State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

November 1 - 2, 2007

BOARD AGENDA

and related material

Board Meeting, Thursday, November 1, 2007 at 2:30 p.m.
Friday, November 2, 2007 at 10:00 a.m.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
MEDICAL BOARD OF CALIFORNIA– Executive Office
1434 Howe Avenue, Suite 92, Sacramento, CA 95825
(916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

MEMBERS OF THE BOARD
Richard Fantozzi, M.D.
President
Vacant, Vice President
Vacant, Secretary
Steve Alexander
Cesar Aristeiguieta, M.D.
Hedy Chang
John Chin, M.D.
Shelton Duruisseau, Ph.D.
Gary Gitnick, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Gerrie Schipske, R.N.P., J.D.
Janet Salomonson, M.D.
Ronald H. Wender, M.D.
Barbara Yaroslavsky
Frank V. Zerunyan, J.D.

QUARTERLY BOARD MEETING

November 1 - 2, 2007

Hilton San Diego Mission Valley
Carmel 3 Room
901 Camino Del Rio South
San Diego, CA 92108
(619) 543-9000

Action may be taken on any item listed on the agenda.

AGENDA

November 1, 2007 – 2:30 p.m. to 5:00 p.m.

November 2, 2007 – 10:00 a.m.
(or at the conclusion of the Division meetings)

Thursday, November 1, 2007 2:30 p.m.

1. Call to Order/Roll Call

2. Approval of Minutes from the July 26 – 27, 2007 Meeting

3. Discussion on Fiscal Audit Report – Ms. Johnston/Ms. Kirchmeyer

4. Legislation Update – Ms. Whitney
   A. 2007 Legislation
      1. Implementation
      2. AB 253 – Board Restructuring
      3. SB 761 – Sunset Plans
   B. 2008 Legislation and Proposals

5. Elections
   A. Timing of Election
   B. Fill Board Officer Position(s)

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

President's Report
A. Panel/Committee Appointments
B. Board Update

Executive Director's Report – Ms. Johnston
A. Budget Overview and Staffing Update
B. Proposed Meeting Dates for April or May 2008
C. Board Meeting Survey

Approval of Vertical Enforcement Report – Ms. Threadgill

9. California Physician Corps Program Update – Dr. Fantozzi/Ms. Yaroslavsky

10. Cultural and Linguistic Physician Competency Workgroup Meeting Update – Ms. Chang

11. Access to Care Committee Update – Mr. Alexander/Dr. Gitnick

12. Public Comment on Items Not on the Agenda

****

Friday, November 2, 2007 - Meeting continues at 10:00 a.m. or at the conclusion of the Division meetings.

13. Call to Order/Roll Call

14. Physician Humanitarian Award – Dr. Fantozzi

15. Strategic Planning – Ms. Kirchmeyer

16. Information Technology Application Demonstration – Angelo Whitfield

17. Wellness Committee Update – Dr. Duruisseau & Dr. Norcross
    A. Presentation on Wellness – Dr. Moskowitz

18. Reports from the Divisions/Committees
    A. Division of Licensing – Ms. Chang
       Midwifery Committee – Ms. Chang
    B. Division of Medical Quality – Dr. Aristeiguieta
       Diversion Committee – Dr. Wender/Dr. Salomonson
       1. Approval of Transition Plan

19. Forums on Use of Lasers Update – Dr. Moran/Dr. Salomonson

20. Agenda Items for February 2008 Meeting

21. Public Comment on Items Not on the Agenda

22. Adjournment

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting Teresa Schaeffer at (916) 263-2389 or sending a written request to Ms. Schaeffer at the Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825. Requests for further information should be directed to the same address and telephone number.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the President may apportion available time among those who wish to speak.

****

For additional information call (916) 263-2389.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
MEDICAL BOARD OF CALIFORNIA – Executive Office
1434 Howe Avenue, Suite 92, Sacramento, CA 95825
(916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

Agenda Item 2

Embassy Suites
Tiburon/Sausalito Room
250 Gateway Boulevard
South San Francisco, CA 94080

July 26 - 27, 2007

MINUTES

DRAFT

Agenda Item 1 Call to Order/Roll Call

Dr. Fantozzi called the meeting to order on July 26, 2007 at 8:05 a.m. A quorum was present and notice had been sent to interested parties.

Members Present:

Richard Fantozzi, M.D., President
Steve Alexander
Hedy Chang
Steven Corday, M.D.
John Chin, M.D.
Dorene Dominguez
Shelton Duruisseau, Ph.D.
Gary Gitnick, M.D.
Laurie C. Gregg, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.
Ronald H. Wender, M.D.
Barbara Yaroslavsky
Frank V. Zerunyan

Members Absent:

Cesar Aristeiguieta, M.D.
Ronald L. Moy, M.D.
Mitchell S. Karlan, M.D.

Staff Present:

David T. Thornton, Executive Director
Kimberly Kirchmeyer, Deputy Director
Kathi Burns, Manager, Licensing Unit
Candis Cohen, Public Information Officer
Janie Cordray, Research Specialist

Kurt Heppler, Staff Counsel, DCA Legal Office
Valerie Moore, Associate Analyst, Enforcement Program
Kelly Nelson, Legislative Analyst
Richard Prouty, Manager, Discipline & Staff Services Unit
Gary Qualset, Chief of Licensing
Regina Rao, Business Services
Paulette Romero, Associate Analyst
Teresa Schaeffer, Executive Assistant
Kevin Schunke, Regulation Coordinator
Anita Scuri, Senior Staff Counsel, DCA Legal Office
Renee Threadgill, Chief of Enforcement
Frank Valine, Diversion Program Administrator
Linda K. Whitney, Chief of Legislation
Curt Worden, Manager, Licensing Section

Members of the Audience:

Sandra Bressler, California Medical Association
George Cate, Senate Business and Professions Committee
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law
James Hay, M.D., California Medical Association
Ed Howard, Center for Public Interest Law
Carrie Lopez, Department of Consumer Affairs
Brett Michelin, California Medical Association
Carlos Ramirez, Office of the Attorney General
Antonette Sorrick, Department of Consumer Affairs

Agenda Item 1 Approval of Minutes from April 26 - 27, 2007 Meeting

It was M/S/C (Yaroslavsky/Moran) to approve the minutes from the April 26 – 27, 2007 meeting.

In order to remain consistent with the record, the agenda items presented in these minutes are listed in the order discussed at the July 26 - 27, 2007 meeting.

Closed Session:

Agenda Item 3 Appointment of Executive Director

Pursuant to Government Code section 11126(a), the board went into closed session at 8:07 a.m. to appoint a new executive director.

Open Session:

The board reconvened in open session at 8:35 a.m.. Dr. Fantozzi announced the appointment of Barbara Johnston as the board's new executive director effective August 1, 2007.

Dr. Fantozzi acknowledged Carrie Lopez, Director of the Department of Consumer Affairs and George Cate, Senate Business and Professions Committee in attendance at the meeting today.

Agenda Item 5 Legislation

Linda Whitney, Chief of Legislation, provided an update on 2007 legislation sponsored by the board.

The board took the following positions on legislation:

AB 3 (Bass)	Physician Assistants - **Support**
AB 253 (Eng)	Restructuring of the Medical Board of California - **Sponsor/Support**
AB 329 (Nakanishi)	Chronic Diseases: Telemedicine - **Sponsor/Support**
AB 1025 (Bass)	Professions: Denial of Licensure - **Oppose unless amended**
AB 1073 (Nava)	Work. Comp.: CA Licensed Physicians on Utilization Review - **Support**
AB 1224 (Hernandez)	Telemedicine: Optometrists - **Support**
SB 102 (Migden)	Blood Transfusions: Brochure - **Support**
SB 472 (Corbett)	Prescription Drugs: Labeling Requirements and Panel - **Support**
SB 620 (Correa)	Anesthesia Permit for Physicians in Dental Offices - **Support**

AB 253 (Eng) - Ms. Whitney reported the Department and the Administration have taken a support if amended position on this bill. She directed the member's attention to a copy of a letter from the Department dated May 29, 2007 recommending the reduction in the size of the board from 21 members to **15 members consisting of 8 physician members and 7 public members**. The Executive Committee held a meeting on June 18, 2007 and voted to support the Department's recommendation to reduce the size of the board to 15 members. Ms. Whitney requested the board's concurrence with the Executive Committee recommendation.

Ms. Yaroslavsky stated for the record she did not support the motion made at the Executive Committee meeting without further analysis of the workload and impact on the board if the two divisions are integrated into one board.

Mr. Thornton responded and stated combining the two divisions will accomplish a more evenly distributed workload. The board will still have two disciplinary panels to review **all** the cases whether they are licensing cases or disciplinary cases. The work of the divisions would then be taken up by

standing committees for enforcement, licensing, diversion, and any other committees the board deems appropriate.

Following a discussion by the members, it was moved (Alexander/Chang) to support the Executive Committee position on the number and composition of the board. The motion carried by a vote of 12-3 with 1 abstention.

At this time Ms. Whitney introduced Jane Simon, Deputy Attorney General, to discuss concerns the Attorney General's office has regarding the proposed bill and the composition of the panels.

Ms. Simon presented an analysis of SB 253 prepared by Deputy Attorney General Beth Faber Jacobs and discussed the problems identified with the bill as currently written. It is the Attorney General's office concern if the panels are not composed of a majority of physician members making decisions, the board will lose the presumption of correctness based on the expertise with the proposed composition. Ms. Simon presented several different alternatives to the board.

After considering the arguments presented and hearing public comment it was moved to amend SB 253 as follows: ***the number of public members assigned to a disciplinary panel shall not exceed the number of physicians and surgeons assigned to that panel and at no time shall a panel consist of less than four members.*** The motion carried.

The next bill Ms. Whitney discussed was SB 761 – Diversion/Enforcement.

Dr. Fantozzi gave a brief history of the board's Diversion Program and discussed the prior audits of the program including the diversion audit ordered as part of SB 231 to be completed by July 1, 2007.

Dr. Gregg made a statement concerning the challenges and struggles associated with the Diversion Program. She stated if the program continues there must be a zero tolerance policy and disclosure of the program participants on the board's Web site.

Mr. Alexander made the following motions:

1. Move that, in light of Medical Board of California's primary mission of consumer protection, and as the regulatory agency charged with the licensing of physicians and surgeons and enforcement of the Medical Practice Act, the board hereby determines it is inconsistent with the board's public protection mission and policies to operate a diversion program within or as part of its consumer protection programs, and that the diversion program, as it's currently structured and operated, be sunset as soon as practicable, but not later than June 30, 2008.
2. Move that, effective immediately, the Medical Board of California develop a transition plan to continue the diversion program on an interim basis until the sunset date.
3. Move that, the president of the board convene a diversion program summit, seeking input from the Diversion Advisory Council, regulatory experts, profession organizations, healthcare and

patient consumer groups, public interest groups, and other appropriate stakeholders and experts to determine the most appropriate policy and mechanism for fulfilling the board's consumer protection mission while addressing the issue of the impaired licensee; the results of the summit to be reported to the board no later than June 2008 for action by the legislature as necessary based upon the findings and recommendations of the summit and the board.

4. Move that, at the summit, a recommendation to the Legislature be considered for the establishment of a new state agency or similar agency to provide diversion/monitoring programs for all California licensed professionals overseen by experienced professionals in alcohol and drug dependency rehabilitation.
5. Move that, the president of the board and chair of the diversion committee work with the author of the legislation on behalf of the board.

Public testimony was heard from the following regarding SB 761:

Jim Hay, representing the California Medical Association (CMA) urged the board to consider all options regarding the Diversion Program. The CMA will work with the board to assure transition and right course of action to improve the program.

Sandra Bressler, representing the CMA spoke in support of keeping the Diversion Program and urged the board to make the necessary improvements to the program.

David Pating, M.D., representing the California Society of Addiction Medicine challenged the assumptions by the board and asked the board to look at all the options regarding the Diversion Program.

Tina Minasian, patient and consumer advocate spoke in support of abolishing the Diversion Program.

Terri Farley, member of the public discussed her sister who was injured by a participant who was in the Diversion Program.

Janet Mitchell, patient and consumer advocate spoke in support of eliminating the Diversion Program and stated the board's primary mission is to protect the citizen's of California.

Linda Starr, patient, testified she suffered injuries sustained during a procedure performed by a participant who was in the Diversion Program. She spoke in support of abolishing the program.

Lee Snook, M.D., treating physician and member of the Diversion Advisory Committee advised the board he was concerned that if the board eliminated the diversion program it would only drive the physician with alcohol/drug problems underground.

Robert Reisfield, M.D, Kaiser Well-Being Committee stated the board should only choose to eliminate the Diversion Program if there are better systems available.

Julie D'Angelo Fellmeth, Administrative Director for the Center for Public Interest Law spoke in support of the motion to eliminate the Diversion Program.

Randall Hagar, California Psychiatric Association stated they support the comments made by CMA, Dr. Pating, and Dr. Snook.

Ed Howard, Senior Counsel, Center for Public Interest Law spoke about the motions before the board and what the board needs to consider when voting on these motions to fix the problem. He stated they first needed to recall the product and then convene a summit to figure out a way to put in place a product that is safe and sound for patients and physicians.

Don Fensterman, Project Manager for Maximus Diversion Program stated he had concerns regarding abolishing the Diversion Program and not having a mechanism in place to monitor physicians once they come out of an in-patient treatment facility.

Following a lengthy discussion by the members and the public regarding the Diversion Program, Mr. Alexander repeated the motion.

The board voted unanimously to approve all five motions made by Mr. Alexander.

Mr. Zerunyan proposed a motion to ask the author of the bill to include a provision to give the board the authority to suspend the license of all participants in the program.

It was moved to table Mr. Zerunyan's motion.

Ms. Whitney and Ms. Threadgill, Chief of Enforcement, provided information on the second part of SB 761 regarding Vertical Enforcement Model. This bill would extend the pilot program.
Ms. Whitney directed the member's attention to their board packet for a copy of the Report to the Legislature on Vertical Enforcement. Ms. Whitney explained the Executive Committee took no position in amending the bill at its June 18, 2007 meeting pending review of the final report by the full board in July.

There was discussion by the members regarding the recommendations in the report to the legislature.

Mr. Alexander moved the board recommend the following option:

1. Transfer the Medical Board investigators to the Department of Justice, however, given that more time is needed to fully analyze this option, recommend option #3 to continue the pilot for another two years to allow the collection of additional data, clean-up language and rename the program

Vertical Enforcement. Further, the report to the Legislature is amended to reflect the board's legislative position.

George Cate, Senate Business and Professions Committee provideded his concerns regarding the direction of the board and the provision currently set forth in the bill regarding reclassifying the investigator positions. He explained the legislative session is over at the end of August. He stated it was the author's understanding the board's direction was to improve the situation for the Medical Board's investigators so they will stay with the board.

In light of the testimony presented, Mr. Alexander withdrew his motion.

It was M/S/C to support the July 18 version of SB 761 with the following amendments: to modify the language related to supervision/direction of investigators by deputy attorneys general, integrate the case tracking systems of the medical board and attorney general's office with ProLaw and to co-locate offices wherever feasible. In addition, medical board investigative staff be paid equivalent to special agents in the Department of Justice.

The motion was approved by unanimous vote.

Mr. Alexander moved that a task force be appointed to complete this report and deliver it timely to the Legislature recognizing the board is already behind the June 30, 2007 due date.

Agenda Item 7 **Executive Director's Report**

A. Budget Overview and Staffing Update

Mr. Thornton reported current board expenditures and revenue appear to be consistent with projections. The final analysis of the board budget will be completed by the November 2007 meeting.

B. Meeting Survey and Rating Sheet

Members were asked to complete the form and provide any comments on any changes they would like to see made to the meeting format or topics.

C. Proposed Meeting Dates for 2008

Mr. Thornton presented the proposed 2008 Board meeting dates and locations to the board for approval.

It was M/S/C to approve the 2008 meeting dates.

D. Federation of State Medical Board's (FSMB) Request to Distribute Pain Management Book to all Licensees

Mr. Thornton explained the Federation of State Medical Boards asked for the board's support of a book entitled Responsible Opioid Prescribing, by Scott M. Fishman, M.D. and is requesting the board's approval to distribute this book to all current in-state licensees and new licensees.

It was M/S/C to approve distribution of the pain management book as proposed and staff was directed to work with the FSMB on the funding to cover the cost of distribution.

E. Status Report – Board notifications of Revocations, Suspensions and Meetings

Mr. Thornton reported the board's on-line subscriber list for notifications sent via email has been very effective in getting information out to the public in a timely manner.

Agenda Item 7 Health Manpower Pilot Project

Dr. Gregg reported the proposed pilot project to allow nurse practitioners, certified nurse midwives and physician assistants to perform early pregnancy termination and management of early pregnancy failures has been approved. She encouraged the board to continue to follow this project with respect to consumer safety.

Agenda Item 14 Workgroup on Cultural and Linguistic Continuing Medical Education

Ms. Chang reported she attended a Continuing Medical Education (CME) provider workshop in April which was very informative. She met with CMA and IMQ on May 4, 2007, and attended another provider workshop on May 11.

Agenda Item 8 California Physician Corps Program Update

Ms. Yaroslavksy reported the Health Professions Education Foundation (HPEF) quarterly meeting will be held on July 30, and 31, 2007 at the LAX Marriott Hotel. A new executive director has been appointed to the HPEF. Ms. Yaroslavsky also reported the HPEF was successful in obtaining $1,000,000 for the Allied Healthcare Loan Repayment. She thanked the members for their continued support of this worthy program while they continue to move forward.

Agenda Item 9 Public Comment on Items not on the Agenda

Tina Minassian, patient and victim of an alcoholic physician who was allowed to practice medicine

while he was a participant in the Diversion Program stated she was in support of abolishing the program and offered additional recommendations for the board's consideration:

1. Require all physicians to tell patients about the existence of the board and its enforcement role.
2. Sponsor legislation to require civil attorneys to inform malpractice victims how to file a complaint with the board.
3. Sponsor legislation repealing or lengthening the statute of limitations.
4. Post every malpractice settlement on the board's web site.
5. Post every criminal conviction on the board's web site.
6. Sponsor legislation creating a "Snitch Law".

Tara Kittle, healthcare consumer spoke in support of improving the safety of the healthcare consumer by providing physicians with the tools they need to perform their job.

John P. Toth, M.D., representing the California Citizens for Health Freedom, read a letter from Frank Cuny to the board regarding the development of a manual for investigators on alternative medicine and the use of an alternative medicine consultant during the review of these cases.

Janet Mitchell, patient and healthcare consumer advocate asked the board to move forward in pursuing cases involving fraud and concealment.

Agenda Item 10 Strategic Plan

This item was deferred to the November 2007 meeting.

The meeting adjourned at 4:00 p.m.

****

Friday, November 2, 2007

Agenda Item 11 Call to Order/Roll Call

Dr. Fantozzi called the meeting to order on November 2, 2007 at 10:10 a.m. A quorum was present and notice had been sent to interested parties.

Members Present:

Richard Fantozzi, M.D., President
Steve Alexander
Hedy Chang
John Chin, M.D.

Steven Corday, M.D.
Dorene Dominguez
Shelton Duruisseau, Ph.D.
Richard D. Fantozzi, M.D.
Gary Gitnick, M.D.
Laurie C. Gregg, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.
Ronald H. Wender, M.D.
Barbara Yaroslavsky
Frank V. Zerunyan, J.D.

Members Absent:
Cesar Aristeiguieta, M.D.
Mitchell S. Karlan, M.D.
Ronald L. Moy, M.D.

order to remain consistent with the record, the agenda items presented in these minutes are listed in the order discussed at the July 26 - 27, 2007 meeting.

Agenda Item 6 President's Report

A. Communication from Interested Parties

Dr. Fantozzi disclosed the following meetings:

- Steve Miller, President of the American Board of Medical Specialties on issues related to licensing.
- Department of Justice regarding legislation.
- William Norcross, M.D., UCSD Medical School regarding issues related to Wellness Programs.

Agenda Item 12 Physician Humanitarian Award

Dr. Fantozzi introduced and presented the Physician Humanitarian Award to Clyde Ikeda, M.D.. Dr. Ikeda is a plastic and reconstructive surgeon from San Francisco. He is a team leader of "Hospital de la Familia," a group of volunteer doctors and nurses, 109 of whom are California physicians. He serves as its medical director and since 1976 provides services four times a year to a hospital in Guatemala. Dr. Ikeda performs reconstructive plastic surgery on many patients, especially children.

