
## Tuesday, April 9

CALPAC Legislative Advocacy Reception
The Mix - Downtown - 1525 L Street, Sacramento, CA
5:00 PM - 7:00 PM

## Wednesday, April 10

Sheraton Grand Sacramento Hotel
1230 J St, Sacramento, CA

| | |
|---|---|
| 8:00 AM | REGISTRATION & CONTINENTAL BREAKFAST |
| 9:00 AM | CMA OPENING REMARKS<br>TANYA SPIRTOS, M.D.<br>PRESIDENT, CMA |
| 9:15 AM | LOBBYING AGENDA REVIEW<br>STUART THOMPSON<br>SENIOR VICE PRESIDENT, GOVERNMENT RELATIONS AND POLITICAL OPERATIONS, CMA |
| 9:50 AM | GROUP PHOTO<br>SAFE CREDIT UNION PERFORMING ARTS CENTER – STEPS FACING K STREET |
| 10:00 AM | LEGISLATIVE MEETINGS |
| 1 1:45 AM | LUNCH |
| 12:30 PM | MCO PRESENTATION |
| 1:00 PM | KEYNOTE SPEAKER - CALIFORNIA SENATE PRESIDENT PRO TEMPORE MIKE MCGUIRE |
| 1:15 PM | CMA CLOSING REMARKS<br>DUSTIN CORCORAN,<br>CMA CHIEF EXECUTIVE OFFICER |
| 1:30 PM | LEGISLATIVE MEETINGS |

Schedule subject to alterations

CALIFORNIA MEDICAL ASSOCIATION

# 50th ANNUAL LEGISLATIVE ADVOCACY DAY

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# Protect Access to Care

## Preserve Quality Health Care for All Californians by Maintaining Last Year's Historic Budget Agreement for Medi-Cal Providers

### Background

Medi-Cal provides essential health coverage to one in three Californians and is foundational to the state's health care delivery system and economy. In fact, 15 million Californians and nearly 50 percent of children get their health care through Medi-Cal programs, making it essential for preventive and routine care for California kids.

Medi-Cal provider rates have not increased in more than a decade, and for most physicians, it's been more than 25 years—leaving millions of patients insured but without meaningful access to health care. Patients with Medi-Cal coverage routinely wait weeks or months for appointments and often must travel long distances to receive care.

### Solutions

Thankfully, the Legislature and the Governor agreed in last year's budget to make a historic investment in the Medi-Cal system through the Managed Care Organization (MCO). In order to truly increase access for patients, the Legislature should ensure that the agreement in 2024 is upheld.

Historically, California has used the Managed Care Organization (MCO) Tax – a tax on health insurance companies – to draw down federal funding and help support the state's General Fund. The last MCO Tax expired at the end of 2022. Last year for the first time, the state dedicated a portion of the MCO tax to increase reimbursement rates and make other investments in Medi-Cal.

The budget proposal:

- Make the Medi-Cal provider rate increases that were included in the 2023-2024 state budget deal permanent, fulfilling the state's promise to physicians.
- Expand access to health care Medi-Cal patients, resulting in reduced emergency room usage, and shortened wait times for all Californians.
- Increases funding for mental health programs that care for children and Medi-Cal patients.

It is imperative that the Legislature upholds the MCO tax agreement which is reflected in the Governor's January proposal.

### Talking Points

- We must uphold last year's agreement to invest in the Medi-Cal system and provide physicians with the certainty they need to treat more patients.
- California has the largest Medi-Cal program in the county, serving nearly 15 million people—a number that has consistently grown over the last decade. California needs to ensure that it has the health care workforce to treat these patients.
- Last year, California reached a historic budget deal that would invest billions of dollars in the Medi-Cal system, and it is important for the Legislature to uphold its promise by investing these funds as intended.
- With growing inflation and the recent pandemic related to health care delivery systems, current Medi-Cal reimbursement rates don't come close to covering the cost of a routine medical visit.
- To meet California's goal of universal access to health care coverage, it must provide equitable funding to strengthen the overall health system and ensure enough providers to meet the demand for patient care.
- Our organization is committed to supporting policies that better fund Medi-Cal and ensure that health insurance actually means access to health care.

## Question and Answer

**Due to the state's budget deficit, is this the right year to increase rates?**
Reimbursement rates have not been raised since the late 1990s and have been cut twice since then. The Medi-Cal system has grown exponentially in the last decade, and the state needs to ensure that there are enough providers to take care of the new enrollees. Part of the MCO tax is dedicated to the general fund to ensure that the investments in the system will not need to be cut in a deficit year.

