California Academy of Family Physicians

POLICY COMPENDIUM

Medical Practice Affairs Policies

CAFP
California Academy of Family Physicians

MEDICAL PRACTICE AFFAIRS

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

20.01 Direct Primary Care

Direct Primary Care Policy Principles

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

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

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

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

20.02 Electronic Health Records and Technology

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20.03 Emergency Care

Emergency Room Coverage

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

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

20.04 Full Spectrum of Family Medicine

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

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

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

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

20.05 Independent Practice

Independent Practice Support

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

20.06 Medical Licensure / Patient Safety

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

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

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

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

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

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

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

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

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

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

Topic: impaired physicians

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

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

20.07 Privileges and Credentialing

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

Board Certification

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

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

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

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

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

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

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

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

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

20.05 Telehealth

Physician Supervision of Telehealth Services

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

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

Telehealth Privacy and Data Integrity

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

Coverage of Telehealth Services

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

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

Telemedicine Definition, Licensure and Payment

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

Some of these processes and services include:

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

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

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

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