entire statement on Definitions Regarding Primary Care, as adopted by the American Academy of Family Physicians. *(CoD 1/1995)*

Definition of Primary Care/OB-GYNs
Adopt a joint statement on the definition of primary care which includes obstetricians-gynecologists whose practice characteristics meet the definition with the American College of Obstetricians-Gynecologists. *(BoD 10/1993)*

Align CAFP and AAFP Policy on the Means To Achieve Health Care For All
CAFP support value-based care models and approaches to achieve Health Care for All, including Single Payer, Public Option with Bismarck Approach, and Primary Care Coverage for All. *(BoD 4/2023)*

UNIVERSAL ACCESS TO CARE/AAFP Board Report F 2017
The California Academy of Family Physicians asks the American Academy of Family Physicians (AAFP) to include the data and conclusions of 2017's Board Report F in evidence-based Academy educational programs, continuing professional development/education activities, and stage presentations at AAFP meetings in the areas of health care policy, health care economics and health care systems. *(BoD 4/2018)*

Health Policy/General Statement
The CAFP affirms the following seven principles:

1. **Health care is a human right.**
   All people should have access to essential, effective health care regardless of their ability to pay. The CAFP supports measures that improve access and quality of care and will advocate for reforms that appropriately value primary and preventive care.

2. **We believe in evidence-based medicine and public health policy.**
   CAFP reaffirms its commitment to the principles of science. Medical research must be non-partisan, unbiased, and based on the scientific method. Public health policy must be evidence-based and free from political motivation. Social determinants of health and such things as a degraded environment that affects a community's drinking water or its air quality also must be addressed.

3. **Mental health services are a fundamental part of health care.**
   CAFP supports parity for mental health care and treatment for substance use disorders. Efforts should be made to reduce stigma and remove barriers to mental health services. Addiction is a chronic and debilitating disease that requires compassion and treatment, not judgment and punishment.

4. **Women's health must be protected.**
   CAFP rejects violence against women in all forms. CAFP supports women's access to comprehensive health services without fear of intimidation or violence. This care must include safe and effective contraception and reproductive health services. CAFP supports every woman's right to self-determination, without government interference in decisions that should be based solely on an individual woman's values and safety in consultation with her physician. CAFP opposes policies designed to restrict access to comprehensive reproductive health care by placing medically unnecessary regulatory burdens on physicians.

5. **CAFP believes patients deserve access to health care, regardless of immigration status.**
   Family physicians treat immigrants and refugees every day. Many in these communities struggle to keep themselves and their families healthy with limited or nonexistent insurance coverage. CAFP believes communities are safer and healthier when all individuals, regardless of immigration status, have access to health care. CAFP rejects policy that requires physicians to report undocumented individuals as it is not consistent with our mission as health care providers.

6. **The neglect and mistreatment of marginalized communities affects health and must be opposed.**
   CAFP believes that the experience of discrimination negatively affects health. Hate crimes and violence against religious, sexual, and racial minorities pose direct harm to

patients. These problems are compounded by disparities in access to quality health care. CAFP opposes prejudice in all health care settings and communities.

7. **All people, regardless of their gender identity or sexual orientation, should be treated with dignity and respect.**
LGBTQ patients face challenges in accessing culturally competent, safe, and comprehensive health care. CAFP supports the equitable treatment of the LGBTQ population and stands against violence towards and victimization of these groups. *(BoD 2/2017)*

Access
CAFP actively pursue measures which ensure the provision of access to basic health care. *(CoD 2/1992)*

Health System Reform
Acknowledge the need to rekindle interest in health system reform to emphasize primary and preventive medicine and revisit the creation of a bill or another vehicle that would mandate any university receiving state moneys increase primary care training and family practice residencies. *(CoD 1/1995)*

Principals for reform developed by the Cognitive Coalition
1. Universal Coverage: All Californians should have insurance coverage for primary and preventive services and for catastrophic costs.
2. Access: All Californians should have access to the primary care and specialist physicians to meet their health care needs.
3. Primary Care Medical Home: A reform plan should include a patient-centered primary care medical home that fosters a partnership between the patient and primary care physician.
4. Health Information Technology (HIT): The state should coordinate a health care infrastructure based on a functioning health information technology system, one that does not put unrealistic economic burden on physician practices.
5. Workforce: There must be an adequate workforce, representing the diversity of California, to address preventive and primary care needs. It is important that appropriate incentives exist to properly attract and deploy this workforce.
6. Health Care Disparities: There must be a clear plan to reduce racial and ethnic disparities in health care.
7. Reporting: Any pay-for-performance or reporting components must be structured so that solo and small physician practices can reasonably participate without facing disproportionate time or technology investments.
8. Financing: Any financing scheme must ensure that small, solo or low-earning practices are not disproportionately affected.

Position on Health Care Reform 2008:
CAFP support only those pieces of health care policy proposals that include the following (LAC recommends points marked with * are first tier priorities):
- Access to health care should be universal and continuous*
- First-dollar or “near first-dollar” (meaning minimum barriers) access to primary and preventive care services (as opposed to catastrophic only)*
- Patients with chronic or other illnesses are included in the general risk pool (or contains some other methodology to ensure that needed care for chronically ill patients is actually covered)
- The financing of health care is affordable, not regressive, and does not cause disproportionate barriers to health care access among poorer people; everyone

should contribute financially to the degree possible—through taxes, premiums, and cost sharing— because all members of society will benefit from universal access to health care services.
- Guaranteed issue, not excluded (either outright or as a result of cost) from health insurance for pre-existing conditions*
- Ensures fairer payment for primary and preventive care services
- Improves support for academic and community based primary care residency recruitment and training.
- Includes "transparent" medical loss ratio of at least 85 percent (and includes auditable accounting methodology)
- Includes "transparent" provider network data from which payers and patients may make informed and meaningful decisions about access to providers by region (and includes auditable methodology)
- Maintains or improves the primary care, patient-centered medical home*
- Addresses the phase-in or new patients within current workforce limitations
- That the health care system strive for efficiency and simplicity by eliminating complex eligibility rules, underwriting, billing procedures and regulatory requirements.
- Establishes a state body that develops recommendations regarding physician pay based on the needs of the state and current unmet physician workforce demands.
- Requires every enrollee to have at least a designated primary care physician, if not a PCMH.

And oppose health care proposals that do the following:
- Provide a lower standard of comprehensive and preventive care such as clinically inadvisable scope of practice expansion (even to allow improved access in poor communities, for example)*
- Increases disparities of access, quality or cost
- Endangers the "team approach" engendered in the medical home with "silo" care" (as defined as limiting the ability to provide full diagnosis or continuity of care as the result of utilizing only one or two members of the team)
- Increase usage of testing, or high end care that increases cost, but not quality;
- Do not offer an opt-out for physicians and reasonable practice alternative(s) for physicians if they do opt out;
- Do not provide for appropriate representation of primary care physicians in any group that negotiates payment (such as the RUC which is tilted toward specialists); and
- Allow the state to subcontract with morphed insurance companies to adjudicate claims.

Single-Payer in California

1) Make CAFP's health care system principles available to any legislators advancing single payer or public option bills; and
2) Prioritize education (of members) on health care reform in 2018, including efforts to move California toward universal health care coverage and access. *(BoD 11/2017)*

Family Physicians the Logical Source

Adopted the revised monograph "Family Physicians – The Logical Resource for Our Evolving Health Care Systems." *8/98 BoD*

10.03a Primary Care for All (PCFA)

Mandatory Primary Care Investment Target

CAFP advocate for regulations and/or legislation to make the Office of Health Care Affordability (OHCA) 15 percent Primary Care Spend target a mandatory rather than voluntary target without changing financing and payment structures. This policy would leave the current structure of health financing intact and convert the OHCA target from its voluntary status to an enforceable one. It would not require all payers to pay the same rates and methods for primary care but would require each plan to conform to the 15 percent target for primary care spending. A state mandate would not apply to Medicare or self-insured employer plans. The plan would include measures to ensure that increased primary care payments to large organizations reach front-line practices and provide appropriate compensation for rural and independent practices. This policy would not include measures to provide insurance coverage of primary care for uninsured individuals. *(BoD 12/2025)*

Topic: HCAI/OHCA

Unified Financing Model or Single Payer Program for Primary Care

CAFP advocate for a state unified financing model or single payer program for primary care carved out from the remaining pluralistic health insurance system. This policy would create a new universal, state-administered single payer program covering primary care services. This would essentially function as a state-sponsored direct primary care model for all Californians with an expectation for all patients to register with a primary care clinician/practice. Californians would retain their other health insurance (private or public plans) for coverage of non-primary care services. For primary care practices operated by large organizations, the plan would include measures to ensure that primary care payments reach front-line practices. The plan would ensure that payment is adequate and appropriate for different settings including rural communities. The budget for the single payer primary care program would be statutorily indexed to 15 percent of total health care expenditures in the state. Primary care physicians who do not wish to participate in this program would be at liberty to practice outside the program and bill patients directly. *(BoD 12/2025)*

10.04 Managed Care

Appropriate Information on Identification Cards

HMOs should be required to furnish patients with written or electronic identification naming the patient's chosen primary care physician, medical group and contracted hospital(s) by the time health care coverage begins. *(CoD 2/1999)*

Assignment of Patients

It is unethical for open panel HMOs to assign or direct patients when the patients have not selected a primary care provider to specific physicians or medical groups. *(CoD 2/1999)*

Support legislation that prohibits open panel HMOs from assigning or directing patients when the patients have not selected a primary care provider to specific physicians or medical groups. *(CoD 2/1999)*

Capitation at Time of Enrollment
Support any appropriate legislative effort that will require the responsible managed care organization to notify physicians of their new enrollees at the time coverage begins and pay the capitation fee from the member's first month of coverage.

Support any appropriate legislative effort that would require the responsible managed care organization to provide an exact accounting and reconciliation of each patient's capitation account on a monthly basis, with financial penalties for failure to comply. *(CoD 2/1999)*

Direct Access Marketing
Actively encourage health plans to evaluate means to improve the referral process and promote adequate communication among physicians; and continue to encourage health plans to collaborate with primary care physicians when developing new products and use marketing strategies that are not disparaging of primary care. *(CoD 2/1997)*

Identify Primary Care Physicians
Support legislation requiring HMOs to furnish patients with written or electronic identification naming the patient's chosen primary care physician, medical group and contracted hospital(s) by the time health care coverage begins. *(CoD 2/1999)*

Maintenance of Physician/Patient Relationships
Maintaining continuity of the physician-patient relationship should be of primary importance in all managed care contracting decisions. Random reassignment of patients by health plans should be avoided. Plans should avoid the problem by notifying physicians and patients in writing, sixty (60) days prior to the anticipated loss of contract, of options to continue existing physician-patient relationships. *(CoD 2/2001)*

Pharmaceuticals-HMO Kickbacks for Drugs
CAFP favors 1) Full disclosure of "kickback" arrangements between health plans and pharmaceutical organizations; and 2) Making sure that discount arrangements are reflected in actuarially sound premiums and capitation rates such that neither patients nor physicians are adversely affected by the use of "kickbacks." *(BoD 10/1997)*

Principles for Managed Care:
Two principles for use in evaluation of managed care legislation:

- Effect on patient care is most important.
- Impact on physicians in managed care settings must be assessed. Follow existing CAFP policy on reimbursement (to influence the government and

third parties in order to assure adequate and fair reimbursement to family physicians.) *(BoD 10/1995)*

Managed Care Access to Care
Advocate on behalf of family physicians and their patients in managed care settings to enhance and protect the following: (1) Access to Care; (2) Comprehensive of benefits; (3) Practice within the scope of competence and training; (4) Fairness to patient, provider and plan; and (5) Patient access to his or her own primary care physicians within the plan. *(CoD 2/1996)*

Standards, Protocols and Due Process
Acknowledge the importance of studying, clarifying and participating in the development of standards, protocols and due process used in determining retention or termination of physicians and communicate the implications of importance of pursuing relationships with major contracting entities to study, clarify and participate in the development of standards, protocols and due process used in determining retention of termination of physicians with the CMA. *(CoD 1/1995)*

Termination without Cause
Oppose the abuse of "termination without cause" provisions in physician contracts. *(CoD 1/1995)*

Timely Designation of PCP
Adopted as policy that patients enrolling in open panel HMO plans must choose a Primary Care Provider by the time of enrollment.

Support legislation requiring that open panel HMOs arrange for all enrollees to choose a primary care provider by the time health care coverage begins.

10.05 Medi-Cal

California Children's Services Recipients of Funding
CAFP seek administrative policy change in the State Office of California Children's Services to require empaneling of qualified family physicians as primary care providers to recipients of CCS funding, and that the CAFP request its members that are caring for such handicapped children and adults to make themselves known to the CAFP, CCS, and their locally elected representatives to the California Senate and Assembly encouraging remedy to this situation. *(CoD 2/1989)*.

Explore legislative and regulatory avenues to expand California Children's Services physician panels to include family physicians. *(BoD 5/1998)*

California Children's Services Discriminatory Policies
CAFP continue to support regulatory changes to California Children's Services to eliminate discriminatory practices and facilitate family physician empanelment; and actively support family physicians in those hospitals where California Children's Services regulations and hospital-related decisions are infringing on core family

medicine competencies and privileging, as well as quality and continuity of patient care. If needed, CAFP support legislation to facilitate regulatory changes in California Children's Services empanelment of family physicians to eliminate discriminatory practices. *(CoD 3/2009)*

Medi-Cal Payment for E/M Services Delivered by Residents
CAFP supports payment policies that allow Medi-Cal reimbursement for all levels of office/outpatient evaluation and management (E/M) codes delivered by residents without direct supervision in such cases where the teaching physician believes such care is clinically appropriate without the presence of a teaching physician, similar to the primary care exception included in Medicare's teaching physician policy. *(CoD 2/2001, updated 9/2026)*

Medi-Cal Payment Rates
CAFP supports increasing Medi-Cal payment rates to match Medicare payments. *(BoD 4/1989, updated 09/2026)*

Increasing State Investment to Expand Home and Community-based Alternative Waiver Program (HCBA) Capacity
CAFP supports ensuring full access to Home and Community Based Services (HCBS) for Californians at need so disabled individuals, older adults, and medically fragile patients can safely remain in their homes and communities and avoid residing in nursing homes when needed. *(BoD 4/2026)*

Medi-Cal Mandated Patient Education
CAFP should oppose an attempt by the Department of Health Services to mandate patient education because it is an unfunded mandate that intrudes on the physician/patient relationship, especially given that medical societies have not been consulted in the development of the standards. *(BoD 11/1999)*

Medi-Cal Audit Exemption to Improve Access to Care
CAFP continue to support:

- Simplified compliance guidelines to provide services to Medi-Cal patients
- Incentive programs and other resources to support primary care clinics to see Medi-Cal patients *(BoD 5/2025)*

Medi-Cal Dietitian Access
CAFP supports policies that provide comprehensive insurance coverage of dietitian referrals for all patients in primary care settings.
Topic: nutrition

Mental Health Carve-Out
Seek to influence implementation of the Medi-Cal mental health carve-out currently being considered for adoption such that family physicians be included as providers for mental health and appropriately compensated; instruct the CAFP legislative advocate and LAC to communicate with appropriate representatives and administrators at the

state level to discourage the fragmentation of care in Medi-Cal managed care proposals. *(CoD 1/1995)*

Oppose Work Requirements for Medicaid
CAFP opposes work, community service and education requirements for individuals to qualify for Medicaid, as it is a deterrent/roadblock for individuals to access care and may lead to more individuals becoming uninsured. *(BoD 4/2026)*

Protect Medicaid Beneficiaries with Disabilities
CAFP opposes any and all attempts to cut federal Medicaid funding, both with respect to the Community First Choice State Plan Option, Medicaid funds to people with disabilities receiving Home and Community-Based Services and the broader Medicaid program. *(BoD 4/2017)*

Support Family Medicine Residency Program Participation in Medi-Cal Managed Care Plans
CAFP will urge state officials to recognize the importance of protecting family medicine residency programs and the patients that they serve; and will urge state officials to ensure that Medi-Cal managed care risk adjustment recognizes the greater complexity of patients in residency-associated populations and encourage contracting decisions that would enable family medicine residency programs to continue to care for such populations. *(CoD 3/2010)*
Topic: graduate medical education

Support for Medi-Cal and Medicaid Coverage of Medication Abortion Services Without Gestational Age Limits
CAFP supports both legislation and executive action to remove the unnecessary gestational limits on medication abortion access for Medi-Cal enrollees, thereby leaving the decision about appropriate medication use to the patient and provider. *(BoD 5/2024, updated 9/2026)*

CAFP oppose limitations on Medicaid coverage of medication abortion. *(CoD 9/2024, updated 9/2026)*
Topic: reproductive health

Support Full-Scope Medi-Cal Access for Californians, Regardless of Immigration Status
CAFP shall support full access to Medi-Cal (including dental coverage) for all income-eligible Californians, regardless of immigration status

CAFP support policies that promote full equitable health care coverage that do not establish disparate levels of financial contributions based on immigrant, citizenship, or residency status. *(BoD 4/2026)*
Topic: immigrant health, undocumented

Support Medicaid Expansion to Include Undocumented People

CAFP support efforts to extend eligibility for full scope Medi-Cal benefits to undocumented individuals in California. *(BoD 6/2021)*
Topic: immigrant health

10.06 Medicare

Medicare Payment
CAFP supports equal pay for similar services for all physicians and supports 100% Medicare payment for new physicians. *(CoD 2/1991)*

Protect Original Medicare
CAFP supports protecting Traditional/Original Medicare from for-profit entities such as insurance companies and private equity firms.