**Is this the right allocation of funding?**
While the MCO Tax provides a historic investment to increase access, it is not a silver bullet. There is not enough funding provided through the tax to cure all of the Medi-Cal's ailments, but CMA strongly believes the current allocation maximizes access in the system and is narrowly targeted to tackle the most pressing needs.


# Senate Bill 516 (Skinner) Prior Authorization

## Patient-Centered Care: Prior Authorization Reform

### Background

In a December 2022 physicians survey, the American Medical Association (AMA) found that 94 percent of physicians reported prior authorization results in care delays, and 89 percent had a negative impact on patient health outcomes because of prior authorization results and delays. California's health care system should revolve around a patient's needs and their ability to receive treatment promptly. Patient-centered care, not corporate health plan profits, should drive medical decision-making.

The process of prior authorization by health insurers often requires patients to wait for treatments that are ordered by their clinician and are within the standard of care for a given diagnosis, there is also no guarantee the authorization will be given. National data from federal regulators shows that insurers reject about 1 in 7 claims for treatment. In many cases where authorization is granted, by the time the health plan has approved the treatment the patient's condition has worsened, and a more intensive and costly treatment regimen is needed. This status quo is proving ineffective at delivering timely treatments to patients who need them the most. SB 516 will reduce unnecessary and regularly approved prior authorizations and modernize the operational process health plans use by making it electronic and give results in real time.

On average, physicians complete 45 prior authorizations per week, taking nearly two working days (14 hours) out of the week. Time spent on unnecessary bureaucracy like this is valuable time that could be better spent with patients in the exam room, coordinating care for patients with chronic conditions and increasing clinical time available to new patients.

### Solution

This bill would be the vehicle we use to pass prior authorization reform. It stalled in the Assembly at the end of last year's legislative session.

CMA is working with stakeholders to finalize language that will provide patients with the care they need when they need it and alleviate the unnecessary administrative burden for physicians.

Core principles of our negotiations are:

- Removing unnecessary prior authorizations from services that are regularly approved.
- Speeding up the appeals process to get physicians to a peer faster & by use of an electronic system.
- Requiring that a "peer" be of the same or similar specialty as the physician who is appealing a plan's decision.
- Requiring health plans to report their prior authorization approval and denial rates.
- Extending the validity of a prior authorization for 1 year. (currently 30-60 days)
- Requiring health plans to consult with physicians when they are developing utilization criteria.

### Talking Points

- **It's time to share your story!** Please provide your or your patient experiences with prior authorization!
- The key to getting this done will require the issue to remain at the forefront of the Legislature's work!
- To do this, we need you to emphasize that despite all the "work" that health plans are doing to "fix" the prior authorization issue, MORE NEEDS TO BE DONE!
- Tell a story about your patients who have not gotten the care they need or have had to stop taking medications because the health plan attached a prior authorization to it or denied it.

- Share a gripping story about how long you were on the phone trying to get a necessary or urgent treatment approved by a health plan and how many patients you could have seen in that time.
- Media reports have begun documenting insurers practice of denying necessary care to patients to boost heath plan profit margins (The New York Times, ProPublica, NPR, Calmatters). This is an imbalance that puts profit margins over treating patients has contributed to delayed patient care, worse health outcomes, administrative burdens on physicians and clinicians, and increased health care costs.
- You and your patients are the key to success!

## Question and Answer

**Utilization review processes are designed to control costs within the health care system; if you exempt physicians from that process, won't that lead to higher health care costs?**
Absolutely not, we know that when physicians are involved in and lead the care team, treatments and care are given in a timely and appropriate manner, leading to better and more timely health outcomes for patients and less costs associated with their care.

Prior authorizations increase profits for insurance companies, while harming both patients and clinicians.

**Have there been other states that have passed legislation to reform the prior authorization process?**
Yes, other states have taken steps to address this issue. Texas passed a prior authorization exemption program that is similar to the one proposed in SB 250. There were some modifications to the implementation and the time frames in their bill, however, the language is similar.

Additionally, the state of Illinois has passed legislation to make the development of health plan utilization criteria more transparent and more readily available to the public, ensure timely responses to prior authorization request so they are not drawn out over longer periods of time and ensure that physicians are reviewing prior authorization for the health plan and not lesser-trained health care providers.

