California Academy of Family Physicians Policy Digest

INT = Internal Policy; EXT = External Policy
POS = Positions (taken on initiatives, legislation, etc.)
Last updated: Dec. 16, 2020

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PREFACE:
This document is a digest of CAFP policy. It is a record all official actions taken by the Board of Directors, Executive Committee, and Congress of Delegates, beginning in 1986. It is organized by major subject areas. Each entry is taken from one of three key source documents: the Minutes of the Board of Directors (BoD), the Minutes of the Executive Committee, (EC) and the CAFP Congress of Delegates Transactions (CoD). The Congress of Delegates became the All Member Advocacy Meeting (AMAM) in 2014 and now acts only on dues increases and special assessments, as well as changes to the CAFP Bylaws.

Each entry is marked by the month and year of its passage. You may click on a topic to go to that section.

Contents

AAFP INT

COMMITTEES and COMMISSIONS

Discuss general philosophy of nominations to AAFP Commissions and Committees, and nominees' responsibilities to the CAFP. Develop a CAFP responsibility form querying applicants how their appointments will benefit CAFP, requiring a 2-3 sentence emailed report after each cluster meeting, and asking for assistance in gathering "intelligence" about political goings-on. Make applicants aware of CAFP's policy manual and consider setting up an annual telephone conference or meeting at the ASA with all members serving on AAFP Commissions and Committees. *7/99 EC*

CONGRESS of DELEGATES RESOLUTIONS

All resolutions proposed for submission to the AAFP Congress of Delegates will be decided upon by the Board of Directors through appropriate non-meeting means, if the Board does not meet in the interim before the next AAFP meeting. *5/93 BoD*

DELEGATION TO AAFP

Budget: CAFP will allocate to reserves $3,000 annually for the future expense of running a campaign for AAFP office; expense of running such a campaign is a minimum of $12,000. Approximately $2,000 is budgeted annually in the event the Delegation chooses, and the Executive Committee concurs, to have a hospitality event. *10/91 BoD*

Candidate/Officer Strategy: Agree to run a candidate for AAFP office only when it is agreed that candidate has an excellent chance for success and meets other criteria established by CAFP. *BoD 2/8/06.*

The recommendation of choice and timing of running candidates for national office will come from the Delegation for discussion; it will then be discussed and approved by the Executive Committee and CAFP Board. This recommendation should be made by the summer Board meeting of the year before a candidate runs for office. *9/88 BoD*

Develop recommended strategies and policies for selection of CAFP Delegation to AAFP with an eye toward a leadership track, positioning for national office and determination of candidates as well as proposed funding for these activities, including asking that an unsuccessful candidate for office step down as Delegate. *2/93 BoD*

Call on District Directors to help identify potential leaders. *2/93 BoD*

Job Description: Adopt with amendment the "Job description for AAFP Delegates and Alternates;" require that candidates interested in higher AAFP office submit a written request for consideration, providing appropriate background information; approve "vetting" of candidates expressing interest in higher office at AAFP first through a formal interview with the President and President-elect, and then with formal approval by the Executive Committee and Board of Directors (which approves CAFP budget) *12/05 EC*

Meetings/Positions on Resolutions: There will be a joint meeting of the Executive Committee and the AAFP Delegation annually. *9/88 BoD*

The Executive Committee is authorized to develop CAFP positions on AAFP resolutions. *9/92 BoD*

Reimbursement for Congress: AAFP Delegates and Alternates shall be reimbursed for travel expenses plus a three day per diem established in the annual budget and determined by consideration of hotel convention rate for headquarters hotel, except travel expenses will not be paid when AAFP meets in California. *9/88 BoD*

Term Limit: An alternate delegate will serve no more than six years unless there is a CAFP member in national office; then one additional year as delegate is allowed (total of seven years). *9/88 BoD*

Turnover: The turnover of delegates and alternates should be active to allow for rapid development of future candidates. If a delegate runs for national office and is not successful, he or she will not continue as a delegate. *9/88 BoD*

Accountable Care Organizations EXT

Accountable Care Joint Principles: Adopt the Accountable Care Joint Principles of the AAFP, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association as follows. *05/13/11 BoD*

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 following principles:

Structure

1. The core purpose of an Accountable Care Organization is to provide accessible, effective, team-based integrated care based on the Joint Principles of the Patient Centered Medical
2. Home for the defined population it serves, which includes assurances that care is delivered in a culturally competent and patient and/or family-centered manner.
3. The Accountable Care Organization should demonstrate strong leadership from among physicians and other healthcare professionals, including significant and equitable representation from primary care and specialty physicians, in its administrative structure, policy development, and decision-making processes; clinical integration in the provision of care; and processes to facilitate operation as a true partnership among physicians and all other participants.
4. Organizational relationships and all relevant clinical, legal, and administrative processes within the Accountable Care Organization should be clearly defined and transparent to physicians, other related healthcare professionals, and the public. This includes methods of payment including the application of any risk adjustment strategies for both pediatric and adult patients, quality management processes, and processes to promote efficiency and value in delivery system performance.
5. Accountable Care Organizations should include processes for patient and/or family panel input in relevant policy development and decision-making.
6. Accountable Care Organizations should include a commitment to improving the health the population served through programs and services that address needs identified by the community including, for example, interfacing with state Title V programs, early intervention programs, Head Start offices, and public education entities.
7. Accountable Care Organizations should provide incentives for patient and/or family engagement in their health and wellness.
8. Participation by physicians, other healthcare professionals, and patients/families in an
9. ACO should be voluntary. However, if patients are assigned to an ACO, they should be encouraged to select a primary care physician.

10. Nationally-accepted, reliable and validated clinical measures focused on ambulatory and inpatient care should be used by Accountable Care Organizations to measure performance and efficiency and evaluate patient experience. These measurement processes should be transparent, and informed by input from primary and specialty care physicians and other healthcare professionals participating in the Accountable Care Organization.
11. Accountable Care Organizations should implement clinically integrated information systems to provide relevant information at the point of care and assist in care coordination among multiple clinicians and across transitions and sites of care.
12. The structure and related payment systems of the Accountable Care Organization should be implemented and monitored to prevent " adverse unintended consequences," such as poor access to physicians, denial of needed care, or discrimination against the treatment of the more medically complex or difficult-to-treat patients.
13. Primary care physicians, specialty physicians, and other healthcare professionals should have the option to participate in multiple Accountable Care Organizations.
14. Barriers to small practice participation within the Accountable Care Organization should be addressed and eliminated. These barriers include the small size of their patient panels and their current limited and future access to capital, health information technology infrastructure needs, and care coordination and management resources.
15. Accountable Care Organizations should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.
16. Accountable Care Organizations should promote processes to reduce administrative complexities and related unnecessary burdens that affect participating practices and the patients/families to whom they provide service.

<u>Payment</u>

17. Payment models and incentives implemented by Accountable Care Organizations must align mutual accountability at all levels, fostered by transparency and focused on health promotion and healthy development, disease prevention, care management, and care coordination.
18. Payment models and incentives implemented by Accountable Care Organizations should adequately reflect the relative contributions of participating physicians and other health care professionals to increased quality and efficiency and demonstrate value in the delivery of care.
19. Payment models should recognize effort required to involve family, community/educational resources and other pertinent entities and activities related to care management/care coordination of patients with complex conditions.
20. Recognition as an Accountable Care Organization and rewards for its performance should be based on processes that combine achievement relative to set target levels of performance, achievement relative to other participants, and improvement that have been developed with significant input from primary and specialty care physicians and other health care professionals.
21. Practices participating within the Accountable Care Organization that achieve recognition as medical homes by NCQA, other nationally accepted certification entities, and/or related processes (e.g. state government recognition) should be provided with additional financial incentives.
22. The structure of the Accountable Care Organization should adequately protect ACO physicians and other healthcare professional participants from “insurance risk,” unless clearly agreed as a requirement for participation.
23. Accountable Care Organizations can employ a variety of payment approaches to align the incentives for improving quality and enhancing efficiency while reducing overall costs including but not limited to blended fee-for-service /prospective payment, shared savings, <u>episode/case rates and partial capitation.</u>

** These principles use the term "other health care professionals" to represent non-physician direct patient care providers licensed to deliver primary care and other healthcare services (e.g. nurse practitioners, physician assistants, licensed clinical social workers, and clinical psychologists).*

ACGME Restriction of Residency Choice EXT

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. *11.03.12 BoD*

Adoption EXT

Second Parent and Joint Adoptions: That the 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. *A-4-97, 2/97 CoD*

Affiliated Physicians Category EXT

Adoption of Affiliated Physician category: That CAFP adopt as policy that there should be a mechanism to document physician hospital affiliation for credentialing purposes, including for those physicians who do not regularly admit inpatients. *A-1-04, 4/04 CoD*

Physician Testing: That CAFP oppose mandatory HIV testing of physicians and other health care workers and lobby against such testing. *2/92 CoD*

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 2/99*

Transmission: That CAFP support education, surveillance and other methods of quality control designed to decrease the likelihood of transmission of HIV in the health care setting. *2/92 CoD*

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. *A-06-07, 03/07 CoD*

All Member Advocacy Meeting INT

The California Academy of Family Physicians' Congress of Delegates' name will be changed to the *All Member Advocacy Meeting* (AM/AM) – open to all members in addition to Delegates and Alternates and held in Sacramento to enhance CAFP's advocacy efforts – to activate, give voice to and empower our members as advocates for themselves and their patients and to present ideas and problems to the CAFP leadership and Board of Directors; and

The California Academy of Family Physicians will undertake an outreach and education effort with members to advise them about the policymaking opportunities and member assistance services CAFP offers, so those members can take advantage of the avenue that best meets their needs and provides immediate assistance in resolving problems encountered in practices; and

The California Academy of Family Physicians All Member Advocacy Meeting will offer the opportunity for the membership to submit resolutions and advocate for them before the Board of Directors, which will have responsibility for vetting and reporting back on those resolutions to the All Member Advocacy Meeting at the next meeting, and that members be encouraged to bring issues and problems to the Board throughout the year, not only at the All Member Advocacy Meeting, to ensure prompt resolution; and

Delegates and Alternates currently elected and/or selected to serve by their respective county chapters at the CAFP Congress of Delegates will continue to be charged with the responsibility of electing CAFP's officers and other officials at an All Member Advocacy Meeting, if adopted, as provided by the CAFP Bylaws and, through the All Member Advocacy Meeting, if adopted, may at any time by majority vote, submit referendums to the members of the Academy on questions affecting the policy or recommendations of the Academy, including actions taken by the Board of Directors during the prior year; and

The Bylaws of the California Academy of Family Physicians shall be rewritten to reflect the name change from Congress of Delegates to All Member Advocacy Meeting and specific sections of the Bylaws amended to place responsibility for policy and disposition of resolutions with the Board of Directors while allowing Delegates to the All Member Advocacy Meeting to elect the officers of the CAFP, approve dues increases and submit referendums to the membership, as is currently the case; these bylaws changes will be publicized to the membership and submitted to the 2013 Congress of Delegates for consideration. *A-03-12 - 3/04/12 CoD*

That a process for obtaining member comments and input on resolutions received between meetings of the All Member Advocacy Meeting be developed and CAFP members have an opportunity to comment on and provide input into the proposed new process for soliciting member input on resolutions received between meetings of the All Member Advocacy Meeting for consideration by the Board of Directors before such policies are adopted. *BOD 4.12-13.18*

Reimbursement to Board: Reimbursement to members of the Board for the Board of Directors meeting at the Forum shall be increased to cover the cost of one night's stay in the convention hotel. *6/94 BoD* Increased to two nights' stay because of change in Congress/AMAM schedule. *10/96 BoD*

Awards **INT**

Set up a nominations schedule to review awards, including the Public Health Award, ABFP Board, Thomas W. Johnson and others, develop process for candidate identification; develop a grid system for chapters and committees, etc. *2/96 BoD*

Board Certification **INT**

Oppose the use of absence of board certification as the sole basis for exclusion of family physicians from provider panels and hospital staff memberships. *D-2-95, 1/95 CoD*

Committee Chairs: Invite Committee Chairs to attend one Board meeting during the year. *11/95 EC*

Adopted a recommendation to invite Committee chairs to attend one Board meeting annually to report on Committee actions and be recognized by the Board for activities; and Board members should be asked/designated to serve as Committee liaisons when appropriate. *2/95 BoD*

Policy on Communicating Board Action on Resolutions to CAFP Membership: In response to requests received at the 2018 All Member Advocacy Meeting as well as policy adopted at the April 13, 2018 meeting of the CAFP Board of Directors, the following is proposed to ensure members are kept abreast of resolutions submitted to the Board of Directors between All Member Advocacy Meetings (AMAM) or after the deadline for submission of resolutions to the AMAM. This proposed policy will provide members an opportunity to comment on "interim" resolutions and be informed about Board actions taken subsequently on those resolutions:

1. All resolutions/policy proposals submitted to the Board of Directors after the deadline for receipt of resolutions at the AMAM and prior to the next meeting of the AMAM will be posted on the CAFP website and notification that they have been received and posted made to members in our *Academy in Action* electronic newsletter. The resolutions will remain on the website until the next quarterly Board meeting at which they will be considered, but no less than one month prior to the next meeting. If a resolution is received within less than one month of a Board meeting, it will be posted but consideration by the Board will be held off until the following meeting to allow adequate time for members to comment.
2. A chart reflecting actions taken by the Board on all resolutions will be posted on the website and updated after each quarterly meeting of the Board of Directors. Members will be notified about the updates via *Academy in Action* newsletter. Authors are and will continue to be notified of Board action taken on their resolutions.
3. A complete listing of the actions taken is included in the Participants' Handbook sent to all registrants at the AMAM. All policies adopted by the Board over the past year also are included in the Handbook for AMAM delegates' review. Time will be provided at the AMAM for the Speaker to review actions on resolutions more thoroughly.
4. Proposed policies may be submitted to CAFP at any time of the year by using the CAFP Policy Resolution form. *7.13.18 BoD*

Conflict of Interest Statement: Adopted a resolution on conflict of interest policy for CAFP and the explanation of conflict of interest statement. *BoD 2/98*

Reaffirmed the Resolution on Conflict of Interest policy for CAFP and the Explanation of Conflict Interest statement and requested signed statements from each Board member annually. *BoD 2/99*

District Directors/AAFP Commission Members: Request a brief report from all members of AAFP Committees and Commissions. A month before the Board agenda is developed, request District Directors and AAFP Committee/Commission members to provide a one-page report. *2/11/93 BoD*

Fiscal Notes: All requests for action from the Board shall be accompanied by a fiscal note when appropriate. *10/89 BoD*

Nominating Committee Service: Approved development of a guide for service on the Nominating Committee to address such issues as precluding those serving on the Nominating Committee from being nominated for office, and planning for the eventuality of running for office in advance of accepting service on the Committee as a representative of the Board or from Congress. *5/96 EC*

Adopted the following statement concerning members of the Board and Congress serving on the Nominating Committee:

"As a matter of policy, it is recommended that candidates from the Board of Directors and Congress of Delegates seeking positions on the Nominating Committee remove themselves from consideration for higher office if elected to serve on that Committee. This recommendation is made to remove any appearance of conflict of interest or self-dealing. The exception to this recommendation is the position of Nominating Committee Chair, which is filled in accordance with the CAFP Bylaws by the Immediate Past President of the organization. This individual, by virtue of his or her experience and position, may be considered for higher office outside the organization, such as AAFP Alternate or Delegate.