CAFP supports AAFP in efforts to protect Traditional/Original Medicare from for-profit entities such as insurance companies and private equity firms.

CAFP supports AAFP in working with the Center for Medicare and Medicaid Services (CMS) to increase guardrails for ACO REACH and to increase the auditing of Medicare Advantage plans and demand increased accountability from Medicare Advantage plans. *(BoD 11/2024)*

10.07 Physician Payment

Advocating for Same-Day Billing of Primary Care and Mental Health Visits
CAFP will support and advocate for state legislative efforts to allow for reimbursement of both primary care and mental health visits when done on the same day and at the same institution by a qualified provider. *(BoD 6/2021)*
Topic: behavioral health integration

Balance Billing
CAFP position is to allow balance billing, but with some type of limit. *(BoD 11/2005)*
Topic: out of network, surprise billing

Payment Equity
CAFP supports payors, health systems, and regulatory bodies to develop policies that reimburse procedures and services based on physician training and demonstrated competence rather than specialty designation. *(BoD 4/2026)*

Third Party Payments
Make known to third party payers the increased cost of certain patient care services, e.g., surgical trays and after-hours services) and encourage them to fairly compensate family physicians for the cost of providing these services. *(CoD 1/1995)*

Acknowledge the importance of studying, clarifying and participating in the development of standards, protocols and due process used in determining retention

or termination of physicians and communicate the implications of importance of pursuing relationships with major contracting entities to study, clarify and participate in the development of standards, protocols and due process used in determining retention of termination of physicians with the CMA. *(CoD 1/1995)*

Workers' Comp Reform
CAFP continue to press for an RBRVS-based fee schedule with a single conversion factor that boosts payments for the Evaluation and Management codes to at least 120 percent of Medicare. Join with CMA and other physician organizations in supporting use of Independent Medical Review to resolve disputes. *(BoD 2005)*

10.08 Prescription Drug Access

10.08a Formularies

Androgen Formulary Coverage
Inform third party administrators of the medical syndrome of androgen deficiency; CAFP to resolutely request coverage of androgen replacement therapy in all third party formularies without requesting a case-by-case appeal. *(CoD 2/1997)*

Formulary Issues
CAFP should:

- Continue to oppose the practice of pharmaceutical discounting to HMOs and make this position widely known.
- Support legislation that would prevent HMOs from transferring inappropriate pharmacy risk on to medical groups.
- Advocate broadly for differential co-pays so that consumers experience costs that are at least somewhat commensurate with the actual price differentials, i.e., requesting Claritin should be a more expensive option that requesting a generic. *(BoD 11/1999)*

Outpatient Medical Formularies
All outpatient medical formularies should be supplied by health plans to a central access point, updated at least monthly, in order to provide easy, immediate, and accurate medication information to prescribers, patients, and pharmacists. *(CoD 2/2001)*

10.08b Prescription Drug Cost / Transparency

Drug Safety and Availability
CAFP recommend the American Academy of Family Physicians consider measures to work through existing channels in the federal government, such as the Food and Drug Administration, the National Institutes of Health, and the U.S. Congress, to ensure the safety and availability of drugs to the American public. *(CoD 4/2005)*

Prescription Drug Cost Containment and Price Transparency Policy

1. CAFP urges the elimination of the Medicare prohibition on drug price negotiation and encourages federal legislation to give the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. CAFP supports an appropriate balance between incentives for innovation and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
3. CAFP opposes anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
4. CAFP encourages the mitigation of restrictions that limit patient access to, and market competition for, prescription medication.
5. CAFP encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. CAFP supports increased manufacturer rebates if the price of a generic drug rises faster than inflation.
7. CAFP supports shortening exclusivity time periods for biologics.
8. CAFP supports the freedom of family physicians to use the most effective pharmaceuticals when prescribing drugs for their patients and encourages family physicians to supplement medical judgment with cost considerations in making these choices;
9. CAFP encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;
10. CAFP encourages family physicians to consider prescribing the least expensive FDA A-rated generic products, unless it is not available; and
11. CAFP encourages family physicians to become familiar with the prices in their communities of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

CAFP supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs incentivize research and development of clinically needed prescription drugs, while ensuring patients can reasonably afford their medications as long as clinically indicated. *(BoD 7/2016)*

CAFP support efforts that ensure medical treatments derived from publicly funded ventures are affordable and accessible to all patients.

CAFP support transparency in publicly funded pharmaceutical research and resultant data, including the publishing of all clinical trials. *(BoD 9/2020)*

Supporting Expanded Research and Rescheduling of Therapeutic Psychedelics
CAFP supports legislation and regulatory changes that facilitate scientifically, rigorous, Institutional Review Board (IRB)-approved, physician-led clinical research into the therapeutic use of psychedelics, including but not limited to psilocybin for the treatment of psychiatric and substance use disorders; and be it further

CAFP supports the rescheduling for research and tightly regulated therapeutic frameworks of ibogaine, MDMA, and LSD, particularly for the treatment of Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) in veterans, refractory depression and anxiety and be it further

CAFP supports federal funding and "Safe Haven" protections for researchers investigating these therapies. *(BoD 4/2026)*

Changing DEA Schedule Class of Psilocybin
CAFP supports changing psilocybin DEA scheduling in order to allow for expanded clinical research. *(BoD 7/2024)*

MEDICAL PRACTICE AFFAIRS

This section contains policy about medical practice affairs. This includes privileges, credentialing, electronic health records, and more. Medical practice affairs encompass policy relating to regulatory compliance, professional governance and physician practice.

20.01 Direct Primary Care

Direct Primary Care Policy Principles

The direct primary care (DPC) model is a variation of the retainer practice framework for primary care physicians. DPC practices charge patients a flat monthly or annual fee, under terms of a contract, in exchange for access to a broad range of primary care and medical administrative services. The retainer practice framework includes any practice model structured around direct contracting with patients/consumers for monthly or annual fees that serve to replace the traditional system of third party insurance coverage for primary care services. Typically, these "retainer fees" guarantee patients enhanced services such as 24/7 access to their personal physician, extended visits, electronic communications, in some cases home-based medical visits, and highly personalized, coordinated, and comprehensive care administration. The AAFP supports the physician and patient choice to, respectively, provide and receive healthcare in any ethical healthcare delivery system model, including the DPC practice-setting.

The DPC contract between a patient and his/her physician provides for regular, recurring monthly revenue to practices that typically replaces traditional fee-for-service billing to third party insurance plan providers. For family physicians, this revenue model can stabilize practice finances, allowing the physician and office staff to focus on the needs of the patient and improving their health outcomes rather than coding and billing. Patients, in turn, benefit from having a DPC practice because the contract fee covers the cost of all primary care services furnished in the DPC practice. This effectively removes any additional financial barriers the patient may encounter in accessing routine care primary care, including preventative, wellness, and chronic care services. Most patients, depending on affordability, choose to still carry some form of insurance, such as a high deductible health plan, for coverage of healthcare services that cannot be provided in the primary care practice setting, such as specialty care and hospitalizations.

Ideally, the DPC model is structured to emphasize and prioritize the intrinsic power of the relationship between a patient and his/her family physician to improve health outcomes and lower overall health care costs. The DPC contract fee structure can enable physicians to spend more time with their patients, both in face-to-face visits, and through telephonic or electronic communications mediums should they choose, since they are not bound by insurance reimbursement restrictions. For these reasons, the DPC model is consistent with the AAFP's advocacy of the PCMH and a blended payment method of paying family medicine practices. *(BoD 11/2014)*

Clarifying that Direct Primary Care Agreements are Not Insurance
CAFP continue to advocate for the Direct Primary Care model based on their previous policy, and support policies in California that define a Direct Primary Care agreement as being between a physician and patient* for primary care medical services and does not constitute the business of insurance. *(BoD 11/2024)*

20.02 Electronic Health Records and Technology

Ambulatory Clinical Pharmacist Care Across State Lines
CAFP supports strategies that allow effective and sustainable integration of clinical pharmacist services into ambulatory clinical settings with collaborative practice agreements with physicians; and

CAFP supports insurance coverage and alternative payment models that incorporate clinical pharmacist services into ambulatory clinical settings with collaborative practice agreements with physicians. *(BoD 8/2025)*
Topic: confidentiality, HIPPA, abortion, gender affirming care

Electronic Monitoring Limits on Prescribing
Recommend to all appropriate state agencies that electronic monitoring be limited to only Schedule II medications. *(CoD 1/1995)*

Error Reporting System
CAFP supports a self-reporting system for medical errors based on a system that:

Protects peer review information – information developed in connection with reporting systems should be privileged – the information should be limited to corrective uses and not used for punitive purposes of federal and state administrative proceedings, discovery, subpoenas, testimony or any other broader action stemming from its disclosure. The protected status of information prepared for a reporting system should extend to any data, report, memorandum, analysis, statement or other communication developed for the purposes of the system. These protections should not interfere with the disclosure of information that is otherwise available, including the right of individuals to access their own medical records.

The submission of health care error information to a reporting system The submission of health care error information to a reporting system, or the sharing of information by health care organizations or reporting systems with third parties in accordance with these principles, should not be construed as waiving this protection or any other protection under federal or state law that exists with respect to the information.

Health care error information received by and from reporting systems should be exempt from the Freedom of Information Act and other similar state laws. Such an exemption is necessary to preserve the privileged status of the information previously discussed in this principle. A federal law is necessary to assure protection of

information submitted to national reporting systems, but the federal protection should not preempt state evidentiary laws that provide greater protection than federal law. Providing such information to reporting systems should not constitute a waiver of any state law privilege.

Hospital Medical Records and Continuity of Care
Encourage hospital medical staff offices to foster improved and timely communication between the respective admitting hospitalists and PCPs. *(CoD 4/2005)*

Encourage admitting hospitals to produce and forward relevant medical records, such as admission history and physicals, consultation reports, and comprehensive discharge summaries, to the patient's respective PCP upon discharge via such means as fax, email, and hospital portal systems. *(CoD 4/2005)*

Work with the California Medical Association and the California Healthcare Association to establish as a standard of care under JCAHO and the California Institute for Medical Quality requiring all California hospitals to routinely list the names of referring physicians along with the admitting physicians on hospital admitting forms. *(BoD 11/2005)*

Protecting Sensitive Medical Information from Inadvertent Sharing Across State Lines
CAFP supports restricting automatic sharing of sensitive EHR and insurance data across state lines without patient approval.

CAFP shares relevant information to members regarding physician and EHR responsibility to prevent sharing of sensitive records across state lines.

CAFP support the requirement that EHR vendors, QHIOs, insurances, and other data aggregators create appropriate data segmentation and privacy settings to limit sensitive data across state lines. *(BoD 1/2025)*

20.03 Emergency Care

Emergency Room Coverage

- The medical community has a moral and ethical responsibility to provide emergency coverage that is equitably shared for the hospitalization and treatment of unassigned patients presenting to the emergency room;
- The issue of emergency room call coverage is one that is best resolved at a local level in a joint effort involving hospitals and their medical staffs;
- Hospitals and their medical staffs should work cooperatively with their communities to identify appropriate incentives, distributed equitably between primary care and sub-specialist physicians, to help guarantee adequate medical staff coverage of local emergency rooms;

CAFP supports the practice of reasonable compensation for all on-call coverage. *(CoD 4/2003)*

20.04 Full Spectrum of Family Medicine

Family Physicians as Hospitalists
With the help of the AAFP, promote family physicians as qualified hospitalists, and family medicine as an efficient and comprehensive model of hospital care. *(CoD 3/2007)*

Support Family Physicians to serve as hospitalists by a range of means that could include continuing medical education, job search, and promoting family physicians' scope of practice to include hospitalist practice. *(CoD 3/2007)*

Pediatric Care
CAFP strongly encourages the opportunity for members to practice the full scope of family medicine. This includes providing pediatric care from birth. Graduates of family medicine residency programs are well-trained in both inpatient and outpatient pediatric care. Furthermore, family physicians are particularly effective providers for children and families because of their wide breadth of experience and training. Because most family physicians see patients of all ages, children can look forward to having the same physician care for their needs from birth through adulthood, and thus truly provide continuity of care. Frequently with knowledge of the entire family, family physicians are at a real advantage in that they may also be more cognizant of the ongoing medical, emotional, and social issues within families that can adversely impact children's health.

It is therefore the CAFP's recommendation that prospective and new parents should be given equal access to selecting a family physician at the level of registration or nursing in a hospital, as a member of a health system, or at any other point in the continuum of care. In particular, when choosing a physician for their yet-to-be-born child, it is the Academy's strong recommendation that the parent be asked, "Who is or will be your baby's doctor," to ensure that patients understand that they may choose a family physician as their child's doctor. CAFP would also encourage, in the interest of fairness, hospital and health system publications to refer more broadly to physicians who care for children, rather than only to pediatricians. Rather than statements that refer to physicians other than pediatricians, the Academy recommends affirmative statements that explicitly refer to family physicians and pediatricians. This policy recommendation is consistent with American Academy of Family Physicians Principles of Interaction between Family Physicians and Health Plans which states that: "Health plans must explicitly include family physicians in any reference to access to 'women's health services and services for children and the aged.'" *(BoD 11/2006)*

20.05 Independent Practice

Independent Practice Support

CAFP will endeavor to support and promote the private or independent practice of medicine, be it solo practice, small group, or large group. *(BoD 7/2021)*

20.06 Medical Licensure / Patient Safety

Abolish the California Postgraduate Training License
CAFP support efforts to abolish the PTL or limit the post-graduate training license (PTL) to residents in their first year so that residents are able to obtain a full, unrestricted license after fulfilling licensure examination requirements and completing PGY1 (United States medical school graduates) or PGY2 (IMGs); and

CAFP encourage the MBC find other less restrictive and onerous means to accomplish the apparent intent of the PTL and advocate for the residents and FMR programs that are affected by this incompletely thought through and poorly executed requirement that affects ALL residents and EVERY residency program in California, not only FMRs. *(BoD 6/2021)*

Interstate Medical Licensure Compact
CAFP supports efforts to ease restrictions and undue burdens to licensure for qualified, eligible physicians, including but not limited to, the adoption of the Federation of State Medical Boards' Interstate Medical Licensure Compact. Changes to the process of physician licensure should prioritize improved patient access to family physicians and must not endanger patients. *(BoD 2/2016)*

Licensure During Residency
CAFP oppose restrictions which mandate more than one year of post-graduate training prior to licensure for individuals in good standing in an accredited residency program. *(BoD 2/1992)*

Probationary Status
CAFP make information available to members about the potential consequences of having a medical license placed on probationary status and its subsequent effect on practice. *(CoD 3/2011)*

Rehabilitation
CAFP supports the development of a program that would allow Medical Board oversight of rehabilitation without jeopardizing the careers of good physicians. *(BoD 11/2001)*
Topic: impaired physicians, physician wellness

Section 805 Enforcement and Compliance
CAFP will oppose legislation calling for increased penalties for failure to report under 805 requirements unless such legislation makes crystal clear what is reportable. CAFP will also work more closely with hospitals to achieve such clarification. CAFP opposes changing the reporting line to the Department of Health Services from the Medical Board of California. CAFP will undertake to educate its members on the value

of peer review and will work toward a climate of practice that encourages self-reporting and fearlessness about doing so, and focuses on correcting behaviors that lead to medical errors.
Topic: impaired physicians

Section 805 Reporting Requirements
The requirement to report practice restrictions by peer review bodies as provided in Section 805 of the Business and Professions Code can be an important safeguard for patients because of the migration of physicians between practice settings which are under separate jurisdictions. However, because Section 805 reports are so injurious to a physician, steps should be taken by the Medical Board to:

- ensure that 805 reports warrant Medical Board discipline, rather than correction and improvement measures;
- ensure that smaller organizations without significant legal resources have clear criteria and/or access to a Medical Board Section 805 legal advisory service;
- develop "severity" categories of 805 reports that distinguish between those which must go to the National Practitioner Data Bank (NPDB), those which it is the Medical Board's jurisdiction to decide, and those which are non-reportable.
- clarify for health care institutions, physicians and other medical providers what is reportable under 805 requirements.

Topic: impaired physicians

Supporting Standardized Licensure for US and International Medical School Graduates (IMGs) in California
Advocate for allowing IMGs currently engaged in ACGME-accredited training programs to be eligible to obtain an unrestricted medical license after one year of residency.

CAFP will work collaboratively with other medical and community organizations, to advocate for the implementation of IMGs currently engaged in ACGME-accredited training programs to be eligible to obtain an unrestricted medical license after one year of residency, recognizing the significant contributions that IMGs can make to the healthcare workforce in California. *(BoD 8/2025, updated 9/2026)*
Topic: Medical Board

20.07 Privileges and Credentialing

Adoption of Affiliated Physician Category
CAFP supports creating a mechanism to document physician hospital affiliation for credentialing purposes, including for those physicians who do not regularly admit inpatients. *(CoD 4/2004)*

Board Certification

Oppose the use of absence of board certification as the sole basis for exclusion of family physicians from provider panels and hospital staff memberships. *(CoD 1/1995)*

Discrimination in Obstetrical Credentialing
That no residency be accredited in a teaching hospital that discriminates against family physicians in obstetrical credentialing. There should be evidence that family physicians can fairly obtain privileges at that teaching hospital. *(BoD 6/1992)*

FP Shortages on Hospital Committees
CAFP supports re-educating members about the importance of maintaining a minimum hospital practice if they wish to be involved in hospital committee work and/or peer review, in keeping with CAFP policy.