This year, New Jersey and Washington state have passed laws that address different issues with the prior authorization process. Across the United States, at least 80 prior authorization bills are underway in 28 other states.

It is time that California acts to put patients first and pass SB 516!

# VOICES ON THE GROUND:
## Prior Authorization is Hurting Patients

### Protect Patient Care

When insurance companies get between patients and physicians, patients get sicker and health care becomes more expensive. These are stories from physicians and health care workers whose patients have been negatively impacted by prior authorization.

**Below are real-world experiences of physicians and their patients:**

### Surgical Oncology

As a breast surgeon, I see the delay in treating breast cancer first hand, ranging from screening to diagnosis, being seen by specialties, and getting surgery scheduled. Every step requires prior authorization, and that results in an unacceptable delay in treating our patients. An average of 3-4 months is required for a breast cancer patient to be surgically treated from the beginning of their diagnosis, and it could take even longer. Mortality increases with the length of delay until treatment. Delays in breast cancer surgery results in an extra 10 women every 4 weeks dying from Breast cancer for every 1000 women being treated. A 12-week delay translates into an extra 30 women dying from breast cancer. No one should be forced to accept these delays because we prioritize prior authorization over speed to treatment.

**Tom Lin, M.D.** | Riverside

### General Surgery

I can't tell the number of times I've had to send a patient to the ED because delayed prior authorizations delayed their surgery. This has caused my patients pain, suffering, uncertainty, and anxiety while waiting to see if their insurance would approve a surgery or treatment they needed.

**Matthew Cooper, M.D.** | Encinitas

### Joint Replacement Surgery

As a joint replacement surgeon our teams struggle with pre-authorization for key medications for the peri-operative care of patients on a daily basis. Finding alternative, less optimal medications, has placed clinical risk on patients, increased anxiety and frustration for patients, and been a "burnout" generator for staff.

**Bradley Graw, M.D.** | Palo Alto

## Ophthalmology

My patient has a serious eye condition that requires higher-level care that is only provided by a regional academic center. Her condition is making it difficult to work and she is incredibly stressed about her vision. Her insurance denied my initial referral. I then wrote a detailed letter explaining exactly which unique services are needed at the academic center; this was reviewed by a neurologist, not an ophthalmologist, and was again denied.

**Anjali Tapadia, M.D.** |

## Internal Medicine/Oncology

I ordered an MRI for a patient with a history of breast cancer, which required prior authorization, which then required a peer-to-peer consult – causing a three-day wait. The prior auth was denied during the peer-to-peer. When I asked "Why?" they said, "The risk of breast cancer has to be over 20%." Using their algorithm, the patient's risk was not above this threshold. I said, "That's ridiculous. Her risk is 100%. She already HAD breast cancer." The next day we got an approval, but with the wrong code for the wrong procedure. The patient had to cancel her appointment for that day and wait three more days for another peer to peer before finally getting approval.

**Ami Laws, M.D.** | Menlo Park

## Ophthalmology

Prior authorization is a huge problem, and a burden especially on a small practice. In ophthalmology, the patient is going blind by the minute and I am on the phone calling the insurance company and yelling at them to approve authorizations. I have spent countless hours doing this while the patient watches me argue with insurance staff who are only doing what they have been instructed. 72+ hours turnaround on an urgent authorization is equivalent to blindness in that time frame.

**Shelly Lapsi, M.D.** | Covina

## Pediatric Rheumatology

I am a pediatric rheumatologist. I have to go through prior authorizations for nearly every MRI and biologic I order. I have never lost a peer review, because I order treatments that are sensible and vital to protect the lives and mobility of my patients with lupus and juvenile arthritis. Insurance companies are getting in the way and causing unnecessary delays in care. My patients deserve to reach their dreams, without crippling arthritis or organ damage, and insurers are getting in the way.

**Amy Gaultney, M.D.** | Orange

## Oncology

In oncology, I am sure there isn't a practicing physician who hasn't had life-threatening delays in approvals for imaging, prescription drugs and chemotherapy. I am often asked to have a peer-to-peer review after a denial; in multiple cases the "peer" wasn't an oncologist and I wasted an hour explaining clinical practice guidelines, or explained that the drug I was requesting is approved for the indication. What a waste of patient and physician time. This is cancer, folks; it grows while you wait.