All candidates for positions on the Nominating Committee should carefully examine their ambitions for CAFP higher office and the timing for seeking such office prior to declaring an intention to run for the Nominating Committee, and are encouraged to remove themselves from consideration if higher office is to be sought within the potential term of service on the Nominating Committee." *8/96 BoD*

Non-discrimination: "The California Academy of Family Physicians supports the principle that membership in the organization, service on the organization's governing bodies, committees and task forces, participation in Academy programs and activities, and Academy collaboration and cooperation with outside entities will be without regard to age, gender, race, ethnicity, sexual orientation, disability, national origin, political affiliation or religious belief." *8/96 BoD*

Restructuring: Restructure CAFP Board of Directors as per Bylaws changes adopted 1/95 by CoD. Restructuring included decreasing number of districts from 13 to 10, reducing the number of directors per district to one from two, eliminating the Editor and AAFP Alternate Directors as members of the Board (Editor may attend ex officio), reducing the student and resident representatives from two to one and creating two at-large director positions, one from a rural practice or area and a new physician (no more than seven years out of residency training). *A-4-95, 1/95 CoD*

Transitioning of current directors and officers to the new structure was accomplished through adoption of a resolution specifying how the transition would take place. *A-3-95, 1/95 CoD*

Adopted procedures for election of District Directors from multi-chapter districts. Note: These procedures are recommendations, not requirements, for chapters to follow in their elections. *6/95 BoD*

Recommend that all chapters include the alternate position on ballots electing District Directors; encourage District Directors to communicate directly with the Alternates in their Districts. *11/96 EC*

CAFP Congress of Delegates INT

The bylaws of the California Academy of Family Physicians were amended to implement the transition from the Congress of Delegates to the All Member Advocacy Meeting. A-01-13 3.5.13 CoD

Recommendation #4: To improve the quality of the resolutions presented, new policy with regard to resolutions should be adopted as follows: *10/96 BoD*

1. Resolutions will be screened by CAFP staff, with assistance as necessary by the Speaker and Vice Speaker. Any resolutions requiring rewriting, clarification or resources should be returned to the author with an explanation of the areas of concern, a request for correction and an offer to assist the author with the rewrite.
2. Resolutions that reaffirm current CAFP policy will be returned to the author with explanation that the resolution reaffirms policy and will be placed on the reaffirmation calendar, with no debate, or may be withdrawn by the author.

Recommendation #5: To assist chapters in preparation for Congress of Delegates activities a set of materials covering such topics as reimbursement for delegates and alternates, possible election procedures, endorsement guidelines for resolutions, guidelines for writing and submitting resolutions, and a review of parliamentary procedure, will be prepared and disseminated to chapter officers, delegates and alternates and other interested parties. *10/96 BoD*

Representation of Membership: Chapters should be strongly encouraged to elect delegates who reflect the demographics of their respective constituencies. *8/99 BoD*

Officers: Induct Officers at ASA/Forum and Hold a Keynote Speech at the same time: *8/99 BoD*

Separate Congress from the ASA: Voted to separate the Congress of Delegates from the Annual Scientific Assembly and expand congress to include Leadership and Legislative training. *11/06 BoD*

Bylaws: Approved amendment of CAFP Bylaws as follows to ensure consistency in scheduling the annual meeting of the Congress of Delegates. Superseded by adoption of new bylaws concerning transition to an All Member Advocacy Meeting from the Congress of Delegates, March 3, 2013.

ARTICLE VI
TRANSITION CAFP CONGRESS OF DELEGATES TO ALL MEMBER ADVOCACY MEETING
A resolution was adopted expressing the intent that the California Academy of Family Physicians' Congress of Delegates' name be changed to the *All Member Advocacy Meeting* (AM/AM) – open to all members in addition to Delegates and Alternates and held in Sacramento to enhance CAFP's advocacy efforts – to activate, give voice to and empower our members as advocates for themselves and their patients and to present ideas and problems to the CAFP leadership and Board of Directors; and

That the California Academy of Family Physicians undertake an outreach and education effort with members to advise them about the policymaking opportunities and member assistance services CAFP offers, so those members can take advantage of the avenue that best meets their needs and provides immediate assistance in resolving problems encountered in practices; and

That the California Academy of Family Physicians All Member Advocacy Meeting offer the opportunity for the membership to submit resolutions and advocate for them before the Board of Directors, which will have responsibility for vetting and reporting back on those resolutions to the All Member Advocacy Meeting at the

next meeting, and that members be encouraged to bring issues and problems to the Board throughout the year, not only at the All Member Advocacy Meeting, to ensure prompt resolution; and

That Delegates and Alternates currently elected and/or selected to serve by their respective county chapters at the CAFP Congress of Delegates continue to be charged with the responsibility of electing CAFP's officers and other officials at an All Member Advocacy Meeting, if adopted, as provided by the CAFP Bylaws and, through the All Member Advocacy Meeting, if adopted, may at any time by majority vote, submit referendums to the members of the Academy on questions affecting the policy or recommendations of the Academy, including actions taken by the Board of Directors during the prior year; and

That the Bylaws of the California Academy of Family Physicians shall be rewritten to reflect the name change from Congress of Delegates to All Member Advocacy Meeting and specific sections of the Bylaws amended to place responsibility for policy and disposition of resolutions with the Board of Directors while allowing Delegates to the All Member Advocacy Meeting to elect the officers of the CAFP, approve dues increases and submit referendums to the membership, as is currently the case; these bylaws changes will be publicized to the membership and submitted to the 2013 Congress of Delegates for consideration. *3/4/12 CoD Res. A-03-12 Bylaws change to this effect approved 3.3.13 by the CoD.*

County Chapter Contributions: Each CAFP County Chapter that charges dues is requested to make an annual contribution of at least $2 per member, to be deducted from the first dues disbursement, unless otherwise directed by the Chapter, to the CAFP/F to support the many programs of the Foundation. *2/94 CoD*

Contributions: The California Academy of Family Physicians increase the membership dues assessment for the CAFP Foundation from fifteen ($15) to twenty dollars ($20) per each Active member. *B-1-02 3/02 CoD*

Foundation President: The Foundation President will be invited to attend Board and Executive Committee meetings of CAFP. *9/90 BoD*

The Presidents of CAFP and CAFP-F shall each be invited to one another's' Board and Executive Committee meetings. Each shall receive agendas of the prospective meetings and determine their need to attend or send a representative from their Board. Each shall receive the minutes of those meetings. They are to serve as non-voting members. *9/90 BoD*

Recipients of Funding: That the CAFP seek administrative policy change in the State Office of California Children's Services to require enpanelling 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. *2/89 CoD.* Seek participation clarification. *11/00 BoD*

Explore legislative and regulatory avenues to expand California Children's Services physician panels to include family physicians. *BoD 5/98*

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. *03/09 CoD*

CMA HOUSE OF DELEGATES

Responsibilities of Delegates/Alternates: Goals of the CAFP Delegation to the CMA House of Delegates shall include increasing access and influence within the CMA, increasing family physician effectiveness within the Specialty delegation and the CMA House, and building the leadership necessary to elect a family physician as the Specialty Delegation Trustees to the CMA Board of Trustees.

- Terms for CAFP Delegates and Alternates to the CMA House of Delegates shall be three years, with no term limit at present.
- The CAFP Delegation Caucus shall make nominations for Delegates and Alternates to the CAFP Board of Directors for election.
- One alternate Delegate seat will be slotted for the CAFP Speaker or Vice Speaker.
- Attendance at *all* CAFP caucuses, Specialty Delegation meetings, CMA reference committee hearings and sessions of the House of Delegates will be required. Reimbursement will be made only to those Delegates and Alternates who fulfill the attendance requirements.
- The Delegation will be required to submit a report to the Board of Directors to be presented at the meeting immediately following the CMA House. This report will include actions of the House that affect CAFP or family physicians, actions which complement or contradict CAFP policy, and other items as appropriate.
- All FPs in the CMA House of Delegates, CAFP members and non-members, will be invited to the CAFP Caucuses at the CAFP Annual Assembly and at the CMA House of Delegates. All FPs in the CMA House of Delegates will be included in CAFP Delegation communications. The CAFP will attempt to identify and assist where possible family physicians running for delegate seats within county medical societies. *10/94 BoD*

CEO's Performance Review INT

CEO currently works under a three-year contract, with annual performance review by President, Immediate Past President and President-Elect. Contract is reviewed by the same three, with notification given in advance of intent not to renew. (subject to executive compensation policy in this manual)

Clinical Lab Improvement Act EXT

CAFP reaffirms its opposition to the Clinical Laboratory Improvement Act of 1988 and seeks its repeal and asks the CAFP delegates to the AAFP COD to introduce a resolution calling on the AAFP Congress to reaffirm its opposition to the Clinical Lab Act of 1988 and seek its repeal. *2/94 CoD*

Work aggressively with CMA and other organizations for the development and passage of legislation that accomplishes the following two objectives: 1) maintains the current exemption from any state regulation of Physicians' Office Laboratories (POLs) in offices of less than five physicians; and 2) exempts all POLs, regardless of the number of physicians in the practice, that only perform those simple tests that are waived under CLIA regulations. *D-6-95, 1/95 CoD*

Coalition Building **INT**

Promotion: Coalition-building should be promoted with organizations interested in improving access to care and increasing the numbers of primary care specialists to help accomplish our legislative and other goals. Consumer groups, business groups, HMOs and IPAs should be included. *10/91 BoD*

Appointments: Committee appointments should attempt to strike a balance considering geography, age, gender, and other appropriate factors. An attempt should be made to have a member of the Board serve on each committee or task force to facilitate communication. *12/88 BoD*

Based on performance and attendance, and other extenuating circumstances, those with unexpired terms may be replaced with individuals to fill the unexpired portion of the term. *11/92 EC*

New committee members will be appointed for one-year probationary terms. The term may be extended an additional two years dependent upon performance and attendance. *11/93 EC*

Chair: A committee chairman will be selected from the committee membership by the Executive Committee, with the approval of the Board. The chairman may, at the end of his/her three-year term, be asked to serve an additional term as chairman, not to exceed three years. *12/88 BoD*

Committee chairs should be invited to attend one Board meeting to report on Committee actions and be recognized by the Board for activities; Board members should be asked/designated to serve as Committee liaisons when appropriate. *11/95 EC*

Consultants: There will be no more than one consultant per committee. *11/92 EC*

Liaisons: That a liaison member of COCPD attend other committee meetings when educational activities are being planned to ensure these activities meet ACCME standards and requirements. *8/97 BoD*

Changed Committee on Continuing Medical Education to Committee on Continuing Professional Development *11/04 BoD*

Merged with Scientific Program Committee under the name of Committee on Continuing Professional Development. *11/06 BoD*

Changed the name of the Managed Care Committee to: “Medical Practice Affairs Committee” to more accurately reflect the committee’s scope of work. *5/93 BoD*

Nominating Committee: Increase size of the committee by one additional member to be elected from the Congress (now All Member Advocacy Meeting) so that the Nominating Committee will consist of three members from the Congress, two from the Board and the past president as chair. *A-8-96, 2/96 CoD.* Bylaws language approved *2/97 CoD.*

Program Decision Making: New CAFP programs should be market-based. In deciding whether to move forward with a proposed program or service, it should be determined whether:

1. The members need and want the program or service.
2. If they need and want a program or service, are they willing to pay a fair market value?
3. The program/service has durability.
4. There is a particular target market.
5. The program/service fits the Long Range Plan

Attention should be given to a range of market research, e.g., the evaluations on the annual scientific meeting, a review of consumer literature to determine the health issues of greatest concern to the public, programs held by other chapters/academies state and nationwide, etc. *2/92 BoD*

Restructuring: Approved consolidation of the Residency Affairs Committee and Student Affairs Committee into *Student and Resident Affairs Committee* with one chair; size of the committee could remain the same but gradually be reduced by attrition.

Approved consolidation of the Editorial Committee and Public Outreach Committee into *Communications Committee* with a total of 11 members in 1998, 10 members in 1999.

Approved elimination of the Membership Committee and made membership recruitment and retention a staff function, with oversight by the Executive Committee/Board; allocated expenses of Membership Committee for retaining a membership consultant in 1998. *8/97 BoD*

Sunset the Medical Student and Resident Affairs and Communications Committees and create a new Membership Engagement Committee. *4/7/17 BoD*

Rotating Terms: Beginning in 1989, the Academy established rotating three-year terms for committee members and chairmen, except when members serve on committees in an ex-officio manner. Task force members serve for one year only. *12/88 BoD*

Term Limits: Committee members may serve a maximum of two, three-year terms; if they are replacing someone with one year or less to serve in an unexpired term, that time will not count toward the term limit. *11/92 EC*

Three Year Plan: Committees develop three-year plans when feasible which follow the mission or charge as given by the Executive Committee. *2/90 BoD*

Knowledge-Based Decision Making: Adopted by Board of Directors as new process for deliberation of committees, Board and Congress. *11/01 BoD*

Confidentiality for Minors **EXT**

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 American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the Organization for Obstetric, Gynecologic and Neonatal Nurses, and the National Medical Association. *A-6-00, 2/00 CoD*

"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." *A-6-00, 2/00 CoD*

Parental Notification Initiatives – Propositions 73 and 85: Confirm position of "oppose" on Proposition 73, Parental Notification for Minors Seeking Abortion ballot initiative and approval of CAFP President Eric Ramos being signatory to a ballot argument against the proposition. *ExCom 09/05 with BoD confirmation 11/05.* CAFP subsequently opposed Proposition 85 in 2006 and 4 in 2008. CAFP President Bo Greaves signed the ballot argument against proposition 73.

Parental Notification Initiative – February 2012 Ballot: Voted to oppose the Parental Notification Initiative on the February 2012 ballot. *05/13/11 BoD*

Patient Protection of Information from Adverse Childhood Experiences (ACEs) Screening
That the CAFP support the collection of information from the ACEs screening be subject to pre-existing conditions protections for health insurance.
That Adverse Childhood Experience (ACE) scores be used as a screening tool, not diagnostic of the implied risk condition. *5/20 BoD*

Conflict of Interest INT

This Conflict of Interest Policy of the California Academy of Family Physicians (Organization): (1) defines conflicts of interest; (2) identifies classes of individuals within the Organization covered by this policy; (3) facilitates disclosure of information that may help identify conflicts of interest; and (4) specifies procedures to be followed in managing conflicts of interest.

1. Definition of conflicts of interest. A conflict of interest arises when a person in a position of authority over the Organization may benefit financially from a decision he or she could make in that capacity, including indirect benefits such as to family members or businesses with which the person is closely associated. This policy is focused upon material financial interest of, or benefit to, such persons.
2. Individuals covered. Persons covered by this policy are the Organization's officers, directors, CEO and chief employed finance executive.
3. Facilitation of disclosure. Persons covered by this policy will annually disclose or update to the Chair of the Board of Directors on a form provided by the Organization their interests that could give rise to conflicts of interest, such as a list of family members, substantial business or investment holdings, and other transactions or affiliations with businesses and other organizations or those of family members.
4. Procedures to manage conflicts. For each interest disclosed to the Chair of the Board of Directors, the Chair will determine whether to: (a) take no action; (b) assure full disclosure to the Board of Directors and other individuals covered by this policy; (c) ask the person to recuse from participation in related discussions or decisions within the Organization; or (d) ask the person to resign from his or her position in the Organization or, if the person refuses to resign, become subject to possible removal in accordance with the Organization's removal procedures. The Organization's CEO and chief financial officer will monitor proposed or ongoing transactions for conflicts of interest and disclose them to the Chair of the Board of Directors in order to deal with potential or actual conflicts, whether discovered before or after the transaction has occurred. *11/08 BoD*

CAFP Policy on Cultural and Language Proficiency: Adopted June 2006

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.

Approved: Committee on Continuing Professional Development, 21 June 2006 Adopted: CAFP Board of Directors, 24 June 2006. *06/06 BoD*

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

CAFP 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. *4/03 BoD, last approved revision 11/15 BoD*

Chapter CME Listings: That the CAFP carry listings of accredited CME programs offered by local chapters at no charge in the *California Family Physician* and the CAFP website. *RC-2-00, 2/00 CoD*

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." *5/96 EC*

Promoting a Conflict-Free CAFP

That the California Academy of Family Physician 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. *7/20 BoD*

CME / Mandates **EXT**

Curriculum: CAFP adopted the following policy on curriculum.