CAFP supports relaxing the standards for hospital committee service so that physicians with less than full admitting privileges can serve on hospital committee. *(BoD 11/1999, updated 9/2026)*

Hospital Privileges
Encourage CAFP members to retain hospital privileges and to exercise them to the extent appropriate to maintain current competence in the specialty of family medicine and cause members to understand the dangers of financial arrangements that penalize member physicians for providing hospital care. A-7-96, 2/96 CoD

Study the issues of voluntary relinquishing of hospital privileges, in-patient hospital care terms, and the ramification of these issues on health plan panel membership and credentialing, and report the findings and recommendations to the CAFP Congress of Delegate; and be it further that the CAFP work with the American Academy of Family Physicians to address how family physicians will be able to maintain their skills and full scope of practice in light of the economic changes and pressures that are behind relinquishing hospital privileges and the creation of in-patient teams. *(CoD 2/1997)*

Joint CAFP and ACOG Statement on Practice Privileges
Privileges should be granted on the basis of education, experience and demonstrated competence, not solely on specialty, membership in a specific scientific organization or a physician's rank or tenure. *(BoD 12/1995)*

Privileging Guidelines
CAFP supports the development of a tool establishing specific objective criteria to be used as a guideline for health care organizations granting privileges to family physicians. *(BoD 8/1998, updated 9/2026)*

Remote Patient Interaction
CAFP publicize to the many payors of health care the value of remote physician-patient interaction and the need for appropriate physician compensation. *(CoD 2/2000)*

20.05 Telehealth

Physician Supervision of Telehealth Services

The delivery of health care services via telehealth should be consistent with the Joint Principles of the Patient Centered Medical Home and state laws governing the scope of practice of health care providers. When telehealth is used:

a) The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by non-physician providers through telehealth.
b) Physician supervision (i.e., standardized procedures and protocols) is required when non-physician providers or technicians deliver services via telehealth in all settings and circumstances.
c) Non-physician providers who deliver services via telehealth should do so according to California's applicable non-physician practice acts.
d) The extent of supervision provided by the physician should conform to the applicable medical practice act.

Telehealth Privacy and Data Integrity

Telehealth systems and interactions should prioritize privacy principles and adhere to legal and ethical requirements with respect to patient confidentiality and data integrity.

Coverage of Telehealth Services

CAFP supports the requirement that public and private payers pay for telehealth services. In addition, CAFP encourages the funding and development of:

a. Demonstration projects to evaluate the effect of care delivered by physicians using telehealth-related technology on costs, quality and the physician-patient relationship, as well as demonstrations to evaluate payment mechanisms for telehealth.
b. Appropriate practice parameters to address the various applications of telehealth and to guide quality assessment and liability issues related to telehealth. *(BoD 5/2014)*

Telemedicine Definition, Licensure and Payment

Telemedicine is the use of medical information that is exchanged from one site to another through electronic communications. It includes varying types of processes and services intended to enrich the delivery of medical care and improve the health status of patients.

Some of these processes and services include:

- Subspecialists' consultations and may involve the patient "seeing" the subspecialist during a live, remote consult. It may also include the transmission of diagnostic images or video that the specialist reviews later.
- Using electronic communications that collect and send information to foster remote patient monitoring, such as vital signs or blood glucose levels. Monitoring of this nature assists homebound patients or care-coordination between providers.
- Closely associated with Telemedicine is the term "telehealth" which is often used to encompass a broader definition of remote healthcare that does not

always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, nurse call centers, and remotely tracking vitals are all considered part of telemedicine or telehealth. *(BoD 5/2014)*

The delivery of health care services via telemedicine should be consistent with the principles of ethical medical practice. Regulation should not unduly restrict accessibility of telemedicine services, but appropriate licensure should be assured to protect the patient and the referring physician. CAFP opposes the creation of unreasonable barriers to the practice of telemedicine across borders by state licensing boards; however, full legal accountability for the ordering and interpreting of telemedicine services must be maintained. Family physicians should have full discretion in selecting the most appropriate consultants for their patients.

By creating ready access to information, telemedicine can provide physicians with current medical information that may not otherwise be available in a given setting. CAFP believes that payment should be made for physician services that are reasonable and necessary, safe and effective, medically appropriate and provided in accordance with accepted standards of medical practice. The technology used to deliver the services should not be the primary consideration; the critical test is whether the service is medically reasonable and necessary. Care provided via telemedicine should be paid as other physician services. A record of telemedicine interactions must be created that becomes part of the patient's medical record. *(BoD 5/2014)*

WORKFORCE

This section contains policy about workforce issues. This includes scope of practice, physician wellness, medical student recruitment, and more. Developing a strong workforce is key to family medicine and ensuring a strong primary care pipeline.

30.01 FM / OB Collaborative Issues

Back-up / Consultation

CAFP believes any specialist or any group of specialists with expertise on a hospital's medical staff should be willing to provide consultation or back-up to family physicians with privileges in the same clinical area. *(BoD 6/1992)*

Topic: privileges

Cooperative Practice

Adopt a statement on Cooperative Practice Between Family Physicians and Obstetricians in Maternity Care, jointly supported by the CAFP and the American College of Obstetricians-Gynecologists, District IX, regarding back-up for obstetrical services. *(BoD 10/1993)*

CAFP members who provide obstetrical care be urged to formalize back-up agreements with OB-Gyns and to report any cases of acceptance and non-acceptance on the part of OB-Gyns back to CAFP, and that CAFP actively solicit this feedback, using the appropriate mechanisms, and report back to the Board by February 1996. *(CoD 1/1995)*

Interspecialty Conflict Resolution

Utilize the FP/OB Task Force as an Interspecialty Conflict Resolution Body to identify and mediate problems between the two specialties. *(BoD 6/1995)*

30.02 Funding for Family Medicine Residency Programs

Support Family Medicine GME Finance Reform

CAFP supports reforms to state GME funding programs in California that prioritize funds for Family Medicine programs and change eligibility criteria to be based on program need, provision of care to underserved populations, and recruitment of trainees who reflect the patients served, reported on an annual basis, in order to strengthen primary care residency training and maintain a pipeline of well-trained primary care physicians to care for Californians in every corner of the state. *(BoD 4/2026)*

Funding for Family Medicine Residency Programs

CAFP work with state legislators to develop new strategies to support family medicine residencies in good standing within the state of California;

CAFP current funding sources and continue to explore possible additional funding sources to support family medicine residencies in good standing within the state of California and disseminate this information to these residencies;

CAFP work with AAFP and other organizations including the AMA, family medicine residency programs, and other organizations to explore alternative funding sources at the state and federal level for graduate medical education. *(BoD 11/2005)*
Topic: graduate medical education

Family Medicine Residency Capacity in Underserved Communities
CAFP advocate for adequate health manpower in the state, particularly in underserved areas. *(BoD 1998, updated 9/2026)*

Song-Brown Funding
CAFP work with other organizations, including CMA, to support continuation and augmentation of Song-Brown funding as a policy priority. *(1/1991, updated 9/2026)*

Work to preserve Song-Brown funding and continue to explore other funding strategies as they materialize. *(BoD 10/1994)*

Latino Physician Representation
CAFP recognizes that Latino physicians are underrepresented in the California workforce and supports efforts to address the disparity, and be it further

CAFP advocates for creation and continuation of Hispanic/Latinx structural policies that help improve the number of Latino/Latina Physicians, such as the Primary Care Residency (PCR) of Song-Brown Healthcare Workforce Training Program and the California Medicine Scholars Program. (*BoD 5/2025)*

30.03 Medical Student Recruitment and Student Loan Debt

Forums at Medical Schools
CAFP-Supported Primary Care Forums at Medical Schools:

- First year students would be encouraged to attend these annual events, to be held at the beginning of the academic year.
- Local family physicians would be present to respond to student questions; their attendance would be coordinated by local chapters.
- Medical school departments and Family Medicine Interest Groups (FMIGs) would handle on-site logistics. *(BoD 6/1992)*

Increasing Underrepresented Minority Representation in Medical Education by Establishing a Mentorship Program
That subject to available staff and budgetary resources, CAFP and/or CAFP Foundation expands upon its efforts to increase representation in medicine by establishing a longitudinal mentorship program or utilizing existing programs targeted towards those underrepresented in medicine. *(BoD 6/2021)*

Medical Student Debt Reform
CAFP supports legislation that encourages primary care specialization by reducing the debt burden of past and current medical student borrowers, reducing the interest rate of medical student loans and removing the adjusted gross income cap to qualify for medical student loan interest payment tax deductions. *(BoD 7/2016)*

State Student Loan Repayment Programs
CAFP supports policies that increase access to state administered loan programs covering up to the cost of attendance to support medical students with financial need who plan to practice in primary care specialties.

CAFP opposes student loan borrowing limits. *(BoD 4/2026)*
Topic: student debt

30.04 Physician Wellness

Confidential Support Resources for Physicians with Impairing Illnesses
CAFP advocate for a California Physician Health Program that is confidential and aligned with national best practices; and be it further

CAFP supports access to online resources designed to assist physicians experiencing mental health conditions or other potentially impairing illnesses, including guidance on navigating hospital credentialing, medical licensing, and other professional responsibilities while seeking treatment. *(BoD 4/2026)*

Impaired Physicians
The California Medical Board has taken the position that physicians who, after investigation, are found to suffer from drug or alcohol impairment and who voluntarily agree to treatment and monitoring by the hospital, must be reported under Section 805. Section 805 reports are sent to the National Practitioner Data Bank, often resulting in total loss of contracts to provide health care with health plans. This approach, therefore, discourages physicians from seeking treatment and presents the reintegration of good doctors into medical practice. CAFP supports efforts that would seek optimal methods of treating impaired physicians.

CAFP also supports efforts to develop early intervention programs that would promote voluntary rehabilitation of the physician with minor practice deficiencies.
Topic: licensure

Physician Health Services
Endorse the California Public Protection and Physician Health Organization Guidelines for Selecting Physician Health Services (for impaired physicians) because they may help hospitals, medical groups or wellness committees organize an approach to assisting physicians in need of health services. *(BoD 11/2012)*

Physician Wellness as a Quality Measure

CAFP advocates for improving the work-life balance of health care providers, and supports making physician wellness a quality measure for healthcare systems. *(BoD 4/2018, updated 9/2026)*
Topic: quality measures

Wellness Curriculum Development for ACGME Training Programs
CAFP supports the development of a wellness curriculum toolkit for family medicine residency programs. *(BoD 7/2023)*
Topic: graduate medical education

30.05 Scope of Practice

Independent Practice of Non-Physician Clinicians
CAFP recognizes nurse practitioners (NPs), certified nurse midwives (CNMs) and physician assistants (PAs) as health care providers. NPs, CNMs and PAs work collaboratively with, and under the supervision of, physicians in providing quality health care. CAFP opposes independent practice of NPs, CNMs and PAs. *(BoD 5/1993)*

Naturopathic Doctors
CAFP opposes any expansion of naturopaths' scope of practice that is not supported by naturopathic education and training. Naturopathic education and training do not prepare naturopaths to safely or effectively prescribe medications, perform physicals for school or employment or perform surgical procedures.

A naturopath must not be allowed, under any circumstances, to use the title "physician," nor should a naturopath ever be considered a "primary care physician."

Public and private payers must not be compelled or mandated to pay for naturopathic services.

Training programs preparing naturopaths should be monitored constantly to assure the quality of the training provided, as is the case with the training for all other providers offering health care services to patients. *(BoD 11/2012)*

Nurse Midwives
CAFP recognizes the contribution of Certified Nurse Midwives to the care of the people of California; advocates that Certified Nurse Midwives working in acute health care settings practice only in situations that include appropriate back-up and referral resources, physician supervision as appropriate and documented measures for quality assurance; and does not support direct, independent admitting privileges for Certified Nurse Midwives. *(CoD 2/1996)*

Nurse Practitioner Policy Principles

- A non-physician health professional's scope of practice should correspond to, but not exceed, his or her level of knowledge, skill, experience, licensure and training (using competency training measures). A non-physician health

professional should never independently deliver care that requires the higher level of education and clinical training of a physician.

- Expansion of scope should not jeopardize the efficacy of any practice or safety of any patient, and must not result in a lower standard of care nor create or further "silos" of care. In team-based models, workflow process redesign should focus on maximizing the capacity of each team member to provide appropriate care, as well to decrease errors and improve quality and access.
- Health professionals should work collaboratively in physician-directed team-based models such as patient-centered medical homes. These models use every member of the team to the fullest capacity of his/her training and skills. They lead to collaborative relationships between physicians, nurses and other health professionals.
- Expansion of scope should only take place within the context of standardized protocol or a written/verbal collaborator agreement. Professional liability should remain commensurate with the level of responsibility and independence of practice of each health professional.
- CAFP supports a greater focus on, and support for, team-based training in physician residency programs.
- CAFP supports increased investment in the recruitment, education, team-based training, and retention of all members of the primary care team (primary care physicians, nurses, physician assistants, and others).
- CAFP believes in a multi-pronged solution to the primary care physician shortage that includes the increased use of efficient team-based models, investment in recruitment, education, team-based training and retention of all members of the primary care team, and valuing primary and preventive care by changing the primary care physician pay structure. The expansion of scope of nurse practitioners is not the solution to the primary care physician shortage.

Nurse Practitioner Scope of Practice Policy Principles

- Health professionals should work collaboratively in physician-directed team-based models such as patient-centered medical homes. These models use every member of the team to the fullest capacity of his/her training and skills. They lead to collaborative relationships between physicians, nurses and other health professionals. In team-based models, workflow process redesign should focus on maximizing the capacity of each team member to provide appropriate care, as well to decrease errors and improve quality and access.
- A non-physician health professional's scope of practice should correspond to, but not exceed, his or her level of knowledge, skill, experience, licensure and training (using competency training measures). A non-physician health professional should not independently deliver care that requires the higher level of education and clinical training of a physician.
- Expansion of scope should not jeopardize the efficacy of any practice or safety of any patient, and must not result in a lower standard of care nor create or further "silos" of care.

- CAFP supports increased investment in the recruitment, education, training, and retention of all members of the primary care team (primary care physicians, nurses, physician assistants, and others).
- CAFP supports a greater focus on, and support for, team-based training in residency programs.
- CAFP believes in a multi-pronged solution to the primary care physician shortage that includes the increased use of efficient team-based models, investment in recruitment, education, training and retention of all members of the primary care team, and valuing primary and preventive care by changing the primary care physician pay structure. The expansion of scope of nurse practitioners is not the solution to the primary care physician shortage.
- Expansion of scope should only take place within the context of standardized protocol or a written/verbal collaborator agreement. *(BoD 5/2011)*

Support NPs and PAs in their efforts to increase their primary care workforce, whether through Song-Brown or a separate vehicle, except when these efforts compete with efforts to increase the family medicine workforce. *(BoD 11/2014)*

Principles on the Independent Practice of Medicine by Nurse Practitioners

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

Nurse practitioners (NPs) are valuable health care providers whose scope of practice should correspond to, but not exceed, their level of knowledge, skill, experience, licensure and training (using competency training measures), and an NP should never independently deliver care without obtaining the higher level of education and clinical training of a physician.

CAFP considers ordering and interpreting diagnostic procedures, certifying disability, and prescribing, dispensing, and administering controlled substances to be the practice of medicine. CAFP believes that it is of utmost importance that consistency of standards and regulations be maintained in the regulation of the practice of medicine in California.

CAFP's position on any proposed legislation and/or regulation that seeks to expand the ability of NPs to practice medicine independently of physician supervision will be guided by core principles related to establishing consistency of standards and regulation, as well as the ability of the proposal to address the problems it purports to resolve, including but not limited to: access to primary care, cost of care, quality of care, and the overall sustainability of the primary care workforce. Any such proposal must demonstrate that it establishes or accounts for the following provisions:

Educational standards

1. A uniform, consistent education program to attain NP certification.
2. A uniform, consistent education program to attain independent practice following NP certification, such as or equivalent to completion of training within an accredited residency training program and appropriate testing for the practice of medicine. Residency training, or its equivalent, must include sufficient primary care hours and patient visits in multiple settings of varying acuity to ensure direct observation of clinical proficiency.
3. Initial and ongoing maintenance of certification specific to primary care.
4. Compensation for education, training and practice supervision of NPs by family physicians.

Regulation and oversight

5. Regulation and oversight by the Medical Board of California.

Liability

6. Obtaining and maintaining sufficient liability insurance.

Bar on the corporate practice of medicine

7. Compliance with California's bar on the corporate practice of medicine.

Provision of primary care to underserved populations

8. A requirement of licensure to remain in primary care as opposed to sub-specialization.
9. Incentives to practice in underserved geographic areas and/or delivery of service to underserved populations.
10. Prospective and ongoing analyses of quality of care, cost of care, health care utilization, and provider and patient satisfaction, upon starting independent practice.

Uniformity of requirements

11. Application of the above provisions to NPs relocating to California from a state with independent practice authority. *(BoD 11/2019)*

EDUCATION

This section contains policy about medical education. This includes continuing professional development and education, graduate medical education, and family medicine residency programs.