Agenda Item 13 Reports from the Divisions/Committees

A. Division of Licensing

Dr. Gregg reported the following:

- Ms. Schipske was appointed to the Application Review Committee and Ms. Chang and Dr. Gitnick were appointed to the Special Programs Committee.
- The Division of Licensing (DOL) approved a motion to support a legislative proposal for issuing a limited license to applicants with disabilities that would otherwise qualify for licensure.
- The Midwifery Committee met and the Midwifery Advisory Council (MAC) was directed to assist Licensing staff in identifying or developing a program for the retraining/re-entry for midwives and to consider using information gathered from reviewing disciplinary cases against midwives to develop measures to prevent future violations.
- The DOL approved the Midwife Annual Report Coding System, in concept, and authorized the MAC to approve the final coding system at its September meeting.
- The DOL approved a motion to grant recognition to Jagiellonian University's English Program without requiring a site visit and to make that recognition retroactive to the inception of the program in 1994.

It was M/S/C to approve the legislative proposal to issue a limited license to applicants with disabilities.

B. Division of Medical Quality

Ms. Yaroslavsky reported the following:

- The Division of Medical Quality (DMQ) approved a motion to increase the expert reviewer's compensation by $50 and staff was directed to provide a report at the next meeting showing the recruitment and retention of medical experts.
- The DMQ approved a motion to set a hearing to amend and establish oral argument regulations.
- The DMQ approved the re-appointment of a DEC member.
- Panel A held two oral argument hearings and discussed two proposed decision, two stipulations, and one judicial review.
- Panel B discussed four proposed decision, four stipulations and one judicial review

Dr. Gregg reported the following:

- The Diversion Committee approved the Diversion Policy and Procedure Manual.
- The Diversion Committee incorporated language on a competency exam into the participants agreement.
- The Diversion Committee made additions to the Quarterly Quality Review Reports to be utilized for future meetings.
- The Diversion Committee directed the Diversion Advisory Council to work on a transition plan.

Agenda Item 14 Cultural and Linguistic Physician Competency Workgroup

Update on AB 1195 – Presentation by Institute for Medical Quality (IMQ)

Ms. Chang introduced Dr. K.M. Tan, Chief of Radiology at San Rafael Medical Center, Kaiser Permanente, who provided a brief overview on the Institute of Medical Quality (IMQ). The IMQ was awarded a grant funded by the California Endowment to provide technical assistance and other resources to providers of CME, to integrate Cultural and Linguistic Competency into their courses. The IMQ also participates in an annual conference and workshop to educate people about the issues raised by AB 1195. The presentation also included a demonstration of their Internet Web site.

B. Update on AB 801

Mr. Qualset gave an update on the status of the workgroup convened pursuant to AB 801. He reported they have meetings convening regularly focusing on AB 1195 and incorporating CLC into the CME courses. They are moving forward with the implementation of AB 801 and continue to identify the interested parties to be involved throughout the state. The next meeting is scheduled for September 25, 2007.

Agenda Item 15 Wellness Update

Dr. Duruisseau presented an issue paper on physician wellness which outlined the purpose, background, conclusion and recommendations to address physician burnout for the board's review and consideration. The focus of the review centered on the benefits that might be derived from the implementation of the program to assist with licensees' well-being. Since the mission of the board is to protect healthcare consumers, it must be recognized that this best can be achieved by having healthy physicians care for their patients. Dr. Duruisseau recommended the board establish a Wellness Committee, comprised of 3 board members and 3-5 public members representing strategic partners to further consider the Board's role in addressing programs to improve in licensees' well being.

Dr. William Norcross, M.D., UCSD School of Medicine provided his comments regarding the meaning of their role and physician well-being. He stated he was glad to see the culture was changing and is looking forward to working together with the board to help change the culture even further. He provided suggestions in which the board could be involved in encouraging well being using staff resources, Newsletter articles and outreach to healthcare facilities in California.

Dr. Fantozzi made a motion to establish a Wellness Committee to promote physician wellness and move forward with the process. The motion carried.

Public testimony was heard from Jim Hay, M.D., representing the CMA who spoke in support of promoting physician wellness.

Tara Kittle, patient, also provided testimony in support of promoting physician wellness.

Agenda Item 16 Access to Care

Dr. Gitnick reported the following:

Rebecca Hafner-Fogarty, M.D. Medical Director, provided a presentation on emergence of the Minute Clinic. The clinics, about 150 nationwide, provide convenient but limited service at a low cost. They treat common ailments only – such as strep throat, ear infections and allergies and offer an alternative to packed doctors' offices and pricey emergency rooms. A Minute Clinic will be opening in Los Angeles County within the next six weeks.

- The committee adopted a motion to use the mission statement drafted by staff.
- Dr. Fantozzi provided an update on developing and expanding chronic care models for Diabetes Prevention and Management Initiative Workgroups to enhance the access to care of the underserved citizens of California. He also described the efforts going forward with telemedicine throughout the state and current importance of our volunteer physician program.
- Dr. Gitnick regrettably reported the Steven Thompson Loan Repayment Program is not funded and will end unless some source of funding is found.

At this point, Dr. Fantozzi took the opportunity to officially welcome and swear-in the new board member, Gerrie Schipske.

Agenda Item 17 Agenda Items for the November 2007 Meeting

No agenda items were offered by members.

Dr. Gregg announced she withdrew her application for reappointment and announced her resignation. She thanked the members and staff for their dedication and support to the mission of the board; it is the ultimate definition of a working board.

Dr. Fantozzi announced the following committee changes:

- Ms. Chang was appointed to the Executive Committee
- Ms. Shipske was appointed to the Application Review, Access to Care and Public Education Committee.
- Dr. Solomonson and Dr. Wender will co-chair the Diversion Committee.
- Dr. Moran was appointed to the Midwifery and Public Education Committees.
- Dr. Low and Dr. Moran were appointed to the Medical Errors Task Force.
- Dr. Duruisseau, Dr. Chin, Dr. Corday, Dr. Gregg, and Dr. Norcross and a representative from Loma Linda to be assigned to the Wellness Committee.

Dr. Fantozzi announced this was Mr. Thornton's last meeting. Mr. Thornton was thanked by the board members and various members of the audience for his years of service.

Mr. Alexander stated for the record that he apologized to Jim Hay, M.D., for his comments made regarding the Diversion program discussion which were not intended to be offensive.

Agenda Item 18 Public Comment on Items Not on the Agenda

There was no further public comment heard.

Agenda Item 18 Adjournment

There being no further business the meeting adjourned at 12:00 noon.

_____
Richard Fantozzi, M.D, President

_____
Vacant, Vice President

_____
Barb Johnston, Executive Director

DRAFT

AGENDA ITEM 3

Medical Board of California:

It Needs to Consider Cutting Its Fees or Issuing a Refund to Reduce the Fund Balance of Its Contingent Fund

October 2007 Report 2007-038

CALIFORNIA STATE AUDITOR

The first five copies of each California State Auditor report are free. Additional copies are $3 each, payable by check or money order. You can obtain reports by contacting the Bureau of State Audits at the following address:

California State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, California 95814
916.445.0255 or TTY 916.445.0033

OR

This report is also available on the World Wide Web http://www.bsa.ca.gov

The California State Auditor is pleased to announce the availability of an on-line subscription service. For information on how to subscribe, please contact the Information Technology Unit at 916.445.0255, ext. 456, or visit our Web site at www.bsa.ca.gov.

Alternate format reports available upon request.

Permission is granted to reproduce reports.

Elaine M. Howle
State Auditor
Doug Cordiner
Chief Deputy

CALIFORNIA STATE AUDITOR
Bureau of State Audits

555 Capitol Mall, Suite 300 Sacramento, CA 95814 916.445.0255 916.327.0019 fax www.bsa.ca.gov

October 16, 2007 2007-038

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As required by the Business and Professions Code, Section 2435, the Bureau of State Audits presents its audit report concerning the Medical Board of California's (medical board) financial status and its projections related to expenses, revenues, and reserves, and the amount of refunds or licensure fee adjustments needed to maintain the reserve level legally mandated for the medical board's contingent fund.

This report concludes that the medical board exceeded the mandated reserve, or fund balance, level by more than 100 percent in fiscal year 2006–07 and, therefore, needs to consider reducing or refunding license fees for physicians and surgeons (physicians). The law requires it to maintain a fund balance that would cover operating expenditures for approximately two months. However, in fiscal year 2006–07, the fund balance grew by $6.3 million to $18.5 million, enough to cover 4.3 months of expenditures. This increase was mostly due to variances between actual and estimated expenditures related to program changes.

The deputy director of the medical board recognizes that the fund balance is high, but stated it is too early to take corrective action because the medical board is currently implementing program changes that will increase expenditures. However, based on the medical board's historical experience of overestimating expenditures by at least $2 million in each of the last four fiscal years, we estimate that the medical board would have 3.8 months of reserves on June 30, 2012.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

Contents

Summary 1

Introduction 3

Audit Results
The Fund Balance of the Medical Board of California's Contingent Fund Increased Significantly in Fiscal Year 2006–07 7

The Fund Balance Likely Will Remain Above Acceptable Levels Unless Fees are Reduced or a Refund Is Issued 8

Recommendations 11

Responses to the Audit
State and Consumer Services Agency 13

Medical Board of California 15

California State Auditor's Comment on the Response From the Medical Board of California 19

Summary

Results in Brief

The Medical Board of California (medical board) is a consumer protection agency responsible for protecting the public through the proper licensing and regulation of California's health care professionals and the enforcement of the Medical Practice Act. The medical board accounts for its activities in the contingent fund, its operating fund, which is supported primarily by license fees collected from physicians and surgeons (physicians). Recently, the fund balance in the contingent fund has exceeded the mandated level by more than 100 percent and, therefore, the medical board needs to consider reducing or refunding license fees for physicians. The law requires the medical board to maintain a reserve, or fund balance,[1] that would cover expenditures for approximately two months. For fiscal years 2003–04 through 2005–06, the medical board maintained year-end fund balances that covered 2.4 to 3.3 months of the next year's estimated expenditures. However, in fiscal year 2006–07 the fund balance grew by $6.3 million to $18.5 million, enough to cover 4.3 months of expenditures. This increase was due mostly to variances between actual and estimated expenditures resulting from program changes related to the implementation of Senate Bill 231 of the 2005–06 Regular Session of the California Legislature (Chapter 674, Statutes of 2005) and increases in the rates charged by the Office of the Attorney General (Attorney General), which were not fully realized by the end of fiscal year 2006–07.

The medical board's deputy director recognizes that the fund balance is high, but stated it is too early to take corrective action because the medical board must continue to implement the program changes mentioned earlier, so actual costs will closely approach estimates in fiscal year 2007–08. Further, the medical board estimates that months of reserves will drop to 1.5 months by fiscal year 2011–12, assuming that it spends all of its appropriations in each of the next five fiscal years. Our review of employee and Attorney General costs, two of the medical board's largest expenditure categories, indicate that expenditures are increasing somewhat. However, while the medical board's estimated revenues have consistently approximated actual revenues in the last four fiscal years, the medical board has consistently overestimated expenditures by at least $2 million each year over the same period.

Audit Highlights . . .

Our review of the Medical Board of California's (medical board) financial status and fund balance revealed that:

- ***The fund balance of the medical board's contingent fund increased by $6.3 million, to $18.5 million, in fiscal year 2006–07. This represented 4.3 months of reserves, more than 100 percent above the reserve level mandated in the law.***
- ***The recent increase in the fund balance resulted from variances between actual and estimated expenditures.***
- ***The medical board estimates that its months of reserves will drop to 1.5 months by June 30, 2012, assuming that it spends all of its appropriations in each of the next five fiscal years.***
- ***However, based on the medical board's historical experience of overestimating expenditures, we estimate that it will have 3.8 months of reserves by June 30, 2012, unless it issues refunds or decreases license fees for physicians.***

[1] Although the Business and Professions Code refers to a reserve, the medical board and the Department of Consumer Affairs interpret this to mean *fund balance*.

Based on the medical board's future revenue and expenditure estimates, adjusted downward by $2 million for the expenditure variance we just described, we estimate that the medical board still would have 3.8 months of reserves on June 30, 2012. The medical board's staff is preparing for the November 2007 board meeting at which the medical board will discuss its financial status. Because no other mechanism is in place to reduce the fund balance sufficiently, the board likely will need to issue refunds or seek legislation to allow it to reduce fees.

Recommendations

The medical board should seek a legislative amendment to Section 2435 of the Business and Professions Code to include language that allows it the flexibility to adjust physicians' license fees when necessary to maintain its fund balance at or near the mandated level.

To ensure the fund balance in the medical board's contingent fund does not continue to significantly exceed the level established in law, it should, in light of its future needs, consider refunding physicians' license fees or, if successful in gaining the flexibility to adjust its fees through an amendment to existing law, consider temporarily reducing them.

Agency Comments

The medical board generally agrees with our recommendations and plans to discuss them at its November 2007 board meeting.

Introduction

Background

The Medical Board of California (medical board) is a consumer protection agency responsible for protecting the public through the proper licensing and regulation of California's health care professionals and the enforcement of the Medical Practice Act. Under the Department of Consumer Affairs (Consumer Affairs), it licenses physicians and surgeons (physicians), investigates complaints against its licensees, and disciplines those found guilty of violating the law. It has 21 appointed members—12 physicians and seven public members appointed by the governor, one public member appointed by the speaker of the Assembly, and one public member appointed by the Senate Rules Committee.

The medical board is composed of two divisions—the Division of Licensing and the Division of Medical Quality—and had 275 authorized positions in fiscal year 2006–07, including an executive and a deputy director to oversee its day-to-day operations. The Division of Licensing approves medical education programs, administers physician and surgeon licensure examinations, issues licenses and certificates, and administers the medical board's continuing education program. The Division of Medical Quality investigates complaints, such as those listed in the text box, and disciplines licensees found guilty of violating the Medical Practice Act.

Types of Complaints Investigated by the Medical Board of California

- Inadequate quality of care and treatment provided by a physician.
- Violation of drug laws, such as misprescribing or overprescribing drugs.
- Substance abuse by a physician.
- Sexual misconduct by a physician.
- Dishonesty, including filing fraudulent insurance claims.
- Unlicensed practice of medicine by a person under the supervision of a physician.

Source: Business and Professions Code, sections 2220 and 2264.

The medical board assesses fees for physicians according to rates and processes established in the California Business and Professions Code (code). The code sets the license fees[2] at $790. These fees constituted at least 91 percent of revenues the medical board collected annually for fiscal years 2003–04 through 2005–06. The code also states that the Legislature expects the medical board to maintain a reserve, or fund balance, in its contingent fund equal to approximately

[2] License fees refer to both initial license and renewal fees. The first time a physician applies and pays for a medical license in California, the medical board assesses an initial license fee. The physician must pay a renewal fee every two years to maintain the medical license.

two months of operating expenditures.[3] Although the level of the fund balance is established in the code, the medical board does not have the authority to reduce license fees, if needed, to maintain the two-month level.

In 2002 the Legislature passed a law requiring Consumer Affairs to hire an independent consultant to review the medical board's disciplinary system and procedures. The consultant, known as the enforcement monitor (monitor), also examined the medical board's fee structure and concluded in its 2004 report that fees had not kept pace with inflation. On an inflation-adjusted basis, the monitor calculated that the medical board's spending power had dropped by 27.9 percent since the fees were established in 1994. At the time of the monitor's review, license fees were limited to $600 per year. In 2005 the Legislature passed, and the governor signed, Senate Bill 231 (SB 231), which increased the license fees 31.7 percent, to $790, effective January 1, 2006.

In 2004 the monitor also recommended, among other things, that the medical board reorganize its process for prosecuting physicians who have had complaints filed against them. Previously, the medical board used what the monitor described as a "hands-off prosecution model." Its investigators received only limited legal support for their investigative work and seldom played a significant role in the prehearing and hearing processes conducted by Attorney General prosecutors, to whom they directed their complaint cases. The monitor pointed out inefficiencies related to this model, citing its inadequacy for handling complex cases of the sort usually handled by the medical board.

The monitor recommended that the medical board instead implement a "vertical prosecution model." Under this model, investigators and prosecutors work together as a team from the day a case is assigned for investigation. The monitor stated that the model would improve efficiency and effectiveness through better communication and coordination, and reduce the time it takes to process cases. The Legislature subsequently required the medical board to establish a vertical prosecution process.

With the passage of SB 231, the Legislature also repealed the medical board's ability to recoup its costs of investigating and prosecuting physicians in disciplinary proceedings brought against them. Before this change, the medical board recovered these costs directly from physicians who violated the law. According to the

[3] Although the Business and Professions Code refers to a reserve for the contingent fund, the medical board and the Department of Consumer Affairs interpret this to mean *fund balance*. The contingent fund is the operating fund for the medical board. The Department of Consumer Affairs defines operating expenditures as all expenditures made by the medical board.

legislative analysis of this bill, the California Medical Association requested this change because it believed that cost recovery discouraged physicians from pursuing their due process rights because they chose to settle cases instead of running the risk of bearing the increased costs of an ongoing investigation. Although the medical board cannot collect investigative costs incurred on or after January 1, 2006, directly from physicians, physicians who were assessed recovery costs before January 1, 2006, are still responsible for reimbursement. The law enables the medical board to increase its license fees to compensate for the loss of these reimbursements. Accordingly, the medical board increased fees by 1.9 percent, from $790 to $805, effective January 1, 2007.

Scope and Methodology

Section 2435 of the code directs the Bureau of State Audits (bureau) to review the medical board's financial status and its projections related to expenses, revenues, and reserves, and to determine the amount of refunds or licensure fee adjustments needed to maintain the reserve level legally mandated for the medical board's contingent fund. The bureau is to report its findings before January 1, 2008.

To understand the medical board's responsibilities and financial reporting, we reviewed the relevant laws, regulations, and policies. We also spoke with medical board and Consumer Affairs staff members who oversee the medical board's accounting, budgeting, and financial reporting functions.

To determine the medical board's financial status, we reviewed its estimated and actual revenues and expenditures for accuracy, identifying and examining significant variances between years, and between estimated and actual figures, for fiscal years 2003–04 through 2006–07. Additionally, we reviewed the medical board's year-end fund balances to determine if they were reported accurately and approximated two months of expenditures, as mandated by law.

Further, we reviewed the medical board's estimates for fiscal year 2007–08 to identify any significant changes in projected revenues, expenditures, or fund balance for the upcoming year.

The U.S. Government Accountability Office, whose standards we follow, requires us to assess the reliability of computer-processed data. Since we used reports generated from the California State Accounting and Reporting System (CALSTARS), we relied on our testing of revenues and expenditures performed each year during our annual financial audit of the State. In addition, we verified that the revenues and expenditures reported for the medical board

reconciled with similar records at the State Controller's Office. This testing indicated that the data were sufficiently reliable for the purposes of this audit.

Audit Results

The Fund Balance of the Medical Board of California's Contingent Fund Increased Significantly in Fiscal Year 2006–07

The fund balance of the Medical Board of California's (medical board) contingent fund[4] increased to $18.5 million in fiscal year 2006–07, resulting in reserves well above mandated levels. It appears that the fund balance will not drop significantly based on its revenue stream and its historical experience in estimating expenditures, so the medical board needs to consider reducing license fees[5] or issuing a refund to physicians and surgeons (physicians). The Business and Professions Code (code) requires the medical board to maintain a reserve, or fund balance,[6] that will cover approximately two months of operating expenditures.[7] The medical board determines its fund balance by adding the difference between the current fiscal year's expenditures and revenues to its beginning fund balance. As the Table shows, the medical board's actual fund balance at the end of fiscal years 2003–04 through 2006–07 ranged from $8.6 million to $18.5 million.