That 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 11/05*

Honoraria: CAFP adopted the following policy on 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. *04/05 BoD*

Physician Competencies: Revise and adopt a modestly-revised Pew Health Professions competencies for the 21st Century to be used as a guide for planning future CAFP CME activities. *10/94 BoD*

Policy: The California Academy of Family Physicians 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 in an effort to fairly distribute the cost of services to those who utilize them, it is the policy of the Academy 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. *1/91 BoD*

Transfer to AAFP: Approved transfer of CME record keeping/reporting function from CAFP to the AAFP, joining all other component chapters and the Uniformed Services chapter which currently are served by the AAFP. *6/95 BoD*

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 11/98*

Criminal Prosecution and Justice System EXT

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 2/98*

The California Academy of Family Physicians 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. A-01-08 CoD 3.8.08

Health Care for Formerly Incarcerated Persons

That CAFP support efforts to improve access to health care for formerly incarcerated persons following their release; and be it further

That CAFP support increased funding for evidence-based programs designed to meet the needs of people recently released from incarceration; and be it further

RESOLVED: That CAFP refer this to AAFP for national action. *7/19 BoD*

Fluoridated Water: CAFP supports the introduction of fluoridated water in all municipalities in California. *2/01 BoD*

Chewing Tobacco: CAFP opposes the use of chewing tobacco products and extends the same policies to them as to other tobacco-related products. *2/01 BoD*

Determining Compensation Process EXT and INT

This Policy on the Process for Determining Compensation of the California Academy of Family Physicians (Organization) applies to the compensation of the following persons employed by the Organization:

a. The Organization's CEO[i]
b. Other Key Employees[ii] of the Organization by title: Deputy Executive Vice President, Senior Vice President for External Relations, Director of Health Policy.

The process includes all of these elements: (1) review and approval by the board of directors or compensation committee of the Organization (the President, President-elect and Immediate Past President); (2) use of data as to comparable compensation; and (3) contemporaneous documentation and recordkeeping.

1. Review and approval. The compensation of the person is reviewed and approved by the board of directors or compensation committee (the President, President-elect and Immediate Past President) of the Organization, provided that persons with conflicts of interest with respect to the compensation arrangement at issue are not involved in this review and approval.
2. Use of data as to comparable compensation. The compensation of the person is reviewed and approved using data as to comparable compensation for similarly qualified persons in functionally comparable positions at similarly situated organizations.
3. Contemporaneous documentation and recordkeeping. There is contemporaneous documentation and recordkeeping with respect to the deliberations and decisions regarding the compensation arrangement. *11/08 BoD*

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[i] **Chief employed executive** – The CEO (i.e., Chief Executive Officer), executive director, CEO or top management official (i.e., a person who has ultimate responsibility for implementing the decisions of the Organization's governing body or for supervising the management, administration, or operations of the Organization).

[ii] **Key Employee** – An employee of the Organization who meets all three of the following tests: (a) $150,000 Test: receives reportable compensation from the Organization and all related organizations in excess of $150,000 for the year; (b) Responsibility Test: the employee: (i) has responsibility, powers, or influence over the Organization as a whole that is similar to those of officers, directors, or trustees; (ii) manages a discrete segment or activity of the Organization that represents 10% or more of the activities, assets, income, or expenses of the Organization, as compared to the Organization as a whole; or (iii) has or shares authority to control or determine 10% or more of the Organization's capital expenditures, operating budget, or compensation for employees; and (c) Top 20 Test: is one of the 20 employees (that satisfy the $150,000 Test and Responsibility Test) with the highest reportable compensation from the Organization and related organizations for the year.

Direct Primary Care **INT and EXT**

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. (2013 AAFP COD-approved policy)
11.15.14 BoD on recommendation of Medical Practice Affairs Committee Minutes of 7.29.14

Disabilities / People Living with Disabilities INT and EXT

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.

4.15 BoD

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. *4/15 BoD*

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

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

RESOLVED: That the California Academy of Family Physicians strongly urges the Governor to designate people with intellectual and developmental disabilities as a medically underserved population in the state of California. *BoD 11.4.17*

Document Retention and Destruction INT

This Document Retention and Destruction Policy of the California Academy of Family Physicians (Organization) identifies the record retention responsibilities of staff, volunteers, members of the Board of Directors, and outsiders for maintaining and documenting the storage and destruction of the Organization's documents and records.

Rules: The Organization's staff, volunteers, members of the Board of Directors and outsiders (i.e., independent contractors via agreements with them) are required to honor these rules: (a) paper or electronic documents indicated under the terms for retention below will be transferred and maintained by the Human Resources, Legal or Administrative staffs/departments or their equivalents; (b) all other paper documents will be destroyed after three years; (c) all other electronic documents will be deleted from all individual computers, data bases, networks, and back-up storage after one year; and (d) **no paper or electronic documents will be destroyed or deleted if pertinent to any ongoing or anticipated government investigation or proceeding or private litigation.**

Terms for retention:

1. Retain permanently:
   Governance records – Charter and amendments, Bylaws, other organizational documents, governing board and board committee minutes.

   Tax records – Filed state and federal tax returns/reports and supporting records, tax exemption determination letter and related correspondence, files related to tax audits.

   Intellectual property records – Copyright and trademark registrations and samples of protected works.

   Financial records – Audited financial statements, attorney contingent liability letters.

2. Retain for ten years:
   Pension and benefit records -- Pension (ERISA) plan participant/beneficiary records, actuarial reports, related correspondence with government agencies, and supporting records.

   Government relations records – State and federal lobbying and political contribution reports and supporting records.

3. Retain for three years:
   Employee/employment records – Employee names, addresses, social security numbers, dates of birth, INS Form I-9, resume/application materials, job descriptions, dates of hire and termination/separation, evaluations, compensation information, promotions, transfers, disciplinary matters, time/payroll records, leave/comp time/FMLA, engagement and discharge correspondence, documentation of basis for independent contractor status (retain for all current employees and independent contractors and for three years after departure of each individual).

   Lease, insurance, and contract/license records – Software license agreements, vendor, hotel, and service agreements, independent contractor agreements, employment agreements, consultant agreements, and all other agreements (retain during the term of the agreement and for three years after the termination, expiration, non-renewal of each agreement).

4. Retain for one year:

All other electronic records, documents and files – Correspondence files, past budgets, bank statements, publications, employee manuals/policies and procedures, survey information.

5. Exceptions. Exceptions to these rules and terms for retention may be granted only by the Organization's CEO or Chair of the Board. *11/08 BoD*

Domestic Violence / Child Abuse EXT

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. *B-2-95, 1/95 CoD*

Drug / Alcohol Issues EXT

Access to Cannaboids: CAFP rescinded policy adopted in 1994 which specified that we support efforts to expedite access to cannabinoids for use under the direction of a physician and 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. *A-2-08 CoD 3.8.08*

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 7.16.16*

Decriminalizing Drugs: Endorse a Hoover Institute Resolution decriminalizing drugs and put it in the form of a resolution for submission to the AAFP and to the CAFP 1994 Congress of Delegates. *5/93 BoD 2/94 CoD*

Electronic Monitoring Limits on Prescribing: Recommend to all appropriate state agencies that electronic monitoring be limited to only Schedule II medications. *B-5-95, 1/95 CoD*

Methamphetamines: That the California American Academy of Family Physicians include information about recognition and treatment of methamphetamine use and exposure in its publications and continuing medical education programs for family physicians. *A-3-04 CoD*

Taxes on Alcohol: The California Academy of Family Physicians 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; and, the CAFP delegation to the AAFP Congress of Delegates introduce a resolution asking the AAFP to recognize the above. *2/94 CoD*

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, and submit resolutions supporting same to AAFP Congress. *B-3-96, 2/96, CoD*

Treatment of Addicts: Support appropriate changes in the law to permit a greater number of qualified physicians to treat narcotic addicts with replacement medications. *B-6-95, 1/95 CoD*

Support a policy of increased funding for drug and alcohol treatment programs. *B-1-96, 2/96, CoD*

Drug Safety EXT

That the California Academy of Family Physicians 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. *A-6-05*, *4-05 CoD*

Expanded Use of Naloxone: Prevention of Drug Overdose-related Deaths: INT and EXT

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. *4.15 BoD*

Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis: That the California Academy of Family Physicians (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. *7/18 BoD*

Creating a Buprenorphine Exemption from the Controlled Substances Act

That 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. *9/20 BoD*

Eating Disorders EXT

CAFP respond to the problem of eating disorders by including the issue in its continuing medical education programs, such as the Annual Scientific Assembly. *B-5-00, 2/00 CoD*

CAFP develop a form letter outlining the dismal prognosis of patients with eating disorders and media responsibility for this illness such that family physicians could utilize such a form letter and personalize it to respond to magazines, television shows, and film studios' any inappropriate portrayal of weight-related standards of beauty. *B-5-00, 2/00 CoD*

Emergency Room Coverage EXT

Emergency Room Coverage: that the California Academy of Family Physicians adopt the following policy:

- 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.
A-4-03, 4/03 CoD

End-of-Life Care EXT

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.

NOTE: This policy was adopted by the CAFP Board of Directors 4.24.15 and replaces policies under the topic of TERMINAL ILLNESS including Compassionate Care RC-1-00, 2/00 Cod, Physician-Assisted Suicide RC-1-00, 2/00 CoD, Statement on Terminal Illness Care 5/93 BoD and Terminal Illness and Physician-Assisted Death A-10-96 CoD. CAFP took a neutral position on pending legislation to enact the End of Life Options Act in 2015.

Congressional Interference in Medical Decisions: CAFP opposes political interference in the medical decision making processes for any individual patient. *4/05 BoD; ER1-05, 2005 CoD*

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

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

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

RESOLVED, that the American Academy of Family Physicians submit a resolution to the House of Delegates of the American Medical Association that calls on that organization to: 1) reject use of the term "assisted suicide" when referring to the practice of medical aid-in-dying; and 2) modify its current policy with language that recognizes medical aid-in-dying as an ethical end-of-life option when practiced where authorized and according to prescribed law. *BOD 11.4.17*

Endorsements INT

Definition (Co-Sponsorship): This term means that a California Academy committee, task force, or appointees of the President have participated in the planning, development and execution of a product, program, or activity primarily developed by an outside organization. The Academy representative must recommend that the product, program, or activity be approved by the Board of Directors for co-sponsorship. Board approval is required. The terms "co-sponsorship," "co-sponsor" or "co-sponsored" may be used with the consent of the Executive Committee if timely action by the full Board is not possible. *2/88 CoD*

Definition (Endorsement): This term means that a California Academy committee, task force, or appointees of the President have reviewed the plans of a product, program or activity of an outside organization and may or may not have had input into those plans. The Academy representative, based on its review, must recommend that the Board of Directors endorse this product, program or activity. Board approval is required. The terms "endorsement," "endorsed" or "endorsed" may be used with the consent of the Executive Committee if timely action by the full Board is not possible. *2/88 CoD*

The Coca-Cola Company: Adopted a resolution for submission to the 2010 AAFP Congress of Delegates asking AAFP to rescind its contract with The Coca-Cola Company and to refrain from affiliating with companies that offer products detrimental to our patients' good health. *A-07-10 03/10 CoD*

Family Practice Prenatal Documentation System: Endorsed. *6/94 BoD; 8/94 EC*

Environment EXT

The California Academy of Family Physicians (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 4.12-13.18*

<u>Physician Representation on Environmental Issues</u>
That CAFP encourage physician representation on government advisory committees working on climate change and environmental issues. *9/20 BoD*

Chapter Visits: Prepared elected officers shall be available to attend local chapter meetings on a regularly schedule basis. This task is to be defined as a portion of their duties. *8/87 BoD*

President's Stipend: Beginning with assumption of office by the new CAFP President in 1994, a $1,250 per month stipend will be paid to the President. *2/01 BoD*

FP / OB Collaborative Issues EXT

Back-up/Consultation: The CAFP urges the AAFP to support the membership wishing to provide perinatal care by negotiating a statement or policy with the American College of Obstetricians and Gynecologists, the American Medical Association Council on Ethical and Judicial Affairs, and JCAHO which states that 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. *6/92 BoD*

Interspecialty Conflict Resolution: Utilize the FP/OB Task Force as an Interspecialty Conflict Resolution Body to identify and mediate problems between the two specialties. *6/95 BoD*

Practice Privileges Statement: Approved the CAFP/ACOG District IX Joint Statement in Practice Privileges. *10/95 BoD*

Change of Custodian for CAFP Employee 401(k) Retirement Plan: Ms. Hogeland reported that the administrator of CAFP's Employee 401(k) plan, Northwestern Mutual Life, has instigated some changes that necessitate moving the custodian duties from Newport Trust Company to American Funds. Overall expense to CAFP for fund administration will decrease by about $1,500/year.

Action: Adopt the following resolutions regarding establishing a new relationship with a custodian for CAFP's employee 401(k) retirement savings plan:

RESOLVED, that the Board of Directors appoint **American Funds**, to act as custodian with respect to the CAFP Employee 401(k) Retirement Plan, effective April 25, 2017.

RESOLVED, that the Board of Directors terminate **Newport Trust Company** as custodian with respect to the CAFP Employee 401(k) Retirement Plan, effective April 25, 2017.
4.17.17 BoD

Checks: Checks written by CAFP that are not cashed by fiscal year end and that are 60 days or older may be voided in order to close the Academy's books. Payees must be notified of the void. Payees must submit a written request stating the amount and date in question before a check can be reissued. *2/89 BoD*

Check Signing Limits: Limit on CAFP staff's check signing authority is $100,000, the amount for which staff members are bonded. Any amount over $100,000 requires the signature of the CAFP Secretary/ Treasurer. *5/12/02 BoD*

CMA Delegation Reimbursement Policy: All Delegates and Alternates are reimbursed air fare and up to three days' per diem as set annually in the CAFP budget. This amount includes the cost of sending the President and President-elect. *9/92 BoD*

Equity Investments: The Academy will invest $150,000 of current reserves in equity investments (approximately 25 percent), and anticipate the investments will be long-term, precluding any financial emergency or failure of funds to perform, with quarterly review of performance and annual review of the investments.

$125,000 will be invested equally in five different mutual funds with Merrill Lynch (which hold no stocks in tobacco funds); and $25,000 in Boatmen's Trust in non-tobacco mutual funds. The performance of the funds in these two accounts will be monitored and compared annually, on a dollar-cost averaging basis. The Board will determine annually whether and what portion of any excess of revenues over expenses should be invested in equities. *6/94 BoD; EC 8/10/94; 10/15/94 BoD*

Agreed to begin the purchase of equity funds in the amounts approved by the Board ($150,000) in a staggered-buy fashion. *1/95 EC*

Place a portion of long-term reserves in equities and ask the Executive Committee to research and report back on appropriate investments. *2/94 BoD*

Invest up to $250,000 in AAFP Pooled Investment Fund using dollar cost averaging at the rate of $25,000 per month based on conditions in the financial market. *11/17 BoD*

Hardship Waiver of Dues: Approved adoption of the following options to address requests for waivers of dues: Charitable/missionary work: Full dues waiver for 1-2 years only; Financial Hardship: Dues reduction, per scale established by CAFP for 1 year; Reduced Income: Dues reduction, per scale established by CAFP for 1 year only; Military Service: Full dues waiver proportionate to time served in the military. *2/01 BoD*

Interest Income: Interest income from long-term reserves shall be allocated annually as operating income and the equivalent of three percent of annual income shall be allocated annually to increase the reserve fund. *10/89 BoD Note: Superceded by CAFP policy on reserves.*

Investment Policy Update: This investment policy offers guidelines for the investment of funds held by the association, including those for the employee Money Purchase Pension Fund.