40.01 Continuing Medical Education (CME)

40.01a CME / Mandates

Continuing Medical Education Policies Paper
Approved the recommendations of the Committees on Continuing Medical Education and Scientific Program regarding planning and implementation of CME activities for the Academy and total quality improvement. *(BoD 11/1998)*

Curriculum
CAFP oppose all mandates on CME curriculum, regardless of topic, because:

1. CME curriculum should be developed by demonstrated clinical need, advances in research, and developments in the field.
2. A physician should be allowed to choose the courses that would best meet the needs of his or her own patients, setting, or practice model.
3. In addition, CAFP should support creation of an advisory group to the Legislature that would be consulted on CME issues. CAFP could work with the Institute for Medical Quality in accomplishing this.
4. Work with the Institute for Medical Quality (an accrediting provider) to create an advisory committee to the Legislature for consultation on CME issues. *(BoD 11/2005)*

Honoraria

1. Honoraria ranges must be consistent and must not be dependent on whether or hot CAFP has received commercial support for the activity.
2. CAFP will delineate in all invitations to participate in academy activities the standard honoraria and reimbursement, and its policies with regard to academy support for a participant.
3. A returned letter of agreement, contract, or assignment form will indicate the acceptance of the honoraria and reimbursement.
4. If honoraria exceed the customary range, documentation explaining the reason for the exception will be placed in the activity file. *(BoD 4/2005)*

Policy
CAFP offers continuing medical education courses to its members as an integral portion of its services. A portion of the membership enjoys these services. In an effort to provide a wide range of services to members and fairly distribute the cost of services to those who utilize them, it is the policy of CAFP to charge a fee for specific services whenever feasible and possible. This policy also provides a foundation for

generating income outside of dues so that dues can remain as low as possible and so that dues income can be allocated to those less tangible services for which fees cannot be charged. *(BoD 1/1991)*

Education on Eating Disorders
CAFP supports responding to the problem of eating disorders by including the issue in its continuing medical education programs. *(CoD 2/2000, updated 9/2026)*

40.01b Continuing Professional Development / Education

ACCME Accreditation and CME Development
Approve the CME Mission Statement as presented for use in ACCME Accreditation and CME development which states: 10/96 The CME Mission Statement is reviewed on an annual basis by the CCPD, and submitted annually to the BOD for approval. *(BoD 10/1996)*

CME Philosophy
Goal: CAFP's continuing medical education mission is to enhance and improve the quality of patient care by maintaining, developing, and increasing the competence, knowledge, skills and professional performance of family physicians, their practice teams and other primary care physicians — within California, nationally and internationally. CAFP's educational programming is based on sound principles of learning and adult education that are tailored for the physician audience through effective needs assessment, development of explicit learning objectives and course content, proven educational methodologies, learning evaluation and physician performance outcome illustrating changes in competence, performance or patient outcomes.

Scope: The scope of the CAFP's CME/CPD Program includes educational activities addressing identified needs and gaps in clinical, scientific and health care socioeconomics, ethics and professionalism areas of interest and importance family physicians worldwide. The program will focus efforts on meeting broad-based competencies as those developed by ABMS, ACGME and/or IOM.

Characteristics of Potential Participants: The target audience for CAFP's educational activities includes allopathic and osteopathic family physicians and other primary care specialists (general internists, pediatricians and obstetricians-gynecologists), family medicine residents and medical students Practice team members (allied health professionals who work within the primary care setting) may also benefit from CAFP educational offerings.

Types of Activities and Services: The format of CAFP's CME/CPD activities includes a variety of educational modalities such as symposia, lectures, small group presentations, case presentations, panel discussions, hands-on workshops, performance improvement, maintenance of certification, interactive online, podcasts, and audio and video conferencing. Individualized learning is facilitated through production of enduring materials including monographs, interactive CD-ROM and Internet applications. These activities may be supported, through registration fees, educational grants, commercial support and joint sponsorship.

Responsibility and Direction: The CME/CPD program is under the direction of the Board of Directors, and receives ongoing physician guidance from the Committee on Continuing Professional Development. Specific planning and implementation input is provided by other CAFP committees and the CAFP professional staff.

Expected Outcomes and Program Evaluation: The expected results of CAFP's continuing medical education program include the following three key elements:
The development and implementation of outcome and output measurement strategies including surrogate markers, follow-up surveys, chart audits, self-assessment surveys pre-and post-tests, case-based assessments and sentinel evaluation methods. These measures will assess improved competence and self-reported performance as well as potentially documented performance improvement.
The promotion of Evidence Based Medicine (EBM) definitions and principles, and the integration of EBM into CME activities.
An increase in the number of learners attending CAFP CME/CPD activities who report an expected change in practice consistent with the identified need, target outcome or activity purpose.

CAFP overall CME/CPD Program evaluation is performed at least annually by the following review process, including these markers:

Activity evaluations summaries and outcome assessments efforts will to continue to expand.
CME/CPD staff effectiveness including financial strength, committee support and communication.
Perception of CME/CPD Program by membership and other stakeholders including an assessment of educational needs.

These activities along with strong membership participation and committee leadership ensure that the CAFP's CME offerings are of relevance to the family physicians and are of the highest quality possible. *(BoD 11/2015)*

Chapter CME Listings
CAFP carry listings of accredited CME programs offered by local chapters at no charge in the *California Family Physician* and the CAFP website. *(CoD 2/2000)*

Committee Charge
Approved a request for amended committee charge by addition: "Expand presentations and activities with FP components, including, but not limited to, grand rounds, hospital lectures, local chapter CME programming, managed care education and academic institution offerings." *(EC 5/1996)*

Cultural and Language Proficiency
The Spirit and the Letter of the Law
Assembly Bill 1195: In 2006, the People of the State of California passed Assembly Bill No. 1195 requiring that continuing medical education courses, except as specified, include curriculum in the subjects of cultural and linguistic competency in the practice of medicine, as defined.

Cultural competency means a set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities.

Cultural competency includes: Linguistic skills Cultural information to establish therapeutic relationships Cultural data in diagnosis and treatment Cultural and ethic data to the process of clinical care.

Linguistic competency means the ability of a physician and surgeon to provide patients who do not speak English or who have limited ability to speak English, direct communication in the patient's primary language.

CAFP has been at the forefront in the discussions on cultural and linguistic competency. Since 2002, CAFP has been the convener of the Medical Leadership Council on Cultural Proficiency, and has developed and presented curriculum and a toolkit on Addressing Language Access. The CAFP and CAFP-F efforts in this arena continue to be supported and recognized by The California Endowment.

The Spirit of the Law: The United States is becoming more culturally and linguistically diverse, and there are proven differences in health outcomes based on cultural and linguistic differences.

It is estimated by the US Bureau of Census that by 2030, minority Americans will constitute more than 40 percent of the total US population. The most prominent growth rates are expected in the Hispanic and Asian American populations. A minimum of 329 languages are currently spoken by residents of the US, and in some US cities, less than 60 percent of the overall population speaks English.

Studies have shown that among other things: Spanish-speaking Latinos are less likely to have physician visits, flu shots, or mammograms than English speaking Latinos or non-Latino whites. Spanish speakers are less likely to be discharged from the ER with an understanding of their medications, special instructions, and plans for follow-up care. Disparities between Limited English Proficiency (LEP) and non-LEP patients in colorectal screening and flu shots decrease after implementation of an interpreter services program.

There are numerous clinical studies, including studies on cholesterol screening, A1c screening and control, acute cardiac events, beta blocker use, breast cancer screening, and mental health hospitalization which all show significant disparities when cultural and linguistic issues are brought to bear. The spirit of AB1195 does not need explanation, or justification.

The Letter of the Law: According to AB 1195, every CME activity must contain elements of cultural and/or linguistic competency. The law says that the Institute of Medical Quality (IMQ) and ACCME will develop standards. It also says that this law is in effect for all California providers, regardless of the location of the activity (for example, CAFP's Hepatitis C curriculum must include C/L competency even when presented in Massachusetts).

A CME activity is defined as: A single activity with a single session, A single activity with multiple session during the same time period, A regularly-scheduled conference (RSC) activity with multiple sessions occurring over time, or an enduring material. The law is in effect for ALL activities planned (and presented) after July 1, 2006. CAFP will be incorporating these elements into all currently activities, including the Influenza panel, Osteoarthritis, and Hepatitis C curriculum, and into all future activities.

Compliance
All CME activities with a patient care component are included under AB1195; exempt activities includes those solely dedicated to research, those not containing patient care (i.e., leadership training), or those offered by providers not located in California (i.e., the AAFP).

For CAFP (and those organizations working with CAFP on CME), compliance will mean:

- Single activity, single session: elements incorporated into the session
- Single activity, multiple sessions: single sessions dedicated to cultural and linguistic issues and/or CL incorporated into multiple sessions
- RSCs: CAFP does not currently offer regularly scheduled conference, but would treat them like single activity/multiple sessions
- Enduring materials: CL must be incorporated into the activity

The requirement is easily understood; the mechanics of compliance are less clear. IMQ and CAFP recommend the following mechanics:

- CL incorporated into sessions with information on differences in incidence, diagnosis, management, prognosis, etc.
- CL issues specific to topic
- CL as dedicated sessions, with general approaches to diversity, appropriate use of interpreters, overview of health disparities

As supporting documents: Websites, handouts, reference cards, patient education materials, tapes/CDs, local resources

CAFP will amend its documentation requirements (and forms) to include proof of CL in the planning process and activity content. We'll also require samples of how these topics are included, and ask for a show of faith in complying with the new law.

We greatly appreciate the work of Carol Havens, MD and Jill Silverman, MPH, and the IMQ for developing a standard we can all adopt. *(BoD 6/2006)*

Educate CAFP Members on Health Care Reform
CAFP will look for opportunities to educate members about health care reform, which could include offering CME at the All Member Advocacy Meeting and the Family Medicine Clinical Forum on Health Care Systems, Health Care Economics, Health Care Policy, and health care reform approaches endorsed by AAFP. *(BoD 6/2021)*

Expansion of Transgender Medical Education
CAFP supports the concept of transgender education for all levels of medical providers and supports the provision of comprehensive care for the transgender community. *(BoD 7/2021, updated 9/2026)*

Promoting a Conflict-Free CAFP
CAFP provide to members information about conflict of interest (COI) resolution and management, including but not limited to CAFP policies and procedures and potential effects of COI. *(BoD 7/2020)*

Requiring Trauma-Informed Care (TIC) & Resilience Training for Family Physicians

CAFP offers ongoing educational opportunities on trauma-informed care and ACEs, either through their own in person or online offerings, or by linking their website to appropriate trainings offered by other entities, and be it further

CAFP support the inclusion of Trauma Informed Care training as an ACGME requirement for residency programs, and be it further

CAFP support more research in how Trauma Informed Care improves patient outcomes and should be included as part of the standard of care. *(BoD 07/2021)*

40.02 Graduate Medical Education and Family Medicine Residency Programs

ACGME Restriction of Residency Choice
CAFP opposes restrictions on graduate medical training that restricts the choices of residency and fellowship training opportunities for new physicians. CAFP believes that both MDs and Dos should have the opportunity to train in their preferred residency or fellowship program and receive credit for previous training at the discretion of the program director. Limiting the potential of new physicians by accepting previous training solely from ACGME-accredited residency programs as a prerequisite for entry into a different ACGME-accredited residency or fellowship program further increases barriers to care for patients and wastes valuable graduate medical education dollars by requiring previous training to be repeated without regard for the quality of that training. *(BoD 11/2012)*

Colonoscopy Training
CAFP actively encourages the training of family medicine residents to be competent in performing colonoscopies and supports their ability to obtain privileges and be supported at capable hospitals. *(CoD Res. A-02-13)*
Topic: privileges

Education on Termination of Pregnancy
Support and recommend that programs offer training of medical students, residents and new physicians in the basic skills of termination of pregnancy, and encourage medical training institutions to provide such training.

Support the education of medical students, residents and new physicians regarding the need for physician providers of termination of pregnancy, and the medical and public health importance of access to safe termination of pregnancy. *(CoD 1/1995)*

End-of-Life Training for Family Practice Residents
Ask AAFP to petition the Residency Review Committee for mandatory family practice residency instruction on end-of-life issues in residency programs and use the Society of Teachers of Family Medicine guidelines on “End-of-Life Issues” as their model. Make these guidelines known to residency directors throughout the state and encourage their implementation. *(CoD 2/1999)*

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

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

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

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

CAFP should advocate to the AAFP to promote expansion, on a national level, of training programs that prepare family medicine physicians for full scope maternity care that supplement the training of family medicine physicians, including operative births. This could include 1) OB training tracks within FM residencies (for those residencies with capacity to support this) and 2) FMOB fellowships. *(BoD 4/2026)*

Family Medicine Interest Groups (FMIG)
Approve strengthening all medical school Family Medicine Interest Groups, using as resources the salaried advisor and administrative personnel. Hold an annual networking conference. Make efforts to involve practicing physicians. *(BoD 10/1991)*

Family Physician Faculty
CAFP support a policy that ensures that all family medicine residency programs have at least one full-time family physician faculty with hospital privileges in obstetrics and who is "actively engaged in providing these services as a role model for their residents." *(BoD 6/1992)*
Topic: privileges

Incorporate Anti-Racism Training into Family Residency Programs
CAFP support efforts to encourage family medicine residency programs to incorporate anti-racism training as part of their equity and diversity training, including measures to reduce implicit bias and encourage community engagement, that addresses health disparities and mends distrust within historically disenfranchised populations;

CAFP support sharing of anti-racism training resources with family medicine residency programs to utilize in their curriculum (*BoD 7/2021)*
Topic: diversity equity and inclusion

Increase Education in Substance Use Disorder for Residency Programs
CAFP use available grant funding to support the integration of addiction training into family medicine residency program curriculum through the California Primary Care Residency Program Collaborative.

CAFP/AAFP write a letter to the Accreditation Council on Graduate Medical Education (ACGME) encouraging increased training in substance use disorder treatment for residency.

CAFP offer x-waiver trainings (as long as a data 2000 waiver continues to be required to treat opioid use disorder) at major conference events such as the All Member Advocacy Meeting, Family Medicine Clinical Forum and Student +FM Resident Summit.

CAFP delegation to AAFP submit a resolution to the AAFP COD requesting the AAFP to write a letter to the Accreditation Council on Graduate Medical Education (ACGME) encouraging increased training in substance use disorder treatment for residency.

CAFP delegation to AAFP submit a resolution to the AAFP COD requesting the AAFP to offer x waiver trainings (as long as a data 2000 waiver continues to be required to treat opioid use disorder) at major conference events such as the FMX Experience, and National Conference for Family Medicine Residents and Medical Students. *(BoD 11/2020)*

Increase Nutrition Education in ACGME Residencies and Medical Schools
CAFP advocate for increased nutrition education embedded into the curriculum of ACGME residencies and medical schools.

Insurance for Residents and Students
CAFP encourage all California family practice residency programs to provide adequate health and disability insurance for their residents, and all California medical schools to provide health and disability insurance to students. *(BoD 2/1992)*

CAFP encourage residency programs to maintain residents' positions, malpractice coverage and benefit packages while individual residents seek educational opportunities during away rotations. *(CoD 2/1994)*

Limited On Call Hours
CAFP encourages all residency programs to limit consecutive in-house on call work hours to 30 hours per shift and permit residents to spend on average at least two out of every 14 days away from the residency program. *(CoD 2/1994)*

Medication Assisted Treatment Training in Graduate Medical Education

CAFP/AAFP encourage ACGME to require substance use disorder curriculum, including medication assisted treatment (MAT) training, in family medicine residency programs. *(BoD 4/2022)*

Medical School Training Duration
CAFP believes in medical education innovations that are grounded in scientific evidence and supports continued research to improve the quality of medical student education, including potential changes in duration of training. CAFP is concerned that decreasing medical school duration to three years may provide an inadequate foundation to prepare students for a future career in primary care, and may inadvertently lead to a devaluation in the perception of primary care. Any pilot programs evaluating three-year medical school training must achieve the goal of increased medical student selection of primary care while decreasing debt burden, and maintaining or improving upon medical student readiness for residency. *(BoD 4/2012)*

Resident Membership
All first year California residents shall be ensured membership in CAFP; the CAFP and/or residency programs will fund the first year of membership. *(BoD 8/1986)*

Moonlighting
CAFP encourage all family medicine residency programs to ensure the ability of all licensed resident physicians in good academic standing and in appropriate rotations to moonlight as part of their education experience. *(CoD 2/1994)*

Parental Leave Policy
All California residency programs be urged to develop clear, written policies on parental leave for residents and adhere to the following guidelines, a combination of AAFP's and AMA's recommendations. The CAFP policy will be distributed to all program directors. *(CoD 2/1999)*

Support Resident Unionization
CAFP support efforts to allow resident labor unions at University of California sponsored residencies, and be it further

CAFP support efforts that promote fair salaries and benefits, and improved working conditions for residents. *(BoD 7/2021)*

Trauma Informed Care Curriculum Development for ACGME Training Programs
CAFP/AAFP encourages collaboration with AAFP/STFM/ACGME in developing and standardizing a trauma-informed care (TIC) curriculum, including mandatory ACEs training, in family medicine residency programs. *(BoD 4/2022)*

ETHICS

This section contains policy about ethics. This includes artificial intelligence, minors and confidentiality, criminal justice and law enforcement, end of life care, liability, and physician autonomy.

50.01 Artificial Intelligence (AI)

Ethical Application of AI in Family Medicine

CAFP supports regulation and review of applied artificial intelligence and machine learning in healthcare based on the Principles of Ethical Application of Artificial Intelligence in Family Medicine set forth by the AAFP. *(BoD 7/2024)*

Medical Practice Affairs Committee (MPAC) is charged with regularly reviewing and to recommend policy and action to address rapid changes in technology implementation. *(BoD 7/2024)*

AI Policy Principles

The following is a summary of CAFP's AI Policy Principles. For more detailed information, please see our Policy Reference Report on Artificial Intelligence here or on CAFP's website at www.familydocs.org/policy.