Table
Contingent Fund of the Medical Board of California
Actual and Estimated Revenues, Expenditures, and Fund Balance (in Millions)

	FISCAL YEAR 2003–04		FISCAL YEAR 2004–05		FISCAL YEAR 2005–06		FISCAL YEAR 2006–07	
	ESTIMATED	ACTUAL	ESTIMATED	ACTUAL	ESTIMATED	ACTUAL	ESTIMATED	ACTUAL
Adjusted beginning balance*	$12.8	$12.4	$11.3	$11.4	$8.6	$8.8	$12.2	$12.8
Total revenues, transfers, and other adjustments	35.3	35.4	36.7	35.5	40.6	41.1	48.7	49.7
Total expenditures and expenditure adjustments	(38.5)	(36.5)	(41.0)	(38.3)	(42.5)	(37.7)	(50.0)	(44.0)
Fund balance	**$9.6**	**$11.3**	**$7.0**	**$8.6**	**$6.7**	**$12.2**	**$10.9**	**$18.5**
Months of reserves†	2.8	3.3	2.0	2.4	1.6	2.9	2.5	4.3

Source: California State Accounting and Reporting System reports for fiscal years 2003–04 through 2006–07 and the Governor's Budget for fiscal years 2004–05 through 2007–08.

Note: The contingent fund is the operating fund for the medical board.

* Beginning balances are adjusted for differences between accruals and actual revenues and expenditures related to prior years.

† This amount is derived by dividing the year-end fund balance by one-twelfth of the subsequent year's estimated annual expeditures. Estimated expenditures for fiscal year 2007–08 were $51.2 million.

4 The contingent fund is the operating fund for the medical board.

5 License fees refer to both initial license and renewal fees. The first time a physician applies and pays for a medical license in California, the medical board assesses an initial license fee. The physician must pay a renewal fee every two years to maintain the medical license.

6 Although the Business and Professions Code refers to a reserve, the medical board and the Department of Consumer Affairs interpret this to mean *fund balance*.

7 The Department of Consumer Affairs defines operating expenditures as all expenditures made by the medical board.

Although actual year-end fund balances between fiscal years 2003–04 and 2005–06 differed as much as $3.6 million, the differences did not significantly affect the medical board's months of expenditures (months of reserves), which ranged from 2.4 months to 3.3 months during this period. However, during fiscal year 2006–07, the fund balance grew by $6.3 million, resulting in an increase in months of reserves to 4.3 months—more than 100 percent above its mandated level.

Provisions Included in Senate Bill 231

- Establish a vertical prosecution model.
- Require the assignment of attorneys to work on location at the intake unit of the Medical Board of California (medical board) to evaluate and screen complaints and develop uniform standards for complaint processing.
- Require the medical board to contract with an outside entity to conduct a study of its peer review process for disciplining physicians.
- Require the Little Hoover Commission to study and make recommendations on the role of public disclosures by the medical board. The medical board is required to reimburse the Little Hoover Commission for these costs.
- Authorize the medical board to cite and fine physicians for not providing requested documents within specified time frames.

Source: Senate Bill 231 of the 2005–06 Regular Session of the California Legislature (Chapter 674, Statutes of 2005).

The increase in the fund balance was caused mostly by the variance between estimated and actual expenditures in fiscal year 2006–07, primarily related to a planned expansion of medical board programs that was not fully realized in that year. The medical board anticipated spending $7.5 million more in fiscal year 2006–07 than it estimated spending in fiscal year 2005–06, mostly for costs associated with implementing Senate Bill 231 (SB 231) (see text box) and for increases in the Office of the Attorney General's (Attorney General) rates. Implementation of SB 231 accounted for $3.9 million of the increased expenditure estimate.

As described in the text box, this legislation required many changes in medical board activities, such as the hiring of additional staff and consultants, as well as implementation of a vertical prosecution model, which requires earlier participation from Attorney General prosecutors. In addition to the increased expenditures necessary for vertical prosecution, estimated expenditures included $760,000 to cover an increase in the hourly rate the Attorney General charges for its services.

The Fund Balance Likely Will Remain Above Acceptable Levels Unless Fees are Reduced or a Refund Is Issued

Although the effect of several issues that contributed to the buildup of the medical board's fund balance in fiscal year 2006–07 is diminishing, we believe the fund balance is unlikely to return to the level legally mandated unless fees are reduced or refunded. By the end of fiscal year 2006–07, the medical board had only spent $44 million, or 88 percent of its estimated budget for that year. The resulting excess in fund balance represents approximately $88 per licensed physician.

The deputy director of the medical board (deputy director) provided two significant reasons to explain why expenditures fell so far below expectations. First, she noted that staff vacancies, which at any point during the year were at least 24, or 8.7 percent of total authorized positions for fiscal year 2006–07, accounted for $1.6 million of the unspent appropriation. She attributed about half of the vacancies to the medical board's difficulty in retaining investigators because of salary inequities and workload issues. Second, the deputy director pointed out that the Attorney General provided only $11.2 million in services to the medical board, $1.2 million below estimates. She attributed this variance to three Attorney General vacancies related to new positions authorized under SB 231. The remaining savings were spread among numerous expenditure categories.

The medical board's deputy director stated that vacant employee positions and lower Attorney General costs explained much of the variance between actual and estimated expenditures in fiscal year 2006–07.

The deputy director also stated that, even though the fund balance is higher than the mandated level, she believes it is too early to take corrective action by adjusting fees or issuing a refund to physicians. She stated that it has been challenging to predict how much the medical board will need to spend because it is implementing major program changes, as described earlier. However, the deputy director believes that actual revenues and expenditures in fiscal year 2007–08 will closely approach estimates of $49.1 million and $51.2 million, respectively. The medical board further estimates that its months of reserves will fall to 1.5 months by the end of fiscal year 2011–12. This is based on the assumption that it will spend all its appropriations in each of the next five fiscal years. The deputy director also noted that the medical board is in the planning stages for purchasing a new information technology application system supporting all medical board business processes, most specifically the new vertical prosecution model, and reestablishing a program focused on unlicensed activity.

Our review of recent trends in two of the medical board's largest expenditure categories—employee and Attorney General costs—indicates that some types of expenditures are indeed increasing. Specifically, the Medical Board's vacancy reports in August show that the number of unfilled staff positions decreased to 18, or 6.5 percent of fiscal year 2007–08 authorized positions. If sustained, this increase in staff would close the prior year's $1.6 million gap between actual and estimated personnel costs by at least $485,000 based on the average cost per position in fiscal year 2006–07.

In addition, invoices issued by the Attorney General showed a steady increase for billed services in fiscal year 2006–07. Monthly invoices increased from an average of $850,000 for the first quarter to $1 million for the last quarter of the fiscal year. These

invoice levels, if maintained in fiscal year 2007–08, would reduce the $1.2 million variance between estimated and actual Attorney General costs experienced in fiscal year 2006–07 by $615,000.

Nevertheless, based on our review of the medical board's estimated and actual revenues and expenditures over the last four fiscal years, we believe it is unlikely that it will reduce its fund balance significantly within the next five years. Specifically, as the Table on page 7 clearly shows, the medical board's actual revenues consistently approximated estimated revenues for fiscal years 2003–04 through 2006–07. In fact, the net difference between estimated and actual revenues for the entire four-year period amounted only to about $400,000. This indicates that the medical board's revenue projections have been fairly accurate.

Based on the medical board's historical experience of overestimating annual expenditures by at least $2 million over each of the last four fiscal years, we estimate that, when we adjusted for this overage, the medical board will still have 3.8 months of reserves on June 30, 2012.

In contrast, actual expenditures fell below estimates by at least $2 million every year, with annual variances ranging between $2 million and $6 million during that four-year period. This pattern, if it continues, will not reduce the fund balance. Although it is possible for the medical board's projections to occur, we think it is unlikely given its historical experience over the last four fiscal years. In particular, using the medical board's estimated revenues and expenditures for fiscal years 2007–08 through 2011–12, we adjusted expenditures downward by $2 million each year, the lowest expenditure variance over the last four-year period. With these adjustments, we estimate that the medical board would have 3.8 months of reserves on June 30, 2012. Thus, months of reserves will likely remain above the legally mandated limit unless the medical board reduces fees or issues refunds.

Medical board staff reports the fund balance and months of reserve to its board members quarterly. The deputy director told us that medical board staff is preparing to discuss the increased fund balance at the November 2007 board meeting. The deputy director also told us that the medical board already is considering reducing its fees to compensate for the discontinuance of its Diversion Program in June 2008. This program cost $1.4 million in fiscal year 2006–07. Although the reduction takes into account the revenue and expenditures of the Diversion Program, it does not consider the general issues we noted earlier. Therefore, because no other mechanism is in place to reduce the fund balance sufficiently, the board likely will need to reduce license fees further or issue refunds. To reduce license fees, the medical board would need to seek legislation giving it the flexibility to reduce fees as needed since the fees are established in law.

Recommendations

The medical board should seek a legislative amendment to Section 2435 of the Business and Professions Code to include language that allows it the flexibility to adjust physicians' license fees when necessary to maintain its fund balance at or near the mandated level.

To ensure the fund balance in the medical board's contingent fund does not continue to significantly exceed the level established in law, it should, in light of its future needs, consider refunding physicians' license fees or, if successful in gaining the flexibility to adjust its fees through an amendment to existing law, consider temporarily reducing them.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of the report.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

Date: October 16, 2007

Staff: Jim Sandberg-Larsen, CPA, CPFO, Project Manager
Barbara Henderson, CPA
Andrew Jun Lee
Salvador Sanchez

Blank page inserted for reproduction purposes only.

(Agency response provided as text only.)

State and Consumer Services Agency
915 Capitol Mall, Suite 200
Sacramento, CA 95814

September 27, 2007

Ms. Elaine Howle, State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Thank you for giving me the opportunity to respond to your audit addressing the Medical Board of California's Contingent Fund. I understand that your sample examined the fund's year ending reserve for 2003–04, 2004–05, 2005–06, and 2006–07. The agency notes that the funds' future year end reserve may be affected by future statutes, collective bargaining, and approved budget increases.

Obtaining resources from fees paid by medical doctors, the Contingent Fund supports operations of the Medical Board of California. These operations include licensing medical doctors, investigating complaints, disciplining those who violate the law, and conducting physician evaluations. It also includes facilitating rehabilitation where appropriate.

I have directed the Medical Board to report their revised 2007–08 budget and proposed 2008–09 budgets through the Department of Consumer Affairs in January 2008. I recognize your recommendations as an opportunity to improve the Medical Board and truly appreciate your support of the Department of Consumer Affairs' goals of protecting California's consumers.

Most Sincerely,

(Signed by: Michael Saragosa for)

Rosario Marin, Secretary
State and Consumer Services Agency

Blank page inserted for reproduction purposes only.

(Agency response provided as text only.)

Medical Board of California—Executive Office
1434 Howe Avenue, Suite 92
Sacramento, CA 95825

September 28, 2007

Elaine M. Howle*
California State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

RE: Draft Audit Report 2007-038—Medical Board of California

Dear Ms. Howle:

The Medical Board of California (Board) is in receipt of your draft audit report for the Board's financial status. I would like to thank the Bureau of State Audits for conducting this audit and for allowing the Board to respond to the issues presented in the audit report.

As stated in the audit report, the Board's fund condition was over the recommended level at the end of fiscal year 2006/2007. Based upon this finding, the audit made two recommendations. We would like to respond to each of these.

Recommendation: The Medical Board should seek a legislative amendment to section 2435 of the Business and Professions Code to include language that allows it the flexibility to adjust physicians' license fees when necessary to maintain its fund balance at or near the mandated level.

Response: The Board concurs with this finding. Prior to passage of Senate Bill 231 (Figueroa, Chapter 674, Statutes 2005) (SB 231), the Board had the flexibility of setting a fee within the cap set by law. At that time, this section stated that the licensing and renewal fee "shall be fixed by the Board at an amount not to exceed six hundred ten dollars ($610)". This authorized the Board to seek regulatory changes, when necessary, to increase or decrease the licensing and renewal fee, as appropriate, and to ensure the Board's fund condition remained near the stated guideline of approximately two months' operating expenditures. However, when SB 231 was passed, it changed section 2435 of the Business and Professions Code to state the initial license and biennial renewal fee "...shall be seven hundred ninety dollars ($790)". It further authorized an increase to the fees to offset funds because legislative language removed the investigative and prosecutorial cost recovery provision. If the statute were changed to allow the Board to vary its fees via the regulatory process, it would provide more flexibility. Therefore, we concur with this recommendation and will present it to the Board at its November meeting.

* California State Auditor's comment appears on page 19.

Response to Audit Report 2007-038
September 28, 2007
Page 2

Recommendation: To ensure the fund balance in the Medical Board's contingent fund does not continue to significantly exceed the level established in law, it should, in light of its future needs, consider refunding physicians' license fees or, if successful in gaining the flexibility to adjust its fees through an amendment to existing law, consider temporarily reducing them.

Response: On January 1, 2006, the Board increased its licensing and renewal fees to $790 as mandated by SB 231. This increase in fees was based upon a report from the Enforcement Monitor that indicated that the Board could not perform the necessary investigative and prosecutorial functions under its current funding and staffing level. This fee was based upon the cost of the new "vertical enforcement-prosecution" (VE-P) program that was to be fully implemented by the transfer of the Board's investigative staff to the Department of Justice (DOJ) and the need, as pointed out by the Enforcement Monitor, to increase investigative staff. The cost of the transfer of positions included the realignment of salaries to those used by DOJ. The bill was amended days before the session ended to make the VE-P program a "pilot program" with the investigative staff remaining with the Board but with added DOJ staff to facilitate the VE-P model without co-location of staff. This amendment included a sunset date with a report due back to the legislature on the recommendations to fully implement the program. A proposal to consider any change in fees could not be undertaken until a decision was made in the 2007 legislative session to fully implement the program, to extend the pilot, or to sunset the program. No matter the outcome of the VE-P program, the Board has given direction to staff to pursue avenues to affect the recommendation to align the salaries of the investigators working in the VE-P program with the salaries of investigators at DOJ.

The Board would like to provide some historical data regarding its fund condition. After the Enforcement Monitor's initial report and prior to SB 231 (increase of fees), the Board proposed reestablishing the unlicensed activity unit that was lost during the vacancy sweep in FYs 2001/2002 and 2002/2003. However, the Board was unable to pursue this course of action due to the decreasing fund balance.

Enforcement staff is again discussing the need for this unlicensed activity unit. This unit would investigate all unlicensed complaints and perform undercover investigations at facilities (or homes) of individuals who are performing the unlicensed practice of medicine. Recent meetings pursuant to SB 1423 (Figueroa, Chapter 873, Statutes of 2006) have increased the staff's awareness of unlicensed activity. Therefore, a request will be brought forward to the Board in November to reestablish this unit with both a Northern and Southern California office through a request for a budget change proposal (BCP).

In addition, at the past July Board meeting, the Board members stated their intention to have the Board's computer applications and systems capable of interacting with the DOJ computer system. Upon this direction, staff has met with the DOJ to determine the feasibility of pursuing this action. The Board will be purchasing and implementing a new information technology application system to implement this request.

Furthermore, the Board will be implementing its new Strategic Plan. After this plan is adopted, it is expected that new programs will need to be implemented to meet the goals of the Board and its mandate of public protection. The cost is undetermined at this time.

(1) If the Board receives authorization to pursue these program changes (through BCP), it will significantly increase the Board's current expenditures and will cause a reduction in the current fund balance. This would bring the fund balance closer to two months' operating expenditures. Thus, immediate action related to changing the amount of the fees would not be prudent at this time.

Response to Audit Report 2007-038
September 28, 2007
Page 3

Finally, the audit report pointed out that in FY 2006/2007 the Board's estimated expenditures were significantly different than the actual expenditures. The report pointed out this was related to the fact the Board was not able to fully implement planned programs. FY 2006/2007 was also the first complete fiscal year with the new fees and the first complete year of implementation of the VE-P pilot program. It is important to recognize that when completing current year projections for the Board's budget, staff reviews expenditures already incurred for the fiscal year at a given point in time, and uses that information, as well as additional information, to estimate how much will actually be spent by the end of that fiscal year. This projection is used to monitor the Board's current year budget to ensure that it does not exceed its authorized expenditure authority. In contrast, when putting together the Board's official fund condition used in the Governor's Budget, Department of Finance requires programs to assume that budgeted expenditures will be fully spent, starting in the current year, as the program is authorized to spend up to its budgeted amount. A fund condition is then used to monitor the fund reserve, to ensure the fund is expected to receive revenue sufficient to support its budgeted expenditures and remain within applicable statutory limitations.

When the Board reviews these matters to determine how to proceed, it will keep in mind that the control agencies want to see several years of fund balance projections, **beginning with budget year**, to make sure the Board can support its expected budget authority, including BCPs. The control agencies also look at whether the Board will be able to show fiscal solvency five to ten years beyond implementation. Standard budget practices use the budget year as the appropriate point in time to review the fund condition and determine the status of the reserve. This ensures that if the prior year expenditures were just an anomaly, the Board will not make a long-term decision about revenue based upon experience in just one year.

Additionally, when control agencies review fund conditions to determine if they are in compliance with statutory limitations, they look at what the reserve amount will be at the end of budget year, not current or prior year. For the Board, the statutory limitation is set at approximately two months' operating expenditures. A reserve ceiling of only two months, in comparison to other Department of Consumer Affairs boards/bureaus, is significantly low. Most other boards/bureaus are required to maintain no more than a 24 month reserve.

Based upon all these factors, the Board agrees this issue must be discussed at the November 2007 Board meeting. The recommendations of this audit as well as the items above will be discussed to determine the appropriate course of action for the Board to take at this time. In addition, staff will request that the Board approve a legislative proposal for 2008 that would allow the Board the flexibility it needs as recommended in the audit report.

The Board appreciates the opportunity to respond to these recommendations and hopes this additional information is explanatory of the Board's future actions. If you have any questions regarding this response, please contact me at (916) 263-2389.

Sincerely,

(Signed by: Barb Johnston)

Barb Johnston
Executive Director

Blank page inserted for reproduction purposes only.

COMMENT

CALIFORNIA STATE AUDITOR'S COMMENT ON THE RESPONSE FROM THE MEDICAL BOARD OF CALIFORNIA

To provide clarity and perspective, we are commenting on the Medical Board of California's (medical board) response to our audit. The number below corresponds to the number we have placed in its response.

We agree that the medical board should consider the extent to which increased expenditures for new programs and projects could help reduce the fund balance in its contingent fund. However, given the lack of financial estimates related to these plans and the extent to which actual expenditures have historically fallen below estimated expenditures, the medical board should also consider adjusting or refunding fees as stated in our recommendation. ①

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press

LEGISLATIVE PACKET

November 1-2, 2007
San Diego, CA

for

EXECUTIVE COMMITTEE,
DIVISIONS,
AND
FULL-BOARD
MEETINGS

Medical Board of California
Tracker - Legislative Bill File
10/22/2007

BILL	AUTHOR	TITLE	STATUS	POSITION	LETTERS to GOVERNOR
AB 3	Bass	Physician Assistants	Chapter #376	Support	9/19/07
AB 253	Eng	MBC: Restructuring	Chapter #678	Sponsor/Support	9/13/07
AB 329	Nakanishi	Chronic Diseases: Telemedicine	Chapter #386	Sponsor/Support	9/10/07
AB 1025	Bass	Professions: Denial of Licensure	Vetoed	Oppose	9/26/07
AB 1073	Nava	Work Comp: CA lic. Physicians on Utilization Review	Chapter #621	Support	9/19/07
AB 1224	Hernandez	Telemedicine: Optometrists	Chapter #507	Support	9/24/07
SB 102	Migden	Blood Transfusions: Brochure	Chapter #88	Support	
SB 472	Corbett	Prescription Drugs: Labeling Requirements & Panel	Chapter #470	Support	9/19/07
SB 620	Correa	Anesthesia Permit for Physicians in Dental Offices	Chapter #210	Support	
SB 761	Ridley-Thomas	Diversion and Vertical Prosecution	Asm. Approps.	Sponsor/Support	
SB 764	Migden	MBC Reporting Licensee Information to OSHPD	Vetoed	Support w/conditions	9/19/07
SB 767	Ridley-Thomas	Drug Overdose Treatment: Liability	Chapter #477	Neutral	9/24/07
SB 797	Ridley-Thomas	Professions and Vocations	Floor	*Contained VE/P - Support*	
SB 1048	Comm. B,P&ED	Healing Arts: Omnibus	Chapter #588	Support MBC Provisions	9/24/07

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 3
Author: Bass
Chapter: 376
Subject: Physician Assistants
Sponsor: California Academy of Physician Assistants (CAPA)
Board Position: Support

DESCRIPTION OF LEGISLATION:

This allows a physician assistant to administer, provide, or issue a drug order under general protocols for Schedule II through Schedule V controlled substances without advanced approval by a supervising physician for each specific patient if the physician assistant completes specified educational requirements. This bill increases the number of physician assistants a physician may supervise from two to four (making this consistent with the number supervised in underserved areas) and specify the services provided by a physician assistant are included as a covered benefit under the Medi-Cal program.