Participating staff members manage their own portfolios in the 401(k) plan. The 401(k) plan is compliant with ERISA Section 404 (c), which requires the investment fiduciaries of a qualified retirement plan to, in effect, provide plan participants with a healthy menu of investment options, with fees and expenses fully disclosed and an option to move among the investment selections within the guidelines of the law. Participants then exercise control. Investments in the 401(k) were selected to afford participants the opportunity to materially affect the potential risk and return on the amounts in their accounts, choose from at least three categories of investments to enable them to achieve a portfolio with aggregate risk and return characteristics at any point within the range normally appropriate for the participants. ERISA requires three categories of risk, and CAFP offers a broad range of funds meeting different asset categories from the American Funds Family. A representative of the plan is available to meet annually with plan participants to review and explain options.

This policy seeks to offer broad guidelines rather than prescriptive behaviors in an effort to ensure sufficient flexibility for management under potentially rapidly changing economic circumstances.

The aim of this policy is to provide:

1. Safety of invested funds entrusted to the Academy by its members and staff.
2. Liquidity to meet changing cash flow requirements.
3. Income — the highest return available commensurate with acceptable risk for Academy funds and the highest return available commensurate with prudent management and safety for retirement funds.

The primary and uppermost concern of the board of directors shall be the safety of the funds. No undue risks shall be taken to secure increased yield at the expense of safety.

Involvement: The board of directors is responsible for approving, monitoring and reviewing the investment policy of the Academy, establishing risk limits for all Academy funds, including the Money Purchase Pension Plan, one of two CAFP employee retirement funds. The board of directors, or its appointed committee, shall review this policy as appropriate to determine if and when changes are necessary. The full board of directors must approve any proposed changes.

The Board will maintain a Finance Committee composed of the elected members of the Executive Committee. The Finance Committee's primary role will be to guide the investment strategies of the Academy and other duties as appropriate.

The CEO of the Academy is responsible for the day-to-day management of the Academy's investments and meets by conference call with the Academy's financial advisor(s) at Merrill Lynch on a quarterly basis to review fund performance, particularly the Money Purchase Pension Fund.

The quarterly Merrill Lynch written report is shared with the CAFP Secretary-Treasurer and includes a comparison between current CAFP holdings and Merrill Lynch "ideal" recommended holdings. From time to time, the Merrill Lynch advisor recommends re-balancing CAFP investments to adhere more closely to the Merrill Lynch ideal. The CEO must seek the approval of the Finance Committee, Board of Directors or Trustees of the Money Purchase Pension Plan respectively before authorizing changes/purchases to Academy funds or the Money Purchase Pension Plan, as advised by Merrill Lynch.

Methodology:

CAFP Operating and Reserve Funds

1. Investment securities shall be limited to the following types of securities:
    a. Direct obligations of the U.S. Government
    b. Federal agency obligations backed by the moral obligation of the U.S.
    c. Insured Savings Accounts (ISAs) or certificates in federally insured institutions not to exceed the current FDIC insurance coverage limit in any individual institution.
    d. Mutual funds, rated 4-star or above by Morningstar, that maintain a net asset value of 1.

2. The final maturity of any fixed-rate investment shall be three years or less, except in the case of the Money Purchase Pension Fund, in which funds may be invested for up to 10 years. Adjustable-rate investments may have final maturities of five years or less.
3. At no time shall greater than 50 percent of the investment portfolio be invested in instruments with a maturity of greater than two years (Note: to ensure CAFP has sufficient numbers of banks in which to invest in FDIC-insured certificates of deposit (CDs), we now invest in both one- and two-year CDs.)
4. Upon authorization of the appropriate oversight body (Finance Committee, Board of Directors, Money Purchase Pension Plan trustees), CAFP's investment advisors at Merrill Lynch shall execute trades on a best execution basis emphasizing the highest proceeds to the fund, and the lowest cost, net of all transaction fees and expenses.
5. Merrill Lynch will process settlement of all trades and CAFP shall receive confirmations of all trades.
6. All purchases shall be accounted for in compliance with ASC 820.

11.15.14 BoD

Money Purchase Pension Plan:

1. The Money Purchase Pension Plan (MPPP) is designed to meet the retirement needs of CAFP's staff, who range in age from early 20s to late-60s and who, after meeting the vesting period for the plan (ranging between 5-6 years) are eligible for the entire Academy contribution of 10 percent of salary per year over their period of employment to that point.

    Prior to meeting the full vesting requirement, employees may be eligible for 20, 40, 60 or 80 percent of the funds contributed on their behalf annually during the period of their employment. The goal of the CAFP Money Purchase Pension Plan is conservative, minimal risk, middle-of-the-road allocations to ensure reasonable long-term growth and to prevent dramatic fluctuations in returns, or loss of principal. Historically, our model has ranged from a 2:1 ratio of bonds to stocks (equities) to a 1:1 ratio, depending on the market and based upon the best advice of our Merrill Lynch representatives. Our equities have a blend of different style funds to participate in various "in favor" sectors in the market. The funds are broken into the various economic sectors, such as health care, technology, industrials, etc. The average cumulative rate of return on our Fund has been 6.4 percent.
2. The "Prudent Man Rule" governs investments for the MPPP.
3. The MPPP is composed of Investment Grade Bonds – B/AA/AAA and mutual funds.
4. No more than 10 percent of funds may be in one particular stock.

5. The MPPP is invested near a 50:50 ratio of mutual funds and bonds, with a slightly higher weighting toward equities during periods of low yields on bonds.
6. Bonds are to be invested in a laddered structure, i.e., a goal of maturity of $50,000 invested in two $25,000 certificates of deposit each year ten years out.
7. Proper diversification of the Plan will mitigate the downsides of the market, but take advantage of the upsides.
8. On an annual basis, the Finance Committee should consider whether the portion of the annual contribution from the Academy for its employees that is to be invested in equities should be invested all at one time or invested by dividing the amount by the remaining months in the year and investing that amount monthly, and so inform the Merrill Lynch representative.

Demonstration: Quarterly reports shall be made to the board and monthly to the President, President-elect and Secretary-Treasurer on CAFP's portfolio's performance. The trustees of the Money Purchase Pension Plan will also receive quarterly reports on the Pension Plan's performance.

Pension Fund: That the Board of Directors of CAFP will annually authorize by the second meeting of the year a payment amount determined by the pension fund administrators into the employee Money Purchase Pension Plan. Federal law requires this action via adoption of a resolution. *2/92 BoD*

President's Stipend: Increased the CAFP President's stipend to $15, 000 from $12,000 per year. *2/01 BoD*

Special Assessment: Adopt a $25/year special assessment on Active Members to support enhanced CAFP Legislative Activities on health care reform for 2008, 2009, and 2010. A-03-07 *03/07 CoD*

Dues Increase: Authorize an increase of $25 for CAFP Active and Supporting members beginning January 1, 2013 such that the dues rate will be $290 and closely monitor the economic impact of the chapter dues rate increase on Active and Supporting membership and the organization, with frequent reports to the Board on recruitment and retention rates. *3/4/12 CoD ER A-05-12*

Special Assessment: Extend the special assessment for the years 2011, 2012, 2013, 2014, 2015. A-02-10, 3/10 CoD

Special Assessment: Enact continuation of CAFP Special Legislative Dues Assessment in the amount of $35 (increased by $10 from $25) for 10 years (through 2023) with evaluation of need for continuation to take place after five years (2019). Res.A-01-14 *AMAM* 3.2.14

Financial Audit **INT**

Audit Committee: Appoint an independent Audit Committee responsible for:

1. Hiring, setting compensation and overseeing the auditor's activities;
2. Setting rules and processes for complaints concerning accounting and internal control practices;
3. Meeting with the auditor, reviewing the annual audit and financial reviews and recommending their approval or modification to the full board;
4. Ensuring that the lead and reviewing partner of the auditing firm rotate off the audit every five years;
5. Pre-approving certain services to be provided by the audit firm such as tax preparation (the pre-approval requirement is waived for non-auditing services if the value of the non-auditing services is less than five percent of the total amount paid by the organization to the auditing firm for auditing services);
6. Requiring the auditor to disclose to the audit committee all critical accounting policies and practices used within the organization as well as share with the audit committee any discussions with management about such practices and policies.
7. Permit the CAFP CEO to staff the Audit Committee, limiting her role to preparing materials and handling logistics for this meeting, taking minutes, and responding to questions when asked.

Appoint the CAFP Secretary-Treasurer as chair of the Audit Committee. Audit Committee members may serve two three-year terms, but the first appointments will be staggered, e.g., one-year, two-year and three-year appointments, to ensure continuity. *12/05 EC*

Audit Firm – Individual Auditor: Accept recommendation that individual auditor, e.g., the person who actually does audit for audit company be changed every five years. *BoD 11/05*

Approved the following recommendations of the March 30, 2006 Audit Committee regarding recommendations from the A. L. Nella Management Letter:

1. CAFP CEO to periodically review the cancelled checks on line.
2. Staff will tighten up policy to require that appropriate approval be made of invoices, check requests, etc.
3. Establish as CAFP financial policy that asset purchases of greater than $500 are capitalized and recorded as fixed assets.
4. Decline to adopt statement of functional expenses as it is not a good use of staff time and this information can be gleaned using the time sheets if needed.
5. Approval all proposed audit adjustments.

Audits and Financial Reviews: Accepted the action of the Audit Committee to approve a CAFP audit every other year, with a financial review in the intervening years, beginning with 2012; in the event any financial irregularities are identified, the return to an audit would be authorized at the committee's discretion. *BoD 5.3.13*

Firearm Violence / Gun Control EXT

Educate FPs/Public on Firearms and Risk of Injury and Death: The California Academy of Family Physicians 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 Congress of Delegates introduce a resolution asking the AAFP to recognize the above. *2/94 CoD*

Firearms Policy: A policy statement on firearms developed by a Task Force of the Public Outreach Committee was approved by the Board of Directors on *6/94.* This policy was superseded by action of the Board of Directors on 5.3.13.

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 5.03.13

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 5.03.13*

Oppose Possession or Private Use of Handguns: The California Academy of Family Physicians 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; and, the CAFP delegation to the AAFP Congress of Delegates introduce a resolution asking the AAFP to recognize the above. *2/94 CoD*

Taxes on Alcohol: The California Academy of Family Physicians 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; and, the CAFP delegation to the AAFP Congress of Delegates introduce a resolution asking the AAFP to recognize the above. *2/94 CoD*

Firearm Violence EXT

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 4.12-13.18

That the California Academy of Family Physicians (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. And that CAFP submit a resolution to the American Academy of Family Physicians (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. *7/18 BoD*

Formularies EXT

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. *B-1-97. 2/97 CoD*

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. *11/99 BoD*

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. *B-2-01, 2/01 CoD*

Future of Family Medicine EXT

That CAFP endorse the principles outlined in the Future of Family Medicine Report which state, in effect, that only through transformation and re-design of family physician practices – including, ultimately, electronic health records and resources to facilitate patient education as well as clinical knowledge on treating chronic diseases such as diabetes – will major improvements in outcomes and patient and physician satisfaction be made. *B-1-05 CoD, 4-05 BoD*

Health Care System Reform EXT

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.

UNIVERSAL

- Access to health care insurance should be universal and continuous.
- Individuals should not be denied health care coverage, have their coverage limited or otherwise capped or cancelled based on a current or pre-existing health care condition(s), age, gender identity, sexual orientation, geographic location, income, race, ethnicity, religious affiliation, health status or immigration status.
- Each health insurance issuer must accept every employer and individual applying for coverage or renewing coverage, permitting annual and special open enrollment periods for those with qualifying lifetime events.
- Non-payment of premiums for health insurance coverage should be the only reason an insurer or employer may discontinue or negatively change an enrollee's health plan.
- Patients on publicly-issued insurance plans should not face discontinuation of coverage based on a reduction in eligibility standards unless provisions are made to transfer the individual into a plan with comparable coverage.
- Annual and lifetime caps on benefits should be prohibited in all health insurance products.
- Health insurance must have uniform standards and requirements. Health plans must not use complex eligibility rules, underwriting, billing procedures and regulatory requirements to deter obtaining and utilizing coverage.
- Premium assistance and cost-sharing reduction subsidies aimed at assisting qualifying individuals with the purchase of health care coverage and/or paying their deductibles and co-pays should be utilized if purchase of coverage is required.
- Out-of-pocket payments should be reasonable and standardized, with maximum limits based on an individual or family's income.

- Premiums in the individual and small group markets should vary only by family structure, geography, the actuarial value of the benefit, age and tobacco use (in an actuarially sound ratio to ensure adequate risk pools).

COMPREHENSIVE

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

TIMELY

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

HIGH QUALITY

- Health care services should be delivered in accordance with high-quality medically- and culturally-appropriate standards of practice.

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

SUSTAINABLE

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

Adopted BoD 7.15.17

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.

Adopted BoD 4.12-13.18

Access to Care During Planned Power Outages
That CAFP support efforts that ensure health facilities can continue to provide needed patient care during planned power outages. *9/20 BoD*

Governance **INT**

Knowledge-based Decision Making: Adopt Knowledge-Based Decision Making Process. For CAFP Board and Committees; urge its adoption by the Congress of Delegates. *11/00 BoD*

Graduate Medical Education EXT

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 4.20.12*

Increase Education in Substance Use Disorder for Residency Programs

That the California Academy of Family Physicians 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.

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

That 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.

That the California Academy of Family Physicians delegation to the American Academy of Family Physicians submit a resolution to the AAFP Congress of delegates 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.

that the California Academy of Family Physicians delegation to the American Academy of Family Physicians submit a resolution to the AAFP Congress of delegates 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. 11/20 BoD

Hassle Factor **EXT**

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. *5/93 BoD*

Health System Reform EXT

Access: That the CAFP actively pursue measures which ensure the provision of access to basic health care. *2/92 CoD*

Expansion of Healthy Families Coverage to Parents of Eligible Children: Support increasing legislation and funding to expand Healthy Families coverage to parents of eligible children. *A-2-01, 2/01 CoD*

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. *B-7-95, 1/95 CoD*

Individual Savings Accounts: Support Individual Savings Accounts (IMSAs) as one means of financing health and medical care costs. *C-7-95, 1/95 CoD*

Insurance: The 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. *2/91 CoD*

Integrated Health Care Delivery Systems for Uninsured Patients: Support legislation whereby eligibility and enrollment for all health insurance plans for the uninsured and underinsured are accessed in one administrative unit, creating "one-stop shopping" for patients, ultimately improving health care accessibility and efficiency; and be it further support legislation allowing families to be enrolled in Medi-Cal for a continuous year (as is now the case in Healthy Families) and support a policy of presumptive eligibilty in order to expedite the entry of beneficiaries into the health care system. *A-1-01, 2/01 CoD*

Purchase of Plans: Oppose any government health or medical care insurance program that limits the right of individuals to purchase appropriate medical care prescribed by physicians. *C-8-95, 1/95 CoD*

Rx for Health: Endorse the principles for health system reform contained in AAFP's Rx for Health as a framework to build upon in the health system reform debate. *2/94 CoD*

Approve using the basic tenets of AAFP's *Rx for Health* as a basis for developing principles to guide reform in California (consistent with resolution adopted at 1994 Congress of Delegates). *10/94 BoD*

State Reform Issues: Agree to identify partners to help develop a reform agenda, including those on the California Primary Care Consortium. *10/94 BoD*

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: That 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.

11.08.08 BoD – combined policy recommended by Legislative Affairs Committee with Res. 03-08, which was referred to the Board by the 2008 Congress of Delegates. Amended by action of the Board of Directors on recommendation of the Single Payer Task Force 2.3.10 and affirmed by the Congress of Delegates 3.7.10.