**Donna L. Walker, M.D.** | Lompoc

## Internal Medicine

One of my patients had abdominal symptoms. His insurance refused a CT scan three separate times. As a result, the patient developed a ruptured colonic diverticulum, requiring a life-changing colostomy. It could have turned out much worse.

**Michael Lynch, M.D.** | Fresno

## Cardiology

In this cardiology practice we have six full-time staff performing scheduling, reception and check-in for patients. We also have six full time staff devoted to requesting, tracking, documenting, and inputting information from authorizations for direct patient care. In addition, the equivalent of one or more full-time medical assistants is also required to do preauthorization medication requests. For 10 providers, we have seven full-time staff devoted to jumping through obstacles created by payers instead of providing anything that can be construed as necessary for medical care to our patients.

**Phil Janke** | Chief Operating Officer, Cardiology Associates Medical Group Inc.

## Neurology

I am a seasoned board-certified neurologist with 20+ years experience and am regularly denied the ability to order the appropriate testing. My staff spends countless hours, which translates into me spending huge sums of money in overhead, trying to advocate to get the treatments and testing that our patients deserve. The insurance companies transfer my staff around for hours and then hang up so they have to start over. I am having to obtain prior authorization for generic drugs that cost $20/month, like donepezil for Alzheimer's or baclofen for spasticity. This problem has to be fixed.

**Karen Garnaas, M.D.** | Redding

## Ophthalmology

Prior authorizations delay care for my patients on a DAILY basis. I get requests for authorization for generic medication on a daily basis. Patients go back to medications that I have discontinued due to ineffectiveness because they are told by the pharmacy that it is not covered. It is a huge burden on my practice, where I have a technician spending more than half of her time taking care of the paperwork that almost 99% of the time are approved anyways. Physician burnout and physicians quitting medicine is a huge problem for every citizen. These unnecessary burdens are not helping us, nor the frustrated patients.

**Lina Amini, M.D.** | Chula Vista

## Family Practice

I am at the point where I never expect any medication or order to be approved the first time. Everything is a fight. There is no accounting for my years of experience, expertise, and assessment of patient's drug interactions, etc.

**Kathryn Shade, M.D.** | Los Gatos

CALIFORNIA MEDICAL ASSOCIATION

**Shannan Velayas**
Vice President, Strategic Communications
**(916) 591-3406 | svelayas@cmadocs.org**


# Senate Bill 1120 (Becker) Health Care Coverage: Utilization Review

## Physicians Make Decisions Act

### Background

In recent years, health insurance plans have increasingly relied on artificial intelligence (AI) to streamline the processing of claims and prior authorization requests.

AI systems can quickly analyze vast amounts of data, expediting the approval or denial process. While these tools can improve access to care and potentially save insurers money, they have faced criticism for inaccuracies and biases, prompting calls for oversight.

The American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and American Hospital Association (AHA) have all issued statements advocating for the regulation of AI in insurance. The AMA has been a vocal proponent of reform, urging for the involvement of doctors and healthcare professionals without incentives to deny care in the AI review process for claims and prior authorizations.

### Solutions

The Physicians Make Decisions Act tackles this pressing issue by requiring a licensed physician to oversee decisions made by artificial intelligence (AI) or algorithms. This approach acknowledges that AI and algorithms cannot replicate the nuanced decision-making process of a physician, ensuring that patients receive fair and appropriate coverage decisions.

This bill would require that a licensed physician or health care provider have final approval of any utilization review decisions made or assisted by AI decision-making tools or algorithms used by a health care insurer.

Additionally, this bill includes safeguards to ensure AI, or algorithms used in utilization review do not discriminate against individuals based on their identity. As powerful as many AI tools are, they can be compromised when they rely on faulty, outdated, or biased data sources, leading to improper treatment recommendations. SB 1120 adopts federal guidance requiring health plans to make certain that their AI technology is free from such problems. Without the Physicians Make Decisions Act, patients could have essential medical services denied by AI when being used for utilization review by health insurers.

By guaranteeing human oversight, SB 1120 seeks to uphold the integrity of the health care system and prioritize patients' well-being above all else.

### Talking Points

- Without the Physicians Make Decisions Act, patients could have essential medical services denied by artificial intelligence (AI) when being used for utilization review by health insurers.