IMPLEMENTATION:

- Newsletter Article
- Notify Board staff
- Inform Enforcement staff

October 15, 2007

Assembly Bill No. 3

CHAPTER 376

An act to amend Sections 3502, 3502.1, 3516, and 3516.5 of, and to repeal Section 3516.1 of, the Business and Professions Code, and to add Section 14132.966 to the Welfare and Institutions Code, relating to physician assistants.

[Approved by Governor October 10, 2007. Filed with Secretary of State October 10, 2007.]

LEGISLATIVE COUNSEL'S DIGEST

AB 3, Bass. Physician assistants.

(1) Existing law, the Physician Assistant Practice Act, establishes the Physician Assistant Committee of the Medical Board of California (the medical board) and provides for its licensure of physician assistants meeting specified criteria and for the regulation of their practice. Under the act, a physician assistant is authorized to perform medical services under the supervision of a physician and surgeon who is authorized to supervise not more than 2 physician assistants at any one time, except under specified circumstances. The act prohibits a physician assistant from administering, providing, or issuing a drug order for Schedule II through Schedule V controlled substances without advance approval from a supervising physician and surgeon.

This bill would authorize a physician assistant to administer, provide, or issue a drug order for these classes of controlled substances without advance approval by a supervising physician and surgeon if the physician assistant completes specified educational requirements. The bill would require a physician assistant and his or her supervising physician and surgeon to establish written supervisory guidelines and would specify that this requirement may be satisfied by the adoption of specified protocols. The bill would increase to 4 the number of physician assistants a physician and surgeon may supervise and would make related changes.

(2) Existing law, the Medi-Cal Act, establishes the Medi-Cal program to provide health care benefits and services to persons who meet specified eligibility criteria.

This bill would specify that services provided by a physician assistant are included as a covered benefit under the Medi-Cal program.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known as the California Physician Team Practice Improvement Act.

SEC. 2. Section 3502 of the Business and Professions Code is amended to read:

3502. (a) Notwithstanding any other provision of law, a physician assistant may perform those medical services as set forth by the regulations of the board when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the board prohibiting that supervision or prohibiting the employment of a physician assistant.

(b) Notwithstanding any other provision of law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from the supervising physician and surgeon.

The supervising physician and surgeon shall be physically available to the physician assistant for consultation when such assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

(c) (1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the followup care.

(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

(2) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant. The physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

(3) Notwithstanding any other provision of law, the board or committee may establish other alternative mechanisms for the adequate supervision of the physician assistant.

(d) No medical services may be performed under this chapter in any of the following areas:

(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501.

SEC. 3. Section 3502.1 of the Business and Professions Code is amended to read:

3502.1. (a) In addition to the services authorized in the regulations adopted by the board, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

(b) "Drug order" for purposes of this section means an order for medication that is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order

of the supervising physician, (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians and surgeons, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician and surgeon before it is filled or carried out.

(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

(2) A physician assistant may not administer, provide, or issue a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the committee. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the committee prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and phone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant and shall otherwise comply with the provisions

of Section 11162.1 of the Health and Safety Code. Except as otherwise required for written drug orders for controlled substances under Section 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

(e) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven days.

(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA).

(g) The committee shall consult with the Medical Board of California and report during its sunset review required by Division 1.2 (commencing with Section 473) the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient.

SEC. 4. Section 3516 of the Business and Professions Code is amended to read:

3516. (a) Notwithstanding any other provision of law, a physician assistant licensed by the committee shall be eligible for employment or supervision by any physician and surgeon who is not subject to a disciplinary condition imposed by the board prohibiting that employment or supervision.

(b) No physician and surgeon shall supervise more than four physician assistants at any one time, except as provided in Section 3502.5.

(c) The board may restrict a physician and surgeon to supervising specific types of physician assistants including, but not limited to, restricting a physician and surgeon from supervising physician assistants outside of the field of specialty of the physician and surgeon.

SEC. 5. Section 3516.1 of the Business and Professions Code is repealed.

SEC. 6. Section 3516.5 of the Business and Professions Code is amended to read:

3516.5. (a) Notwithstanding any other provision of law and in accordance with regulations established by the board, the director of emergency care services in a hospital with an approved program for the training of emergency care physician assistants, may apply to the board for authorization under which the director may grant approval for emergency care physicians on the staff of the hospital to supervise emergency care physician assistants.

(b) The application shall encompass all supervising physicians employed in that service.

(c) Nothing in this section shall be construed to authorize any one emergency care physician while on duty to supervise more than four physician assistants at any one time.

(d) A violation of this section by the director of emergency care services in a hospital with an approved program for the training of emergency care physician assistants constitutes unprofessional conduct within the meaning of Chapter 5 (commencing with Section 2000).

(e) A violation of this section shall be grounds for suspension of the approval of the director or disciplinary action against the director or suspension of the approved program under Section 3527.

SEC. 7. Section 14132.966 is added to the Welfare and Institutions Code, to read:

14132.966. (a) Services provided by a physician assistant are a covered benefit under this chapter to the extent authorized by federal law and subject to utilization controls.

(b) Subject to subdivision (a), all services performed by a physician assistant within his or her scope of practice that would be a covered benefit if performed by a physician and surgeon shall be a covered benefit under this chapter.

(c) The department shall not impose chart review, countersignature, or other conditions of coverage or payment on a physician and surgeon supervising physician assistants that are more stringent than requirements imposed by Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code or regulations of the Medical Board of California promulgated under that chapter.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 253
Author: Eng
Chapter: 678
Subject: Restructuring of the Medical Board of California
Sponsor: Medical Board of California
Board Position: Sponsor/Support

DESCRIPTION OF LEGISLATION:

This bill:

1. Combines the two divisions of the board into one Board on January 1, 2008.

2. Revises the decision making authority of the board by allowing the board to delegate to the Executive Director the authority to adopt default decisions and stipulations to surrender a license in disciplinary proceedings, in effect January 1, 2008.

3. Reduces the board membership from 21 members (12 physician members, and 9 public members) to 15 members (8 physician members, and 7 public members), effective January 1, 2008 to 17 members and August 1, 2008 to 15 members.

IMPLEMENTATION:

- Newsletter Article
- Notify Board staff
- Update Board website
- Restructure the two divisions into one board:
  - The Board needs to hold elections for the President, Vice President, and Secretary positions with the new full board.
  - Elections may be held at the November Board meeting, in which case the newly elected positions take effect January 1, 2008. Or the elections may be held at the February meeting. The new positions would then take effect as of that meeting. ***Recommendation:*** *hold elections now so the officers are in place January 1, 2008.*
  - If the elections are held at the November meeting:
    - There is no need to hold division elections to replace the elected positions that members vacated pursuant to term expiration at that time.

- The Board needs to decide the length of the term for the newly structured positions:
    1. Keep current term, thus 6 month term (through the May 2008 Board meeting) to continue elections based on a fiscal year basis; or
    2. Change term, thus 12 month term (through the November 2008 Board meeting) to revise elections for members to the calendar year basis.

- The Board must establish and appoint the panels and committees for 2008 pursuant to restructuring:
    1. Panels A and B for disciplinary decisions.
    2. Applicant Review Committee
    3. Special Programs Committee
    4. Executive/Legislative Committee
    5. Confirm continuation of current committees, work groups, and task forces
    - The structure for the February 2008 meeting can be decided by the Executive Director/Board President.

- Delegate authority to the Executive Director to adopt default decisions and stipulations to surrender a license in disciplinary proceedings.
    - If the authority is delegated:
        - Enforcement policies and procedures need to be revised
        - Notify Attorney General's office
        - Secretary of Board to review and report back on the delegation of authority by January 1, 2009.
- Plan for reduction of board members
    - January 1, 2008:
        - Two of the four physician member positions with a term expiration of June 1, 2007 that were held by Steve Corday M.D., Laurie Gregg M.D., Mitch Karlan M.D., and Ron Moy M.D. will <u>not</u> be filled and will expire. The Governor makes the decisions on which two positions will be filled.
        - Two of the four public member positions with terms that expire on June 1, 2010 will <u>not</u> be filled. Three of these positions are currently vacant. The remaining position is held by Frank Zerunyan. The Governor makes the decisions on which two positions will be filled.
    - August 1, 2008:
        - Two of the three physician member positions with a term expiration of June 1, 2008 will expire on August 1, 2008. These three positions are held by Cesar Aristeiguieta M.D., Mary Lynn Moran, M.D., and Ron Wender M.D. The Governor makes the decisions on which two positions will be filled.

Assembly Bill No. 253

CHAPTER 678

An act to amend Sections 2001, 2002, 2004, 2012, 2013, 2014, 2015, 2017, 2018, 2041, 2224, 2228, 2230, 2311, 2317, 2335, 2506, 2529, 2529.5, 2546.2, and 2550.1 of, to add Section 2540.1 to, to repeal Sections 2003, 2005, 2009, 2035, and 2223 of, and to repeal and add Section 2008 of, the Business and Professions Code, relating to medicine.

[Approved by Governor October 14, 2007. Filed with Secretary of State October 14, 2007.]

LEGISLATIVE COUNSEL'S DIGEST

AB 253, Eng. Medical Board of California.

The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California that consists of 21 members. Existing law establishes a Division of Licensing and a Division of Medical Quality, each consisting of specified members of the board, with each division having certain responsibilities. Under existing law, the Division of Medical Quality is responsible for implementing the disciplinary provisions of the act and is prohibited from delegating its authority to take final disciplinary action against a licensee.

This bill would reduce the board's membership to 15 and would abolish the 2 divisions of the board. The bill would instead provide for the board as a whole to handle the responsibilities of the divisions. The bill would require the board to delegate to its executive director the authority to adopt default decisions and certain stipulations in disciplinary proceedings. The bill would make other related changes.

The people of the State of California do enact as follows:

SECTION 1. Section 2001 of the Business and Professions Code is amended to read:

2001. (a) There is in the Department of Consumer Affairs a Medical Board of California that consists of 15 members, seven of whom shall be public members.

(b) The Governor shall appoint 13 members to the board, subject to confirmation by the Senate, five of whom shall be public members. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a public member.

(c) Notwithstanding any other provision of law, to reduce the membership of the board to 15, the following shall occur:

(1) Two positions on the board that are public members having a term that expires on June 1, 2010, shall terminate instead on January 1, 2008.

(2) Two positions on the board that are not public members having a term that expires on June 1, 2008, shall terminate instead on August 1, 2008.

(3) Two positions on the board that are not public members having a term that expires on June 1, 2011, shall terminate instead on January 1, 2008.

(d) This section shall become inoperative on July 1, 2010, and, as of January 1, 2011, is repealed, unless a later enacted statute, which becomes effective on or before January 1, 2011, deletes or extends the dates on which it becomes inoperative and is repealed. The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473).

SEC. 2. Section 2002 of the Business and Professions Code is amended to read:

2002. Unless otherwise expressly provided, the term "board" as used in this chapter means the Medical Board of California. As used in this chapter or any other provision of law, "Division of Medical Quality" and "Division of Licensing" shall be deemed to refer to the board.

SEC. 3. Section 2003 of the Business and Professions Code is repealed.

SEC. 4. Section 2004 of the Business and Professions Code is amended to read:

2004. The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

SEC. 5. Section 2005 of the Business and Professions Code is repealed.

SEC. 6. Section 2008 of the Business and Professions Code is repealed.

SEC. 7. Section 2008 is added to the Business and Professions Code, to read:

2008. The board may appoint panels from its members for the purpose of fulfilling the obligations established in subdivision (c) of Section 2004. Any panel appointed under this section shall at no time be comprised of less than four members and the number of public members assigned to the panel shall not exceed the number of licensed physician and surgeon members assigned to the panel. The president of the board shall not be a

member of any panel. Each panel shall annually elect a chair and a vice chair.

SEC. 8. Section 2009 of the Business and Professions Code is repealed.

SEC. 9. Section 2012 of the Business and Professions Code is amended to read:

2012. The board shall elect a president, a vice president, and a secretary from its members.

SEC. 10. Section 2013 of the Business and Professions Code is amended to read:

2013. (a) The board and a panel appointed under this chapter may convene from time to time as deemed necessary by the board.

(b) Four members of a panel of the board shall constitute a quorum for the transaction of business at any meeting of the panel. Eight members shall constitute a quorum for the transaction of business at any board meeting.

(c) It shall require the affirmative vote of a majority of those members present at a board or panel meeting, those members constituting at least a quorum, to pass any motion, resolution, or measure. A decision by a panel to discipline a physician and surgeon shall require an affirmative vote, at a meeting or by mail, of a majority of the members of that panel; except that a decision to revoke the certificate of a physician and surgeon shall require the affirmative vote of four members of that panel.

SEC. 11. Section 2014 of the Business and Professions Code is amended to read:

2014. Notice of each meeting of the board shall be given in accordance with the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 12. Section 2015 of the Business and Professions Code is amended to read:

2015. The president of the board may call meetings of any duly appointed and created committee or panel of the board at a specified time and place.

SEC. 13. Section 2017 of the Business and Professions Code is amended to read:

2017. The board and each committee or panel shall keep an official record of all their proceedings.

SEC. 14. Section 2018 of the Business and Professions Code is amended to read:

2018. The board may adopt, amend, or repeal, in accordance with the provisions of the Administrative Procedure Act, those regulations as may be necessary to enable it to carry into effect the provisions of law relating to the practice of medicine.

SEC. 15. Section 2035 of the Business and Professions Code is repealed.

SEC. 16. Section 2041 of the Business and Professions Code is amended to read:

2041. The term "licensee" as used in this chapter means the holder of a physician's and surgeon's certificate or doctor of podiatric medicine's

certificate, as the case may be, who is engaged in the professional practice authorized by the certificate under the jurisdiction of the appropriate board.

SEC. 17. Section 2223 of the Business and Professions Code is repealed.

SEC. 18. Section 2224 of the Business and Professions Code is amended to read:

2224. (a) The board may delegate the authority under this chapter to conduct investigations and inspections and to institute proceedings to the executive director of the board or to other personnel as set forth in Section 2020. The board shall not delegate its authority to take final disciplinary action against a licensee as provided in Section 2227 and other provisions of this chapter. The board shall not delegate any authority of the Senior Assistant Attorney General of the Health Quality Enforcement Section or any powers vested in the administrative law judges of the Office of Administrative Hearings, as designated in Section 11371 of the Government Code.

(b) Notwithstanding subdivision (a), the board shall delegate to its executive director the authority to adopt a decision entered by default and a stipulation for surrender of a license.

SEC. 19. Section 2228 of the Business and Professions Code is amended to read:

2228. The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

SEC. 20. Section 2230 of the Business and Professions Code is amended to read:

2230. (a) All proceedings against a licensee for unprofessional conduct, or against an applicant for licensure for unprofessional conduct or cause, shall be conducted in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code) except as provided in this chapter, and shall be prosecuted by the Senior Assistant Attorney General of the Health Quality Enforcement Section.

(b) For purposes of this article, "agency itself," as used in the Administrative Procedure Act, means any panel appointed by the board pursuant to Section 2008. The decision or order of a panel imposing any disciplinary action pursuant to this chapter and the Administrative Procedure Act shall be final.

SEC. 21. Section 2311 of the Business and Professions Code is amended to read:

2311. Whenever any person has engaged in or is about to engage in any acts or practices that constitute or will constitute an offense against this chapter, the superior court of any county, on application of the board or of 10 or more persons licensed as physicians and surgeons or as podiatrists in this state, may issue an injunction or other appropriate order restraining the conduct. Proceedings under this section shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure.

SEC. 22. Section 2317 of the Business and Professions Code is amended to read:

2317. If a person, not a regular employee of the board, is hired, under contract, or retained under any other arrangement, paid or unpaid, to provide expertise or nonexpert testimony to the Medical Board of California or to the California Board of Podiatric Medicine, including, but not limited to, the evaluation of the conduct of an applicant or a licensee, and that person is named as a defendant in an action for defamation, malicious prosecution, or any other civil cause of action directly resulting from opinions rendered, statements made, or testimony given to, or on behalf of, the committee or its representatives, the board shall provide for representation required to defend the defendant in that civil action. The board shall be liable for any judgment rendered against that person, except that the board shall not be liable for any punitive damages award. If the plaintiff prevails in a claim for punitive damages, the defendant shall be liable to the board for the full costs incurred in providing representation to the defendant. The Attorney General shall be utilized in those actions as provided in Section 2020.

SEC. 23. Section 2335 of the Business and Professions Code is amended to read:

2335. (a) All proposed decisions and interim orders of the Medical Quality Hearing Panel designated in Section 11371 of the Government Code shall be transmitted to the executive director of the board, or the executive director of the California Board of Podiatric Medicine as to the licensees of that board, within 48 hours of filing.

(b) All interim orders shall be final when filed.

(c) A proposed decision shall be acted upon by the board or by any panel appointed pursuant to Section 2008 or by the California Board of Podiatric Medicine, as the case may be, in accordance with Section 11517 of the Government Code, except that all of the following shall apply to proceedings against licensees under this chapter:

(1) When considering a proposed decision, the board or panel and the California Board of Podiatric Medicine shall give great weight to the findings

of fact of the administrative law judge, except to the extent those findings of fact are controverted by new evidence.

(2) The board's staff or the staff of the California Board of Podiatric Medicine shall poll the members of the board or panel or of the California Board of Podiatric Medicine by written mail ballot concerning the proposed decision. The mail ballot shall be sent within 10 calendar days of receipt of the proposed decision, and shall poll each member on whether the member votes to approve the decision, to approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of additional evidence, to defer final decision pending discussion of the case by the panel or board as a whole, or to nonadopt the decision. No party to the proceeding, including employees of the agency that filed the accusation, and no person who has a direct or indirect interest in the outcome of the proceeding or who presided at a previous stage of the decision, may communicate directly or indirectly, upon the merits of a contested matter while the proceeding is pending, with any member of the panel or board, without notice and opportunity for all parties to participate in the communication. The votes of a majority of the board or of the panel, and a majority of the California Board of Podiatric Medicine, are required to approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of further evidence, or to nonadopt the decision. The votes of two members of the panel or board are required to defer final decision pending discussion of the case by the panel or board as a whole. If there is a vote by the specified number to defer final decision pending discussion of the case by the panel or board as a whole, provision shall be made for that discussion before the 90-day period specified in paragraph (3) expires, but in no event shall that 90-day period be extended.

(3) If a majority of the board or of the panel, or a majority of the California Board of Podiatric Medicine vote to do so, the board or the panel or the California Board of Podiatric Medicine shall issue an order of nonadoption of a proposed decision within 90 calendar days of the date it is received by the board. If the board or the panel or the California Board of Podiatric Medicine does not refer the case back to the administrative law judge for the taking of additional evidence or issue an order of nonadoption within 90 days, the decision shall be final and subject to review under Section 2337. Members of the board or of any panel or of the California Board of Podiatric Medicine who review a proposed decision or other matter and vote by mail as provided in paragraph (2) shall return their votes by mail to the board within 30 days from receipt of the proposed decision or other matter.

(4) The board or the panel or the California Board of Podiatric Medicine shall afford the parties the opportunity to present oral argument before deciding a case after nonadoption of the administrative law judge's decision.

(5) A vote of a majority of the board or of a panel, or a majority of the California Board of Podiatric Medicine, are required to increase the penalty from that contained in the proposed administrative law judge's decision. No member of the board or panel or of the California Board of Podiatric

Medicine may vote to increase the penalty except after reading the entire record and personally hearing any additional oral argument and evidence presented to the panel or board.

SEC. 24. Section 2506 of the Business and Professions Code is amended to read:

2506. As used in this article the following definitions shall apply:

(a) "Board" means the Medical Board of California.

(b) "Licensed midwife" means an individual to whom a license to practice midwifery has been issued pursuant to this article.

(c) "Certified nurse-midwife" means a person to whom a certificate has been issued pursuant to Article 2.5 (commencing with Section 2746) of Chapter 6.