California Universal Health Care Act:

1. Commission a complete analysis of the California Universal Health Care Act based on the CAFP Healthcare Reform criteria; and,

2. If necessary, develop a formal proposal of amendments to the bill that would strengthen its alignment with CAFP Healthcare Reform Criteria and submit it to the bill's author. *03/09 CoD*

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. *A-04-10 03/10 CoD*

Health Benefit Exchange: Adopt AAFP Insurance Exchange Principles to provide guidance for monitoring and providing input to California Health Benefit Exchange. *11.5.11 BoD*

Officially endorse the HEART Mission Statement and Principles on Team-based Care, Consumer Information and Competition. *11.5.11 BoD*

Single-Payer in California: ER-01-17 – Studying Single Payer in California

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

RESOLVED: CAFP will:

1) Make CAFP's health care system principles available to any legislators advancing single payer or public option bills; and
2) Prioritize education (of members) on health care reform in 2018, including efforts to move California toward universal health care coverage and access. *BoD 11.4.17*

Health Policy/General Statement EXT

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.

Based on a statement by the Cambridge Health Alliance and existing CAFP policy

https://medium.com/@socialjusticecoalition/a-letter-to-our-patients-in-the-trump-era-d99c9007f960#.w9im9sr9d

BoD 2-1-2017

Hospitalists EXT

Hospitalists: Adopted the monograph on family physicians and inpatient care in the era of the hospitalist. *2/98 BoD*

Hospitalist Continuity of Care: Encourage hospital medical staff offices to foster improved and timely communication between the respective admitting hospitalists and PCPs. *A-1-2-3-05, 4/05 CoD*

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. *A-1-2-3-05, 4/05 CoD*

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. *11/05 BoD*

With the help of the AAFP, promote family physicians as qualified hospitalists, and family medicine as an efficient and comprehensive model of hospital care. *ER-1-07, 03/07 CoD*

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. *ER-1-07, 03/07 CoD*

Impaired Physicians **EXT and INT**

Request for additional funding from California Public Protection and Physician Health, Inc.: The California Public Protection & Physician Health, Inc. (CPPPH) provides assistance to physicians with disruptive behavioral issues, substance abuse, mental and physical health, aging, the effects of stress and burnout. CPPPH, at inception, sought to enact legislation that would have funded its activities through medical licensure after the Medical Board of California discontinued all impaired physician funding and activities it previously had undertaken. CAFP paid $10,000 of a promised contribution of $20,000 to CPPPH in start-up funding before the CPPPH legislative effort failed. If CPPH cannot establish financial sustainability within the allotted two years (2014 and 2015), it will not seek additional contributions. Any funds CAFP provided would be matched by the California Hospital Association. Contribute $17,000 over two years to CPPPH, in addition to the $10,000 already contributed. *BoD 5.8.14*

Immigration Issues/ICE INT

That the 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. *7/18 BoD*

Advocacy for Closure of Detention Camps

That the 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. *5/20 BoD*

Consultants: Health plans, medical groups, and IPAs must make current and accurate lists of plan consultants available on a monthly basis. *B-1-01, 2/01 CoD*

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. *C-6-96, 2/96 CoD*

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. *A-6-97, 2/7/97 CoD*

Gag Clauses: Declare gag clauses an unethical and unacceptable interference in the patient-physician relationship. *C-8-96, 2/96 CoD*

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. *11/01 BoD*

Forms-Central Listing: That a central listing of required and/or un-funded forms required by state and federal agencies be kept at the CAFP, and CAFP communicate to its members asking for their input on any new required form. *11/01 BoD*

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. *C-7-96, 2/96 CoD*

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. *B-6-01, 2/01 CoD*

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. *2/94 CoD*

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. *ER-3-02, 1/03 BoD*

Joint Venture INT

This Joint Venture Policy of the California Academy of Family Physicians (Organization) requires that the Organization evaluate its participation in joint venture arrangements under Federal tax law and take steps to safeguard the Organization's exempt status with respect to such arrangements. It applies to any joint ownership or contractual arrangement through which there is an agreement to jointly undertake a specific business enterprise, investment, or exempt-purpose activity as further defined in this policy.

1. Joint ventures or similar arrangements with taxable entities. For purposes of this policy, a joint venture or similar arrangement (or a "venture or arrangement") means any joint ownership or contractual arrangement through which there is an agreement to jointly undertake a specific business enterprise, investment, or exempt-purpose activity without regard to: (1) whether the Organization controls the venture or arrangement; (2) the legal structure of the venture or arrangement; or (3) whether the venture or arrangement is taxed as a partnership or as an association or corporation for federal income tax purposes. A venture or arrangement is disregarded if it meets both of the following conditions:
    (a) 95% or more of the venture's or arrangement's income for its tax year ending within the Organization's tax year is excluded from unrelated business income taxation [including but not limited to: (i) dividends, interest, and annuities; (iii) royalties; (iii) rent from real property and incidental related personal property except to the extent of debt-financing; and (iv) gains or losses from the sale of property]; and
    (b) the primary purpose of the Organization's contribution to, or investment or participation in, the venture or arrangement is the production of income or appreciation of property.

2. Safeguards to ensure exempt status protection. The Organization will: (a) negotiate in its transactions and arrangements with other members of the venture or arrangement such terms and safeguards adequate to ensure that the Organization's exempt status is protected; and (b) take steps to safeguard the Organization's exempt status with respect to the venture or arrangement. Some examples of safeguards include:
    (a) control over the venture or arrangement sufficient to ensure that it furthers the exempt purpose of the organization;
    (b) requirements that the venture or arrangement gives priority to exempt purposes over maximizing profits for the other participants;
    (c) that the venture or arrangement not engage in activities that would jeopardize the Organization's exemption; and
    (d) (iv) that all contracts entered into with the organization be on terms that are arm's length or more favorable to the organization. *11/08 BoD*

Public Policy Principles for Improving Cultural Proficiency and Care to Minority and Medically Underserved Communities

Introduction

Importance of Improving Cultural Proficiency in the Delivery of Health Services
The California Academy of Family Physicians 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.

Organizing Principles

Provider Education:

- Medical societies and provider associations should work with their members to educate them about cultural proficiency, health disparities among racial and ethnic medically-underserved populations, and the impact on health outcomes of limited English proficiency. These organizations should link to available information, trainings, and other resources so that health professionals may continually improve access to quality care and reduce health and health care disparities.
- Health professionals should be aware of, and sensitive to, the cultural and ethnic diversity of patients they serve so they can develop and implement best practices such as providing interpreter services and culturally proficient care in their offices. Health professionals should be aware of the connection between good cross-cultural communication and ensuring patient safety.
- The Office for Civil Rights should disseminate information and provide technical assistance about best practices in the provision of culturally, ethnically, and linguistically sensitive care delivery.

Workforce Issues:

- The State of California should encourage the racial, ethnic, religious, and linguistic diversity of its health care workforce to reflect the needs of the population it serves.
- Medical and other health professional schools should increase efforts to recruit and retain minority faculty and promote minority faculty into leadership positions.
- Cultural proficiency training should be incorporated into residency programs in every specialty and should be available as part of the continuing professional development of health professionals.
- To meet the needs of LEP patients, the State of California should provide incentives for the development of a trained interpreter workforce.
- Medical school admissions policies should reflect the importance of increasing the representation of under-represented minority students.

Language Access:

- Language assistance services, including, but not limited to, qualified bilingual health professionals, trained health care interpreters, telephonic and video language services, translated or in-language written materials, and translated or in-language signage, are an essential element of delivering culturally proficient care in all settings, particularly to LEP, racial and ethnic medically-underserved communities.
- Any language access requirements placed on health professionals must recognize the logistical difficulties in the provision of interpreter services for unusual/rarely encountered languages and in urgent/emergent situations, and provide exemptions and additional assistance for these situations, as appropriate.
- State, regional and local systems of language assistance service should take into account the limited capabilities and resources of health plans, hospitals, clinics, health departments, medical groups, physician practices and other health professionals. To the extent possible, there should be efforts to collaborate, coordinate and centralize the provision of language assistance services to increase efficiencies and minimize costs and administrative burdens to health professionals.
- Payment for interpreter services in both publicly- and privately-funded health care systems must be the responsibility of the insuring or purchasing entity.

Research and Data Collection:

- Health insurers and health care plans should be required to collect and/or report socio-cultural health information (e.g., patient race and ethnicity, including subpopulations, primary language, etc.) to assist physician offices, while respecting the individual privacy of patients. This data collection shall not be delegated to the treating physician without an explicit paid, contractual agreement.
- Culturally and ethnically diverse populations must be fully represented in clinical studies supported by both private and public sector funds. Researchers from minority communities must be trained to conduct research and clinical trials.
- Diseases and conditions disproportionately affecting LEP, racial and ethnic medically- underserved populations should be adequately investigated. Research on specific populations should be conducted to document health issues and successful interventions.

Health Care Financing:

- The availability of, and access to, quality, affordable health services are integral to eliminating disparities among LEP, racial and ethnic medically-underserved populations.
- Public insurance programs should promote access for beneficiaries by advertising availability, providing applications and other documents in other languages, and reviewing application processes to see what barriers may exist for eligible populations.

Written Resources:

- The state and other interested stakeholders should examine the feasibility of statewide or local clearinghouses for translated or in-language materials that could increase access to quality health education, medication information, and other health-related information.

Quality Assessment:

- Quality indicators that measure cultural proficiency should be developed.
- A review of current quality assessment measures should be conducted to identify areas for integration of cultural proficiency measures and make appropriate recommendations.

Payment:

- Payment for interpreter services in both publicly- and privately-funded health care systems must be the responsibility of the insuring or purchasing entity.
- The primary financial entity (state, insurance company, or managed care company) should contract with and pay interpreters directly unless medical groups or physicians explicitly choose to accept risk for such

services in their contracts. Health professionals, including medical groups, shouldn't unwillingly bearing the burden or expense of providing interpreter services.

- There should be consideration of reimbursement of physician office bilingual staff who serve as interpreters, as long as they have been trained and assessed for linguistic competency. There should be consideration of compensation for bilingual physicians who would otherwise require an interpreter, provided they have been assessed for linguistic competency.

Policy Options

Medi-Cal/SCHIP/Medicare:

- The State of California should work with the Centers for Medicare and Medicaid Services (CMS) and the State Health Insurance Program (SHIP) to ensure the cultural and linguistic proficiency of their respective staffs. Materials used to detail Medicare services, in particular Medicare-covered preventive care, should meet the language and health literacy levels of the beneficiaries they serve. CMS should evaluate the materials and strategies used by SHIPs to reach the LEP, racial and ethnic populations they serve.
- The State of California should work with CMS to ensure that reliable and comprehensive data are collected and reported with regard to beneficiaries' race, ethnicity, and primary language, while respecting the individual privacy rights of beneficiaries.
- The State of California should work with CMS to ensure that any program developed by CMS that bases a payment, bonus or reward on quality measures, includes quality measures of care for minority beneficiaries.
- The State of California should seek federal matching funds for the provision of interpreter services for patients in the Medi-Cal and Healthy Families (SCHIP) programs; the State should also address funding issues within the Workers' Compensation program.
- The State of California and Council members should work with federal policy makers to ensure that language services are a covered benefit under the Medicare program.
- Ideally, the State or federal government would organize a centralized service for interpretation that can be accessed easily by physicians. Models with significant promise include that in place in Washington State and the national telephonic interpreting service in Australia. The State of California should support a regional pilot project to test delivery models for such a service.

Managed Care/Health Plans:

- Managed care/health plan organizations, including public and private HMOs, should work with physician and other health provider organizations to ensure the development, evaluation, and diffusion of curricula, training, and education programs that address cultural proficiency, medically underserved communities, and health disparities.
- Managed care organizations/health plans and health plan regulators should use cultural proficiency and the provision of high quality, easily accessed language services, as indicators of access and quality.
- Both public and private HMOs and health plans should be asked to take explicit responsibility for paying and arranging for interpreter services as a covered benefit for members with the caveat that such services are the responsibility of the primary financial entity (HMO or purchaser) and are not to be borne by fiscal intermediaries such as local medical groups or physicians and other health professionals, unless they have explicitly contracted for the provision of such interpreter services.
- Managed care organizations/health plan organizations should negotiate with both public and private payers for adequate reimbursement to cover the expenses of interpreter services so that they can establish services without burdening physicians.

Private Industry:

- Private industry should be engaged by medical organizations and patient advocacy groups to consider innovative ways to provide interpreter services to both employees and the medically underserved. *A-02-07, 03/07 CoD*

Eliminate the Use of Race-Based Medicine

That CAFP eliminate the use of race as a proxy for biology and genetics, and develop policies to ensure this is communicated in CAFP education. 7/20 BoD

Lead Poisoning EXT

Childhood Lead Poisoning: Voted to support CMA in opposing a lawsuit challenging the Childhood Lead Poisoning Prevention Act and to contribute $500 to the lawsuit. *6/95 BoD*

Early Detection of Lead Poisoning: CAFP will support initiatives that would facilitate early detection of, and lead to, medical intervention for childhood poisoning. *2/96 BoD*

Committee Charge: Adopt a revised committee charge for incorporation in CAFP Long Range Plan. *"Develop and implement plans to achieve the Academy's legislative goals, focusing on the top priorities of: 1) Advocate for patient health and well- being, and access to health care. 2) Obtain stable, secure funding for residency programs; and other health financing agencies. 3) Ensure appropriate reimbursement for family physicians in all areas of the medical marketplace based on the value they contribute to the delivery of health care. 4) Preserve affordable malpractice premiums; 5) Advocate for minimal levels of regulation by government. 10/94 BoD*

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. *B-9-95, 1/95 CoD*

CAFP adopt, but not limit itself to, the entire statement on Definitions Regarding Primary Care, as adopted by the American Academy of Family Physicians. *B-10-95, 1/95 CoD*

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. *10/93 BoD*

Endangered Species Act: Support re-authorization of the Endangered Species Act. *10/95 BoD*

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. *4/99 EC*

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 11/98*

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 the Academy's delegates to the California Medical Association (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 the Academy'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 the Academy on this matter. *2/89 CoD*

Residency Program Issues: Direct the CAFP Legislative Affairs Committee to make residency program funding a priority legislative issue.

Direct the Legislative Affairs Committee to introduce legislation in 1996 to change state funding for residencies to a per-resident mechanism for primary care programs. *4/95 EC*

Advocate an appropriate number of family practice residencies in our State. *B-8-95, 1/95 CoD*

State Ballot Propositions — See Separate Section

Song-Brown Funding: That the CAFP request CMA, through its House of Delegates, to support continuation and augmentation of Song-Brown funding as one of its priorities. *1/91*

Work to preserve Song-Brown funding and continue to explore other funding strategies as they materialize. *10/94 BoD*

Welfare Reform: The Board voted to monitor state and federal actions regarding welfare reform for their impact on access to health care and provide comment and advocacy where appropriate, especially with regard to access to care for mothers and children. *10-96 BoD*

Whenever possible, the Academy should work within broad coalitions of health care providers and others to advocate for inclusion/maintenance of access to health care under welfare reform, especially for women and children. *10-96 BoD*

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. *2/99 CoD*

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. *2/99 CoD*

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. *2/99 CoD*

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. *2/99 CoD*

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. *B-6-97, 2/97 CoD*

Full-Risk Contracting: Approved the monograph on full-risk contracting developed by the Medical Practice Affairs Committee and staff; and approved the following actions to ensure that this issue is brought to the attention of the membership: *10/96 BoD*

- Include articles in *CFP* on full-risk contracting;
- Include a topic on full-risk contracting at the managed care conference or at the Annual Scientific Assembly;
- Provide information on full-risk contracting to health care purchasing coalitions;
- Develop a list of resources for family physicians considering full-risk, such as availability of actuarial information, data bases, consultants, etc.
- Encourage the Committee on Continuing Medical Education to make full-risk contracting a topic for an audio or video conference;
- Include the monograph or a fact sheet in the November "Report to the Membership;"
- Include the topic in a web site forum, when CAFP develops a web site; and
- Remind members occasionally of available resources – include an order form in *CFP.*
- Send the monograph to the AAFP for national distribution. *10/96 BoD*

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. *2/99 CoD*

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. *B-5-01, 2/01 CoD*

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." *10/97 BoD*

Principles for Managed Care: Approved the following 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.) *10/95 BoD*

- 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. *C-4-96, 2/96 CoD*

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. *D-3-95, 1/95 CoD*

Termination without Cause: Oppose the abuse of "termination without cause" provisions in physician contracts. *D-8-95, 1/95 CoD*

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.