1. If AI tools are utilized, the patient-physician relationship must be preserved and enhanced. When AI is applied to primary care, it must enhance the 4 C's of primary care (first contact, comprehensiveness, coordination, and continuity) and expand primary care's capacity and capability to provide longitudinal care that achieves the quintuple aim.
2. Maximize transparency, including that of patient data (e.g. usage and storage), sourcing of medical recommendations, and assumptions used to train the models, algorithms and limitations.
3. Require processes in place to identify and mitigate implicit bias within AI models from learning those same biases. As appropriate, AI should have a process for monitoring and remediating for differential outcomes, particularly those that affect vulnerable patient populations.
4. Maximize training data diversity so that it is representative of the populations cared for by family medicine.
5. Provide clear policies around how AI developers collect, store, use and share data from patients and end-users as well as identify what data is not covered by appropriate laws and regulations. Developers must get consent for collecting any identifiable data and the consent should clearly state how the data will be used or shared.
6. Take a systems view in design that aligns with user-centered, real-world workflows and maintains rigorous quality assurance processes. AI should support clinical care only when chosen by patients and physicians.

7. AI solutions should assume appropriate liability and undergo rigorous evaluations as any other medicine intervention, including research-based demonstration of efficacy.
8. Design for trustworthiness by ensuring developers have the highest levels of safety, reliability and accuracy in their AI solutions.
9. Research and evaluation should include family physician input on potential harms and benefits in patient care, including automation bias, reduced information integrity, safety concerns, and implications for privacy and security. Research and evaluation data should be shared and include an assessment of AI's broader societal impacts. *(BoD, 12/2025)*

50.02 Confidentiality for Minors

Minors and Confidentiality

Minors have the right of confidentiality in the areas of contraception, pregnancy, STDs and physical and/or sexual abuse in accordance with the following AAFP policy statement and the Joint Statement of the AAFP, the ACOG, the American Academy of Pediatrics, the Organization for Obstetric, Gynecologic and Neonatal Nurses, and the National Medical Association. *(CoD 2/2000)*

"One must attempt to achieve a balance between the rights of the parents and what is necessary to maintain and promote the health and well-being of the adolescent. It is proper and ethical for the family physician to protect an adolescent's confidentiality. Withholding information from third parties, including parents, may be appropriate when it pertains to but is not limited to contraception, pregnancy, sexually transmitted diseases and physical and/or sexual abuse by a parent. Parental involvement, consent, or notification should not be a barrier to care for the adolescent." (Paragraph 55 of the report of the Commission on Special Issues and Clinical Interests – "Adolescent Health Care—Confidentiality" Adopted 1994:243-244; 347.

"Adolescents tend to under-utilize existing health care resources. The issue of confidentiality has been identified by both providers and young people themselves, as a significant access barrier to health care.

Adolescents in the United States, while generally considered healthy, have a range of problems, including some of such severity as to jeopardize their development and health, their future opportunities, and even their lives. To illustrate, there is an urgent need to reduce the incidence of adolescent suicide, substance abuse, and sexually transmitted diseases and unintended pregnancy.

As the primary providers of health care to adolescents, we urge the following principles for the guidance of our professional members and for broad consideration in the development of policy:

1. Health professionals have an ethical obligation to provide the best possible care and counseling to respond to the needs of their adolescent patients.

2. This obligation includes every reasonable effort to encourage the adolescent to involve parents, whose support can, in many circumstances, increase the potential for dealing with the adolescent's problems on a continuing basis.
3. Parents are frequently in a patient relationship with the same providers as their children or have been exercising decision-making responsibility for their children with these providers. At the time providers establish an independent relationship with adolescents as patients, the providers should make this new relationship clear to parents and adolescents with regard to the following elements:
    a. The adolescent will have an opportunity for examination and counseling apart from parents, and the same confidentiality will be preserved between the adolescent patient and the provider as between the parent/adult and the provider.
    b. The adolescent must understand under what circumstances (e.g., life-threatening emergency), the provider will abrogate this confidentiality.
    c. Parents should be encouraged to work out means to facilitate communication regarding appointments, payment, or other matters consistent with the understanding reached about confidentiality and parental support in this transitional period when the adolescent is moving toward self-responsibility for health care.
4. Providers, parents, and adolescents need to be aware of the nature and effect of laws and regulations in their jurisdictions that introduce further constraints on these relationships. Some of these laws and regulations are unduly restrictive and in need of revision as a matter of public policy. Ultimately, the health risks to the adolescents are so impelling that legal barriers and deference to parental involvement should not stand in the way of needed health care." *(CoD 2/2000)*

Patient Protection of Information from Adverse Childhood Experiences (ACEs) Screening

CAFP support the collection of information from the ACEs screening be subject to pre-existing conditions protections for health insurance. Adverse Childhood Experience (ACE) scores be used as a screening tool, not diagnostic of the implied risk condition. *(BoD 5/2020)*

50.03 Criminal Justice and Law Enforcement

Criminal Prosecution of Physicians for Medical Acts

CAFP opposes: 1) the criminal prosecution of physicians for acts committed within the scope of their professional conduct, for which there is no criminal intent; and 2) opening peer review records for criminal cases because it may have a chilling effect on medical expert's willingness to testify in court and could destroy a valuable process for finding and fixing health care problems quickly. *(BoD 2/1998)*

CAFP opposes the criminalization of medical practice and opposes legislation that allows the federal government to define appropriate medical practice and regulate such practice through the use of criminal penalties. *(CoD 3/2008)*

End Police Brutality and Reinvest in Public Health
CAFP advocate for diversion programs and community alternatives to incarceration including

- that law enforcement agencies should adopt and enforce policies prohibiting profiling and discrimination based on race, ethnicity, national origin, religion, age, gender, gender identity/expression, sexual orientation, immigration status, disability, housing status, occupation, and language fluency,
- the universal adoption of evidence-based de-escalation techniques and the use of the lowest level of force when force becomes necessary to maintain safety,
- investing in community resources, including schools, childcare and youth programs, safe and affordable housing, fair wages, food pantries, specialized case workers and first responders, mental health workers, including programs that use crisis workers with mental health training to respond to emergency calls.

Topic: mental health

CAFP support legislation that improves access to health care upon release from prison or jail.

CAFP advocate for sustainable investment in comprehensive mental health services that include long-term treatment and care.

CAFP advocate for sustainable funding to provide clinical services for people with serious mental illnesses and substance use disorders, including those who need mental health services upon release from a correctional facility. *(BoD 11/2022)*

Health Care for Formerly Incarcerated Persons
CAFP support efforts to improve access to health care for formerly incarcerated persons following their release; and be it further

CAFP support increased funding for evidence-based programs designed to meet the needs of people recently released from incarceration. *(BoD 7/2019)*

Improved Quality of Reproductive Health for Incarcerated People
CAFP advocate for improved access to timely but non-coercive abortion for incarcerated people in California, and improved accountability of correctional facilities in complying with existing reproductive health law. *(BoD 9/2020)*

Oppose Forced Sterilization and Contraceptive Coercion of Incarcerated and Detained Individuals
CAFP will work with AAFP to advocate for public transparency of the investigation of allegations of forced sterilizations in detention centers and for policies that prevent contraceptive coercion.

Topic: reproductive health, contraception

Protect Patients from Extremist Groups in Policing
CAFP oppose affiliation with hate groups or participation in public expressions of hate or violence by law enforcement officials. *(BoD 11/2021)*

Reporting of Injuries Resulting from Law Enforcement Actions
CAFP support the creation of a process for Family Physicians to report injuries sustained from law enforcement agents, and be it further

CAFP provides education to Family Physicians in California on the established process for Family Physicians to report injuries sustained from law enforcement agents and the care of patients who sustain such injuries. *(BoD 11/2021)*

50.04 End of Life Care

Patient-Centered End of Life Care
CAFP recognizes the need for appropriate end-of-life care, which may include:

- Appropriate treatment of physical pain, recognizing that in some cases such treatment may hasten the end of life;
- Compassionate care which is interpersonal, existential or spiritual, and may include working together with social workers, hospice, clergy, family and friends; and
- Eliciting and addressing a patient's reasons for considering physician aid-in-dying.

Only through dialogue can family physicians, their patients and society as a whole continue to explore what is reasonable and morally appropriate. The highest-quality health care is an outgrowth of a partnership between the patient, the family and the health professional or professional team.

Within the context of this continuing relationship, family physicians must seek the underlying causes of suffering at the end of life, and then aggressively implement measures to correct them. Appropriate education in palliative care and medical management, advanced communication skills to discover the patient's wishes and value choices, and appropriate sharing of decision-making with the patient and the patient's family can go a long way toward alleviating suffering and improving care at the end of life. Family physicians should continue to provide assistance in dealing with dying patients' symptoms, needs and fears. *(BoD 4/2015)*

Medical Aid-in-Dying Is Not "Assisted Suicide"
CAFP rejects the term "assisted suicide" to describe the process whereby terminally ill patients of sound mind ask for and receive prescription medication they may self-administer to hasten death should their suffering become unbearable, and be it further

CAFP acknowledges that use of medical aid in dying is an ethical, personal end-of-life decision that should be made in the context of the doctor-patient relationship, and be it further

CAFP recognizes medical aid-in-dying as an ethical end-of-life option when practiced where authorized and according to prescribed law. *(BoD 11/2017, updated 9/2026)*

POLST Registry
CAFP support development of a state-wide electronic Physician Orders for Life Sustaining Treatment (POLST) registry. *(BoD 6/2021)*

Supporting End of Life Autonomy and Improving the Aid in Dying Process
CAFP reaffirms its values of respecting patient autonomy and the doctor-patient relationship in regards to end of life care, and be it further

Medical aid in dying continues to represent a viable option for patients of sound mind who are experiencing terminal suffering and who have been informed of all their options, and be it further

CAFP supports the ability of terminally suffering patients to have access to medical aid in dying services including telemedicine, and be it further

CAFP supports a reduced waiting period for patients to access medical aid in dying, as is available in other states. *(BoD 7/2021)*

50.05 Liability

Ensuring Confidential Peer Review
CAFP adopt as its policy that, in the public interest, peer review activities by medical staffs, medical societies, medical groups, health plans and other entities should be confidential, protected and not subject to disclosure by administrative subpoena;

CAFP supports appropriate introduced state legislation that will prevent disclosure of peer review be administrative subpoena; and CAFP communicate and cooperate with the California Medical Association to establish common peer review confidentiality policy. *(CoD 2/1997)*

Malpractice Coverage for 'High Risk' Providers
CAFP supports the development of statewide solutions to lower or completely cover the cost of malpractice coverage for clinicians offering critical reproductive health services – which include but are not limited to maternity care, abortion, and gender-affirming services – in underserved areas of California and for clinicians offering these services under the state's shield laws as interstate telehealth medical clinicians. *(BoD 11/2024)*

CAFP supports exploring options for a state based malpractice coverage, similar to the Federal Tort Claims Act. *(BoD 11/2024)*

Medical Injury Compensation Reform Act (MICRA)
CAFP supports the preservation of MICRA and opposes legislative proposals intended to weaken MICRA. *(BoD 6/1992)*

Periodic Payments
Support legislation that would eliminate periodic payments for non-economic losses and physician liability for periodic payments relating to economic losses. Continue to deep malpractice premiums affordable by defending the structure of, and cap on MICRA. Maintain the quality of peer review by ensuring the protection against liability of those physicians who participate in peer review. *(BoD 5/1998)*

Preserve MICRA
Develop a policy statement, action plan and designate a spokesperson to represent CAFP's interests in tort reform issues, including the preservation of MICRA. *(BoD 10/1994)*

50.06 Clinician Autonomy

Conscientious Objection and Right to Withdrawal
No physician shall be compelled to perform any act which violates his/her good judgment or personally held moral standards. In these circumstances, the physician may withdraw from the case so long as the withdrawal is consistent with good medical practice. *(COD 2/1993)*
Topic: reproductive health, abortion

Personal Moral Objections in Clinical Practice
Support the concept that no physician or other health professional shall be required to perform any act violative of personally held moral principles. *(CoD 1/1995)*
Topic: reproductive health, abortion

Pharmacists' Conscience Clause
CAFP believes that a pharmacist's right of conscientious objection to filling a specific prescription should be reasonably accommodated, but to safeguard the physician-patient relationship, governmental policies must be in place to protect patients' rights to obtain legally prescribed and medically indicated treatments. *(BoD 11/2005)*
Topic: prescription drugs

Political Interference in Medical Decision Making
CAFP opposes political interference in the medical decision-making processes for any individual patient. *(BoD 4/2005)*

GENDER, SEXUAL AND REPRODUCTIVE HEALTH

This section contains policy about gender, sexual and reproductive health.

60.01 Abortion Rights

60.01a Access

Abortion Access Under Publicly Funded Health Plans
CAFP endorses the principle that women receiving healthcare paid for through health plans funded by state or federal governments should be provided with access to the full range of reproductive options when facing an unintended pregnancy.

CAFP urges the AAFP to engage in advocacy efforts to overturn the Hyde Amendment that bans federal funding for abortions. *(CoD 3/2008)*
Topic: Medi-Cal

Beyond Roe: Reproductive Health Care Accessible to Everyone
CAFP will work with the AAFP to advocate against restrictions to funding for reproductive services, including the Hyde Amendment, and further be it

CAFP will work with other medical professional societies, such as ACOG, to oppose restrictions to funding for reproductive services, including the Hyde Amendment, and further be it

CAFP encourage the AAFP to work with other medical professional societies, such as ACOG, to oppose restrictions to funding for reproductive services, including the Hyde Amendment. (BoD 6/2021)

Informed Consent and Resource Provision
The woman considering an elective abortion should be informed adequately of the potential health risks of both abortion and continued pregnancy. The physician should also provide to the pregnant patient either:

- Information regarding: financial and other assistance available to her; financial and other assistance available to the child; and the availability of licensed and/or regulated adoption agencies; or
- Resources where such information can be obtained. *(CoD 2/1993)*

Removing Routine Ultrasound in Medication Abortion Protocols
CAFP advocate for the elimination of barriers to abortion access resulting from ultrasound requirements that are not clinically indicated.

CAFP support the unbundling of pre- and post- abortion ultrasound in the Medi-Cal reimbursement requirements for medication abortion.

CAFP support efforts by AAFP to unbundle ultrasound in medication abortion protocols for Medicaid reimbursement in all states. *(BoD 7/2020)*

Repeal the Hyde Amendment
CAFP endorses the principle that women receiving health care paid for through health plans funded by state or federal governments who have coverage for continuing a pregnancy also should have coverage for ending a pregnancy.

CAFP will urge the AAFP to engage in advocacy and lobbying efforts to overturn the Hyde Amendment, which bans federal funding for abortions. *(BoD 4/2017)*

Reproductive Freedom and Comprehensive Counseling
CAFP believes physicians should seek, through extensive education and patient counseling, to decrease the number of unwanted pregnancies. However, should a woman become pregnant, it is her legal right to make reproductive decisions, including the decision to carry the pregnancy to term or to have a safe, legal abortion. *(CoD 2/1993)*

60.01b Mifepristone / Misoprostol

Deregulation and Prescriber Support for Mifepristone
CAFP share resources that educate family physicians on any changes to medication abortion regulations.

CAFP support access to Mifepristone and Misoprostol in pharmacies.

CAFP support FDA deregulation of Mifepristone or other evidence-based medication for miscarriage management and abortion. *(BoD 4/2023)*

REMS / Mifepristone
CAFP endorses the principle that the REMS classification on mifepristone is not based on scientific evidence and limits access to abortion care. *(BoD 4/2018)*

CAFP support the safety and efficacy of mifepristone by continuing advocacy efforts with the FDA to remove the risk evaluation and mitigation strategies (REMS) classification on mifepristone to conform with current evidence.

AAFP consider providing education, as appropriate, on early pregnancy loss management in relevant programming at FMX, maternity care conference, and women's health conference on a rotational basis. *(BoD 3/2019)*

Support for Over-the-Counter Application for Misoprostol
CAFP support the over-the-counter status of misoprostol or other abortion medication without a prescription if evidence shows it to be safe and effective. *(BoD 4/2023)*

60.02 Contraception

Access to Oral Contraceptive Pills Over-the-Counter
CAFP endorses the policy that oral contraceptive pills be made available over-the-counter, weighing the risks versus the benefits based on currently available data; and

CAFP endorses the policy that oral contraceptive pills be included among FDA-approved over-the-counter contraceptive methods and supplies covered by insurers and Medicaid. *(CoD Res. A-05-13)*

Access to Oral Contraceptives Pills Over-the-Counter Without Regard to Age
CAFP endorses the policy that there be no age restriction to oral contraceptive pill availability over-the-counter. *(BoD 7/2016)*

End Age Restriction on Emergency Contraception (EC) Access
CAFP will advocate for emergency contraception to be available over-the-counter to all women of reproductive. *(CoD 3/2012)*

Support for over-the-counter application for Ulipristal Acetate (Ella)
That the CAFP support the over-the-counter status of Ulipristal and oral emergency contraceptives without a prescription if evidence shows it to be safe and effective *(BoD 4/2023)*

Insurance Coverage of Contraception and Contraception Services
All California insurers should provide coverage for the full array of available contraceptive methods, including both devices and insertion of IUD and contraceptive implants.

CAFP encourages all California insurers including Medi-Cal to cover a minimum of a 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.

CAFP will work toward ensuring equal compensation for family physicians with other physicians for all family planning services. *(CoD 3/2008)*

Long-Acting Reversible Contraception (LARC)
CAFP support a policy that long-acting reversible contraceptive methods be a recommended option for postpartum women prior to hospital discharge.