(d) "Accrediting organization" means an organization approved by the board.

SEC. 25. Section 2529 of the Business and Professions Code is amended to read:

2529. Graduates of the Southern California Psychoanalytic Institute, the Los Angeles Psychoanalytic Society and Institute, the San Francisco Psychoanalytic Institute, the San Diego Psychoanalytic Institute, or institutes deemed equivalent by the Medical Board of California who have completed clinical training in psychoanalysis may engage in psychoanalysis as an adjunct to teaching, training, or research and hold themselves out to the public as psychoanalysts, and students in those institutes may engage in psychoanalysis under supervision, if the students and graduates do not hold themselves out to the public by any title or description of services incorporating the words "psychological," "psychologist," "psychology," "psychometrists," "psychometrics," or "psychometry," or that they do not state or imply that they are licensed to practice psychology.

Those students and graduates seeking to engage in psychoanalysis under this chapter shall register with the Medical Board of California, presenting evidence of their student or graduate status. The board may suspend or revoke the exemption of such persons for unprofessional conduct as defined in Sections 725, 2234, and 2235.

SEC. 26. Section 2529.5 of the Business and Professions Code is amended to read:

2529.5. Each person to whom registration is granted under the provisions of this chapter shall pay into the Contingent Fund of the Medical Board of California a fee to be fixed by the Medical Board of California at a sum not in excess of one hundred dollars ($100).

The registration shall expire after two years. The registration may be renewed biennially at a fee to be fixed by the board at a sum not in excess of fifty dollars ($50). Students seeking to renew their registration shall present to the board evidence of their continuing student status.

The money in the Contingent Fund of the Medical Board of California shall be used for the administration of this chapter.

SEC. 27. Section 2540.1 is added to the Business and Professions Code, to read:

2540.1. Any reference to the "Division of Medical Quality" or to the "Division of Licensing" in this chapter shall be deemed to refer to the Medical Board of California.

SEC. 28. Section 2546.2 of the Business and Professions Code is amended to read:

2546.2. All references in this chapter to the division shall mean the Medical Board of California.

SEC. 29. Section 2550.1 of the Business and Professions Code is amended to read:

2550.1. All references in this chapter to the board or the Board of Medical Examiners or division shall mean the Medical Board of California.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 329
Author: Nakanishi
Chapter: 386
Subject: Chronic Diseases: Telemedicine
Sponsor: Author / Medical Board of California
Board Position: Sponsor/Support

DESCRIPTION OF LEGISLATION:

This bill allows the Medical Board to establish a telemedicine pilot program. It authorizes the Board to implement the program by convening a working group of interested parties. The Board is required to make recommendations to the legislature within one calendar year of the commencement date of the pilot program.

IMPLEMENTATION:

- Newsletter Article
- Notify Board staff
- Assign to Access to Care Committee

October 15, 2007

Assembly Bill No. 329

CHAPTER 386

An act to add Section 2028.5 to the Business and Professions Code, relating to medicine.

[Approved by Governor October 10, 2007. Filed with Secretary of State October 10, 2007.]

LEGISLATIVE COUNSEL'S DIGEST

AB 329, Nakanishi. Chronic diseases: telemedicine.

Existing law, the Medical Practice Act, creates the Medical Board of California that is responsible for issuing a physician and surgeon's certificate to practice medicine and for regulating the practice of physicians and surgeons. The act also regulates the practice of telemedicine, defined as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

This bill would authorize the board to establish a pilot program to expand the practice of telemedicine, and would authorize the board to implement the program by convening a working group. The bill would specify that the purpose of the pilot program would be to develop methods, using a telemedicine model, of delivering health care to those with chronic diseases and delivering other health information. The bill would require the board to make recommendations regarding its findings to the Legislature within one calendar year of the commencement date of the pilot program.

The people of the State of California do enact as follows:

SECTION 1. Section 2028.5 is added to the Business and Professions Code, to read:

2028.5. (a) The board may establish a pilot program to expand the practice of telemedicine in this state.

(b) To implement this pilot program, the board may convene a working group of interested parties from the public and private sectors, including, but not limited to, state health-related agencies, health care providers, health plan administrators, information technology groups, and groups representing health care consumers.

(c) The purpose of the pilot program shall be to develop methods, using a telemedicine model, to deliver throughout the state health care to persons with chronic diseases as well as information on the best practices for chronic disease management services and techniques and other health care information as deemed appropriate.

(d) The board shall make a report with its recommendations regarding its findings to the Legislature within one calendar year of the commencement date of the pilot program. The report shall include an evaluation of the improvement and affordability of health care services and the reduction in the number of complications achieved by the pilot program.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1025
Author: Bass
Chapter: VETOED (see attached veto message)
Subject: Denial of Licensure
Sponsor: Author
Board Position: Oppose

DESCRIPTION OF LEGISLATION:

This bill creates more additional screening for all professions regulated by the Department of Consumer Affairs (DCA). Provisions of this bill enact limitations on disqualifying offenses, while also incorporating consumer protections that would allow applicants to obtain a copy of their criminal history record when they are being denied employment or licensing so that they can immediately correct any mistakes and avoid unnecessary and unfair appeal delays.

This bill would have had a negative impact on consumer protections in the licensing of physicians because it would have taken away one of the reviews the Division of Licensing uses in licensing physicians. This bill would have created an assumption that a physician is rehabilitated and puts the burden of proof of rehabilitation on the board instead of the applicant. The Board raised concerns to staff working on the bill and requested that amendments be made to exclude physicians, however, no such amendment was made.

IMPLEMENTATION:

None

October 15, 2007

BILL NUMBER: AB 1025
VETOED DATE: 10/13/2007

To the Members of the California State Assembly:

I am returning Assembly Bill 1025 without my signature.

This bill could jeopardize the public health, safety, and welfare in a well-intentioned but flawed attempt to permit individuals convicted of crimes to work in a regulated profession. I am concerned that this bill goes too far in taking away a licensing entity's discretion to deny a license or take other licensing actions, even if it is in the best interest of the state's consumers. The State of California licenses various professions in order to protect consumers from unqualified, dangerous, or unscrupulous individuals. All statutes establishing licensing programs mandate that the protection of the public is the highest priority and that "whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

AB 1025 creates a presumption of rehabilitation based on an expungement of a conviction. This is problematic for two reasons. First, expungement is not intended to be indicative of rehabilitation. Second, this provision places the burden of proof on state licensing bodies to show than an individual is not rehabilitated, which would result in increased litigation and extensive investigations.

For this reason, I am unable to sign this measure.

Sincerely,

Arnold Schwarzenegger

CHAPTER _____

An act to amend Sections 480, 485, 490, and 491 of the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 1025, Bass. Professions and vocations: licensure.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law authorizes a board to deny licensure on certain bases, including an applicant's conviction of a crime regardless of whether the conviction has been dismissed on specified grounds, an applicant's performance of any act involving dishonesty, fraud, or deceit with the intent to substantially benefit himself or herself or another or to substantially injure another, or an applicant's performance of any act that would be grounds for suspension or revocation of the license. Existing law requires a board that denies an application for licensure to provide the applicant with notice of the denial, as specified. Existing law authorizes a board to suspend or revoke a license on the basis that a licensee has been convicted of a crime that is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued, regardless of whether the conviction has been dismissed on specified grounds, and requires the board to provide the ex-licensee with certain information upon doing so.

This bill would provide that a person may not be denied licensure based solely on a criminal conviction if the person has been rehabilitated, as specified. The bill would also provide that a person may not be denied licensure or have his or her license suspended or revoked solely based on a criminal conviction that has been dismissed on certain grounds, unless the board provides substantial evidence, as specified, justifying the denial, suspension, or revocation. The bill would require the board to provide an applicant or ex-licensee whose application has been denied or whose license has been suspended or revoked based upon a crime with a copy of his or her criminal history record, as specified. The bill would require the board to maintain certain information pertaining to the

provision of criminal history records and to make that information available upon request by the Department of Justice or the Federal Bureau of Investigation. The bill would require the department to prepare annual reports to the Legislature documenting the board's denial, suspension, or revocation of licenses based on the bill's provisions.

The people of the State of California do enact as follows:

SECTION 1. Section 480 of the Business and Professions Code is amended to read:

480. (a) A board may deny a license regulated by this code on the grounds that the applicant has done one of the following:

(1) Been convicted of a crime. A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo contendere. Any action which a board is permitted to take following the establishment of a conviction may be taken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence.

(2) Done any act involving dishonesty, fraud or deceit with the intent to substantially benefit himself or another, or substantially injure another; or

(3) Done any act which if done by a licentiate of the business or profession in question, would be grounds for suspension or revocation of license.

The board may deny a license pursuant to this subdivision only if the crime or act is substantially related to the qualifications, functions or duties of the business or profession for which application is made.

(b) Notwithstanding any other provision of this code:

(1) No person shall be denied a license solely on the basis that he or she has been convicted of a felony if either of the following apply:

(A) He or she has obtained a certificate of rehabilitation under Chapter 3.5 (commencing with Section 4852.01) of Title 6 of Part 3 of the Penal Code.

(B) The felony conviction has been dismissed pursuant to Section 1203.4 of the Penal Code, which creates a presumption of rehabilitation for purposes of this paragraph, unless the board

provides substantial evidence to the contrary in writing to the person justifying the board's denial of the license based solely on his or her dismissed felony conviction that is substantially related to the qualifications, functions, or duties of the business or profession for which application is made.

(2) No person shall be denied a license solely on the basis that he or she has been convicted of a misdemeanor if either of the following apply:

(A) He or she has met all applicable requirements of the criteria of rehabilitation developed by the board to evaluate the rehabilitation of a person when considering the denial of a license under subdivision (a) of Section 482.

(B) The misdemeanor conviction has been dismissed pursuant to either Section 1203.4 or 1203.4a of the Penal Code, which creates a presumption of rehabilitation for purposes of this paragraph, unless the board provides substantial evidence to the contrary in writing to the person justifying the board's denial of the license based solely on his or her dismissed misdemeanor conviction that is substantially related to the qualifications, functions, or duties of the business or profession for which application is made.

(c) A board may deny a license regulated by this code on the ground that the applicant knowingly made a false statement of fact required to be revealed in the application for such license.

(d) The department shall annually prepare a report, to be submitted to the Legislature on October 1, that documents board denials of licenses based solely on dismissed felony or misdemeanor convictions as specified in subdivision (b).

SEC. 2. Section 485 of the Business and Professions Code is amended to read:

485. (a) Upon denial of an application for a license under this chapter or Section 496, the board shall do either of the following:

(1) File and serve a statement of issues in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) Notify the applicant that the application is denied, stating (A) the reason for the denial, and (B) that the applicant has the right to a hearing under Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code if a written request for a hearing is made within 60 days after

service of the notice of denial. Unless a written request for a hearing is made within the 60-day period, the applicant's right to a hearing is deemed waived.

Service of the notice of denial may be made in the manner authorized for service of summons in civil actions, or by registered mail addressed to the applicant at the latest address filed by the applicant in writing with the board in his or her application or otherwise. Service by mail is complete on the date of mailing.

(b) If the denial of a license is due at least in part to the applicant's state or federal criminal history record, the board shall include with the information provided pursuant to paragraph (1) or (2) of subdivision (a) a copy of the applicant's criminal history record.

(1) The state or federal criminal history record shall not be modified or altered from its form or content as provided by the Department of Justice.

(2) The criminal history record shall be provided in such a manner as to protect the confidentiality and privacy of the applicant's criminal history record, and the criminal history record shall not be made available by the board to any employer.

(3) The board shall record and maintain the name of the applicant, the applicant's address, and the date the criminal history record was provided by the board to the applicant pursuant to this section. The board shall make that information available upon request by the Department of Justice or the Federal Bureau of Investigation.

SEC. 3. Section 490 of the Business and Professions Code is amended to read:

490. (a) A board may suspend or revoke a license on the ground that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued. A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo contendere. Any action which a board is permitted to take following the establishment of a conviction may be taken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence.

(b) No license shall be suspended or revoked based solely on any criminal conviction that has been dismissed pursuant to Section 1203.4 or 1203.4a of the Penal Code, since that dismissal creates a presumption of rehabilitation for purposes of this section, unless the board provides substantial evidence to the contrary in writing to the person justifying the board's suspension or revocation of the license based solely on his or her dismissed conviction that is substantially related to the qualifications, functions, or duties of the business or profession for which the license was made.

(c) The department shall annually prepare a report, to be submitted to the Legislature on October 1, that documents board suspensions or revocations of licenses based solely on dismissed criminal convictions as specified in subdivision (b).

SEC. 4. Section 491 of the Business and Professions Code is amended to read:

491. (a) Upon suspension or revocation of a license by a board on one or more of the grounds specified in Section 490, the board shall do both of the following:

(1) Send a copy of the provisions of Section 11522 of the Government Code to the ex-licensee.

(2) Send a copy of the criteria relating to rehabilitation formulated under Section 482 to the ex-licensee.

(b) If the suspension or revocation of a license is due at least in part to the ex-licensee's state or federal criminal history record, the board shall include with the information provided pursuant to subdivision (a) a copy of the ex-licensee's criminal history record.

(1) The state or federal criminal history record shall not be modified or altered from its form or content as provided by the Department of Justice.

(2) The criminal history record shall be provided in such a manner as to protect the confidentiality and privacy of the ex-licensee's criminal history record, and the criminal history record shall not be made available by the board to any employer.

(3) The board shall record and maintain the name of the ex-licensee, the ex-licensee's address, and the date the criminal history record was provided by the board to an ex-licensee pursuant to this section. The board shall make that information available upon request by the Department of Justice or the Federal Bureau of Investigation.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1073
Author: Nava
Chapter: 621
Subject: Workers' Compensation: medical treatment utilization schedule
Sponsor: Author
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill makes important changes in the Workers' Compensation law that will benefit injured workers. This bill provides that the current limit of 24 visits shall not apply to visits for post-surgical physical medicine and rehabilitation services.

IMPLEMENTATION:

- Newsletter Article
- Notify Board staff

October 15, 2007

Assembly Bill No. 1073

CHAPTER 621

An act to amend Section 4604.5 of the Labor Code, relating to workers' compensation.

[Approved by Governor October 13, 2007. Filed with Secretary of State October 13, 2007.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1073, Nava. Workers' compensation: medical treatment utilization schedule.

Existing law establishes a workers' compensation system to compensate an employee for injuries sustained in the course of his or her employment. Existing law requires that the Administrative Director of the Division of Workers' Compensation, on or before January 1, 2004, adopt, after public hearings, a medical treatment utilization schedule, as specified. Existing law provides that, notwithstanding the medical treatment utilization schedule or guidelines set forth in the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury, but specifies that this limit shall not apply when an employer authorizes, in writing, additional visits to a health care practitioner for physical medicine services.

This bill would also prohibit the limit on the number of chiropractic, occupational therapy, and physical therapy visits from applying to visits for postsurgical physical medicine and postsurgical rehabilitative services, as provided.

The people of the State of California do enact as follows:

SECTION 1. Section 4604.5 of the Labor Code is amended to read:

4604.5. (a) Upon adoption by the administrative director of a medical treatment utilization schedule pursuant to Section 5307.27, the recommended guidelines set forth in the schedule shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof.

(b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices that are evidence and

scientifically based, nationally recognized, and peer reviewed. The guidelines shall be designed to assist providers by offering an analytical framework for the evaluation and treatment of injured workers, and shall constitute care in accordance with Section 4600 for all injured workers diagnosed with industrial conditions.

(c) Three months after the publication date of the updated American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, and continuing until the effective date of a medical treatment utilization schedule, pursuant to Section 5307.27, the recommended guidelines set forth in the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines shall be presumptively correct on the issue of extent and scope of medical treatment, regardless of date of injury. The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury, in accordance with Section 4600. The presumption created is one affecting the burden of proof.

(d) (1) Notwithstanding the medical treatment utilization schedule or the guidelines set forth in the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury.

(2) Paragraph (1) shall not apply when an employer authorizes, in writing, additional visits to a health care practitioner for physical medicine services.

(3) Paragraph (1) shall not apply to visits for postsurgical physical medicine and postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the administrative director pursuant to Section 5307.27.

(e) For all injuries not covered by the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines or official utilization schedule after adoption pursuant to Section 5307.27, authorized treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1224
Author: Hernandez
Chapter: 507
Subject: Telemedicine: Optometrists
Sponsor: California Optometric Association
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill adds optometrists to the list of health care professionals who are allowed to practice via telemedicine. This bill defines collaborating optometrist for purposes of his or her participation in treating primary open angle glaucoma.

IMPLEMENTATION:

- Newsletter Article
- Notify Board staff

October 9, 2007

Assembly Bill No. 1224

CHAPTER 507

An act to amend Sections 2290.5 and 3041 of the Business and Professions Code, relating to healing arts.

[Approved by Governor October 11, 2007. Filed with Secretary of State October 11, 2007.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1224, Hernandez. Optometrists: telemedicine.

Existing law, the Optometry Practice Act, creates the State Board of Optometry, which licenses optometrists and regulates their practice. The act defines the practice of optometry as including the treatment of primary open-angle glaucoma with the participation, as specified, of a collaborating ophthalmologist. Existing law, the Medical Practice Act, regulates the practice of telemedicine, defined as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications, by a health care practitioner, as defined. A violation of the provisions governing telemedicine is unprofessional conduct.

This bill would make a licensed optometrist subject to these telemedicine provisions and would define collaborating ophthalmologist for purposes of his or her participation in treating primary open angle glaucoma.

The people of the State of California do enact as follows:

SECTION 1. Section 2290.5 of the Business and Professions Code is amended to read:

2290.5. (a) (1) For the purposes of this section, "telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes "telemedicine" for purposes of this section.

(2) For purposes of this section, "interactive" means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.

(b) For the purposes of this section, "health care practitioner" has the same meaning as "licentiate" as defined in paragraph (2) of subdivision (a) of Section 805 and also includes a person licensed as an optometrist pursuant to Chapter 7 (commencing with Section 3000).

(c) Prior to the delivery of health care via telemedicine, the health care practitioner who has ultimate authority over the care or primary diagnosis of the patient shall obtain verbal and written informed consent from the patient or the patient's legal representative. The informed consent procedure shall ensure that at least all of the following information is given to the patient or the patient's legal representative verbally and in writing:

(1) The patient or the patient's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the patient or the patient's legal representative would otherwise be entitled.

(2) A description of the potential risks, consequences, and benefits of telemedicine.

(3) All existing confidentiality protections apply.

(4) All existing laws regarding patient access to medical information and copies of medical records apply.

(5) Dissemination of any patient identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the patient.

(d) A patient or the patient's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the patient or the patient's legal representative understands the written information provided pursuant to subdivision (a), and that this information has been discussed with the health care practitioner, or his or her designee.

(e) The written consent statement signed by the patient or the patient's legal representative shall become part of the patient's medical record.

(f) The failure of a health care practitioner to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(g) All existing laws regarding surrogate decisionmaking shall apply. For purposes of this section, "surrogate decisionmaking" means any decision made in the practice of medicine by a parent or legal representative for a minor or an incapacitated or incompetent individual.

(h) Except as provided in paragraph (3) of subdivision (c), this section shall not apply when the patient is not directly involved in the telemedicine interaction, for example when one health care practitioner consults with another health care practitioner.

(i) This section shall not apply in an emergency situation in which a patient is unable to give informed consent and the representative of that patient is not available in a timely manner.

(j) This section shall not apply to a patient under the jurisdiction of the Department of Corrections or any other correctional facility.

(k) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

SEC. 2. Section 3041 of the Business and Professions Code is amended to read:

3041. (a) The practice of optometry includes the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of rehabilitative optometric services, and is the doing of any or all of the following:

(1) The examination of the human eye or eyes, or its or their appendages, and the analysis of the human vision system, either subjectively or objectively.

(2) The determination of the powers or range of human vision and the accommodative and refractive states of the human eye or eyes, including the scope of its or their functions and general condition.

(3) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, vision training, or orthoptics.

(4) The prescribing of contact and spectacle lenses for, or the fitting or adaptation of contact and spectacle lenses to, the human eye, including lenses which may be classified as drugs or devices by any law of the United States or of this state.

(5) The use of topical pharmaceutical agents for the sole purpose of the examination of the human eye or eyes for any disease or pathological condition. The topical pharmaceutical agents shall include mydriatics, cycloplegics, anesthetics, and agents for the reversal of mydriasis.