Marriage Amendment **EXT**

California Academy of Family Physicians 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. *A-04-07, 03/07 CoD*

Medi-Cal **EXT**

California Department of Health Services: Seek out administrative, regulatory, and legislative avenues with the California Department of Health Services to apply the same primary care supervision exemption in Medi-Cal as the Health Care Financing Administration follows for Medicare reimbursement, as outlined in section 15016B.2 of the Medicare Carrier Manual. *B-7-01, 2/01 CoD Note: HCFA is now CMMS.*

Fees: The Academy supports an across the board increase in Medi-Cal fees in an attempt to get the program in parity with the Medicare program. Changes are to be monitored. *4/89 BoD*

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. *D-5-95, 1/95 CoD*

Medi-Cal: 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. *11/99 BoD*

Reaffirmation of support: CAFP work with CMA and other medical organizations to fight proposed cuts to Medi-Cal reimbursement rates, the cap on Healthy Families enrollment, and other proposals that would sharply reduce access to care. That CAFP fight cuts to both Medi-Cal fee-for-service and Medi-Cal Managed Care payments. That CAFP work with other physician organizations on the Administration's proposed Medi-Cal reform process. That CAFP fight potential cuts to the Song-Brown Family Physician Training Program. *4/04 BoD*

Medical Home EXT and INT

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. *03/09 CoD*

Medical Licensure INT/EXT

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. *2/3/16 BoD*

Probationary Status: That 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. *03/11 CoD*

Medical Practice Affairs INT

Charge: Change the charge of the Committee to be: Advocate for positions that support and enhance the role and practice of family physicians in California: Help Academy members working in all types of health care settings respond to the changing health care environment by providing: 1) tools for practice management and patient care; 2) information about the health care environment, practices, and careers; and 3) continuing professional education on medical practice and leadership development issues. *5/99 BoD*

Formulary Issues: CAFP should:

1. Continue to oppose the practice of pharmaceutical discounting to HMOs and make this position widely known.
2. Support legislation that would prevent HMOs from transferring inappropriate pharmacy risk on to medical groups.
3. 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. *11/99 BoD*

FP Shortages on Hospital Committees: CAFP should:

1. Re-educate 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.
2. Request that AAFP approach JCAHO about relaxing the standards for hospital committee service so that physicians with less than full admitting privileges can serve on hospital committee. *11/99 BoD*

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

Medical Group Insolvencies/Capitation Difficulties: CAFP should:

1. Continue to oppose unfunded mandates
2. 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. *11/99 BoD*

Remote Patient Interaction: That the CAFP publicize to the many payors of health care the value of remote physician-patient interaction and the need for appropriate physician compensation. *B-1-00, 2/00 CoD*

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. *D-1-95, 1/95 CoD*

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. *D-3-95, 1/95 CoD*

Medical Schools **EXT**

CAFP will write a letter in support of building a new medical school at UC Riverside; the letter will summarize our support for increased medical school slots, and in particular, family medicine graduates. CAFP will stress its desire for ongoing communication and a serious commitment to family medicine and primary care. *11/06 BoD*

Medical Students Recruitment / Preceptorship / Debt INT

Medical Student Debt Reform: 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.

CAFP to write a letter to AAFP on behalf of CAFP members detailing our solutions to improving/reforming medical school debt. Res. A-04-16 – *BoD 7.16.16*

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. *6/92 BoD*

Support of FMIGs: Additional CAFP Support of FMIGs:

- CAFP would provide financial support to medical school FMIGs in addition to the $1,000 per year now available from a pharmaceutical company grant.
- This additional funding would be for specific events and programs designed by these groups and their associated departments to enhance student interest in family practice and approved in advance by CAFP. *6/92 BoD*

Undergraduate Outreach Program: Approve an action plan for outreach to undergraduates in California colleges and universities. *10/94 BoD*

Medicare **EXT**

Pay Equity: CAFP adopt as policy equal pay for similar services for all physicians, and support as policy the AMA-sponsored legislation to secure 100% Medicare payment for new physicians. *2/91 COD*

Meetings INT

Facility Labor Strike / Lock-Outs

CAFP adopted the following policy on strikes/lock-outs at facilities with which it has contracted for meetings:

1. Include unions/strike issues in all force majeure clauses in future facility contracts to ensure CAFP will not incur if it elects to move its meetings to another facility,
2. When feasible, and given sufficient advance notice of a problem, relocate small CAFP meetings away from facilities being struck,
3. When not feasible, acknowledge to attendees of situation, provide CAFP rationale for not relocating, provide refunds if applicable to attendees to elect not to attend. *01/05 BoD*

Working Toward Zero Waste

The CAFP support improving the environmental health of our patients and planet by requesting all future conference and meeting sites reduce waste.
That CAFP alert members that future events will attempt to significantly reduce waste and encourage participants to bring their own reusable items.
That CAFP request conference host sites not use disposable silverware, cups, napkins, beverage containers, etc., unless they are compostable.
That CAFP consider a site's ability or willingness to avoid waste-generation when contracting for meetings and conferences.
That CAFP "swag" seek to be reusable (water bottles, coffee mugs, utensils) or biodegradable items.
That safety practices be considered in environmental stewardship. *5/20 BoD*

Child Care at Meetings

That the AAFP adjusts its recommendations regarding children at AAFP meetings from "Out of consideration for others, please do not bring children to CME events" to "AAFP supports families. Please use your best judgment regarding bringing children to CME events;"
That CAFP ask the AAFP to explore providingan on-site play area for children and their caregivers at AAFP FMX and COD;
That CAFP ask the AAFP to enhance efforts to accommodate breastfeeding parents at AAFP meetings by providing a lactation lounge with basic services including privacy, running water, and other amenities. *3/19 BoD*
(AAFP adopted the following substitute resolution:
RESOLVED: That the American Academy of Family Physicians (AAFP) adjust its recommendation regarding children at AAFP meetings from "Out of consideration for others, please do not bring children to CME events" to "AAFP supports families. Please use your best judgment regarding bringing children to CME events," and be it further
RESOLVED: That the American Academy of Family Physicians (AAFP) provide an on-site play area for children and their caregivers at AAFP Family Medicine Experience and Congress of Delegates, and be it further
RESOLVED, That the American Academy of Family Physicians (AAFP) consider providing on-site child care services at AAFP Family Medicine Experience and Congress of Delegates, and be it further
RESOLVED: That the American Academy of Family Physicians (AAFP) enhance efforts to accommodate lactating parents at AAFP Family Medicine Experience and Congress of Delegates by providing a lactation lounge, not located in a restroom, with basic services including privacy, running water, refrigerated milk storage, and opportunities to donate excess breast milk.) 3/19 BoD

Gender Pronouns on Meeting Badges

That the American Academy of Family Physicians ask registrants for AAFP-sponsored events and conferences how they want their gender to be identified on printed name badges, with the option not to include gender pronouns. *3/19 BoD*

Member Assistance INT

CAFP's policy on individual assistance is to provide three tiers of service:

1. Sharing basic, first-hand knowledge and information on key issues related to family practice and common questions fielded by the Academy.
    a. Referrals for more specialized assistance (CMA, AAFP, practice management consultants, attorneys).
2. Direct intervention on behalf of members to interpret and communicate existing CAFP policy. Regretfully, CAFP can NOT directly intervene in:
    a. Current or potential litigation
    b. Intra-family physician disputes
    c. Employment or reimbursement-related issues*
    d. Managed care logistical problems/hassles*
3. Any situation for which CAFP doesn't have explicit policy to guide CAFP staff.

** Issues of employment, reimbursement, and managed care logistics/hassles will be monitored so that CAFP develop broadly applicable programs and policies.*

Protocol for member assistance: Member contacts CAFP staff. Staff clarifies nature of request, if follow-up assistance is needed and turnaround time. Requests are classified into the following categories:

Phone consultations/referrals: CAFP staff will, at no charge, provide informal consults and referrals on an as-needed basis and will track information requests, but will not formally notify MPA Committee or Chair. (Example: a question about how long medical records are maintained).

Research assistance: Staff will use the following resources to research member issues: polling the Medical Group Management Association Primary Care Assembly, looking up basic legal questions in the *California Physician's Legal Handbook*, and polling members of the Medical Practice Affairs Committee. Staff will cc MPA Chair and track member satisfaction with research results.

Scope of practice assistance/intervention: Staff will follow *AAFP Protocol for Handling Privileging Problems* and handle correspondence with members, copying MPA Chair. Any correspondence with hospital committees will be approved and signed by either MPA Chair or CAFP President, depending on availability. Staff will track member satisfaction with scope of practice assistance.

"Miscellaneous" intervention/existing policy: Staff will communicate CAFP policy to members, in writing. Interventions to third parties stating CAFP policy will be approved and signed by MPA Chair. (Example: Writing to a health plan to clarify why a vaccination has been added to the formulary without existing modification of pm/pm.)

"Miscellaneous" intervention/no existing policy: Staff will consult with MPA Committee, which will either recommend no action or will recommend establishment of policy to Board/Congress. MPA Chair will approve and sign response to member.

Requests for Financial Assistance: CAFP recognizes the importance of its role protecting family physicians' scope of practice. The Academy occasionally receives requests for financial assistance to offset the costs of legal expenses incurred to defend privileges. The CAFP Board of Directors will weigh such requests against the following criteria:

- Physician(s) requesting funds must be active members of CAFP
- Non-judicial avenues of advocacy must be pursued and exhausted

- Physician(s) must agree to match the Academy's contribution dollar for dollar
- Funds must be used to defend family physician scope of practice in the hospital setting
- More than one physician must benefit, or have potential to benefit, from CAFP assistance

CAFP reserves the right to inquire about potential quality-of-care issues at play. CAFP further reserves the right to deny requests for financial assistance for any reason. Financial assistance will be limited to a maximum of $2,500 in legal fees per member with a maximum expenditure of $10,000 per group incident. This is considered a one-time benefit of membership over the life of the individual(s) concerned. Funds will be paid against invoices submitted on stationary of the member's legal counsel. *8/02 BoD*

Membership Dues INT

Adopted an amended resolution to authorize a five-year special assessment of $25 per year in 2011, 2012, 2013, 2014 and 2015 dedicated to support of legislative activities outlined in the 2010-2012 Strategic Plan; and to continue efforts to educate and inform CAFP members about the nature of the Academy's greatly expanded activities in legislative affairs to increase member involvement in advocacy activities at both the state and national levels. *A-02-10, 03/10 CoD*

Increase CAFP Active Dues by $24 and allocate those funds to the CAFP Family Physician Political Action Committee unless the member is not a U.S. Citizen and/or holds a green card, his/her organization pays his/her dues and does not permit contribution to a political action committee or the member does not wish him/herself to contribute to the FP-PAC. In each case, the $24 will go into CAFP's general operating fund rather than FP-PAC. *Res. A-03-18 AMAM 3.11.18*

Life Members: Dues for Life Members to be consistent with new AAFP policy of a one-time payment by setting $150 as the CAFP one-time payment and offering that option only. *06/08 BoD*

Supporting Members: Approved "Supporting Member" dues equal to CAFP Active member dues. (non-voting, non-office holding). *10/95 BoD*

Membership Engagement Committee INT

1. Sunset the Medical Student and Resident Affairs and Communications Committees;
2. Create a new Membership Engagement Committee;
3. Charge the new Membership Engagement Committee with development of a CAFP Member Engagement campaign that includes defining member engagement measures, launching an engagement scoring protocol and applying it to CAFP membership, leveraging engagement touchpoints, setting targets for increases in engagement, and evaluating the project on an annual basis, but specifically:
    a. Create with staff a "ladder of engagement" for each segment of membership, with successfully higher-bar asks that increase engagement and appreciation of CAFP;
    b. Establish with staff metrics for measuring engagement (e.g., Net Promoter Score);
    c. Establish with staff benchmarks for reengagement and plans to reach them.
    d. Work with the Board, other CAFP committees and staff to support the successful implementation of the Academy's strategic plan; and
    e. Report ongoing engagement efforts to the Board.

4.7.17 BoD

MICRA / Professional Liability INT

MICRA: CAFP supports the preservation of MICRA and opposes legislative proposals intended to weaken MICRA. *6/92 BoD*

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. *5/98 BoD*

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. *10/94 BoD*

Opposed Proposition 46 on the 2014 November ballot which would have rescinded the protections in MICRA and required drug testing of physicians within 24 hours of a professional liability lawsuit being filed. Contribute $20,000 to defeating Prop 46. The proposition was not passed. *5/8/14 BoD*

Mid-Level Providers EXT

Independent Practice: CAFP recognizes nurse practitioners, certified nurse midwives and physician assistants 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. *5/93 BoD*

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. *A-1-96, 2/96 CoD*

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.

Naturopathic Doctors EXT

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.
11.03.12 BoD

Non-Discrimination Policy / Sexual Harassment INT

CAFP is committed to providing a work place free of sexual harassment, as well as harassment based on such factors as race, color, religion, national origin, ancestry, age, medical condition, marital status, handicap, or veteran status. CAFP strongly disapproves of and will not tolerate harassment of employees by managers, supervisors, or co-workers. CAFP will also make an effort to protect employees from harassment by non-employees in the work place.

Harassment includes verbal, physical and visual conduct that creates an intimidating, offensive, or hostile working environment or that interferes with work performance. Some examples include racial slurs, ethnic jokes, posting of offensive statements, posters or cartoons, or other similar conduct. Sexual harassment includes solicitation of sexual favors, unwelcome sexual advances, or other verbal, visual or physical conduct of a sexual nature.

Employees should report any incident of harassment, including work related harassment by any CAFP personnel or any other person promptly to their supervisor or any other member of management. Supervisors and other senior employees who receive complaints or who observe harassing conduct should immediately inform the Executive Director. CAFP emphasizes that employees are not required to complain first to their supervisor if their supervisor is the individual responsible for the harassment.

Every complaint of harassment that is reported to the Executive Director will be investigated thoroughly, promptly and in a confidential manner. In addition, CAFP will not tolerate retaliation against any employee for making a complaint to the Executive Director or to any other supervisor or management employees.

In the case of CAFP employees, if harassment is established, CAFP will discipline the offender. Disciplinary action for a violation of this policy can range from verbal and/or written warnings up to and including immediate termination, depending on the circumstance. *10/96 BoD*

Member Non-Discrimination: The California Academy of Family Physicians supports the principle that membership in the organization, service on the organization's governing bodies, committees and task forces, participation in Academy programs and activities, and Academy collaboration and cooperation with outside entities will be without regard to age, gender, race, ethnicity, sexual orientation, disability, national origin, political affiliation or religious belief. *12/02 BoD*

Non-Dues Revenue INT

Criteria: All Academy programs and activities, whether dues- or non-dues supported, must meet the criteria established in the policy adopted by the Board. *10/91 BoD*

Obstetrical Care / Perinatal Services EXT

Back-up/Consultation: The CAFP urges the AAFP to support the membership wishing to provide perinatal care by negotiating a statement or policy with the American College of Obstetricians and Gynecologists, the American Medical Association Council on Ethical and Judicial Affairs, and JCAHO which states that 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. *6/92 BoD*

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. *10/93 BoD*

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 the Academy, and that the Academy actively solicit this feedback, using the appropriate mechanisms, and report back to the Board by February 1996. *B-11-95, 1/95 CoD*

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. *6/92 BoD*

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.