- AI has been and will continue to be an essential tool in improving health care access and affordability for patients, but physicians must have oversight of critical utilization review decisions to ensure the best health outcomes for our communities.
- This bill is necessary because, as leaders in the health care delivery system, we want to be proactive in guaranteeing that no patient's health condition or diagnosis is missed due to AI.
- This bill provides essential guardrails to allow us to continue successfully integrating AI into our health care system.
- SB 1120 provides protection for patients from AI-generated rejections of medical services.

## Question and Answer

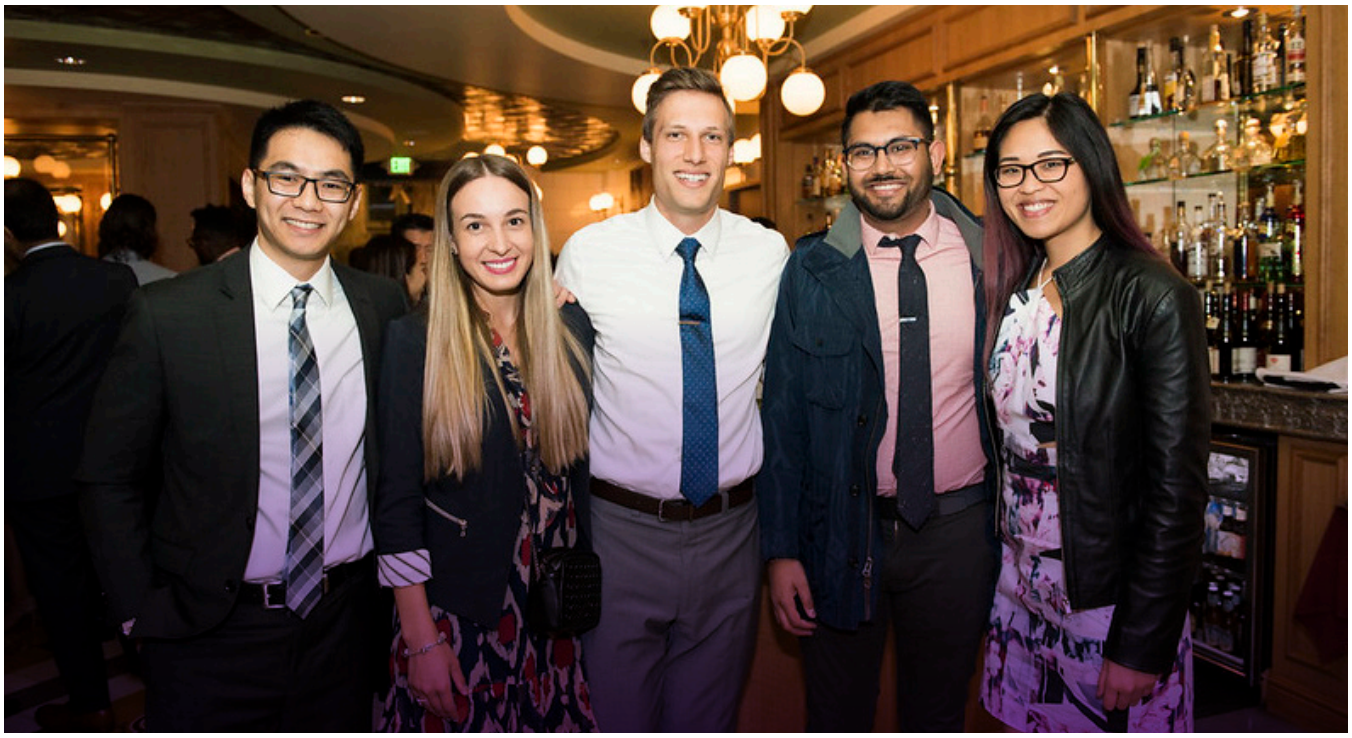
**Does artificial intelligence (AI) already exist within the clinical health care setting?**
Yes, it exists to various degrees depending on specialty, type of care, and type of system. Some physicians have been using forms of AI for years. That is why we sometimes refer to it as augmented intelligence instead of artificial intelligence.

**Have you ever had a prior authorization request denied due to the usage of AI or an algorithm?**
*This answer can vary per physician*. The physician can choose to share their experience or mention how this bill is also preventative to ensure health plans do not use AI or algorithms to blanket deny services requested by a physician.

**Under existing law can a health plan deny prior authorization requests just using AI without a physician's input?**
Yes. Existing law states that a physician or health care provider must oversee prior authorization requests but there is nothing specific to AI or algorithms. That is why there is a strong need for SB 1120.