(b) (1) An optometrist who is certified to use therapeutic pharmaceutical agents, pursuant to Section 3041.3, may also diagnose and exclusively treat the human eye or eyes, or any of its appendages, for all of the following conditions:

(A) Through medical treatment, infections of the anterior segment and adnexa, excluding the lacrimal gland, the lacrimal drainage system and the sclera. Nothing in this section shall authorize any optometrist to treat a person with AIDS for ocular infections.

(B) Ocular allergies of the anterior segment and adnexa.

(C) Ocular inflammation, nonsurgical in cause, limited to inflammation resulting from traumatic iritis, peripheral corneal inflammatory keratitis, episcleritis, and unilateral nonrecurrent nongranulomatous idiopathic iritis in patients over 18 years of age. Unilateral nongranulomatous idiopathic iritis recurring within one year of the initial occurrence shall be referred to an ophthalmologist. An optometrist shall consult with an ophthalmologist if a patient has a recurrent case of episcleritis within one year of the initial occurrence. An optometrist shall consult with an ophthalmologist if a patient has a recurrent case of peripheral corneal inflammatory keratitis within one year of the initial occurrence.

(D) Traumatic or recurrent conjunctival or corneal abrasions and erosions.

(E) Corneal surface disease and dry eyes.

(F) Ocular pain, not related to surgery, associated with conditions optometrists are authorized to treat.

(G) Pursuant to subdivision (f), primary open-angle glaucoma in patients over 18 years of age.

(2) For purposes of this section, "treat" means the use of therapeutic pharmaceutical agents, as described in subdivision (c), and the procedures described in subdivision (e).

(c) In diagnosing and treating the conditions listed in subdivision (b), an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3, may use all of the following therapeutic pharmaceutical agents exclusively:

(1) All of the topical pharmaceutical agents listed in paragraph (5) of subdivision (a) as well as topical miotics for diagnostic purposes.

(2) Topical lubricants.

(3) Topical antiallergy agents. In using topical steroid medication for the treatment of ocular allergies, an optometrist shall do the following:

(A) Consult with an ophthalmologist if the patient's condition worsens 72 hours after diagnosis.

(B) Consult with an ophthalmologist if the inflammation is still present three weeks after diagnosis.

(C) Refer the patient to an ophthalmologist if the patient is still on the medication six weeks after diagnosis.

(D) Refer the patient to an ophthalmologist if the patient's condition recurs within three months.

(4) Topical antiinflammatories. In using topical steroid medication for:

(A) Unilateral nonrecurrent nongranulomatous idiopathic iritis or episcleritis, an optometrist shall consult with an ophthalmologist if the patient's condition worsens 72 hours after the diagnosis, or if the patient's condition has not resolved three weeks after diagnosis. If the patient is still receiving medication for these conditions six weeks after diagnosis, the optometrist shall refer the patient to an ophthalmologist.

(B) Peripheral corneal inflammatory keratitis, excluding Moorens and Terriens diseases, an optometrist shall consult with an ophthalmologist if the patient's condition worsens 48 hours after diagnosis. If the patient is still receiving the medication two weeks after diagnosis, the optometrist shall refer the patient to an ophthalmologist.

(C) Traumatic iritis, an optometrist shall consult with an ophthalmologist if the patient's condition worsens 72 hours after diagnosis and shall refer the patient to an ophthalmologist if the patient's condition has not resolved one week after diagnosis.

(5) Topical antibiotic agents.

(6) Topical hyperosmotics.

(7) Topical antiglaucoma agents pursuant to the certification process defined in subdivision (f).

(A) The optometrist shall not use more than two concurrent topical medications in treating the patient for primary open-angle glaucoma. A single combination medication that contains two pharmacological agents shall be considered as two medications.

(B) The optometrist shall refer the patient to an ophthalmologist if requested by the patient, if treatment goals are not achieved with the use of

two topical medications or if indications of narrow-angle or secondary glaucoma develop.

(C) If the glaucoma patient also has diabetes, the optometrist shall consult in writing with the physician treating the patient's diabetes in developing the glaucoma treatment plan and shall notify the physician in writing of any changes in the patient's glaucoma medication. The physician shall provide written confirmation of those consultations and notifications.

(8) Nonprescription medications used for the rational treatment of an ocular disorder.

(9) Oral antihistamines. In using oral antihistamines for the treatment of ocular allergies, the optometrist shall refer the patient to an ophthalmologist if the patient's condition has not resolved two weeks after diagnosis.

(10) Prescription oral nonsteroidal antiinflammatory agents. The agents shall be limited to three days' use. If the patient's condition has not resolved three days after diagnosis, the optometrist shall refer the patient to an ophthalmologist.

(11) The following oral antibiotics for medical treatment as set forth in subparagraph (A) of paragraph (1) of subdivision (b): tetracyclines, dicloxacillin, amoxicillin, amoxicillin with clavulanate, erythromycin, clarythromycin, cephalexin, cephadroxil, cefaclor, trimethoprim with sulfamethoxazole, ciprofloxacin, and azithromycin. The use of azithromycin shall be limited to the treatment of eyelid infections and chlamydial disease manifesting in the eyes.

(A) If the patient has been diagnosed with a central corneal ulcer and the condition has not improved 24 hours after diagnosis, the optometrist shall consult with an ophthalmologist. If the central corneal ulcer has not improved 48 hours after diagnosis, the optometrist shall refer the patient to an ophthalmologist. If the patient is still receiving antibiotics 10 days after diagnosis, the optometrist shall refer the patient to an ophthalmologist.

(B) If the patient has been diagnosed with preseptal cellulitis or dacryocystitis and the condition has not improved 72 hours after diagnosis, the optometrist shall refer the patient to an ophthalmologist. If a patient with preseptal cellulitis or dacryocystitis is still receiving oral antibiotics 10 days after diagnosis, the optometrist shall refer the patient to an ophthalmologist.

(C) If the patient has been diagnosed with blepharitis and the patient's condition does not improve after six weeks of treatment, the optometrist shall consult with an ophthalmologist.

(D) For the medical treatment of all other medical conditions as set forth in subparagraph (A) of paragraph (1) of subdivision (b), if the patient's condition worsens 72 hours after diagnosis, the optometrist shall consult with an ophthalmologist. If the patient's condition has not resolved 10 days after diagnosis, the optometrist shall refer the patient to an ophthalmologist.

(12) Topical antiviral medication and oral acyclovir for the medical treatment of the following: herpes simplex viral keratitis, herpes simplex viral conjunctivitis, and periocular herpes simplex viral dermatitis; and varicella zoster viral keratitis, varicella zoster viral conjunctivitis, and periocular varicella zoster viral dermatitis.

(A) If the patient has been diagnosed with herpes simplex keratitis or varicella zoster viral keratitis and the patient's condition has not improved seven days after diagnosis, the optometrist shall refer the patient to an ophthalmologist. If a patient's condition has not resolved three weeks after diagnosis, the optometrist shall refer the patient to an ophthalmologist.

(B) If the patient has been diagnosed with herpes simplex viral conjunctivitis, herpes simplex viral dermatitis, varicella zoster viral conjunctivitis, or varicella zoster viral dermatitis, and if the patient's condition worsens seven days after diagnosis, the optometrist shall consult with an ophthalmologist. If the patient's condition has not resolved three weeks after diagnosis, the optometrist shall refer the patient to an ophthalmologist.

(C) In all cases, the use of topical antiviral medication shall be limited to three weeks, and the use of oral acyclovir shall be limited to 10 days.

(13) Oral analgesics that are not controlled substances.

(14) Codeine with compounds and hydrocodone with compounds as listed in the California Uniform Controlled Substances Act (Section 11000 of the Health and Safety Code et seq.) and the United States Uniform Controlled Substances Act (21 U.S.C. Sec. 801 et seq.). The use of these agents shall be limited to three days, with a referral to an ophthalmologist if the pain persists.

(d) In any case where this chapter requires that an optometrist consult with an ophthalmologist, the optometrist shall maintain a written record in the patient's file of the information provided to the ophthalmologist, the ophthalmologist's response and any other relevant information. Upon the consulting ophthalmologist's request, the optometrist shall furnish a copy of the record to the ophthalmologist.

(e) An optometrist who is certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 may also perform all of the following:

(1) Mechanical epilation.

(2) Ordering of smears, cultures, sensitivities, complete blood count, mycobacterial culture, acid fast stain, and urinalysis.

(3) Punctal occlusion by plugs, excluding laser, cautery, diathermy, cryotherapy, or other means constituting surgery as defined in this chapter.

(4) The prescription of therapeutic contact lenses.

(5) Removal of foreign bodies from the cornea, eyelid, and conjunctiva. Corneal foreign bodies shall be nonperforating, be no deeper than the anterior stroma, and require no surgical repair upon removal. Within the central three millimeters of the cornea, the use of sharp instruments is prohibited.

(6) For patients over 12 years of age, lacrimal irrigation and dilation, excluding probing of the nasal lacrimal tract. The State Board of Optometry shall certify an optometrist to perform this procedure after completing 10 of the procedures under the supervision of an ophthalmologist as confirmed by the ophthalmologist.

(7) No injections other than the use of an auto-injector to counter anaphylaxis.

(f) The State Board of Optometry shall grant a certificate to an optometrist certified pursuant to Section 3041.3 for the treatment of primary open-angle glaucoma in patients over 18 years of age only after the optometrist meets the following requirements:

(1) Satisfactory completion of a didactic course of not less than 24 hours in the diagnosis, pharmacological and other treatment and management of glaucoma. The 24-hour glaucoma curriculum shall be developed by an accredited California school of optometry. Any applicant who graduated from an accredited California school of optometry on or after May 1, 2000, shall be exempt from the 24-hour didactic course requirement contained in this paragraph.

(2) After completion of the requirement contained in paragraph (1), collaborative treatment of 50 glaucoma patients for a period of two years for each patient under the following terms:

(A) After the optometrist makes a provisional diagnosis of glaucoma, the optometrist and the patient shall identify a collaborating ophthalmologist.

(B) The optometrist shall develop a treatment plan that considers for each patient target intraocular pressures, optic nerve appearance and visual field testing for each eye, and an initial proposal for therapy.

(C) The optometrist shall transmit relevant information from the examination and history taken of the patient along with the treatment plan to the collaborating ophthalmologist. The collaborating ophthalmologist shall confirm or refute the glaucoma diagnosis within 30 days. To accomplish this, the collaborating ophthalmologist shall perform a physical examination of the patient.

(D) Once the collaborating ophthalmologist confirms the diagnosis and approves the treatment plan in writing, the optometrist may begin treatment.

(E) The optometrist shall use no more than two concurrent topical medications in treating the patient for glaucoma. A single combination medication that contains two pharmacologic agents shall be considered as two medications. The optometrist shall notify the collaborating ophthalmologist in writing if there is any change in the medication used to treat the patient for glaucoma.

(F) Annually after commencing treatment, the optometrist shall provide a written report to the collaborating ophthalmologist about the achievement of goals contained in the treatment plan. The collaborating ophthalmologist shall acknowledge receipt of the report in writing to the optometrist within 10 days.

(G) The optometrist shall refer the patient to an ophthalmologist if requested by the patient, if treatment goals are not achieved with the use of two topical medications, or if indications of secondary glaucoma develop. At his or her discretion, the collaborating ophthalmologist may periodically examine the patient.

(H) If the glaucoma patient also has diabetes, the optometrist shall consult in writing with the physician treating the patient's diabetes in preparation of the treatment plan and shall notify the physician in writing if there is any

change in the patient's glaucoma medication. The physician shall provide written confirmation of the consultations and notifications.

(I) The optometrist shall provide the following information to the patient in writing: nature of the working or suspected diagnosis, consultation evaluation by a collaborating ophthalmologist, treatment plan goals, expected followup care, and a description of the referral requirements. The document containing the information shall be signed and dated by both the optometrist and the ophthalmologist and maintained in their files.

(3) When the requirements contained in paragraphs (1) and (2) have been satisfied, the optometrist shall submit proof of completion to the State Board of Optometry and apply for a certificate to treat primary open-angle glaucoma. That proof shall include corroborating information from the collaborating ophthalmologist. If the ophthalmologist fails to respond within 60 days of a request for information from the State Board of Optometry, the board may act on the optometrist's application without that corroborating information.

(4) After an optometrist has treated a total of 50 patients for a period of two years each and has received certification from the State Board of Optometry, the optometrist may treat the original 50 collaboratively treated patients independently, with the written consent of the patient. However, any glaucoma patients seen by the optometrist before the two-year period has expired for each of the 50 patients shall be treated under the collaboration protocols described in this section.

(5) For purposes of this subdivision, "collaborating ophthalmologist" means a physician and surgeon who is licensed by the state and in the active practice of ophthalmology in this state.

(g) Notwithstanding any other provision of law, an optometrist shall not treat children under one year of age with therapeutic pharmaceutical agents.

(h) Any dispensing of a therapeutic pharmaceutical agent by an optometrist shall be without charge.

(i) Notwithstanding any other provision of law, the practice of optometry does not include performing surgery. "Surgery" means any procedure in which human tissue is cut, altered, or otherwise infiltrated by mechanical or laser means in a manner not specifically authorized by this chapter. Nothing in the act amending this section shall limit an optometrist's authority, as it existed prior to the effective date of the act amending this section, to utilize diagnostic laser and ultrasound technology.

(j) All collaborations, consultations, and referrals made by an optometrist pursuant to this section shall be to an ophthalmologist located geographically appropriate to the patient.

(k) An optometrist licensed under this chapter is subject to the provisions of Section 2290.5 for purposes of practicing telemedicine.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 102
Author: Migden
Chapter: 88
Subject: Blood Transfusions
Sponsor: Author
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill allows a nurse practitioner, certified midwife, or physician's assistant acting under the supervision of a physician to provide a patient with the written summary of the risks associated with blood transfusions, prior to the performance of a blood transfusion. The registered nurse or physician's assistant would be required to make that notation on the medical record that this information had been provided and by whom.

This bill includes a doctor of podiatric medicine as a professional who may have standardized written procedures allowing a registered nurse or a physician assistant to provide the written summary.

IMPLEMENTATION:

- Newsletter Article
- Notify Board staff

October 15, 2007

Senate Bill No. 102

CHAPTER 88

An act to amend Section 1645 of the Health and Safety Code, relating to blood transfusions.

[Approved by Governor July 20, 2007. Filed with Secretary of State July 20, 2007.]

LEGISLATIVE COUNSEL'S DIGEST

SB 102, Migden. Blood transfusions.

Existing law requires, whenever there is a reasonable possibility, as determined by a physician, that a blood transfusion may be necessary as a result of a medical procedure, that the physician, by means of a standardized written summary that is published by the Medical Board of California and distributed upon request, inform the patient of the positive and negative aspects of receiving autologous blood and directed and nondirected homologous blood from volunteers.

This bill would also include a doctor of podiatric medicine within the scope of these requirements. It would require the information to be given by the physician or doctor of podiatric medicine, directly or through a nurse practitioner, certified nurse midwife, or physician assistant, authorized to order a blood transfusion.

The people of the State of California do enact as follows:

SECTION 1. Section 1645 of the Health and Safety Code is amended to read:

1645. (a) Whenever there is a reasonable possibility, as determined by a physician and surgeon or doctor of podiatric medicine, that a blood transfusion may be necessary as a result of a medical or surgical procedure, the physician and surgeon or doctor of podiatric medicine, by means of a standardized written summary as most recently developed or revised by the State Department of Public Health pursuant to subdivision (e), shall inform, either directly or through a nurse practitioner, certified nurse midwife, or a physician assistant, who is licensed in the state and authorized to order a blood transfusion, the patient of the positive and negative aspects of receiving autologous blood and directed and nondirected homologous blood from volunteers. For purposes of this section, the term "autologous blood" includes, but is not limited to, predonation, intraoperative autologous transfusion, plasmapheresis, and hemodilution.

(b) The person who provided the patient with the standardized written summary pursuant to subdivision (a) shall note on the patient's medical record that the standardized written summary was given to the patient.

(c) Subdivisions (a) and (b) shall not apply when medical contraindications or a life-threatening emergency exists.

(d) When there is no life-threatening emergency and there are no medical contraindications, the physician and surgeon or doctor of podiatric medicine shall allow adequate time prior to the procedure for predonation to occur. Notwithstanding this chapter, if a patient waives allowing adequate time prior to the procedure for predonation to occur, a physician and surgeon or doctor of podiatric medicine shall not incur any liability for his or her failure to allow adequate time prior to the procedure for predonation to occur.

(e) The State Department of Public Health shall develop and annually review, and if necessary revise, a standardized written summary which explains the advantages, disadvantages, risks, and descriptions of autologous blood, and directed and nondirected homologous blood from volunteer donors. These blood options shall include, but not be limited to, the blood options described in subdivision (a). The summary shall be written so as to be easily understood by a layperson.

(f) The Medical Board of California shall publish the standardized written summary prepared pursuant to subdivision (e) by the State Department of Public Health and shall distribute copies thereof, upon request, to physicians and surgeons and doctors of podiatric medicine. The Medical Board of California shall make the summary available for a fee not exceeding in the aggregate the actual costs to the State Department of Public Health and the Medical Board of California for developing, updating, publishing and distributing the summary. Physicians and surgeons and doctors of podiatric medicine shall purchase the written summary from the Medical Board of California for, or purchase or otherwise receive the written summary from the Web site of the board or any other entity for, distribution to their patients as specified in subdivision (a). Clinics, health facilities, and blood collection centers may purchase the summary if they desire.

(g) Any entity may reproduce the written summary prepared pursuant to subdivision (e) by the State Department of Public Health and distribute the written summary to physicians and surgeons and doctors of podiatric medicine.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 472
Author: Corbett
Chapter: 470
Subject: Prescription drug labeling requirements
Sponsor: Author
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill requires the State Board of Pharmacy to promulgate regulations that require a standardized, patient-centered, prescription drug label on all prescription medication dispensed to patients in California. The board would be required to hold special statewide public meetings in order to seek information from certain groups, and would be required to consider specified factors in developing the label requirements.

The bill requires the Board of Pharmacy to report to the Legislature on or before January 1, 2010, on its progress at the time of the report, and to report to the Legislature on or before January 1, 2013, on the status of implementation of the requirements.

IMPLEMENTATION:

- Newsletter Article
- Notify Board Staff
- Board staff to contact State Board of Pharmacy to participate in public meetings.

October 15, 2007

Senate Bill No. 472

CHAPTER 470

An act to add Section 4076.5 to the Business and Professions Code, relating to pharmacy.

[Approved by Governor October 11, 2007. Filed with Secretary of State October 11, 2007.]

LEGISLATIVE COUNSEL'S DIGEST

SB 472, Corbett. Prescription drugs: labeling requirements.

Existing law, the Pharmacy Law, provides for the licensure and regulation of the practice of pharmacy by the California State Board of Pharmacy in the Department of Consumer Affairs. Existing law prohibits a pharmacist from dispensing a prescription, except in a container that meets certain labeling requirements.

This bill would require the board to promulgate regulations that require, on or before January 1, 2011, a standardized, patient-centered, prescription drug label on all prescription medication dispensed to patients in California. The bill would require the board to hold special public meetings statewide in order to seek information from certain groups, and would require the board to consider specified factors in developing the label requirements. The bill would require the board to report to the Legislature on or before January 1, 2010, on its progress at the time of the report, and to report to the Legislature on or before January 1, 2013, on the status of implementation of the requirements.

Because a knowing violation of the Pharmacy Law constitutes a crime, and because the above-described provisions would impose additional duties under that law, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known and may be cited as the California Patient Medication Safety Act.

SEC. 2. The Legislature hereby finds and declares all of the following:

(a) Health care costs and spending in California are rising dramatically and are expected to continue to increase.

(b) In California, prescription drug spending totaled over $188 billion in 2004, a $14 billion dollar per year spending increase from 1984.

(c) Prescription drug cost continues to be among the most significant cost factors in California's overall spending on health care.

(d) According to the Institute of Medicine of the National Academies, medication errors are among the most common medical errors, harming at least 1.5 million people every year.

(e) Up to one-half of all medications are taken incorrectly or mixed with other medications that cause dangerous reactions that can lead to injury and death.

(f) Approximately 46 percent of American adults cannot understand the label on their prescription medications.