Support the concept that no physician or other health professional shall be required to perform any act violative of personally held moral principles. *B-12-95, 1/95 CoD*

Joint Statement on Primary Care adopted by CAFP and ACOG District IX, recognizes that physicians meeting the definition of primary care providers may include obstetricians-gynecologists. *10/93 BoD*

Joint Statement on Practice Privileges: Adopted by the CAFP and ACOG District IX, December 1995. Specifically, "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 12/95*

Prenatal Care: Continue to support prenatal access to undocumented women as a high legislative priority. *5/98 BoD*

Pain Management EXT

Work with appropriate organizations to disseminate the California Intractable Pain Treatment Act so its provisions may be adopted in other states. *2/94 CoD*

Inappropriate Use of CDC Guidelines for Prescribing Opioids

That our California Academy of Family Physicians (CAFP) applaud 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.

That our 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.

That 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. *7/19 BoD*

Patient Centered Medical Home: Also see Medical Home EXT

Patient Centered Medical Home: Adopted the AAFP Principles for Physician Payment Reform to support transformation to the Patient Centered Medical Home. *11/10 BoD*

805 Reports: 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.

Error Reporting System: Guidance for legislative testimony for CAFP: 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.

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.

Section 805 Reports: 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.

Rehabilitation: CAFP supports the development of a program that would allow Medical Board oversight of rehabilitation without jeopardizing the careers of good physicians. *11/01 BoD*

Pay for Performance (P4P) EXT

CAFP 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. *11/05 BoD*

Physician Reporting – California Physician Practice Information (CPPI):

Approved policy that the 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. *A-03-10 03/10 CoD*

Pediatric Care EXT

The California Academy of Family Physicians (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.'" *11/06 BoD*

<u>Parental Leave</u>
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. *7/19 BoD*

That CAFP refer this to AAFP for national action.
(The AAFP made minor amendments and passed the following language: "the American Academy of Family Physicians (AAFP) support policies that provide employees with reasonable benefits, including job security, wage replacement, and continued availability of health plan coverage in the event that 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; (4) protections for small businesses.")

Peer Review EXT

Ensuring Confidential Peer Review: That the 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; and CAFP will introduce a resolution to the next American Academy of Family Physicians Congress of Delegates that the AAFP adopt as its policy that peer review activities by medical staff, medical societies, medical groups, health plans and other entities should be confidential, protected and not subject to disclosure by administrative subpoena. *B-3-97, 2/97 CoD; AAFP Resolution adopted 9/97*

Personal Responsibility EXT

CAFP holds the position that any federal or state health program should encourage individuals to assume responsibility for their own health and healthy lifestyles to the extent feasible, and give them the knowledge and incentives to do so. *A-3-94, 2/94 CoD*

Pharmacists' Conscience Clause EXT

The 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. *11/05 BoD*

Physical Exercise as a Vital Sign EXT

The California Academy of Family Physicians (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.

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

Res. A-02-17 Call for a Physical Activity Vital Sign in Clinical Practice – Substitute resolution adopted for A-02-17. *BoD 4.7.17*

Physician Health Services – Guidelines for Selecting INT and EXT

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. *11.03.12 BoD*

Physician Payment EXT

Balance Billing: CAFP position is to allow balance billing, but with some type of limit. *BoD 11/05*

Political Action Committee - FP-PAC INT

The CAFP Board authorized and funded administrative support for a political action committee. *ER-2-03, 4/03 CoD, 7/03 BoD*

Increase CAFP Active Dues by $24 and allocate those funds to the CAFP Family Physician Political Action Committee unless the member is not a U.S. Citizen and/or holds a green card, his/her organization pays his/her dues and does not permit contribution to a political action committee or the member does not wish him/herself to contribute to the FP-PAC. In each case, the $24 will go into CAFP's general operating fund rather than FP-PAC. *Res. A-03-18 AMAM 3.11.18*

Political Interference in Medical Decision Making EXT

CAFP opposes political interference in the medical decision-making processes for any individual patient *4/05 BoD*

Prescription Drug Costs / Transparency EXT

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 7.16.16*

That CAFP support efforts that ensure medical treatments derived from publicly funded ventures are affordable and accessible to all patients.
That CAFP support transparency in publicly funded pharmaceutical research and resultant data, including the publishing of all clinical trials. *9/20 BoD*

Privileges **EXT**

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. *A-7-97, 2/97 CoD*

Joint Statement on Practice Privileges: Adopted by the CAFP and ACOG District IX, December 1995. Specifically, "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." *12/95 BoD*

Privileging Guidelines*:* The Board will submit a resolution to the AAFP seeking national action on privileging guidelines, with the RESOLVED to read: That the AAFP work with appropriate groups to develop a tool establishing specific objective criteria to be used as a guideline for health care organizations granting privileges to family physicians. *8/98 BoD* Resolution referred to AAFP Board of Directors, no action.

Protect Medicaid/Medi-Cal Beneficiaries with Disabilities EXT

The CAFP opposes any and all attempts to cut federal Medicaid funding, both with respect to the Community First Choice State Plan Option, Medicaid funds to people with disabilities receiving Home and Community-Based Services and the broader Medicaid program.

ER-02-17 Protecting Medicaid Beneficiaries with Disabilities against Per Capita Caps – Accept Res. ER-02-17 as current CAFP policy. *BoD 4.7.17*

Control of Influenza Vaccine Supply: It is CAFP policy that manufacturers preferentially supply influenza vaccine to physicians in time of shortage or public need. *A-3-01, 2/01 CoD*

Quadruple Aim/Physician Wellness EXT

The California Academy of Family Physicians advocates for the Triple Aim to be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of health care providers, and to make Physician Wellness a quality measure for healthcare systems and asks the American Academy of Family Physicians to do the same by working with Congressional leaders. *BoD 4.12-13.18*

Reproductive Health EXT

Confidentiality for Minors: See Separate Section

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: California Academy of Family Physicians endorses the policy that there be no age restriction to oral contraceptive pill availability over-the-counter. *Res. A-03-16 7.16.16 BoD*

CAFP ask the American Academy of Family Physicians to write to the U.S. Food and Drug Administration (FDA) to urge that all adolescents be included in the over-the-counter (OTC) oral contraceptives studies required by the FDA (e.g., label comprehension study, actual use study) to determine whether OTC access is appropriate for this population.

End Age Restriction on Emergency Contraception (EC) Access: The California Academy of Family Physicians will advocate for emergency contraception to be available over-the-counter to all women of reproductive age and will instruct its delegates to present a resolution calling for emergency contraception to be available over-the-counter to all women of reproductive age to the AAFP Congress of Delegates. *3/4/12 CoD Res. A-02.12*

Increased Percentage of Women's Reproductive Health Topics at AAFP FMX and NCRS: That the California Academy of Family Physicians will advocate through the American Academy of Family Physicians to the Family Medicine Experience (FMX) Curriculum Advisory Panel (CAP) to increase the weight of women's reproductive health topics at future FMX events and remove the four percent cap. And that the California Academy of Family Physicians via its delegation will submit a resolution to the American Academy of Family Physicians (AAFP) calling on the AAFP to increase the representation of women's reproductive health topics among future AAFP CME events. *7/18 BoD*

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. ER-01-08 CoD 3.8.08

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*

Long-Acting Reversible Contraception:

1. That the California Academy of Family Physicians (CAFP) support a policy that long-acting reversible contraceptive methods be a recommended option for postpartum women prior to hospital discharge.
2. That the 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.
3. That the CAFP submit a resolution asking the AAFP to support a policy that long-acting reversible contraceptive methods be a recommended option for postpartum women prior to hospital discharge.
4. That the CAFP submit a resolution asking the AAFP to 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.

4.15 BoD

Medicaid Coverage of Over-the-Counter Emergency Contraception: California Academy of Family Physicians will advocate that over-the-counter emergency contraception be a covered benefit under Medi-Cal for all women of reproductive age.

CAFP will submit a resolution calling on the AAFP to advocate that emergency contraception, whether over-the-counter or by prescription, be a covered benefit under all Medicaid programs for all women of reproductive age. *Res. A-05-16 7.16.16 BoD*

Scope of Comprehensive Reproductive Health Training:
Statement on Comprehensive Reproductive Training

CAFP and the CAFP Residency Network 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? *2/3/16 BoD Policy adopted in lieu of Res. A-04-15, Transparency in Medical Education*

United States Medical Eligibility Criteria for Contraceptive Use (USMEC): The California Academy of Family Physicians 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. *3/4/12 CoD Res. A-01-12*

REPEAL THE HYDE AMENDMENT

The California Academy of Family Physicians (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.

The CAFP will urge the AAFP to engage in advocacy and lobbying efforts to overturn the Hyde Amendment, which bans federal funding for abortions.

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

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

Res. A-01-17 Repeal the Hyde Amendment – First two Resolveds of Res.A-01-17 accepted as current CAFP policy substitute Resolveds adopted for the third and fourth in the original resolution. *BoD 4.7.17*

TERMINATION OF PREGNANCY

The 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.

The CAFP endorses the concept that abortion should be performed only by a duly licensed physician in conformance with standards of good medical practice as determined by the laws and regulations governing the practice of medicine in that locale.

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.

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 2/93*

Improved Quality of Reproductive Health for Incarcerated People

That 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.

That CAFP submit a resolution to the AAFP COD to advocate for national policy that helps to improve reproductive health care for incarcerated patients, including non-directive options counseling and access to timely abortion, if desired. *9/20 BoD*

Removing Routine Ultrasound in Medication Abortion Protocols

That the CAFP advocate for the elimination of barriers to abortion access resulting from ultrasound requirements that are not clinically indicated.

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

That the CAFP support efforts by AAFP to unbundle ultrasound in medication abortion protocols for Medicaid reimbursement in all states. 7*/20 BoD*

Criminalization

That the CAFP oppose the criminalization of physicians providing abortion care.

That the CAFP urge the AAFP to adopt policy opposing the criminalization of physicians providing abortion care. *7/19 BoD*

TERMINATION OF PREGNANCY – 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.

Support the concept that no physician or other health professional shall be required to perform any act violative of personally held moral principles. *B-12-95, 1/95 CoD*

Recommend Family Medicine Residency Programs provide residents with annual up-to-date lectures in all evidence-based contraception and pregnancy options counseling. *B-7-05, 4/05 CoD*

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. *B-7-05, 4/05 CoD*

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. *ER-02-08 CoD 3.8.08*

TERMINATION OF PREGNANCY – Access to Mifepristone

Joined a lawsuit by the American Civil Liberties Union against the Food and Drug Administration (*Graham T. Chelius, MD on behalf of himself and his patients; Society of Family Planning, on behalf of its members and their patients; California Academy of Family Physicians, on behalf of its members and their patients; and Pharmacists Planning Services Inc., on behalf of its members and their patients v. Don J. Wright, MD, MPH, in his official capacity as Acting Secretary, United States Department of Health and Human Services, et al)* to discontinue the REMS on mifepristone. *4/17 BoD*

REMS / MIFSPRISTEONE

The California Academy of Family Physicians (CAFP) endorses the principle that the REMS classification on mifepristone is not based on scientific evidence and limits access to abortion care. *BoD 4.12-13.18*

That the American Academy of Family Physicians 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.
That the American Academy of Family Physicians consider providing education, as appropriate, on early pregnancy loss management in relevant programming at FMX, maternity care conference, and women's health conferenceon a rotational basis. *3/19 BoD*

VASECTOMY

That the CAFP ask the AAFP to advocate that the Department of Health and Human Services (DHHS) amend the list of preventive services provided under the Affordable Care Act to include contraceptive services for all, including vasectomy. *5/14 BoD*

Resident and Student Affairs INT

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*

Cross-Cultural Training for Family Practice Residents: Ask the American Academy of Family Physicians to petition the Residency Review Committee for mandatory family practice residency instruction on culturally sensitive and competent health care in residency programs and use the Society of Teachers of Family Medicine guidelines of "Culturally Sensitive and Competent Health Care" as their model. Make these guidelines known to residency directors throughout the state and encourage their implementation. *2/99 CoD*

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. *6/92 BoD*

Dual-Track Residencies: Study and develop a policy on dual-track residencies within family practice departments with a report back to the 1997 CAFP Congress of Delegates. *A-2-96, 2/96 CoD*

Approve the draft criteria for evaluation of dual track residency programs developed by the Task Force on Dual Track Training. *10/96 BoD*

Approve the policy paper on Dual Track Residency Training. The policy paper will be forwarded to the AAFP for consideration in its deliberations on dual track residencies. *10/96 BoD*

End-of-Life Training for Family Practice Residents: Ask the American Academy of Family Physicians 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. *2/99 CoD*

Family Physician Faculty: That the Academy 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." *6/92 BoD*

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. *10/91 BoD*

Funding for Family Medicine Residency Programs: That the California Academy of Family Physicians work with state legislators to develop new strategies to support family medicine residencies in good standing within the state of California;

That the California Academy of Family Physicians support 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;

That CAFP work with the American Academy of Family Physicians 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. *11/05 BoD*

Support Family Medicine Residency Program Participation in Medi-Cal Managed Care Plans 2010: 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. *A-08-10 03/10 CoD*

Insurance: That the 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. *2/92 BoD*

CAFP encourage residency programs to maintain residents' positions, malpractice coverage and benefit packages while individual residents seek educational opportunities during away rotations. *2/94 CoD*

Licensure: That the 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. *2/92 BoD*

Limited On Call Hours: That the California Academy of Family Physicians 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. *2/94 CoD*

Membership: All first year California residents shall be ensured membership in the Academy; the CAFP and/or residency programs will fund the first year of membership. *8/86 BoD*

Moonlighting: The 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. *2/94 CoD*

Parental Leave Policy: The recommended policy is that 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. *B-7-98, 02/99 CoD*

RRC Delegate: That the AAFP delegates to the RRC be instructed to request the above recommendations (re: faculty, discrimination) be codified into the accreditation process. *6/92 BoD*

Residency Training: Advocate for adequate health manpower in the state, particularly in underserved areas. *98 BoD*

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

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

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

The Board approved a recommendation of the CRN that CAFP include a voluntary question on its annual Residency Directory survey about whether programs provide "an elective and/or training in reproductive health." (CAFP staff updated the survey appropriately, and sent it to programs on September 29, 2017.) Responses will be monitored. BoD 11.4.17

Resolution Format **INT**

Adopt a hybrid model resolution format that includes both the old WHEREAS format and the knowledge-based decision making questions of the new format. *7/18/15 BoD*

Restrict Antibiotic Use in Food Animals ENT

The 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.

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

Res. A-03-17 Endorse Restriction of Antibiotic Use in Food Animals – Substitute resolution adopted for A-03-17. *BoD 4.7.17*

Retaining CAFP Dues Dollars INT

CAFP Dues Dollars Policy: that it be the policy of the California Academy of Family Physicians that it annually make a determination of all county chapters' desire to collect dues, based on the active nature of the chapters, and to make at least six (6) attempts, including letters, phone calls, and registered mail if appropriate, to encourage all county chapters to cash their respective dues checks within 12 months of when they are issued; and be it further

Resolved, that if after at least six (6) attempts by the CAFP to encourage county chapters to cash their respective dues checks, they fail to do so within two months of the last attempt within 12 months of when they are issued, the dues dollars from these uncashed checks be contributed to the California Academy of Family Physicians Foundation, and that all county chapters be advised in advance that this will be the Academy's practice. *ER-1-03, 4/03 CoD*

Scope of Practice **EXT**

CAFP 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.

It is the policy of the California Academy of Family Physicians (CAFP) that 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.

11.02.19 BoD

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.