CAFP support a policy assuring coverage of LARC device and placement separate from the global fee, prior to hospital discharge for all women who select these methods. *(BoD 4/2015)*
Topic: IUD

Medicaid Coverage of Over-the-Counter Emergency Contraception

CAFP will advocate that emergency contraception, whether over-the-counter or by prescription, be a covered benefit under Medi-Cal for all women of reproductive age. *(BoD 7/2016)*

United States Medical Eligibility Criteria for Contraceptive Use (USMEC)
CAFP endorses the United States Medical Eligibility Criteria for Contraceptive Use (USMEC) and will promote USMCE with an announcement and link on www.familydocs.org and will request that the AAFP join the American College of Obstetricians and Gynecologists in endorsing the US Medical Eligibility Criteria for Contraceptive Use (USMEC) and similarly promote USMCE with an announcement and link on www.aafp.org. (*CoD 3/2012)*

60.03 Inclusive Pathways to Parenthood

Second Parent and Joint Adoptions
CAFP supports adoption based solely on the welfare of the child regardless of marital status, gender, race, ethnicity, sexual orientation, disability, national origin, political affiliation or religious belief. *(CoD 2/1997)*

Support for Full Coverage of Infertility and Fertility Diagnoses and Treatments
CAFP supports legislation and advocacy efforts encouraging all insurers to include coverage for treatments to help build families for people of all sexual and gender identities and single individuals including infertility, assisted reproductive technology, fertility preservation, ovarian stimulation, cryopreservation, and sperm banking. (*BoD 4/23)*

Marriage Amendment
CAFP opposes any proposed marriage amendment to the Constitution of the United States related to its impact on financial access to care and legal protections for children in diverse and traditional families. *(CoD 3/2007)*

60.04 Menstrual Health

Power to Menses
CAFP support efforts that expands access to menstrual hygiene products (pads, tampons, menstrual cups, etc.) for all people who menstruate, regardless of gender identity. *(BoD 4/2023)*

60.05 Postpartum Care

Increasing Transportation Access in the Postpartum Period
CAFP support that persons of any gender identity in their postpartum period and foster parents, adoptive parents, and legal guardians have access to transportation, including but not limited to ride shares, from delivery to one year, and should include transportation, for maternal care, newborn visits and ongoing care as needed without any barriers to access. *(BoD 4/2023)*

60.06 Reproductive Health Education

Abortion Education
Support and recommend that programs offer training of medical students, residents and new physicians in the basic skills of termination of pregnancy, and encourage medical training institutions to provide such training.

Support the education of medical students, residents and new physicians regarding the need for physician providers of termination of pregnancy, and the medical and public health importance of access to safe termination of pregnancy.

Recommend Family Medicine Residency Programs provide residents with annual up-to-date lectures in all evidence-based contraception and pregnancy options counseling. *(CoD 4/2005)*

Recommend Family Medicine Residencies consider adopting an "opt out" policy on abortion training, in which medication and aspiration abortion would be included in residency curriculum, but residents may choose not to participate if they are opposed to performing abortions. *(CoD 4/2005)*

Increase IUD Education in Family Medicine
CAFP supports training and competency in appropriate use of Intrauterine Devices as an integral part of full-scope family medicine.

CAFP advises all California residency programs to include core curriculum on evidence-based indications and hands-on insertion training to competency.

CAFP endorses increased continuing professional development opportunities and resident education regarding Intrauterine Device eligibility and insertion. *(CoD Res. A-06-13)*

Increased Percentage of Women's Reproductive Health Topics at AAFP FMX and NCRS
CAFP will advocate through AAFP to the Family Medicine Experience (FMX) Curriculum Advisory Panel (CAP) to increase the weight of women's reproductive health topics at future FMX events and remove the four percent cap. And that the CAFP via its delegation will submit a resolution to the AAFP calling on the AAFP to increase the representation of women's reproductive health topics among future AAFP CME events. *(BoD 7/2018)*

Scope of Comprehensive Reproductive Health Training
Statement on Comprehensive Reproductive Training

CAFP and the CRN recognize the interest of medical students in understanding the scope of reproductive training they will receive at a prospective family medicine residency program. In order to best understand these issues, CAFP encourages

students to engage with residency faculty in person during the interview process and has prepared a set of questions to facilitate the conversation.

The following questions will be available at the student and resident page on the CAFP website and linked from the statement on the CAFP Residency Program Directory:

1. What forms of birth control does your program train residents to provide/administer? How is this training incorporated into the curriculum and/or rotations? Are there outside opportunities or electives to receive additional education on forms of birth control that residents are not trained to administer? Would a resident at your program be able counsel patients but not provide certain types of birth control if it was not in line with his or her beliefs?
2. Does your program train residents in vaginal deliveries and care of the pregnant female? How is this training incorporated into the curriculum and/or rotations?
3. Are there any hospitals or clinics I would do rotations at in this program that would have limitations on reproductive health training?
4. Does your program train residents in elective pregnancy termination? How is this training incorporated into the curriculum and/or rotations?
5. If not, are there outside opportunities or electives to receive this training? Would a resident be able to opt out of certain parts of reproductive health training, such as pregnancy termination?
6. How does your program fully educate and also accommodate learners that have beliefs and practices that are not in line with all of your curricular components as it relates to reproductive training? *(BoD 2/2016)*

60.07 Reproductive Justice and the Legal System

Improved Quality of Reproductive Health for Incarcerated People
CAFP advocate for improved access to timely but non-coercive reproductive health care, including non-directive options counseling and abortion for incarcerated people in California, and improved accountability of correctional facilities in complying with existing reproductive health law. (*BoD 9/2020, updated 9/2026)*

Oppose Criminalization of Abortion Care
CAFP oppose the criminalization of physicians providing abortion care. *(BoD 7/2019)*

Oppose Forced Sterilization and Contraceptive Coercion of Incarcerated and Detained Individuals
CAFP will work with AAFP to advocate for public transparency of the investigation of allegations of forced sterilizations in detention centers and for policies that prevent contraceptive coercion. *(BoD 6/2021)*

Stand with our Patients, Prevent Criminalization for Pregnancy Outcomes

CAFP help disseminate available materials regarding general constitutionally protected medical information and mandated reporting laws around pregnancy and pregnancy outcomes, and be it further

CAFP consider including a session on protecting physicians and patients from criminalization regarding pregnancy outcomes, including self-managed abortion at a Clinical Forum, and be it further

CAFP support legislative efforts to ensure that Health Information Exchanges protect sensitive medical records related to abortion, gender affirming care, or substance use across state lines, and be it further

CAFP help disseminate available materials related to reproductive rights navigation tools. *(BoD 8/2023)*

60.08 Transgender Health

Policy Principles on Transgender and Gender Expansive Patients

- Asserts that every patient or learner presenting to a family physician, family medicine residency or other health care/practice environment has the right to be provided with a safe, equitable, knowledgeable, culturally sensitive, and accepting environment free from discrimination regardless of gender identity status.
- Opposes all public and private discrimination against transgender and gender-expansive individuals in the areas, including but not exclusive of, health care, employment, housing, public accommodation, education, and licensing.
- Supports existing state and federal laws that protect people from discrimination based on gender expression and identity and opposes laws that compromise the safety and health of transgender and gender-expansive people by failing to provide this protection.
- Asserts that family physicians should not discriminate against classes or categories of patients in the delivery of needed health care. Such classes and categories include gender identity and expression.
- Asserts that the medical procedures attendant to gender-affirming/confirming surgeries and therapies such as hormones or other medications that adhere to the prevailing standards of care are not “cosmetic” or “elective,” but are understood to be medically necessary.
- Supports safe and humane conditions for transgender people in any form of detention, with individuals’ right to self-identify their gender under such detention conditions, and asserts that transgender and gender-expansive prisoners should have the same access to medically necessary care as non-incarcerated transgender and gender-expansive people and that medically necessary care includes gender-affirming treatments and procedures.
- Recognizes that biological sex, gender identity, and sexual orientation are separate facets of a patient’s intersectional identity.
- Asserts that electronic health records, billing systems, and insurance be designed to respect the asserted gender identity and preferred name of each patient while

maintaining confidentiality and avoiding duplicate charts. The inclusion of sexual orientation/gender identity allows for more accurate information and measurement of health disparities.
- Supports the inclusion of transgender and gender-expansive people in development of both health and social determinants of health research and policy, including clinical trials and observational studies, in order to better understand health disparities and to build a stronger evidence base for transgender and gender minority health.
- Encourages medical schools and graduate medical education programs to develop and incorporate educational material, tools, and training that will allow physicians to provide knowledgeable and respectful care to transgender and gender-expansive patients. *(BoD 1/2019)*

Topic: gender affirming care

Defend and Uphold Provision of Gender Affirming Care

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

CAFP opposes the exclusion of insurance coverage of gender affirming care for any age groups

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

CAFP opposes policies that would prevent health care professionals from receiving payment from government-funded health insurance programs solely because they provide gender-affirming care. *(BoD 4/2026)*

Topic: gender affirming care

Expansion of Transgender Medical Education

CAFP supports the concept of transgender education for all levels of medical providers and supports the provision of comprehensive care for the transgender community. CCPD supports the principal; however, recommends the CAFP Board collaborate with other state chapters to bring this issue to AAFP. (*BoD 7/2021)*

Topic: gender affirming care

Genital Surgeries in Intersex Children

CAFP supports the delay of medically unnecessary sex organ modification procedures on an individual born with variations in their physical sex characteristics until the child is able to participate in the informed consent process; and be it further

CAFP supports policies that protect the right of minors for self-determination of their bodies and identities. *(BoD 7/2021)*

60.09 Vasectomy

Vasectomy as a Preventive Service

CAFP supports amending the list of preventative services provided under the Affordable Care Act to include contraceptive services for all, including vasectomy. *(BoD 5/2014, updated 9/2026)*

Vasectomy Training During Family Medicine Residency

CAFP support the training of vasectomy in all ACGME-accredited family-medicine residency programs in California. (*BoD 4/2026)*

PUBLIC HEALTH

This section contains policy about public health. This includes child health, environment, food and nutrition, pain management, infectious diseases, and more.

70.01 Child Health

Affordable Childcare for All

CAFP recognize that access to stable, affordable, accessible, high quality child care is preventative medicine and a social determinant of physical and mental health. *(BoD 7/2024)*

Early Detection of Lead Poisoning

CAFP will support initiatives that would facilitate early detection of, and lead to, medical intervention for childhood poisoning. *(BoD 2/1996)*

Epinephrine Auto-Injectors

Endorse legislation that would permit schools to have personnel trained to administer epinephrine through an auto-injector to school children/others suffering potentially life-threatening anaphylactic reactions. *(EC 4/1999)*

Parental Leave

That CAFP support policies that provide employees with reasonable job security, wage replacement, and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should include: (1) medical leave for the employee, including pregnancy; (2) parental leave for the employee-parent, including leave for birth, adoption, or foster care leading to adoption; (3) leave if medically appropriate to care for a member of the employee's immediate family. Any legislative proposals will be reviewed through the Academy's normal legislative process for appropriateness, taking into consideration all elements therein. *(BoD 7/2019)*

Safe Social Media Use in Youth, Young Adults, and Adults

CAFP support policies that fund research, strengthen safety and informed engagement with social media, and enhance systemic social media literacy for youth, young adults, and adults.

CAFP engage in efforts to equip family physicians with the tools to help parents and their children model and establish healthy and safe relationships with social media, mitigating its harms and reaping its benefits. *(BoD 5/2025)*

Topic: mental health

70.02 Civic Engagement

Free Speech to Advocate for Humanitarian Efforts

CAFP supports the right of free speech of medical students, residents, fellows, and doctors in their efforts to advocate for humanitarian efforts, and for the right to do so without repercussion and silencing from their schools and employers. *(BoD 5/2024)*

Voter Registration in the Clinics and Offices of Family Physicians
CAFP supports efforts of nonpartisan organizations that promote voter registration. *(BoD 7/2024)*

CAFP encourages family physicians across the state of California to register people to vote in their clinics and offices. *(BoD 7/2024)*

70.03 Dementia

The Dementia Gap
CAFP supports measures that create processes (including involuntary holds) for hospitals and other acute care settings to provide support to patients who lack capacity and are unable to care for themselves due to dementia.

CAFP support incentivizing the establishment of "Neuro-Behavioral Skilled Nursing Facilities" in rural and underserved regions, specifically designed to accept involuntary patients with dementia who require secure perimeters but do not meet criteria for acute inpatient psychiatry. *(BoD 4/2026)*

70.04 Dental Health

Fluoridated Water
CAFP supports the introduction of fluoridated water in all municipalities in California. *(BoD 2/2001)*

70.05 People Living with Disabilities

Disabled as Medically Underserved
CAFP acknowledges the significant health disparities experienced by individuals with intellectual and developmental disabilities and recognizes the benefits that could be realized with federal designation as a medically underserved population; and be it further

CAFP strongly urges the Governor to designate people with intellectual and developmental disabilities as a medically underserved population in the state of California. *(BoD 11/2017)*

Eliminating Health Disparities for Transition Age Youth and Adults with Developmental Disabilities
Adopted a resolution in support of a modified CART model of health care reform for transition age youth and adults with developmental disabilities as follows:

- Clinical services such as physician-led patient centered medical homes, health checks with primary care and access to specialized medical services, and assessment and consultation services;
- Advocacy for health policy system reform and for patients who need support to access health care and to cooperate as a partner in maintaining their own good health;
- Research programs in clinical service, health surveillance, health services and health policy; and
- Technical assistance for clinicians at the point-of-care. *(CoD 3/2010)*

Increasing Access to Care for Patients with Mobility Disabilities:
CAFP supports training for students, residents and physicians on how to adapt physical exam maneuvers and use assistive medical equipment to meet individuals' abilities,

CAFP support accessible exam rooms and exit/entry routes of appropriate size and entry in all clinics to accommodate various types of equipment,

CAFP supports improved reimbursement for home visits to empower physicians to provide care for patients with mobility limitations. *(BoD 12/2025)*

Intellectual and/or Developmental Disability Care in Primary Care Settings
CAFP supports increased education for physicians in the care for individuals with intellectual and developmental disabilities. *(BoD 4/2026)*

Least Restrictive Setting
To reduce segregation and to ensure people with disabilities can exercise their right to full community inclusion, CAFP supports the Healthy People 2020 goals on disability and health including:

a. reduce the number of children and youth with disabilities aged 21 years and under living in congregate care residencies;
b. reduce the number of adults with disabilities aged 22 years and older living in congregate care residencies;
c. increase the proportion of people with disabilities who participate in the social, spiritual, recreational, community and civic activities to the degree they wish;
d. reduce the proportion of people with disabilities who report barriers to obtaining the assistive devices, service animals, technology services and accessible technologies that they need; and
e. reduce the proportion of older adults with disabilities who use inappropriate medications. *(BoD 4/2015)*

Self-Determination and Supported Decision Making for People with Disabilities:
1. CAFP supports initiatives to improve access to supported decision making as an alternative to Power of Attorney, Conservatorship or Guardianship for people who have the capacity to make their own decisions with support.

2. CAFP supports initiatives to help people with disabilities complete their own advanced directives.
3. When leading or participating in ethics, end-of-life and/or informed consent discussions, CAFP encourage members to:
    a. assume that the lives of people with disabilities are inherently meaningful and valuable regardless of ability or support need;
    b. prioritize doing no harm;
    c. challenge discrimination;
    d. respect the self-determination of people with disabilities who make informed choices with or without support;
    e. include people with disabilities on advisory councils, ethics committees and institutional review boards. *(BoD 4/2015)*

70.06 Diversity, Equity and Inclusion

Eliminate the Use of Race-Based Medicine
CAFP eliminate the use of race as a proxy for biology and genetics, and develop policies to ensure this is communicated in CAFP education. *(BoD 7/2020)*

Ending Discrimination in Blood Donation for Gay and Bisexual Men
CAFP oppose the practice of banning or deferring gay and bisexual men from donating blood based strictly on their sexual orientation or that of their patients, and be it further

CAFP support the use of fair and scientifically-based standards for donating blood products. *(BoD 4/2023)*

Ensuring Equitable Representation – MENA Community
CAFP commits to supporting initiatives that address the unique health challenges faced by the Middle Eastern and North African (MENA) community, as evidenced by research demonstrating disparities in health conditions and outcomes. *(BoD 5/2024)*

CAFP calls for increased awareness and education within the healthcare system regarding the specific needs of the MENA community, emphasizing the importance of tailored healthcare strategies. *(BoD 5/2024)*

Ensuring Equity in Rural Health Policy
CAFP ensure that a Rural Health perspective is considered and accounted for as part of their legislative and regulatory advocacy activities. *(BoD 5/2024)*

Fair Bilingual Compensation to Advance Health Equity and Language-Concordant Care
CAFP encourages the recruitment and retention of medical students, residents, fellows, and physicians with language competency aligned with the linguistic needs of the diverse California communities,

CAFP supports transparency of existing bilingual pay structures among its members' practices and institutions to create awareness around bilingual compensation,

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

CAFP promotes medical language training programs at the medical school, residency, and continuing medical education level. *(BoD 11/2024)*

Family Physicians for the Condemnation of Violence and Discrimination Against Asian Americans and Pacific Islanders

CAFP officially condemns violence and discrimination against the Asian American and Pacific Islander community, and be it further

CAFP issues a statement denouncing the violence and discrimination against Asian American and Pacific Islander communities, especially during the COVID-19 pandemic. *(BoD 6/2021)*

Indigenous Health Care

CAFP supports efforts to enhance Indigenous health access and outcomes in California. *(BoD 5/2025)*

Promoting Health Equity for American Indian and Alaskan Native Populations

CAFP supports Medi-Cal and Medicare coverage of evidence-based traditional healing services provided through Indian Health programs to compliment allopathic medicine.

CAFP supports tribal consultation in the development of best patient care practices, and culturally appropriate data collection within Indian Health Programs.