(g) Ninety percent of Medicare patients take medications for chronic conditions and nearly one-half of them take five or more different medications.

(h) Nearly six out of 10 adults in the United States have taken prescription medications incorrectly.

(i) The people of California recognize the importance of reducing medication-related errors and increasing health care literacy regarding prescription drugs and prescription container labeling, which can increase consumer protection and improve the health, safety, and well-being of consumers.

(j) The Legislature affirms the importance of identifying deficiencies in, and opportunities for improving, patient medication safety systems in order to identify and encourage the adoption of structural safeguards related to prescription drug container labels.

(k) It is the intent of the Legislature to adopt a standardized prescription drug label that will be designed by the California State Board of Pharmacy for use on any prescription drug dispensed to a patient in California.

SEC. 3. Section 4076.5 is added to the Business and Professions Code, to read:

4076.5. (a) The board shall promulgate regulations that require, on or before January 1, 2011, a standardized, patient-centered, prescription drug label on all prescription medicine dispensed to patients in California.

(b) To ensure maximum public comment, the board shall hold public meetings statewide that are separate from its normally scheduled hearings in order to seek information from groups representing consumers, seniors, pharmacists or the practice of pharmacy, other health care professionals, and other interested parties.

(c) When developing the requirements for prescription drug labels, the board shall consider all of the following factors:

(1) Medical literacy research that points to increased understandability of labels.

(2) Improved directions for use.

(3) Improved font types and sizes.

(4) Placement of information that is patient-centered.

(5) The needs of patients with limited English proficiency.

(6) The needs of senior citizens.

(7) Technology requirements necessary to implement the standards.

(d) (1) On or before January 1, 2010, the board shall report to the Legislature on its progress under this section as of the time of the report.

(2) On or before January 1, 2013, the board shall report to the Legislature the status of implementation of the prescription drug label requirements adopted pursuant to this section.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 620
Author: Correa (Coauthor: Assembly Member Horton)
Chapter: 210
Subject: Dentistry: general anesthesia.
Sponsor: The California Dental Association
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill removes the January 1, 2008 sunset date on the permitting process for physicians who administer general anesthesia for dental patients.

IMPLEMENTATION:

- Newsletter Article
- Notify Board staff

October 9, 2007

Senate Bill No. 620

CHAPTER 210

An act to amend Sections 1646.9 and 2079 of the Business and Professions Code, relating to dentistry, and making an appropriation therefor.

[Approved by Governor September 11, 2007. Filed with Secretary of State September 11, 2007.]

LEGISLATIVE COUNSEL'S DIGEST

SB 620, Correa. Dentistry: general anesthesia.

Existing law, the Dental Practice Act, authorizes a physician and surgeon, until January 1, 2008, to administer general anesthesia to a dental patient in the office of a dentist who does not possess a general anesthesia permit if, among other things, the physician and surgeon holds a valid general anesthesia permit issued by the Dental Board of California. In order to obtain that permit, existing law requires the physician and surgeon, among other things, to pay specified fees, which are deposited in the State Dentistry Fund, a continuously appropriated fund, and in the Contingent Fund of the Medical Board of California, continuously appropriated funds, and to submit his or her application to the Medical Board of California for review, as specified.

This bill would delete the January 1, 2008, repeal date, thereby extending the operation of these provisions indefinitely. By extending the operation of the provisions dealing with the payment of fees into a continuously appropriated fund, the bill would make an appropriation.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1646.9 of the Business and Professions Code is amended to read:

1646.9. (a) Notwithstanding any other provision of law, including, but not limited to, Section 1646.1, a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) may administer general anesthesia in the office of a licensed dentist for dental patients, without regard to whether the dentist possesses a permit issued pursuant to this article, if both of the following conditions are met:

(1) The physician and surgeon possesses a current license in good standing to practice medicine in this state.

(2) The physician and surgeon holds a valid general anesthesia permit issued by the Dental Board of California pursuant to subdivision (b).

(b) (1) A physician and surgeon who desires to administer general anesthesia as set forth in subdivision (a) shall apply to the Dental Board of California on an application form prescribed by the board and shall submit all of the following:

(A) The payment of an application fee prescribed by this article.

(B) Evidence satisfactory to the Medical Board of California showing that the applicant has successfully completed a postgraduate residency training program in anesthesiology that is recognized by the American Council on Graduate Medical Education, as set forth in Section 2079.

(C) Documentation demonstrating that all equipment and drugs required by the Dental Board of California are possessed by the applicant and shall be available for use in any dental office in which he or she administers general anesthesia.

(D) Information relative to the current membership of the applicant on hospital medical staffs.

(2) Prior to issuance or renewal of a permit pursuant to this section, the Dental Board of California may, at its discretion, require an onsite inspection and evaluation of the facility, equipment, personnel, including, but not limited to, the physician and surgeon, and procedures utilized. At least one of the persons evaluating the procedures utilized by the physician and surgeon shall be a licensed physician and surgeon expert in outpatient general anesthesia who has been authorized or retained under contract by the Dental Board of California for this purpose.

(3) The permit of a physician and surgeon who has failed an onsite inspection and evaluation shall be automatically suspended 30 days after the date on which the board notifies the physician and surgeon of the failure unless within that time period the physician and surgeon has retaken and passed an onsite inspection and evaluation. Every physician and surgeon issued a permit under this article shall have an onsite inspection and evaluation at least once every six years. Refusal to submit to an inspection shall result in automatic denial or revocation of the permit.

SEC. 2. Section 2079 of the Business and Professions Code is amended to read:

2079. (a) A physician and surgeon who desires to administer general anesthesia in the office of a dentist pursuant to Section 1646.9, shall provide the Medical Board of California with a copy of the application submitted to the Dental Board of California pursuant to subdivision (b) of Section 1646.9 and a fee established by the board not to exceed the costs of processing the application as provided in this section.

(b) The Medical Board of California shall review the information submitted and take action as follows:

(1) Inform the Dental Board of California whether the physician and surgeon has a current license in good standing to practice medicine in this state.

(2) Verify whether the applicant has successfully completed a postgraduate residency training program in anesthesiology and whether the

program has been recognized by the American Council on Graduate Medical Education.

(3) Inform the Dental Board of California whether the Medical Board of California has determined that the applicant has successfully completed the postgraduate residency training program in anesthesiology recognized by the American Council on Graduate Medicine.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 761
Author: Ridley-Thomas
Bill Date: July 18, 2007, amended
Subject: Healing arts: diversion and investigations
Sponsor: Medical Board of California
Board Position: Sponsor/Support

STATUS OF BILL:

This bill was held in the Assembly Appropriations Committee on Suspense.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would have extended the dates on which the provisions for the diversion program are repealed from January 1, 2009 to January 1, 2011. It would have required the board to create and appoint a Diversion Advisory Council (DAC). It would have extended the sunset date of the Vertical Enforcement/Prosecution (E/P) model, extending the dates on which the provisions for the vertical (E/P) model are repealed from January 1, 2009 to January 1, 2011. It would have authorized the board to employ special agents and to transition investigators who are peace officers to a special agents classification. It would here deleted the requirement that an investigator be under the direction of the deputy attorney general who is simultaneously assigned a complaint, and instead, required that investigator assist the deputy attorney general, who would be responsible for the legal direction of the case.

This bill was set to be amended to delete all the provisions related to Diversion once it passed out of the Assembly Appropriations Committee. This bill was held in the committee due to concerns related to the legislative reclassification of investigators.

The provisions of this bill regarding Vertical Enforcement/Prosecution were incorporated into SB 797 (see analysis) which was held on the Assembly Floor.

IMPLEMENTATION:

- Sunset Diversion Program
    - The Diversion Advisory Council (DAC) met in September to develop recommendations to the Diversion Committee on the options for the future of the participants since the program is terminating. DAC to present recommendations to the committee in November.

- Diversion summit will be held in January 2008 to discuss options for physicians seeking rehabilitation programs.

- Sunset Vertical Enforcement Prosecution Pilot Program
  - Board President and Executive staff have met with the AG's office regarding that VE-P program. The program will continue in the same/similar manner. Pursuit of computer compatibility and co-location will continue.
  - With NO extension – meet with AG to discuss necessary funding to pay for continuation of a Vertical Enforcement/Prosecution style program and additional enhancements to strengthen the program. May require submission of budget augmentation request.
  - Investigator pay:
    - Pursue with DCA the upgrades for all DCA investigative staff.
    - Contract out a study of the workload performed by MBC investigators to compare with investigators of other DCA and state agencies to determine correct level.

AMENDED IN ASSEMBLY JULY 18, 2007

AMENDED IN SENATE MARCH 27, 2007

SENATE BILL No. 761

Introduced by Senator Ridley-Thomas

February 23, 2007

An act to amend Sections 2006, *2020,* and 2358 of, and to add Section 2347 to, the Business and Professions Code, and to amend Sections 12529, 12529.5, and 12529.6 of the Government Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 761, as amended, Ridley-Thomas. Healing arts: diversion: investigations.

Existing law, the Medical Practice Act, creates the Medical Board of California within the Department of Consumer Affairs. Existing law, until July 1, 2010, authorizes the board to employ an executive director and to employ investigators, legal counsel, medical consultants, and other assistance as it deems necessary.

This bill would also authorize the board to employ special agents, and would require the board, commencing on July 1, 2008, to transition investigators who are peace officers and who handle the most complex and varied types of disciplinary investigations into a special agent classification, as specified. The bill would require the first reclassification to be completed on or before June 30, 2009.

~~Existing law, the~~

The Medical Practice Act~~,~~ provides for the Division of Medical Quality of the Medical Board of California to oversee diversion programs for physician and surgeons with impairment due to abuse of drugs or alcohol, or due to mental or physical illness. Under existing

law, these provisions become inoperative on July 1, 2008, and are repealed on January 1, 2009.

This bill would extend the dates on which the provisions become inoperative to July 1, 2010, and would extend the dates on which the provisions are repealed to January 1, 2011. The bill would also require the board to create and appoint a Diversion Advisory Council. The council would be required to make recommendations and provide clinical quality improvement advice on matters specified by the board or a committee of the board. The council would also be required to elect a chairperson who would be required to report to the board, or a committee of the board, at its regularly scheduled meetings, as specified.

Existing law creates the Health Quality Enforcement Section within the Department of Justice with the primary responsibility of investigating and prosecuting proceedings against licensees and applicants within the jurisdiction of the Medical Board of California and various other boards. Existing law requires that attorneys staff the intake unit of specified regulatory boards to evaluate and screen complaints and develop uniform standards for their processing. Existing law also simultaneously assigns a complaint received by the medical board to an investigator and a deputy attorney general in the Health Quality Enforcement Section, *and provides that, for the duration of the assignment, the investigator is under the direction of the deputy attorney general.* Existing law makes these provisions inoperative on July 1, 2008, and repeals them on January 1, 2009, unless a later enacted statute deletes or extends those dates.

This bill would make those provisions inoperative on July 1, 2010, repeal them on January 1, 2011, unless a later enacted statute deletes or extends those dates, and would make other related changes. *The bill would delete the requirement that an investigator be under the direction of the deputy attorney general simultaneously assigned to a complaint, and would instead require that the investigator assist the deputy attorney general, who would be responsible for legal case direction.*

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 2006 of the Business and Professions
2 Code is amended to read:

2006. (a) On and after January 1, 2006, any reference in this chapter to an investigation by the board, or one of its divisions, shall be deemed to refer to an investigation conducted by employees of the Department of Justice.

(b) This section shall become inoperative on July 1, 2010, and as of January 1, 2011, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2011, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 2020 of the Business and Professions Code is amended to read:

2020. *(a)* The board may employ an executive director exempt from the provisions of the Civil Service Act and may also employ *special agents,* investigators, legal counsel, medical consultants, and other assistance as it may deem necessary to carry into effect this chapter. ~~The~~

(b) The board may fix the compensation to be paid for services subject to the provisions of applicable state laws and regulations and may incur other expenses as it may deem necessary. ~~Investigators~~

(c) Investigators employed by the board shall be provided special training in investigating medical practice activities.

~~The~~

(d) The Attorney General shall act as legal counsel for the board for any judicial and administrative proceedings and his or her services shall be a charge against it. ~~This~~

(e) The board shall begin the transition of investigators who are peace officers and who handle the most complex and varied types of disciplinary investigations into the special agent classification used by the Attorney General pursuant to Article 6 (commencing with Section 12570) of Chapter 6 of Part 2 of Division 3 of Title 2 of the Government Code. The first reclassification shall be initiated on or before July 1, 2008, and shall be completed on or before June 30, 2009.

(f) This section shall become inoperative on July 1, 2010, and, as of January 1, 2011, is repealed, unless a later enacted statute, which becomes effective on or before January 1, 2011, deletes or extends the dates on which it becomes inoperative and is repealed.

~~SEC. 2.~~

SEC. 3. Section 2347 is added to the Business and Professions Code, to read:

2347. (a) The board shall create and appoint a Diversion Advisory Council.

(b) The council shall make recommendations and provide clinical quality improvement advice on matters specified by the board or a committee of the board. The council shall elect from its membership a chairperson. The chairperson, or his or her designee, shall report to the board, or a committee of the board, at its regularly scheduled meetings.

(c) For purposes of this section, "committee" means a committee created by the board.

~~SEC. 3.~~

SEC. 4. Section 2358 of the Business and Professions Code is amended to read:

2358. This article shall become inoperative on July 1, 2010, and, as of January 1, 2011, is repealed, unless a later enacted statute that is enacted before January 1, 2011, deletes or extends the dates on which it becomes inoperative and is repealed.

~~SEC. 4.~~

SEC. 5. Section 12529 of the Government Code, as amended by Section 24 of Chapter 674 of the Statutes of 2005, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California including all committees under the jurisdiction of the board or a division of the board, including the Board of Podiatric Medicine, and the Board of Psychology.

(b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions.

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the

most complex and varied types of disciplinary actions against the licensees of the division or board.

(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, and the committees under the jurisdiction of the Medical Board of California or a division of the board, and the Board of Psychology, with the intent that the expenses be proportionally shared as to services rendered.

(e) This section shall become inoperative on July 1, 2010, and, as of January 1, 2011, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2011, deletes or extends the dates on which it becomes inoperative and is repealed.

~~SEC. 5.~~

SEC. 6. Section 12529 of the Government Code, as added by Section 25 of Chapter 674 of the Statutes of 2005, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California including all committees under the jurisdiction of the board or a division of the board, including the Board of Podiatric Medicine, and the Board of Psychology, and to provide ongoing review of the investigative activities conducted in support of those prosecutions, as provided in subdivision (b) of Section 12529.5.

(b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions.

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the division or board.

(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, and the committees under the jurisdiction of the Medical Board of California or a division of the board, and the Board of Psychology, with the intent that the expenses be proportionally shared as to services rendered.

(e) This section shall become operative July 1, 2010.

~~SEC. 6.~~

SEC. 7. Section 12529.5 of the Government Code, as amended by Section 26 of Chapter 674 of the Statutes of 2005, is amended to read:

12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California or the Board of Psychology shall be made available to the Health Quality Enforcement Section.

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to work on location at the intake unit of the boards described in subdivision (d) of Section 12529 to assist in evaluating and screening complaints and to assist in developing uniform standards and procedures for processing complaints.

(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards, division, or allied health committees, including the Board of Podiatric Medicine, in designing and providing initial and in-service training programs for staff of the division, boards, or allied health committees, including, but not limited to, information collection and investigation.

(d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, the board, or allied health committee, including the Board of Podiatric Medicine, or the Board of Psychology, as appropriate in consultation with the senior assistant.

(e) This section shall become inoperative on July 1, 2010, and, as of January 1, 2011, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2011, deletes or extends the dates on which it becomes inoperative and is repealed.

1 ~~SEC. 7.~~
2 *SEC. 8.* Section 12529.5 of the Government Code, as added
3 by Section 27 of Chapter 674 of the Statutes of 2005, is amended
4 to read:
5 12529.5. (a) All complaints or relevant information concerning
6 licensees that are within the jurisdiction of the Medical Board of
7 California or the Board of Psychology shall be made available to
8 the Health Quality Enforcement Section.
9 (b) The Senior Assistant Attorney General of the Health Quality
10 Enforcement Section shall assign attorneys to assist the division
11 and the boards in intake and investigations and to direct
12 discipline-related prosecutions. Attorneys shall be assigned to
13 work closely with each major intake and investigatory unit of the
14 boards, to assist in the evaluation and screening of complaints from
15 receipt through disposition and to assist in developing uniform
16 standards and procedures for the handling of complaints and
17 investigations.
18 A deputy attorney general of the Health Quality Enforcement
19 Section shall frequently be available on location at each of the
20 working offices at the major investigation centers of the boards,
21 to provide consultation and related services and engage in case
22 review with the boards' investigative, medical advisory, and intake
23 staff. The Senior Assistant Attorney General and deputy attorneys
24 general working at his or her direction shall consult as appropriate
25 with the investigators of the boards, medical advisors, and
26 executive staff in the investigation and prosecution of disciplinary
27 cases.
28 (c) The Senior Assistant Attorney General or his or her deputy
29 attorneys general shall assist the boards, division, or allied health
30 committees, including the Board of Podiatric Medicine, in
31 designing and providing initial and in-service training programs
32 for staff of the division, boards, or allied health committees,
33 including, but not limited to, information collection and
34 investigation.
35 (d) The determination to bring a disciplinary proceeding against
36 a licensee of the division or the boards shall be made by the
37 executive officer of the division, the board, or allied health
38 committee, including the Board of Podiatric Medicine, or the Board
39 of Psychology, as appropriate in consultation with the senior
40 assistant.

(e) This section shall become operative July 1, 2010.

~~SEC. 8.~~

SEC. 9. Section 12529.6 of the Government Code is amended to read:

12529.6. (a) The Legislature finds and declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state government. Because of the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons, and the evidentiary burden in the board's disciplinary cases, the Legislature finds and declares that using a vertical prosecution model for those investigations is in the best interests of the people of California.

(b) Notwithstanding any other provision of law, as of January 1, 2006, each complaint that is referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so assigned shall~~, under the direction of the deputy attorney general,~~ *assist the deputy attorney general, who shall provide legal case direction, and shall* be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action.

(c) The Medical Board of California, the Department of Consumer Affairs, and the Office of the Attorney General shall, if necessary, enter into an interagency agreement to implement this section.

(d) This section does not affect the requirements of Section 12529.5 as applied to the Medical Board of California where complaints that have not been assigned to a field office for investigation are concerned.

(e) This section shall become inoperative on July 1, 2010, and, as of January 1, 2011, is repealed, unless a later enacted statute,

1 that is enacted before January 1, 2011, deletes or extends the dates
2 on which it becomes inoperative and is repealed.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 764
Author: Migden
Chapter: VETOED (see attached veto message)
Subject: Health Care Providers
Sponsor: California Association of Physician Groups
Board Position: Support

DESCRIPTION OF LEGISLATION:

The Medical Board must report licensee information to OSHPD so that OSHPD can run projections and statistical data regarding primary care physicians in California. OSHPD must then prepare a report projecting the workforce of physicians in California.

IMPLEMENTATION:

None

October 10, 2007

BILL NUMBER: SB 764
VETOED DATE: 10/10/2007

To the Members of the California State Senate:

I am returning Senate Bill 764 without my signature.

While I share the goal of ensuring all Californians have access to physician services, I am unable to sign this bill as its goal can be more effectively accomplished administratively. In fact, my Administration already has efforts under way, in the context of my comprehensive health care reform proposal to discuss and develop strategies to improve the diversity and capacity of this State's health care workforce.

For these reasons, I am returning this bill without my signature.

Sincerely,

Arnold Schwarzenegger

CHAPTER _____

An act to amend Section 127775 of the Health and Safety Code, relating to health care providers.

LEGISLATIVE COUNSEL'S DIGEST

SB 764, Migden. Health care providers.

Existing law authorizes the Office of Statewide Health Planning and Development to receive basic data that the Medical Board of California may provide on individual licentiates.

This bill would, instead, require the office to receive, and the Medical Board of California and the Osteopathic Medical Board of California to provide, information respecting individual board licentiates upon request by the office.

The bill would also require, on or before June 1, 2009, the office to prepare and provide to the Legislature and the State Department of Health Care Services a report that makes a 5-year projection on the full time, practicing primary care physician and surgeon workforce in the state, as specified.