05.13.11 BoD

The Board of Directors adopted the following policy regarding amendments that would be required to SB493, introduced in 2014 by Senator Hernandez and anticipated to be reintroduced in 2015:

- An amendment that ensures physician involvement is maintained through nurse practitioner-physician collaboration. Whether the setting be a "clinic," "health facility" or "accountable care organization," physician collaboration must be defined and care must be team-based;
- An amendment that better reflects NP training regarding evaluating and managing a diagnosis: NPs have significant training in managing an already-made diagnosis, but not in making a diagnosis. An amendment should be made to change "establishing a diagnosis" to "evaluate and manage a diagnosis;"
- An amendment that ensures the practice of medicine is still overseen by the Medical Board: The bill as written on August 14, 2013 sets up two standards of medical care, one overseen by the Medical Board and one overseen by the Nursing Board. An amendment should require the Boards to jointly oversee the practice of medicine by NPs;
- An amendment to ensure that the same restrictions on physician and facilities resulting from the bar on the corporate practice of medicine also apply to NPs;
- An amendment that clearly delineates financial, quality and other areas of accountability for each provider and facility.

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.
11.15.14 BoD

Social Determinants of Health **INT**

Food Insecurity Screening in Healthcare Settings as Higher Standards of Health Care: That the California Academy of Family Physicians (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?

That the California Academy of Family Physicians (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.
11/18 BoD

Sugar Sweetened Beverages EXT

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

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

A-2-04, 4/04 CoD

Tax on Sugar-Sweetened Beverages: The 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 4.12-13.18*

State Ballot Propositions EXT

Prop 166 – Affordable Basic Care: Support Prop 166, the Affordable Basic Care Initiative; reduce the amount of the proposed 1993 contribution to MICRA by half (from $5,000 to $2,500); allocate $2,500 as a contribution to ABC Proposition 166; encourage members to contribute to Prop 166 through the chapter newsletter. *9/92 BoD*

Props 187/188 – Save Our State and Smoking 1994: Oppose both initiatives, SOS as bad medicine because it upsets physician-patient relationship and Smoking as a ploy by tobacco companies to weaken anti-smoking laws. *EC 9/94 Conference Call, Confirmed 10/94 BoD*

Support potential lawsuit against Proposition 187 based on its requirement that MDs turn patients in to INS; contribute $1,000 to Planned Parenthood legal fund against Proposition 187. *11/94 EC*

Prop 99: Support redirection of Proposition 99 funds only to those programs with proven efficacy, such as CHDP, and only within limits which will not make ineffective the tobacco cessation efforts supported by the proposition. As alternative funding for these safety net programs is found, Proposition 99 funds should be reallocated to the original research and education funds. *3/96 EC*

Prop 209 – California Civil Rights Initiative: Oppose Proposition 209, because it will adversely affect the number of women and minority students admitted to California medical schools, with the potential of decreasing access to health care by the underserved populations in California. *8/96 BoD*

Props 214 and 216 – Managed Care Ballot Initiatives: Adopted a "Neutral" position on the California Nurses Association's "Patient Protection Act" and The Neighbor to Neighbor Coalition/SEIU "The Health Care Patient Protection Act of 1996" statewide ballot initiatives on managed care because either or both initiatives ban incentives for physicians (some of which may be appropriate), may promote nurses as "watchdogs," contain criteria for denial of care which could result in development of confusing language, contain ambiguous language on claim denials, give non-contracting and dependent practitioners the same rights re: termination language, imposes additional liability on providers doing utilization and quality assurance, mandates staffing standards in physician clinics, imposes new fees on closure of hospital beds and mergers, and more. *5/96 BoD*

Amendment: Oppose the Managed Care Initiatives, Propositions 214 and 216, the "HMO Patients' Rights Initiative" and "The Patient Protection Act of 1996" respectively. *8/96 BoD*

Prop 215 – Medical Use of Marijuana Initiative Statute: Endorsed the "Medical Use of Marijuana Initiative Statute." *8/96 BoD*

Props 73, 85, and 4 – Parental Notification for Minors Seeking Abortion: Confirm position of "oppose" on Proposition 73, Parental Notification for Minors Seeking Abortion ballot initiative and approval of CAFP President Eric Ramos signing a ballot argument against the proposition. *ExCom 09/05 with BoD confirmation 11/05.*

CAFP subsequently opposed Proposition 85 in 2006 and 4 in 2008, which was essentially the same proposition as Prop 73. CAFP President Bo Greaves signed the ballot argument against.

Prop 8 – Eliminate the Rights of Same Sex Marriage: Oppose Proposition 8. (Ratified by the Board of Directors on 23 October, 2008, confirmed in approval of minutes as addenda on 8 November, 2008.) *11/08 BoD*

Propositions 1A, 1D, 1E: Adopted a Neutral Position on Ballot Propositions

Proposition 1A: Create a spending cap on public programs including health care, create "rainy day" reserve fund, and prolong state tax increases for 2 extra years.

Proposition 1D: Redirect $340 million from current Prop 10 funds (also known as the First 5 Program), and $268 million from future funds annually for five years, to back fill existing state health and human services programs for children up to age five.
Proposition 1E: Redirect $460 million of Prop 63 mental health funds for two years to back fill funds for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. *07/09 BoD*

The Board voted to take no position on other initiatives on the May 2009 Special Election Ballot (1B, 1C and 1F).

November 2010 Election:
Proposition 23 – Suspend Air Pollution Control Laws until Employment Drops Below 5.5 Percent – Oppose. *9.22.10 BoD Conference Call*

Proposition 24 – Repeal Legislation Allowing Businesses to Carry Back Losses, Share Tax Credits and Use Sales-Based Income Calculations to Lower Taxable Income – Support. *9.22.10 BoD Conference Call*

Proposition 25 – Change Budget Vote from Two-Thirds to a Simple Majority While Retaining Two-Thirds Vote for Taxes - Support. *9.22.10 BoD Conference Call*

Proposition 26 – Increase Legislative Vote Requirement to Two-Thirds for State Levies and Charges, and Impose Additional Requirements for Voters to Approve Local Levies and Charges – Oppose. *9.22.10 BoD Conference Call*

Proposition 46 Anti-MICRA Initiative 2014: Oppose and contribute $20,000 to defeat. *5.8.14 BoD*

State Revenue Sources **EXT**

To preclude drastic cuts in health care and other programs, CAFP supports the following potential new sources of state revenues:

1. Implement an Oil Severance Tax – Estimated Revenue: $400+ million
   Variable: Oil production varies with price changes so estimated revenue will fluctuate.
   Rationale: California is the only state out of the 22 major oil producing states without a tax on oil production or royalty revenue, despite being the third largest producer. This has left billions of dollars on the table each year. States like Alaska currently tax at a rate of 25 percent. In January, the Governor suggested a rate of 9.9 percent.

2. Increase Tobacco Tax on Cigarettes – Estimated Revenue: $1+ billion
   Variable: Revenues would presumably decrease each year as more people quit smoking due to the higher costs.
   Rationale: In 2006, CAFP supported Proposition 86 (which did not pass), also known as the "Tobacco Tax Act of 2006," which would have increased the tax on cigarettes by $2.60 per pack. Under Prop 86, after backfilling First 5 funds, 95 percent of the revenue generated would have gone to health programs.

3. Restore Vehicle License Fee to 1998 level (2%) – Estimated Revenue $2.5+ billion
   Variable: Revenue would grow slowly from that amount as the economy recovers and more people purchase vehicles.
   Rationale: The Vehicle License Fee (VLF) was established by the Legislature in 1935 in lieu of a property tax on vehicles. The formula for VLF assessment established by the Legislature is based upon the purchase price of the vehicle or the value of the vehicle when acquired. The VLF decreases with each renewal for the first 11 years. The VLF is part of the total fees due upon initial and annual vehicle registration renewal. It is deductible from federal income taxes.

   This amount was temporarily increased to 1.15 percent for most vehicles effective May 19, 2009. By bringing the VLF back in line with its 1998 level, funding for city and county programs could be restored and offset money the State may take from cities and counties to back fill the General Fund.

4. Enact "nickel-a-drink" Tax on Alcohol – Estimated Revenue $700+ million
   Variable: As with the proposed tobacco tax, revenues would presumably decrease as more people avoid purchasing alcohol due to the higher costs.
   Rationale: In addition to the potential health benefits of decreased alcohol consumption, cost savings on alcohol-related problems could be realized. The price of these problems have increased dramatically and now cost the state $38 billion dollars annually in healthcare, criminal justice, addiction treatment, lost productivity and myriad other costs.

The last alcohol tax increase in California was in 1992, and was a penny on a glass of wine and two cents per can of beer and shot of spirits. Since that time, rising inflation has led to a 49% decrease in the real value of state alcohol taxes.

CAFP Policy on Budget Reductions: The proposed $60 million transfer from the Cigarette and Tobacco Products Surtax Funds to Medi-Cal – this would affect county health, clinic, Breast Cancer Early Detection, Asthma, Major Risk Medical Insurance, Access for Infants and Mothers programs, rural health demonstration projects and consumer assessment projects.

The proposed $10 million cut from Maternal, Child and Adolescent Health Grants that provide services and programs to improve the health of mothers, infants, children, adolescents, and families.

The proposed reduction of $8.8 million by implementing a 10 percent rate reduction for all drug Medi-Cal treatment modalities. This program funds substance abuse treatment services for Medi-Cal eligible individuals.

The proposed elimination of State funding for the California Poison Control System.

Restrictions to the In-Home Supportive Services program that would limit services to recipients with a Functional Index score of 4.0 and above. *06/09 BoD*

Succession Planning INT

1. The president will form a search committee consisting of three members of the board of directors. The search committee will be charged with reviewing the current CEO's job description and updating it as appropriate, reviewing applications, rank ordering candidates, interviewing the top candidates and recommending candidates to be considered by the board of directors.
2. The executive committee may opt to choose an interim CEO to assume the functions of the CEO if necessary or appropriate. The interim CEO may be a candidate for the permanent position of CEO, but that is not required or a condition of becoming interim CEO. The interim CEO will be the fiscal agent for all CAFP fiscal instruments, along with the CAFP secretary-treasurer. Other CAFP staff members, including the deputy Executive Vice President, vice president for health policy and membership and marketing director have check signing privileges to cover the time it may take to arrange privileges for an interim CEO, if he or she does not already have them.
3. The search committee may retain the services of a search firm or search consultant to assist in promoting the opening, reviewing candidates' applications and arranging and participating in interviews, if desired. If the interim CEO is not a candidate for the permanent CEO position, then the search firm or search consultant will work with and through the interim CEO. If the interim CEO is a candidate, then the president will select another staff person to assist the search firm or search consultant.
4. The CAFP may opt to restrict the search to California candidates to reduce expenses required for relocation or may choose to undertake a nationwide search.
5. The search process can be accomplished within three months from hiring a search firm or search consultant to having the board interview the top candidates. It may take up to three months more for the new CEO to start work with the Academy, depending on his or her employment situation.

BoD 11.15.14

Telehealth Policy Statement **EXT**

The Board of Directors adopted the following policy statement on Telehealth at its May 8, 2014 meeting. *5.14 BoD*

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

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.

Telemedicine: 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.

Telemedicine, Licensure and Payment: 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.

Terminal Illness / Also see End-of-Life Care EXT

Intractable Pain Treatment Act: Work with appropriate organizations to disseminate the California Intractable Pain Treatment Act so its provisions may be adopted in other states. *2/94 CoD*

Congressional Interference in Medical Decisions: CAFP opposes political interference in the medical decision making processes for any individual patient. *4/05 BoD; ER1-05, 2005 CoD*

Tobacco-Related Issues EXT

Chewing Tobacco Products: CAFP opposes the use of chewing tobacco products and extends the same policies to them as to other tobacco-related products. *2/01 BoD*

Electronic Cigarettes: The following policy was adopted on electronic cigarettes and similar products by the Board of Directors. *5/14 BoD*

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.

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. A-4-99, *2/99 CoD.*

"Smoke Free Class of 2000": That the CAFP endorse and support the efforts of the American Cancer Society, the American Heart Association, and the American Lung Association on behalf of the Smoke Free Class of the Year 2000 and will distribute this resolution to every member of our organization. *2/89 BoD*

Tobacco Settlement Funds: That the CAFP encourage the family physicians of California to become aware of the uses of tobacco settlement funds and to become involved through contact with legislators regarding the appropriate allocation of these funds; and be it further. *A-7-00, 2/00 CoD*

Tobacco settlement funds should be dedicated to health care and a substantial portion of the funds should be dedicated to comprehensive and effective tobacco use prevention programs. *A-7-00, 2/00 CoD*

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. *B-2-96, 2/96 CoD, B-2-09*

Transgender and Gender-Expansive Patients EXT

California Academy of Family Physicians

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. Recognizes that biological sex, gender identity, and sexual orientation are separate facets of a patient's intersectional identity.

8. 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.

9. 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.

10. 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.

11.02.19 BoD

Vaccines **EXT/INT**

Personal and Religious Belief Exemptions to Immunizations
Support legislation to eliminate the personal and religious belief exemptions for school-aged children as contained in 2015's SB 277 (Pan-D). *BoD 4/24/15*

Annual Influenza Vaccine Mandate Among Required Vaccinations for School
That 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. *9/20 BoD*

Preferential Supply of Influenza Vaccine: Manufacturers should preferentially supply influenza vaccine to physicians in time of shortage or public need. *2/01 CoD*

Support legislation providing physicians priority access to the first available seasonal influenza vaccine. *A-05-10 03/10 CoD*

Immunization: Support the completion of the immunization registry state hub and encourages members' participation in such registries. *03/09 CoD*

Personal and Religious Belief Exemption for Required Childhood Immunizations: Support SB277 (Pan-D) to eliminate the personal and religious belief exemption for required childhood immunizations. *5.14 BoD*

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 5.03.13

Whistleblower Policy INT

This Whistleblower Policy of the California Academy of Family Physicians (Organization): (1) encourages staff and volunteers to come forward with credible information on illegal practices or serious violations of adopted policies of the Organization; (2) specifies that the Organization will protect the person from retaliation; and (3) identifies where such information may be reported.

1. Encouragement of reporting. The Organization encourages complaints, reports or inquiries about illegal practices or serious violations of the Organization's policies, including illegal or improper conduct by the Organization itself, by its leadership, or by others on its behalf. Appropriate subjects to raise under this policy would include financial improprieties, accounting or audit matters, ethical violations, or other similar illegal or improper practices or policies. Other subjects on which the Organization has existing complaint mechanisms should be addressed under those mechanisms, such as raising matters of alleged discrimination or harassment via the Organization's human resources channels, unless those channels are themselves implicated in the wrongdoing. This policy is not intended to provide a means of appeal from outcomes in those other mechanisms.

2. Protection from retaliation. The Organization prohibits retaliation by or on behalf of the Organization against staff or volunteers for making good faith complaints, reports or inquiries under this policy or for participating in a review or investigation under this policy. This protection extends to those whose allegations are made in good faith but prove to be mistaken. The Organization reserves the right to discipline persons who make bad faith, knowingly false, or vexatious complaints, reports or inquiries or who otherwise abuse this policy.

3. Where to report. Complaints, reports or inquiries may be made under this policy on a confidential or anonymous basis. They should describe in detail the specific facts demonstrating the bases for the complaints, reports or inquiries. They should be directed to the Organization's CEO or Chair of the Board of Directors; if both of those persons are implicated in the complaint, report or inquiry, it should be directed to the President-elect or Secretary-Treasurer. The Organization will conduct a prompt, discreet, and objective review or investigation. Staff or volunteers must recognize that the Organization may be unable to fully evaluate a vague or general complaint, report or inquiry that is made anonymously. *11/08 BoD*

Workers' Compensation Report EXT

Workers' Comp Reform: That 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. *05 BoD*

Workforce Reform EXT

Communication with UC: Voted to encourage a concerted effort to expand communications between and among the CAFP Board, UC Chairs and LAC members. *5/99 BoD*

Principles of Workforce Reform: Endorse the principles, but not necessarily the numbers, in AAFP Board Report H, "Family Physician Workforce Reform," approved by the 1995 AAFP Congress of Delegates, as a guide to CAFP activities in the area of workforce reform. *10/95 BoD*

Residency Funding: Adopted a change in current CAFP workforce policy, with the addition of the underlined language, "Maintaining stable and secure funding for residency program and medical student education in family medicine." *5/99 BoD*