# CALPAC

## LEGISLATIVE ADVOCACY RECEPTION



**TUESDAY, APRIL 9 | 5PM–7PM**

**MIX DOWNTOWN | 1525 L Street, Sacramento, CA**

This event is a great opportunity to meet with California state legislators, as well as colleagues from across the state, the night before CMA Legislative Advocacy Day. Enjoy music, conversation and excellent refreshments.

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Space is limited. Please RSVP by **Clicking Here.**

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# CALPAC

# GOLDEN GAVEL CONTEST

## CALPAC HOSTS 4TH ANNUAL GOLDEN GAVEL CONTEST

Help your county medical society win by donating to CALPAC by April 10, 2024! The county with the highest average total of new donations will win bragging rights, and a shiny golden gavel engraved with the winning county society's name.

Donations made between March 26 and April 10, 2023 are eligible, including increases to a donor's current giving level.

**Please donate now at CALPAC.org/Donate.**

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# CALPAC

**CALIFORNIA MEDICAL ASSOCIATION**
**POLITICAL ACTION COMMITTEE**

# MEMBERSHIP FORM

## PARTICIPATION LEVEL:

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| **Diamond** | ☐ $6500 or | ☐ $541.67 per month |
| **Platinum** | ☐ $2500 or | ☐ $208.34 per month |
| **President's Circle** | ☐ $1000 or | ☐ $83.34 per month |
| **Congressional** | ☐ $500 or | ☐ $41.67 per month |
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## YOUR POLITICAL VOICE!

CALPAC, the California Medical Association (CMA) Political Action Committee, supports candidates and legislators who understand and embrace medicine's agenda. Health care in California is highly regulated and legislated. As government and the insurance industry continue their quest to control health care, your clinical autonomy is in great jeopardy. Now, more than ever, you need to fight to keep medical decisions in your well-trained hands.

**FORTUNATELY, YOU DO NOT HAVE TO WAGE THE FIGHT ALONE.**

Successful legislative advocacy depends upon an integrated approach, consisting of lobbying, continuing grassroots activity and political action through CALPAC. CALPAC is operated by physicians, for physicians. By focusing physician resources, CALPAC supports hundreds of candidates for state and federal office who share our philosophy and vision of the future of health care and medical practice.

CALPAC is a voluntary political organization that contributes to physician-friendly candidates for state and federal office. Political law and CALPAC policy determine how your contribution to CALPAC is allocated. CMA will not favor or disadvantage anyone based on the amounts of or failure to make CALPAC contributions, nor will it affect your membership status with the CMA. Contributions to CALPAC are voluntary and not limited to the suggested amounts. Contributions are not deductible for state or federal income tax purposes.

☐ **Self Employed / Employer:** _____

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# CALIFORNIA MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE

## PARTICIPATION LEVEL INFORMATION

### DIAMOND | $6500 ANNUALLY OR $541.67 MONTHLY

- Exclusive membership pin
- VIP invitation to CALPAC's major events and events in your area
- Invitation to meet with CMA's Government Relations Team
- Name recognition at major events and on the CMA website
- 1 year online subscription to the California Physician's Legal Handbook (CPLH)

### PLATINUM | $2500 ANNUALLY OR $208.34 MONTHLY

- Exclusive membership pin
- VIP invitation to CALPAC's major events and events in your area
- Name recognition at major events and on the CMA website
- 1 year online subscription to the California Physician's Legal Handbook (CPLH)

### PRESIDENT'S CIRCLE | $1000 ANNUALLY OR $83.34 MONTHLY

- Exclusive membership pin
- VIP invitation to CALPAC's major events
- Name recognition at major events and on the CMA website

### CONGRESSIONAL | $500 ANNUALLY OR $41.67 MONTHLY

- Exclusive membership pin
- Invitation to CALPAC's major events
- Name recognition at major events

### 300 CLUB | $300 ANNUALLY OR $25.00 MONTHLY

- Exclusive membership pin
- Invitation to CALPAC's major events
- Name recognition at major events

### SUSTAINING MEMBER | $150 ANNUALLY

- Exclusive membership pin

# CMA Wants to Share YOUR Story!

**The California Medical Association (CMA) is recruiting physicians to share their experiences and expertise with media and on social media.**

Why is this important? No one understands the complexity of the health care ecosystem, or what patients need, better than physicians. We provide you with training, messaging and resources. Share your story to create meaningful change toward public health and advocacy.