CAFP supports the inclusion of Family Medicine rotations in graduate medical education at Indian Health Services, Tribal and Urban Indian Health Programs. *(BoD 5/2025)*

Topic: Medi-Cal

Support Reparations for Black Americans

CAFP will prioritize opportunities to offer education on the interconnection of racism and public health, and be it further

CAFP supports efforts to address historic and systemic racism, which may include a study of reparations, and be it further

CAFP will encourage the AAFP to support federal efforts that address historic and systemic racism. *(BoD 6/2021)*

70.06a Farm Workers

Extend Disability Benefits to Breast Feeding Mothers Exposed to Pesticides in the Workplace

CAFP will advocate for the California EDD to expand supplementary income assurances to breastfeeding women who are exposed to pesticides in the workplace up to 6 months after giving birth. *(BoD 11/2013)*

Promoting Healthy Pregnancies for Farmworkers through the California State Disability Insurance Program

CAFP raise awareness among physicians and healthcare clinicians about the health risks associated with exposure to pesticides during pregnancy and while chest feeding, and be it further

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

CAFP expand its current policy advocating for the extension of disability benefits for chest feeding parents who are exposed to pesticides in the workplace to include comprehensive access to paid leave (State Disability Insurance, Paid Family Leave, sick days, etc.) for farmworkers during pregnancy and while chest feeding. *(BoD 11/2024)*

70.06b Immigrant Health

Immigration Enforcement Protocols in Clinical Settings

CAFP create or endorse a policy that clarifies the legal rights and obligations of physicians, health care workers and patients relating to ICE raids in health care settings and that the CAFP distribute this policy among CAFP members, including but not limited to members practicing in Federally Qualified Health Centers. And that CAFP investigate the existence of and evaluate a toolkit and protocol, similar to Code Blue, with the scripts, roles, and algorithms for health care staff (legal observer, recorder, video recorder, etc.) that family physicians might use when responding to an ICE raid in a health care setting and make their availability known to CAFP members. *(BoD 7/2018)*

Advocacy for Closure of Detention Camps

CAFP issues an official statement calling for: (a) immediate end of the use of detention; (b) immediate end to separation of families (consistent with previous CAFP/AAFP positions); (c) immediate implementation of independent medical oversight of migrant detention centers to ensure standards of medical care are being met; and (d) immediate cessation of dangerous deportations, in which individuals are

deported to life-threatening conditions in their countries of origin or are deported to settings in which they face life-threatening medical complications. (BoD 5/2020)

Health Care Rights of Patients who are Detained by ICE
CAFP supports policies that affirm that people who are detained by immigration authorities have the right to appropriate, evidence-based private medical care led by a physician, within a timely manner; allow medical providers to communicate confidentially with patients and their family/loved ones in their preferred language, and also have access to legal resources and a copy of their medical record. *(BoD 4/2026)*

Protect Confidentiality and Access to Care for Immigrant Patients
CAFP supports protections that prohibit sharing or utilizing information from medical records or insurance enrollee information with immigration or other law enforcement agencies to pursue immigration enforcement actions against patients; and

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

CAFP opposes any requirements for physicians and healthcare systems to ask for immigration status or to report undocumented individuals *(BoD 04/2026)*

CAFP Support for Policies Limiting Government Organization Access to HIPAA Protected Data
CAFP supports policies that prohibit government organizations from utilizing HIPAA protected healthcare data, including demographic and medical treatment, for taking legal action against individuals. *(BoD 4/2026)*

Prenatal Care
Continue to support prenatal access to undocumented women as a high legislative priority. *(BoD 5/1998)*

Support Full-Scope Medi-Cal Access for Californians, Regardless of Immigration Status
CAFP shall support full access to Medi-Cal (including dental coverage) for all income-eligible Californians, regardless of immigration status

CAFP support policies that promote full equitable health care coverage that do not establish disparate levels of financial contributions based on immigrant, citizenship, or residency status. *(BoD 4/2026)*

70.06c Language and Cultural

Language and Cultural Proficiency

CAFP is committed to ensuring quality of care and patient safety by promoting access for limited English proficient (LEP) patients, cultural proficiency, expanded health workforce diversity, and reduced health disparities in the provision of medical care to California's LEP and racial/ethnic medically underserved populations. Cultural proficiency is a necessary component for patient safety and compliance. All persons, regardless of race, ethnicity or primary language, deserve access to high-quality health services.

Cultural proficiency is defined as a set of congruent behaviors, attitudes and policies that come together in a system, agency or among health professionals that enables work in cross-cultural situations. A culturally proficient organization values diversity; conducts cultural self-assessments; is conscious of and manages the dynamics of difference; institutionalizes cultural knowledge; and adapts services to fit the cultural diversity of the community served.

CAFP's Language and Cultural Proficiency Policy Principles include positions related to provider education, workforce issues, language access, research and data collection, healthcare financing, written resources, quality assessment, payment, Medi-Cal SCHIP & Medicare, Managed Care, and Private industry. For the full organizing principles for improving cultural proficiency and care to minority and medically underserved communities, see our Policy Reference Report on Language and Cultural Proficiency here or on CAFP's website at www.familydocs.org/policy. *(CoD 3/2007)*

70.07 Drugs and Alcohol

Access to Cannaboids

CAFP encourages more research on the purported risks and purported benefits of medical marijuana.

CAFP supports access to medical marijuana for patients with chronic pain, nausea and vomiting or wasting syndrome who are under the care of a physician and for whom other medications are either ineffective or intolerable and if the benefits outweigh the risks. *(CoD 3/2008, updated 9/2026)*

Adult Use of Marijuana

CAFP supports the decriminalization of the possession and personal use of marijuana, but lack of scientific data and peer-reviewed research prevents CAFP from endorsing its recreational use. CAFP supports the following measures to improve patient safety and expand the reliability and strength of marijuana research:

1. The federal government should change pharmaceutical cannabinoids from a Schedule I to a Schedule II drug to facilitate research, and private manufacturing and distribution of marijuana should be permitted for research purposes.

2. In states in which marijuana is legalized, research should be conducted into the overall safety and health effects of the recreational use of marijuana, as well as the effects of legalization on patient and societal health.
3. The federal Food and Drug Administration, or a similar state agency, should thoroughly investigate recreational and medicinal marijuana for safety and efficacy, including monitoring for purity, standardization of strength and proper usage, as well as testing for harmful contaminants such as insecticides, herbicides or molds.

In addition, CAFP believes our society must recognize drug use and abuse as medical and social problems that must be treated with medical and social solutions. CAFP calls on the President and Congress to empower an objective commission to recommend revision of national drug laws to reduce the harm caused by current policies. *(BoD 7/2016)*

Methamphetamines
CAFP include information about recognition and treatment of methamphetamine use and exposure in its publications and continuing medical education programs for family physicians. *(CoD* A-3-04*)*

Taxes on Alcohol to Finance Health Care
Support the increase of taxes on alcohol as a means of financing the health-related costs to the State of its use, and allocation of these taxes for the prevention, education and the health care expenses attached to alcohol-related illness. *(CoD 2/1996)*

Taxes on Alcohol to Finance Violence Prevention
CAFP encourages and supports legislation which will increase the excise tax on alcoholic beverages with the moneys used to help fund educational programs on violence prevention and treatment of alcoholism and related illnesses. *(CoD 2/1994)*

Treatment of Substance Use Disorder
CAFP supports appropriate changes in the law to permit a greater number of qualified physicians to treat individuals with substance use disorders with medication assisted treatment. *(CoD 1/1995, updated 9/2026)*

CAFP supports a policy of increased funding for drug and alcohol treatment programs. *(CoD 2/1996)*

70.08 Environment

Access to Care During Planned Power Outages
CAFP support efforts that ensure health facilities can continue to provide needed patient care during planned power outages. *(BoD 9/2020)*
Topic: climate health, wildfires

Environmental Standards for Hospitals and Medical Offices

CAFP supports stronger regulations regarding the sources of energy for California hospitals and standards for energy efficiency in new hospitals, such that all existing hospitals in California reach a minimum of 30 percent renewable energy by the year 2030 and 50 percent by 2050, and all new hospitals are required to use a minimum of 90 percent renewable energy starting in the year 2020.

For hospitals to reach the goals of a minimum of 30 percent renewable energy by the year 2030 and 50 percent by 2050 and all new hospitals using a minimum of 90 percent renewable energy by the year 2020, hospitals should be encouraged to install rooftop solar panels, switch to LED light bulbs, maximize insulation within new hospital buildings, shut off air conditioning in operating rooms that are not in use, use hybrid and electric vehicles in their fleet and for transporting supplies, initiate recycling and compost programs, and re-use sterilized instruments for procedures.

New and existing medical office buildings and other locations with physician offices should be encouraged to undertake energy saving efforts to help them achieve a goal of 30 percent renewable energy by the year 2030 and 50 percent by 2050. *(BoD 4/2018)*

Climate Health Policy Principles

CAFP recognizes that human-caused climate change is not only an environmental issue but a pressing and increasing individual and public health threat. Family physicians witness firsthand the health impacts of extreme heat, poor air quality, wildfires, environmental toxicants exposure, and other climate-related events that disproportionately affect vulnerable populations and frontline communities.

CAFP is committed to advancing policies and practices that protect patients, strengthen health system resilience, and promote environmental justice and sustainability.

1. Recognize Climate Change as a Public Health Threat

CAFP affirms that climate change poses serious and escalating threats to the health and well-being of all Californians.

2. Integrate Climate Health into CAFP Operations

CAFP reaffirms its commitment to incorporating climate health principles into its organizational decision-making, operations, and educational programs. This includes considering opportunities to reduce CAFP's environmental impact, and embedding climate considerations and prioritizing sustainability into ongoing initiatives and events. CAFP affirms its commitment to transparency and accountability in organizational, climate-related efforts.

3. Advance Environmental Justice and Equity

CAFP supports centering environmental justice and equity in all climate health policies, recognizing that frontline communities–particularly low-income populations, indigenous people, and communities of color–experience disproportionate health

burdens from climate change. CAFP will pursue opportunities to use equity advancing tools, such as the CAFP's JEDI Equity Tool Worksheet and CalEnviroScreen Tool when evaluating climate-related initiatives and policies to ensure equitable impact and support for vulnerable populations.

4. Build Resilient and Sustainable Health Systems

CAFP supports policies and programs that invest and strengthen the resilience and sustainability of healthcare systems. This may include:

- Making available environmentally sustainable healthcare practices and systems with transparency on environmental impact.
- Development and dissemination of resources, toolkits, and education for family physicians to apply sustainability principles in their practices.
- Making available climate-health education into medical school, residency, and continuing medical education curricula.

5. Promote Climate-Resilient Healthy Communities

CAFP recognizes that a healthy environment is prerequisite to healthy communities. This includes but is not limited to clean air, clean water, development of climate-resilient infrastructure, and a just, clean energy transition. CAFP supports the development and dissemination of resources for family physicians to effectively counsel patients and communities about climate-related health issues.

6. Ensure Evidence-Based Climate Health Policies

CAFP advocates for regulatory and legislative decisions grounded in scientific evidence and public health principles. This may include:

- Promoting accountability and transparency in the development and implementation of climate health policies.
- Supporting the use of data and surveillance systems to monitor health impacts and guide evidence-based action.
- Advancing research, education, and early warning systems to protect communities from emerging climate threats.
- Supporting policies and initiatives that will reduce greenhouse gas emissions as a preventative strategy. *(BoD 12/2025)*

Family Medicine Physicians as Advocates for Climate Change

CAFP will support the integration of climate change topics into medical school and residency curricula as well as continuing medical education programs to equip healthcare providers with the knowledge and skills to further inform their patients on environmental health impacts. *(BoD 5/2024)*

CAFP will support family medicine physicians to educate their patients on the potential health impacts of climate change and ways their patients can individually help alleviate the negative effects of climate change; including but not limited to increasing energy efficiency, recycling, walking or biking to work, and avoiding heavily processed foods. *(BoD 5/2024)*

CAFP supports physicians in advocating for environmental sustainability within their workplaces and local organizations. *(BoD 5/2024)*

Physician Representation on Environmental Issues
CAFP encourage physician representation on government advisory committees working on climate change and environmental issues. *(BoD 9/2020)*

Support California Fire Prevention, Safety, and Preparedness
CAFP distribute educational materials to prepare members for wildfires, such as on creating evacuation and meet-up plans, preparing fire preparedness kits, and prevention of wildfires,

CAFP support both local and state legislation that addresses wildfire prevention,

CAFP continue to support and advocate for legislation that overall decreases the effects of climate change, including the impact of the healthcare system on carbon emissions
(BoD 4/2022)

Support Environmental Justice in Environmental Health Policy
CAFP support policies and research that invest in environmental justice through supporting culturally vibrant sustainable and resilient communities in which every person has safe, clean and affordable options for housing, energy and transportation. *(BoD 5/2025)*

70.09 Food and Nutrition

70.09a Food Literacy and Access

Food Insecurity Screening in Healthcare Settings as Higher Standards of Health Care
CAFP supports and encourages family physicians and their practice teams to screen for food insecurity by using two validated screening tool questions as a higher standard of health care, such as:

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

CAFP educate its membership about how to use and interpret the validated food insecurity screening tools and identify local resources to which to refer patients in need. *(BoD 11/2018)*

Food Literacy
CAFP supports the need for validated and comprehensive food literacy assessments that can be practically utilized by family physicians, and

CAFP advocate for the funding, development and validation of evidence-based and culturally inclusive food literacy assessments, as well as food literacy education programs, and

CAFP support medical and educational experts at the community and state levels in their means to develop and propagate evidence-based and culturally inclusive educational programs addressing general nutrition competency and food literacy based on data collected from healthy literacy assessment tools. *(BoD 4/2026)*

Opposing the Expansion of SNAP Work Requirements
CAFP opposes the expansion of SNAP work requirements that reduce access to food assistance, which will directly affect vulnerable California families; and be it further

CAFP update its policy statements to explicitly recognize access to healthy and culturally appropriate food as a core component of health equity, and to support advocacy, clinical practices, and community partnerships that promote reliable access to nutritious food for all patients. *(BoD 4/2026)*

Transforming Access to Nourishment: Physicians for Food Security
That the California Academy of Family Physicians (CAFP) advocate for the continued development and use of evidence-based practices to strengthen follow-up care for patients experiencing food insecurity, including primary-care integrated referral pathways to both local and national resources to ensure comprehensive care and support. *(BoD 5/2025)*

70.09b General Nutrition

Tax on Sugar-Sweetened Beverages
CAFP advocates for the AAFP to work with Congressional leaders to implement a nationwide excise tax on sugar-sweetened beverages, the revenue generated from a statewide and/or nationwide excise tax on sugar-sweetened beverages should be earmarked to support health care programs, such as those related to childhood nutrition, obesity prevention and subsidizing healthier foods and beverages for those who need them. *(BoD 4/2018)*
Topic: soda

Restrict Antibiotic Use in Food Animals
CAFP urges that non-therapeutic use in animals of antimicrobials that are also used in humans should be terminated or phased out to protect the efficacy of these medications in human medicine and urges that AAFP do the same.

CAFP encourages bulk purchasers of foodstuffs, including restaurant chains, school and hospitals, to adopt policies encouraging procurement of foodstuffs from food animals raised with no medically important antibiotics except when given on a therapeutic basis (on a non-routine basis, or for a diagnosed disease) by a licensed veterinarian with an established veterinarian client-patient. *(BoD 4/2017)*

70.09c School and Child Nutrition

Diversifying School Meals to Reduce Chronic Disease, Improve Health Equity, and Improve Climate Health

CAFP endorse legislation that provides for healthy and diverse plant-based meal options for every K-12 grade child in public and charter California schools. *(BoD 7/2024)*

Eliminating Fruit Juice from WIC Food Packages to Combat Childhood Obesity and Dental Caries

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

CAFP support educational initiatives aimed at WIC beneficiaries to clarify that fruit juice is not a necessary component of a healthy pediatric diet. *(BoD 4/2026)*

Soft Drinks in Schools Policy

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

- Vended soft drinks and fruit-flavored drinks should be eliminated in all elementary schools.
- Incentives based on the amount of soft drinks sold per student should not be included as part of exclusive contracts.
- Within the contract, the number of machines vending sweetened drinks should be limited. Schools should insist that the alternative beverages listed in recommendation 1 be provided in preference over sweetened drinks in school vending machines.
- Schools should preferentially vend drinks that are sugar-free or low in sugar to lessen the risk of excessive weight gain and/or obesity.
- Consumption or advertising of sweetened soft drinks within the classroom should be eliminated. *(CoD 4/2004)*

Topic: soda

Supporting School Policies that Substantially Reduce Items Containing High-Fructose Corn Syrup and Derivatives

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

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

CAFP support the development of educational outreach for school administrators, food service staff, parents, and students about the health effects of concentrated added sugars and highly refined sugars. *(BoD 4/2026)*

70.10 Public Health Infrastructure

State and Local Public Health Department Investment

CAFP support efforts that promote investment of resources in state and local public health departments as guided by the current needs of the communities, which may include, but are not limited to, pandemic preparedness, mitigation of climate change effects on health, increase in public health labs, and higher paying salaries for qualified personnel, with the purpose of improving population health outcomes, and be it further

CAFP support efforts to increase coordination between primary care teams and public health programs to improve population health and health equity in the face of evolving public health challenges, and be it further

CAFP support efforts to improve transparency of current public health funding and perform regular assessments of that funding to ensure the necessary amount of resources are available and distributed to the appropriate public health programs based on the current health climate. *(BoD 4/2022)*

70.11 Health Education

Addressing Misinformation Through Physician Education and Community Engagement

CAFP supports efforts to equip family physicians with tools and resources to identify and combat health misinformation through education and training opportunities; and be it further

CAFP support the promotion of accurate, evidence-based health information; and be it further

CAFP supports family physicians as leaders and experts in combatting and debunking medical misinformation from social media or other sources; and be it further

CAFP recognizes the importance of thoughtful and responsible engagement by family physicians when disseminating health information on social media and other public platforms. *(BoD 4/2026)*

Physical Exercise as a Vital Sign

CAFP encourages family physicians to recommend that adults aged 18–64 do at least 150 minutes of moderate-intensity aerobic physical activity throughout the week or do at least 75 minutes of vigorous-intensity aerobic physical activity throughout the week or an equivalent combination of moderate- and vigorous-intensity activity.