## HOW IT WORKS: MEDIA SURROGATES

From interviews to op-eds to speaking engagements, you'll receive training to share your story with media.

We'll work to determine your schedule and interest level – and plug you in accordingly. For example, early morning the only time you have? Then maybe you become specialized in morning talk radio. Have zero time for media interviews in the middle of the day? Then perhaps you focus on op-eds.

CMA will vet and facilitate all media requests. We handle the scheduling on your behalf, and once confirmed, we'll walk you through the context, messaging and logistics so that you feel 110 percent prepared and comfortable.

Once the article/interview/op-ed is "live," we'll make sure you have a copy and provide any constructive feedback.

**Visit cmadocs.org/media-surrogate to learn more!**

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# HOW IT WORKS: SOCIAL MEDIA AMBASSADORS

Social media is a powerful communications tool to connect with colleagues, policy makers and the media. Your participation will keep colleagues and other medical professionals informed, connected and engaged. Similar to media, you'll receive training and resources from CMA's experienced staff.

## GENERAL TIPS / ADVICE

**The internet (including social media) is written in stone** – don't post anything you wouldn't want quoted in the *New York Times*.

**Stay positive** – avoid sarcasm and snark.

**Be genuine** – robotic messages don't resonate. Let your personality shine.

**Keep it short and sweet.**

**Make it visual** – pictures/videos get more engagement.

**Don't feed the trolls** – ignore baiting or negative responses.

**For discussions of state legislation**, use #CaLeg and hashtag the bill number (e.g., #SB516). Any social media posts that feature CMA members should be tagged with #CMAdocs.

**Retweeting/sharing CMA content is highly recommended!** To add your own take on the issue, fill in the "Add a comment" box before hitting "Retweet."

**Tag people relevant to the post** – @CMAdocs, your local county medical society, colleagues and/or elected officials.

**Nothing is mandatory** – we want you to share what appeals to you and your interests!

**Send us links or tag us** in your own posts relevant to CMA issues! Sharing goes both ways.

#CMAdocs

## REMINDER TO FOLLOW CMA:

Twitter, Facebook, LinkedIn and Instagram: **@CMAdocs**

## COMMONLY USED HASHTAGS:

For relevant news or issues: **#CMAdocs**

For advocacy efforts and campaigns: **#CMAleads**

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# CALIFORNIA MEDICAL ASSOCIATION
## POLICIES ON PROFESSIONALISM

The following is a non-exhaustive summary of CMA's policies that concern the professional conduct of members and attendees at CMA functions.

**The California Medical Association (CMA) is committed to providing an inclusive, and harassment-free environment for all attendees, including members, staff, and invited guests in order to facilitate constructive, thoughtful, unbiased, useful, and relevant dialogue, debate, education, networking, and the exchange of information in a respectful, professional manner.**

Some behaviors are, therefore, specifically prohibited:

1) Harassment or intimidation based on race, religion, language, gender, sexual orientation, gender identity, gender expression, disability, appearance, or other protected group status per applicable local, state, and federal law;
2) Sexual harassment or intimidation, including unwelcome sexual attention, stalking (physical or virtual), or unsolicited physical contact;
3) Using defamatory, or profane language against other attendees;
4) Engaging in or threatening violence against other attendees;
5) Disrupting any portion of the event;
6) Breaking confidentiality where required; and
7) Engaging in other unlawful activity.

CMA reserves the right to immediately address any disorderly conduct of attendees; including warning, expelling, and calling security or law enforcement as it deems appropriate.

Full copies of CMA's policies are available on the CMA website for your review. Policies may be updated and new policies concerning professionalism may be created in the future.

- Prohibition of Harassment
- Conflict of Interest Policy
- Antitrust Compliance Program
- Forum Guidelines
- Terms of Use
- Privacy Policy

Members have a Duty of Loyalty to act in the best interest of CMA, it's mission and its members. We appreciate your adherence to these policies on professionalism to ensure a successful event for all.

**Real Talk on Decency, Kindness and Being Respectful**

California Medical Association (CMA) members come from all corners of the state, represent every medical specialty, span all generations, and hold diverse viewpoints and social expectations reflecting their myriad of backgrounds, cultures and lived experiences.