CAFP develop policy to encourage family physicians to make a routine, standardized and widespread practice of measuring patients' habitual physical activity, and consider physical activity a "vital sign," be to assessed at clinical visits as appropriate and to engage patients in conversation and preventative counseling to ensure they are aware of and understand the proven connection between regular physical activity and optimal health. *(BoD 4/2017)*

Promotion of Resistance Training and Physical Activity as Standard Preventative Health Recommendations in Family Medicine

CAFP recommends adults engage in guideline-directed recommendation for muscle-strengthening activities of moderate or greater intensity and that involve all major muscle groups on two or more days a week, in addition to aerobic activity. *(BoD 4/2026)*

70.12 Housing

Decriminalize People Experiencing Homelessness

CAFP recognize and support the importance of affordable housing initiatives as a means to supporting better health, and be it further,

CAFP support policy measures that address policy issues that increase affordable, accessible housing, including rent control, rental assistance programs, and other low income housing efforts. *(BoD 5/2024)*

Support Rent Control Initiative on a Local, State, and National Level
CAFP recognize and support the importance of affordable housing initiatives as a means to supporting better health, and be it further,

CAFP support policy measures that address policy issues that increase affordable, accessible housing, including rent control, rental assistance programs, and other low income housing efforts. *(BoD 5/2024)*

70.13 Infectious Diseases

70.13a HIV / AIDS

Physician Testing
CAFP oppose mandatory HIV testing of physicians and other health care workers and lobby against such testing. *(CoD 2/1992)*

Reporting and Contact Notification

- Support mandatory reporting by name all cases of HIV infection/sero-positivity to local health departments, except for positive tests received at anonymous sites.
- Support confidential tracing by public health officials of the contacts of HIV infected individuals and partner notification of exposure, with the goal of offering testing and counseling to potentially exposed persons in time for prevention, or if infection has already occurred, early treatment and interruption of further transmission.
- Support preservation of anonymous HIV testing sites to attract any persons who might be more inclined to come in for early testing and counseling within this type of setting. *(CoD 2/1999)*

Transmission
CAFP support education, surveillance and other methods of quality control designed to decrease the likelihood of transmission of HIV in the health care setting. *(CoD 2/1992)*

HIV Testing and Documentation

- Resolved, CAFP should advocate for policy that HIV testing and documentation of results no longer have exceptional privacy requirements within the medical record; and, be it further
- Resolved, that a General Release of Medical Information request be sufficient for disclosure of HIV testing and/or results; and, be it further
- Resolved, that CAFP introduce and support the adoption of this resolution at the CMA House of Delegates. *(CoD 3/2007)*

70.14 Mental Health

Improving Suicide Screening for Adolescence
CAFP support increased access to mental health services for adolescents.

CAFP support regular screenings with validated screening tools for mental health in the school setting. *(BoD 4/2023)*

Reallocation of Resources in Police Department Budgets for a Mobile Crisis Intervention Team
CAFP support state and local policies to reallocate police department budgets to a mobile crisis multi-disciplinary intervention team trained in conflict resolution and deescalation techniques particularly with people experiencing mental health crises, homelessness, and substance abuse, and be it

CAFP support more research on the fiscal and public health impacts of a mobile crisis intervention team responding to non-violent calls in lieu of police officers. *(BoD 11/2021)*

70.15 Opioids / Pain Management

Creating a Buprenorphine Exemption from the Controlled Substances Act
CAFP support efforts to increase patient access to safe, effective and evidence-based treatment for opioid use disorder, such as reducing physician training requirements for prescribing buprenorphine. *(BoD 9/2020)*

Expanded Use of Naloxone: Prevention of Drug Overdose-related Deaths
1. Support the implementation of programs that allow first responders and non-medical personnel to possess and administer naloxone in emergency situations;
2. Support the implementation of policies that allow licensed providers to prescribe naloxone auto-injectors to patients using opioids or other individuals in close contact with those patients; and
3. Support the implementation of legislation that protects any individuals who administer naloxone from prosecution for practicing medicine without a license. *(BoD 4/2015)*

Expanding Naloxone Access in Schools: A Critical Step in Combating the Opioid Epidemic
CAFP support efforts that mandate training and access to emergency naloxone in primary/secondary schools. *(BoD 4/2023)*

Inappropriate Use of CDC Guidelines for Prescribing Opioids
CAFP applauds the Centers for Disease Control and Prevention (CDC) for its efforts to prevent the incidence of new cases of opioid misuse, addiction, and overdose deaths, and misapplication of its guidelines.

CAFP affirms that no entity should use MME (morphine milligram equivalents) thresholds as anything more than guidance, and physicians should not be subject to professional discipline, loss of board certification, loss of clinical privileges, criminal prosecution, civil liability, or other penalties or practice limitations solely for prescribing opioids at a quantitative level that prescribing the MME thresholds found in the CDC Guideline.

That the CDC guidelines do not constitute a standard of practice and should be considered by physicians alongside other guidelines, such as those produced by the Medical Board of California. As such, CAFP will advocate against misapplication of the CDC Guideline by pharmacists, health insurers, pharmacy benefit managers, legislatures, and governmental and private regulatory bodies in ways that prevent or limit patients' medical access to opioid analgesia.

CAFP collaborate with the AAFP, the American Medical Association, pharmacy associations and the pharmacy board to communicate with the nation's largest pharmacy chains to recommend a review of practices related to denial of prescriptions for opioids that exceed certain numerical thresholds, including, policies, procedures and directives to retail pharmacists. Authors informed. Staff to engage with other organizations to identify opportunities to collaborate. *(BoD 7/2019)*
Topic: privileges

Overdose Preparedness in Primary Care Settings
CAFP encourage state-wide and national requirement of primary care facilities to implement overdose preparedness protocols that include naloxone storage with on-site emergency kits and all-clinic staff training in naloxone administration;

CAFP make physician-facing information available about medico-legal aspects in providing intoxication and overdose treatment; and,

CAFP encourage AAFP to formally recommend clinical guidelines addressing overdose in the ambulatory setting. *(BoD 5/2024)*

Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis
CAFP support the creation of facilities that provide a supervised framework and enhanced aseptic conditions for the injection of self-provided illegal substances with medical monitoring, with legal and liability protections for persons working or volunteering in such facilities and without risk of criminal penalties for recipients of such services. *(BoD 7/2018)*

70.16 Tobacco

Chewing Tobacco Products
CAFP opposes the use of chewing tobacco products and extends the same policies to them as to other tobacco-related products. *(BoD 2/2001)*

Electronic Cigarettes
CAFP opposes the use of electronic cigarettes (e-cigarettes) and other nicotine delivery devices not approved by the United States Food and Drug Administration (FDA) as smoking cessation aids and in those places where smoking is prohibited by law. CAFP supports the requirement that a tobacco permit be required by law for the sale or furnishing of e-cigarettes and other nicotine delivery devices not approved by the FDA as smoking cessation aids. CAFP supports the extension of tobacco laws to e-cigarettes. Such devices should not be sold to children under 18.

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

There are concerns about the lack of any regulatory oversight by the Food and Drug Administration's Center for Tobacco Products (FDA CTP) on the manufacture, distribution and safety of e-cigarettes. Therefore, the CAFP calls for rigorous research in the form of randomized controlled trials of e-cigarettes to assess their safety, quality, and efficacy as a potential cessation device. CAFP also recommends that the marketing and advertising of e-cigarettes, especially to children and youth, should cease immediately until e-cigarette's safety, toxicity, and efficacy are established. *(BoD 5/2014)*

Pharmacies Selling Cigarettes
Oppose the sale of cigarettes and other tobacco products in pharmacies.

Work with the Pharmacy Partnership Project to contact the management of independent and chain pharmacies to explain the CAFP position opposing tobacco sales in pharmacies, and help them understand the implications for their business. *(CoD 2/1999)*

Smoking Cessation for Minors
CAFP supports access for minors aged 16 and older for smoking cessation programs and nicotine replacement therapy (NRT) for the treatment of nicotine dependence,

without requiring parental or guardian consent, and encourages the use of evidence-based modalities in the treatment of youth nicotine dependence. *(BoD 12/2025)*

Taxes on Tobacco
Support the increase of taxes on tobacco as a means of financing the health-related costs to the State of its use, and allocation of these taxes for the prevention, education and the health care expenses attached to tobacco-related illnesses. *(CoD 2/1996)*

70.17 Vaccines

Minor Consent for Vaccines
CAFP advocate that vaccines recommended by the California Department of Public Health, the AAFP, and other designated evidence-based assessment entities, be available to adolescents aged 12 years and older who desire vaccination without requiring consent from their legal guardians, and

CAFP advocate that SARS-Co-V2 vaccines be available to adolescents aged 12 years and older who desire vaccination without requiring consent from their legal guardians.. *(BoD 4/2022, updated 9/2026)*

Annual Influenza Vaccine Mandate Among Required Vaccinations for School
CAFP support efforts to increase annual influenza vaccine adherence in children, through such efforts as required vaccination for school or childcare enrollment, with appropriate medical exemptions. *(BoD 9/2020)*

Control of Influenza Vaccine Supply
CAFP policy that manufacturers preferentially supply influenza vaccine to physicians in time of shortage or public need. *(CoD 2/2001)*

Ensuring Equitable Distribution of the COVID-19 Vaccine
CAFP lobby for the specific inclusion of collaboration with non-governmental community organizations and clinics to address equitable distribution of the COVID-19 vaccine among communities of racial and ethnic minorities as well as undocumented individuals. (BoD 6/2021)

Ensuring Equitable Vaccine Access for Independent and Rural Family Physicians to Protect Public Health in California
CAFP advocate for state-level vaccine policy reforms to ensure independent and rural physician practices have equal access to ordering, storing, and administering all evidence-based recommended vaccines

CAFP supports the creation of an evaluation and report on vaccine-access disparities among independent practices, rural counties, and large systems, including recommendations for system-level improvements. *(BoD 4/2026)*

Immunization Registry

Support the completion of the immunization registry state hub and encourages members' participation in such registries. *(CoD 3/2009)*

Personal and Religious Belief Exemptions to Immunizations
Support the elimination of the personal and religious belief exemptions for immunization requirements for school-aged children. *(BoD 4/2015, updated 9/2026)*

Preferential Supply of Influenza Vaccine
Manufacturers should preferentially supply influenza vaccine to physicians in time of shortage or public need. *(CoD 2/2001)*

Support legislation providing physicians priority access to the first available seasonal influenza vaccine. *(CoD 3/2010)*

Public School Vaccine Education
CAFP supports policies that formalize and implement a school curriculum that includes evidenced-based vaccine education. *(BoD 8/2025)*
Topic: health education, schools

Vaccine Information Mobile Application
CAFP advocate for the development and maintenance of a mobile application and/or mobile-friendly web-based platform that provides up-to-date vaccination information corresponding to evidence-based recommendations that is readily accessible to the general public that addresses common questions and misconceptions related to vaccination. *(BoD 4/2026)*

Vaccines/Immunizations Policy

- When medical practices incur a cost for vaccines, physicians should be adequately paid for the vaccine itself and all associated overhead costs (i.e., acquisition, storage, inventory, insurance, spoilage/wastage, etc.) of all immunizations and their administration with no patient cost-sharing.
- All children and adults, regardless of economic and insurance status, should have access to all immunizations recommended by the AAFP.
- Vaccine manufacturers and distributors should have payment policies that minimize physicians' financial risk involved in maintaining a vaccine inventory.
- Government programs (e.g., Vaccines for Children (VFC), 317 Immunization Grants, or state "universal purchasing") that subsidize the costs of vaccines at no cost to medical practices should be adequately funded by the federal and state government.
- Patients should receive all immunizations in their medical home; when recommended vaccines are provided outside of the medical home, all pertinent vaccine related information should be provided to the patient's medical home.
- The government should allow physicians to intermingle storage of VFC and other vaccine supplies, with appropriate documentation and cost accounting,

due to the burdensome and unnecessary administrative hassle of doing otherwise. *(BoD 5/2013)*

70.18 Violence and Injury Prevention

70.18a Domestic Violence and Child Abuse

Mandatory Reporting Harms Patients Impacted by Intimate Partner Violence
CAFP supports elimination of mandatory reporting to law enforcement for adult intimate partner violence victims; and be it further

CAFP supports requirements for referrals to local and/or national domestic and sexual violence advocacy services for adult intimate partner violence victims. *(BoD 4/2023)*

Prevent Child Abuse
CAFP support primary prevention of child abuse and neglect through the education of family physicians, including residents, about identifying families at risk for child abuse, and support allocation of funds, public and private, for the expansion of primary prevention home visitation programs and direct this issue to the Education and Legislative Affairs Committees to consider how best to support the primary prevention of child abuse. *(CoD 1/1995)*

70.18b Firearm Violence

Educate FPs/Public on Firearms and Risk of Injury and Death
CAFP should continue to develop programs to educate family physicians, their patients and the public on the issue of ownership of firearms and the concurrent risk of injury and death, domestic and family violence, alcohol and other drug abuse and the concurrent risk of violent injury and death, the relationship of increasing violence in the media and increasing violence in our society, the preventable nature of violence, and the importance of addressing the root causes of violence as part of a comprehensive violence prevention approach; and, the CAFP delegation to the AAFP COD introduce a resolution asking the AAFP to recognize the above. *(CoD 2/1994)*

Firearm Violence
1. CAFP recognizes that firearm violence is a public health issue and supports targeted public education campaigns on firearm violence prevention to improve public understanding of the risks associated with firearms and to enlist community partners in the effort to reduce morbidity and mortality from firearms.
2. As with other public health issues, physicians have a unique responsibility as trusted public health figures to respond to the harms associated with firearm violence, both as individual clinicians and as community advocates. Through their role in routine screening and assessment, physicians can counsel and educate patients about firearm safety and storage, including best practices to reduce injuries, deaths and psychological trauma related to firearm use. Particular care should be given to individuals in risk categories such as a history of alcohol or substance abuse, history of violence, and risk of harm to self or others.

3. CAFP supports California's strong legal and regulatory protections related to firearms and commits to working with the American Academy of Family Physicians and others to improve federal policy in that regard.
4. CAFP supports:
    - Restriction of access to firearms for individuals at increased risk for firearm violence, including individuals with a history of alcohol or substance abuse, those convicted of domestic violence, or those with suicidal ideation or other intent to physically harm themselves or others.
    - Appropriate regulation and taxation of firearm and ammunition purchases, and that such items be subject to legal and regulatory protections in regard to design, sale or transfer, possession and storage.
    - Establishment of a universal background check system and the successful completion of a use and safety course for all persons buying or otherwise taking ownership of a firearm or purchasing ammunition.
    - Mandated reporting by firearm owners of the theft or loss of a firearm within 72 hours of becoming aware of the loss.
    - Appropriate possession limitations on firearms and ammunition with features designed to increase their rapid killing capacity.
    - Waiting periods prior to firearm purchases.
    - Funding of research into gun violence as a public health issue, including overturning the Dickey Amendment and funding the CDC to investigate how to reduce morbidity and mortality related to firearms. *(BoD 4/2018)*

Oppose Possession or Private Use of Handguns

CAFP recognizes the crisis created by handguns and endorses and supports legislation prohibiting the manufacture, sale, transfer or possession of handguns and handgun ammunition for private use. *(CoD 2/1994)*

Policy on Keeping People Safe from Firearm-related Harms

CAFP supports legislative and regulatory approaches to keeping people safe from firearm-related harms, which may include:

- Increasing public and private funding for the development, evaluation and implementation of evidence-based programs and policies to reduce firearm-related injury and death;
- Supporting consumer product regulations regarding gun design, access and safety similar to those used for other consumer products;
- Regulating gun purchases through waiting periods and background check;
- Limiting the availability of firearms to those whose ability to responsibly handle weapons is assured, including relevant mental health diagnoses and criminal background restrictions; and
- Prohibiting the sale of assault-type weapons and high capacity ammunition magazines. *(BoD 5/2013)*

Restrictions on Physicians' Ability to Counsel Patients on Firearms

CAFP opposes restrictions on physicians' ability to counsel patients on reducing injuries and deaths from firearms in the home. *(BoD 5/2013)*

Tax on Gun and Ammunition Sales

CAFP support a tax on gun and ammunition sales and that the revenue generated from such a tax be used to fund mental health support services, such as behavioral health therapists at schools, programs to identify at risk children, and post- incident support services for individuals affected by any gun violence.

CAFP submit a resolution to the AAFP to support a tax on gun and ammunition sales, and that the revenue generated from such a tax be used to fund mental health support services, such as behavioral health therapists at schools, programs to identify at risk children and post- incident support services for individuals affected by any gun violence. *(BoD 7/2018)*

70.18c Injury Prevention

Mandatory Use of Motorcycle Helmets

Affirms support for legislation requiring mandatory use of approved helmets by all motorcycle riders, regardless of age, urging both houses of the California legislature to enact, and the Governor to sign, such legislation as a matter of urgency.

Direct CAFP's delegates to the CMA to actively pursue this position before the CMA's House of Delegates and Legislative Action Committee, so that this position may be forcefully pressed by the CMA's lobbying team in Sacramento.

Direct CAFP's Executive, and administrative staff to communicate directly with the Governor, appropriate legislative leaders and with the public through appropriate media, expressing the position of CAFP on this matter. *(CoD 2/1989)*