When physician, resident and medical student members come together to support CMA's common mission, it is expected that we will encounter differences in opinion – sometimes passionate ones. In order to arrive at informed consensus, we ask all participants to remember the value of respectful communication, and to be courteous and patient with democratic decision-making. We also encourage participants to err on the side of civility, grace, curiosity kindness and patience.

Regardless of our many differences, everyone is capable of respecting personal boundaries and comporting themselves with decency. Some basics:

- Generally avoid or else save provocative, edgy, inflammatory, aggressive, or sarcastic remarks for close personal acquaintances, who know you well and understand your intent.

- It is disrespectful to invalidate the experiences of others. If you don't share or haven't witnessed those experiences communicated by others, it's probably a time for listening instead of speculation, playing devil's advocate or one-upmanship.

- Please refrain from remarks of a sexual nature or any potential unwelcome commentary on people's bodies or appearances, including, but not restricted to, clothing, age, hair, jewelry, etc. Take care to make sure that any physical touch is consensual.

- You are expected to self-regulate your own behavior, as every individual is the best judge of their limits on socializing, hours worked or awake, alcohol consumed, or any other stressor that may impact a person's disposition or behavior.

- If you make an error in social judgement, apologize and then leave the other party alone.

*CMA doesn't need policy on kindness to expect civil conduct from all attendees*. Those lacking the ability to navigate these common social expectations should consider alternative ways of engagement within our organization.

CMA is committed to providing an inclusive and harassment-free environment, and we believe that creating an ongoing dialogue is a key tenet to supporting that goal.

We are all human and mistakes or miscommunications can be expected. There is no policy that will prevent misunderstandings or rude incidents from occurring or eliminate

the inevitable discomfort that can arise when you bring large, diverse groups of people together.

If you feel safe doing so, you are encouraged to communicate directly with the other party in the moment or soon after when someone offends or is flatly inappropriate. This allows the individual the opportunity to apologize, make amends, and learn from the experience. Not every incident described above may rise to the level of a formal complaint or disciplinary action, but we would still like to hear from you so that we are able to have important conversations and be aware of those behaviors for the future.

**How to Communicate a Concern or File a Complaint:**

*Concerns* can be discussed informally or a *complaint* can be formally registered by contacting any of the following groups of individuals.

- CMA Chief Executive Officer: Dustin Corcoran
- CMA Chief Legal Officer: Jamie Ostroff, Esq.
- CMA elected physician leaders:
- For events related to the Board of Trustees: Sergio Flores, MD, or Eric Hansen, DO
- For events related to the House of Delegates: Jack Chou, MD, or George Fouras, MD

CMA reviews every complaint brought to our attention. A group of Association leaders and appropriate staff will meet to review the incident. In order to help us understand and respond to the complaint, please include as much of the following information as possible:

- Your name* (and contact information)
- The name of the person experiencing the harassment (*if not you*) (and their contact information, if available)
- The name of the person who is alleged to have committed the harassment
- A brief description of what happened or of the concern*
  - The general circumstances of the incident
  - When and where the incident occurred
  - Other people who were involved or who may have witnessed it
  - If you are seeking to convey a concern informally or a formal complaint

**Please note that anonymous or non-descriptive complaints may be submitted but may reduce or eliminate the ability for CMA to conduct a formal investigation or make recommendations for further action.*

In addition to bringing a complaint directly to our team, you can submit one online using the form at the bottom of the Conduct page. All of the fields in the contact form are optional, should you want to submit an anonymous complaint. Please note, however, that anonymous or non-descriptive complaints may be submitted but may reduce or eliminate the ability for CMA to conduct a formal investigation or make recommendations for further action.

**What Happens After You Make a Report**

Once we receive a report, we will contact the individual who experienced the harassment. We will invite them to meet with us to discuss the situation so that we can conduct an initial assessment. Depending on the circumstances and information available we might conduct a formal investigation, embark down a path of conflict resolution, or close the report.

Should a formal investigation be undertaken, a notice of the allegation will be sent to all parties, a report will be created, and the leadership team will determine appropriate discipline if applicable. Complainants and respondents will both be afforded the opportunity to speak with the investigators, and to provide evidence, testimony or materials, as applicable.

The leadership team may request any or all of affected parties take steps to help facilitate a safe, peaceful and impartial investigation.

**What to Do When You Don't Feel Safe**

Please know that we are not crisis responders and do not provide emergency services. If you are experiencing an emergency or need immediate assistance with a matter of sexual violence, please dial 9-1-1 for all emergencies.