The people of the State of California do enact as follows:

SECTION 1. Section 127775 of the Health and Safety Code is amended to read:

127775. The office shall receive, and the Medical Board of California and the Osteopathic Medical Board of California shall provide, information respecting individual licentiates licensed by the board upon request by the office.

Information provided to the office pursuant to this section shall be transmitted in a form so that the name or license number of an individual licensee is not identifiable. However, an encoding procedure shall be used to assign a unique identifying number to the other information provided upon the questionnaire so as to allow the office to track the geographical movements of physicians for planning purposes.

SEC. 2. (a) The Office of Statewide Health Planning and Development shall, on or before June 1, 2009, prepare and provide to the Legislature and the State Department of Health Care

Services, for the department's consideration in setting Medi-Cal provider reimbursement rates, a report that makes a five-year projection on the full time, practicing primary care physician and surgeon workforce in the state for use in addressing geographic gaps in health care provided by these physicians and surgeons. The office shall request and use licentiate information provided by the Medical Board of California and the Osteopathic Medical Board of California and use publicly available information from any other public or private source necessary to make its projection. In preparing the report, the office shall consider all of the following:

(1) Demographic changes within the state's population.

(2) Immigration trends.

(3) Actual and potential impacts of health care reforms on the physician and surgeon workforce.

(4) The ages of practicing primary care physicians and surgeons.

(5) The expected number of primary care physicians and surgeons medical school graduates.

(6) Population growth.

(7) The current and recommended ratio of the number of primary physicians and surgeons to the state population.

(8) Geographic gaps in health care based on the location of primary care physicians and surgeons as compared to the locations of underserved populations.

(9) The number of physicians and surgeons enrolled as Medi-Cal providers.

(10) Cultural and linguistic proficiency of physicians and surgeons.

(b) For purposes of this section, "primary care physician and surgeon" means a physician and surgeon who provides medical services in any of the following specialties:

(1) Family practice.

(2) General internal medicine.

(3) General pediatrics.

(4) General practice.

(5) Gynecology.

(6) Obstetrics.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 767
Author: Ridley-Thomas
Chapter: 477
Subject: Drug overdose treatment: liability
Sponsor: County of Los Angeles and Harm Reduction Coalition
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill provides that any licensed physician who believes that another person is experiencing a drug overdose and who acts with reasonable care may administer an opioid antagonist, provided by specified health care professionals, to the person experiencing a drug overdose without being subject to civil liability for damages or criminal penalties as a result of that act. Other provisions also address avenues to minimize drug overdoses. This bill requires that local health jurisdictions operating opioid overdose prevention and treatment training programs collect prescribed data and report it to the State Department of Public Health. The Department of Public Health will be required to compile those reports for submission to the Legislature.

IMPLEMENTATION:

- Newsletter Article

October 15, 2007

Senate Bill No. 767

CHAPTER 477

An act to add and repeal Section 1714.22 of the Civil Code, relating to drug overdose treatment.

[Approved by Governor October 11, 2007. Filed with Secretary of State October 11, 2007.]

LEGISLATIVE COUNSEL'S DIGEST

SB 767, Ridley-Thomas. Drug overdose treatment: liability.

Existing law authorizes a physician and surgeon to prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment, as specified. Existing law prohibits, except in the regular practice of his or her profession, any person from knowingly prescribing, administering, dispensing, or furnishing a controlled substance to or for any person who is not under his or her treatment for a pathology or condition other than an addiction to a controlled substance, except as specified.

This bill would authorize, until January 1, 2011, a licensed health care provider, who is already permitted pursuant to existing law to prescribe an opioid antagonist, as defined, if acting with reasonable care, to prescribe and subsequently dispense or distribute an opioid antagonist in conjunction with an opioid overdose prevention and treatment training program, as defined, without being subject to civil liability or criminalprosecution. The bill would require a local health jurisdiction that operates or registers an opioid overdose prevention and treatment training program to collect prescribed data and report it to the Senate and Assembly Committees on Judiciary by January 1, 2010. The bill would provide that these provisions apply only to specified counties.

The people of the State of California do enact as follows:

SECTION 1. The Legislature hereby finds and declares that because drug overdose deaths are preventable, it is therefore an appropriate role for the state to do all of the following:

(a) Seek to prevent the onset of drug use through preventive measures.

(b) Provide cessation treatment for those addicted to drugs.

(c) Prosecute those who sell controlled substances.

(d) Seek to prevent needless death and damage caused by drug overdose by implementing appropriate crisis interventions when these interventions are needed.

SEC. 2. Section 1714.22 is added to the Civil Code, to read:

1714.22. (a) For purposes of this section:

(1) "Opioid antagonist" means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of a drug overdose.

(2) "Opioid overdose prevention and treatment training program" or "program" means any program operated by a local health jurisdiction or that is registered by a local health jurisdiction to train individuals to prevent, recognize, and respond to an opiate overdose, and that provides, at a minimum, training in all of the following:

(A) The causes of an opiate overdose.

(B) Mouth to mouth resuscitation.

(C) How to contact appropriate emergency medical services.

(D) How to administer an opioid antagonist.

(b) A licensed health care provider who is permitted by law to prescribe an opioid antagonist may, if acting with reasonable care, prescribe and subsequently dispense or distribute an opioid antagonist in conjunction with an opioid overdose prevention and treatment training program, without being subject to civil liability or criminal prosecution. This immunity shall apply to the licensed health care provider even when the opioid antagonist is administered by and to someone other than the person to whom it is prescribed.

(c) Each local health jurisdiction that operates or registers an opioid overdose prevention and treatment training program shall, by January 1, 2010, collect, and report to the Senate and Assembly Committees on Judiciary, all of the following data on programs within the jurisdiction:

(1) Number of training programs operating in the local health jurisdiction.

(2) Number of individuals who have received a prescription for, and training to administer, an opioid antagonist.

(3) Number of opioid antagonist doses prescribed.

(4) Number of opioid antagonist doses administered.

(5) Number of individuals who received opioid antagonist injections who were properly revived.

(6) Number of individuals who received opioid antagonist injections who were not revived.

(7) Number of adverse events associated with an opioid antagonist dose that was distributed as part of an opioid overdose prevention and treatment training program, including a description of the adverse events.

(d) This section shall apply only to the Counties of Alameda, Fresno, Humboldt, Los Angeles, Mendocino, San Francisco, and Santa Cruz.

(e) This section shall remain in effect only until January 1, 2011, and as of that date is repealed, unless a later enacted statute, that is enacted on or before January 1, 2011, deletes or extends that date.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 797
Author: Ridley-Thomas
Bill Date: September 7, 2007, amended
Subject: Professions and Vocations
Sponsor: Author
Board Position: Recommend: Support

STATUS OF BILL:

This bill was held on the Assembly Floor.

DESCRIPTION OF LEGISLATION:

This bill would have extended the provisions of the Health Quality Enforcement Section within the Department of Justice which is responsible for investigating and prosecuting proceedings against licensees and applicants within the jurisdiction of the Medical Board of California and various other boards. This bill would make those provisions inoperative on July 1, 2010, repeal them on January 1, 2011, and would make other related changes.

The bill would have specified that an investigator is not under the supervision of the deputy attorney general who is simultaneously assigned to a complaint. The bill would have required the medical board to increase its computer capabilities and compatibilities with the Health Quality Enforcement Section and to establish and implement a plan to locate its enforcement staff and the staff of the Health Quality Enforcement Section in the same offices. The bill would have required the medical board, in consultation with specified agencies, to report and make recommendations to the Governor and the Legislature on this enforcement and prosecution model by July 1, 2009.

IMPLEMENTATION:

- This bill was held on the floor, thus did not pass this session. This means there is no legislative extension of the pilot. The Board needs to examine issues related to the expiration of the pilot program. (see sunset of VE/P implementation under SB 761)

PAGES 28-38 OF 38

(2) Paragraph (7) of subdivision (a) shall apply only if all tax returns prepared by that employee are signed by an employer described in paragraph (7) of subdivision (a).

(3) No person described in this subdivision as an employee may sign a tax return, unless that employee is otherwise exempt under this section, is registered as a tax preparer with the Council, or is an employee of either a trust company or trust business described in paragraph (3) of subdivision (a), or any employee of a financial institution described in paragraph (4) of subdivision (a).

(4) In the case of any employee of a trust company or trust business described in paragraph (3) of subdivision (a), or any employee of a financial institution described in paragraph (4) of subdivision (a), the exemption provided under this subdivision shall only apply to activities conducted by that employee that are within the scope of his or her employment.

(c) For purposes of this section, preparation of a tax return includes the inputting of tax data into a computer.

SEC. 20. Section 22259 of the Business and Professions Code is amended to read:

22259. This chapter shall be subject to the review required by Division 1.2 (commencing with Section 473).

This chapter shall become inoperative on July 1, ~~2008~~ *2009*, and, as of January 1, ~~2009~~ *2010*, is repealed, unless a later enacted statute, which becomes effective on or before January 1, ~~2009~~ *2010*, deletes or extends that date on which it becomes inoperative and is repealed.

SEC. 21. Section 12529 of the Government Code, as amended by Section 24 of Chapter 674 of the Statutes of 2005, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California including all committees under the jurisdiction of the board or a division of the board, including the Board of Podiatric Medicine, and the Board of Psychology.

(b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed

to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions.

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the division or board.

(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, and the committees under the jurisdiction of the Medical Board of California or a division of the board, and the Board of Psychology, with the intent that the expenses be proportionally shared as to services rendered.

(e) This section shall become inoperative on July 1, ~~2008~~ *2010*, and, as of January 1, ~~2009~~ *2011*, is repealed, unless a later enacted statute, that becomes operative on or before January 1, ~~2009~~ *2011*, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 21.5 Section 12529 of the Government Code, as amended by Section 24 of Chapter 674 of the Statutes of 2005, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California ~~including all committees~~, *the California Board of Podiatric Medicine, the Board of Psychology, or any committee* under the jurisdiction of the ~~board~~ *Medical Board of California* or a division of the board~~, including the Board of Podiatric Medicine, and the Board of Psychology~~.

(b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the

management and supervision of attorneys performing those functions.

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the division or board.

(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, *the Board of Psychology,* and the committees under the jurisdiction of the Medical Board of California or a division of the board~~, and the Board of Psychology~~, with the intent that the expenses be proportionally shared as to services rendered.

(e) This section shall become inoperative on July 1, ~~2008~~ *2010*, and, as of January 1, ~~2009~~ *2011*, is repealed, unless a later enacted statute, that becomes operative on or before January 1, ~~2009~~ *2011*, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 22. Section 12529 of the Government Code, as added by Section 25 of Chapter 674 of the Statutes of 2005, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California including all committees under the jurisdiction of the board or a division of the board, including the Board of Podiatric Medicine, and the Board of Psychology, and to provide ongoing review of the investigative activities conducted in support of those prosecutions, as provided in subdivision (b) of Section 12529.5.

(b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions.

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the division or board.

(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, and the committees under the jurisdiction of the Medical Board of California or a division of the board, and the Board of Psychology, with the intent that the expenses be proportionally shared as to services rendered.

(e) This section shall become operative July 1, ~~2008~~ *2010.*

SEC. 22.5 Section 12529 of the Government Code, as added by Section 25 of Chapter 674 of the Statutes of 2005, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California ~~including all committees~~, *the California Board of Podiatric Medicine, the Board of Psychology, or any committee* under the jurisdiction of the ~~board~~ *Medical Board of California* or a division of the board~~,~~ ~~including the Board of Podiatric Medicine, and the Board of Psychology~~, and to provide ongoing review of the investigative activities conducted in support of those prosecutions, as provided in subdivision (b) of Section 12529.5.

(b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions.

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the

most complex and varied types of disciplinary actions against the licensees of the division or board.

(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, *the Board of Psychology,* and the committees under the jurisdiction of the Medical Board of California or a division of the board~~, and the Board of Psychology,~~ with the intent that the expenses be proportionally shared as to services rendered.

(e) This section shall become operative July 1,~~2008~~ *2010.*

SEC. 23. Section 12529.5 of the Government Code, as amended by Section 26 of Chapter 674 of the Statutes of 2005, is amended to read:

12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California or the Board of Psychology shall be made available to the Health Quality Enforcement Section.

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to work on location at the intake unit of the boards described in subdivision (d) of Section 12529 to assist in evaluating and screening complaints and to assist in developing uniform standards and procedures for processing complaints.

(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards, division, or allied health committees, including the Board of Podiatric Medicine, in designing and providing initial and in-service training programs for staff of the division, boards, or allied health committees, including, but not limited to, information collection and investigation.

(d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, the board, or allied health committee, including the Board of Podiatric Medicine, or the Board of Psychology, as appropriate in consultation with the senior assistant.

(e) This section shall become inoperative on July 1,~~2008~~ *2010,* and, as of January 1,~~2009~~ *2011,* is repealed, unless a later enacted statute, that becomes operative on or before January 1,~~2009~~ *2011,*

deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 23.5. Section 12529.5 of the Government Code, as amended by Section 26 of Chapter 674 of the Statutes of 2005, is amended to read:

12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California, *the California Board of Podiatric Medicine,* or the Board of Psychology shall be made available to the Health Quality Enforcement Section.

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to work on location at the intake unit of the boards described in subdivision (d) of Section 12529 to assist in evaluating and screening complaints and to assist in developing uniform standards and procedures for processing complaints.

(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards, division, or ~~allied health committees, including the Board of Podiatric Medicine,~~ *committees* in designing and providing initial and in-service training programs for staff of the division, boards, or ~~allied health~~ committees, including, but not limited to, information collection and investigation.

(d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, ~~the board, or allied health committee, including the Board of Podiatric Medicine, or the Board of Psychology~~ *boards, or committees*, as appropriate in consultation with the senior assistant.

(e) This section shall become inoperative on July 1, ~~2008~~ *2010*, and, as of January 1, ~~2009~~ *2011*, is repealed, unless a later enacted statute, that becomes operative on or before January 1, ~~2009~~ *2011*, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 24. Section 12529.5 of the Government Code, as added by Section 27 of Chapter 674 of the Statutes of 2005, is amended to read:

12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of

California or the Board of Psychology shall be made available to the Health Quality Enforcement Section.

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to assist the division and the boards in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit of the boards, to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations.

A deputy attorney general of the Health Quality Enforcement Section shall frequently be available on location at each of the working offices at the major investigation centers of the boards, to provide consultation and related services and engage in case review with the boards' investigative, medical advisory, and intake staff. The Senior Assistant Attorney General and deputy attorneys general working at his or her direction shall consult as appropriate with the investigators of the boards, medical advisors, and executive staff in the investigation and prosecution of disciplinary cases.

(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards, division, or allied health committees, including the Board of Podiatric Medicine, in designing and providing initial and in-service training programs for staff of the division, boards, or allied health committees, including, but not limited to, information collection and investigation.

(d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, the board, or allied health committee, including the Board of Podiatric Medicine, or the Board of Psychology, as appropriate in consultation with the senior assistant.

(e) This section shall become operative July 1, ~~2008~~ *2010*.

SEC. 24.5 Section 12529.5 of the Government Code, as added by Section 27 of Chapter 674 of the Statutes of 2005, is amended to read:

12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of

California, *the California Board of Podiatric Medicine,* or the Board of Psychology shall be made available to the Health Quality Enforcement Section.

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to assist the division and the boards in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit of the boards, to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations.

A deputy attorney general of the Health Quality Enforcement Section shall frequently be available on location at each of the working offices at the major investigation centers of the boards, to provide consultation and related services and engage in case review with the boards' investigative, medical advisory, and intake staff. The Senior Assistant Attorney General and deputy attorneys general working at his or her direction shall consult as appropriate with the investigators of the boards, medical advisors, and executive staff in the investigation and prosecution of disciplinary cases.

(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards, division, or ~~allied health committees, including the Board of Podiatric Medicine,~~ *committees* in designing and providing initial and in-service training programs for staff of the division, boards, or ~~allied health~~ committees, including, but not limited to, information collection and investigation.

(d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, ~~the board, or allied health committee, including the Board of Podiatric Medicine, or the Board of Psychology~~ *boards, or committees*, as appropriate in consultation with the senior assistant.

(e) This section shall become operative July 1, ~~2008~~ *2010.*

SEC. 26. Section 12529.6 of the Government Code is amended to read:

12529.6. (a) The Legislature finds and declares that the Medical Board of California, by ensuring the quality and safety

of medical care, performs one of the most critical functions of state government. Because of the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons, and the evidentiary burden in the board's disciplinary cases, the Legislature finds and declares that using a vertical *enforcement and* prosecution model for those investigations is in the best interests of the people of California.

(b) Notwithstanding any other provision of law, as of January 1, 2006, each complaint that is referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so assigned shall, under the direction *but not the supervision* of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action.

(c) The Medical Board of California, the Department of Consumer Affairs, and the Office of the Attorney General shall, if necessary, enter into an interagency agreement to implement this section.

(d) This section does not affect the requirements of Section 12529.5 as applied to the Medical Board of California where complaints that have not been assigned to a field office for investigation are concerned.

(e) It is the intent of the Legislature to enhance the vertical enforcement and prosecution model as set forth in subdivision (a). The Medical Board of California shall do both of the following:

(1) Increase its computer capabilities and compatibilities with the Health Quality Enforcement Section in order to share case information.

(2) Establish and implement a plan to locate its enforcement staff and the staff of the Health Quality Enforcement Section in

the same offices, as appropriate, in order to carry out the intent of the vertical enforcement and prosecution model.

~~(e)~~

(f) This section shall become inoperative on July 1, ~~2008~~ *2010*, and, as of January 1, ~~2009~~ *2011*, is repealed, unless a later enacted statute, that is enacted before January 1, ~~2009~~ *2011*, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 27. Section 12529.7 of the Government Code is amended to read:

12529.7. By July 1, ~~2007~~ *2009*, the Medical Board of California, in consultation with the Department of Justice, the Department of Consumer Affairs, the Department of Finance, and the Department of Personnel Administration, shall report and make recommendations to the Governor and the Legislature on the vertical *enforcement and* prosecution model created under Section 12529.6.

SEC. 28. Section 1.5 of this bill incorporates amendments to Section 490 of the Business and Professions Code proposed by both this bill and AB 1025. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2008, (2) each bill amends Section 490 of the Business and Professions Code, and (3) this bill is enacted after AB 1025, in which case Section 1 of this bill shall not become operative.

SEC. 29. Sections 21.5 and 22.5 of this bill incorporate amendments to Section 12529 of the Government Code proposed by both this bill and SB 1048. They shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2008, (2) each bill amends Section 12529 of the Government Code, and (3) this bill is enacted after SB 1048, in which case Sections 21 and 22 of this bill shall not become operative.

SEC. 30. Sections 23.5 and 24.5 of this bill incorporate amendments to Section 12529.5 of the Government Code proposed by both this bill and SB 1048. They shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2008, (2) each bill amends Section 12529.5 of the Government Code, and (3) this bill is enacted after SB 1048, in which case Sections 23 and 24 of this bill shall not become operative.

1 ~~SEC. 3.~~
2 *SEC. 31.* No reimbursement is required by this act pursuant to
3 Section 6 of Article XIII B of the California Constitution because
4 the only costs that may be incurred by a local agency or school
5 district will be incurred because this act creates a new crime or
6 infraction, eliminates a crime or infraction, or changes the penalty
7 for a crime or infraction, within the meaning of Section 17556 of
8 the Government Code, or changes the definition of a crime within
9 the meaning of Section 6 of Article XIII B of the California
10 Constitution.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1048
Author: Senate Business and Professions Committee
Chapter: 588
Subject: Healing Arts: Omnibus
Sponsor: Author
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill is the vehicle by which omnibus legislation is being carried. Some provisions impact statutes governing the Medical Practices Act.

The first provision, amending B&P code section 2177, allows an applicant who obtains a passing score on Part III of the USMLE in more than four attempts and who meets the requirements of Section 2135.5 to be eligible for a physician's license.

The second provision, amending B&P code section 2313, makes current the language to reflect changes specified in SB 1438 (2006) making references to B&P Code section 801 to now refer to section 801.1. It also revises language on collecting information on complaint forms as it is no longer practical to report on forms sent out by mail, as many are printed from the Web site.

A third provision, amending B&P code section 2335, adds 10 days to the 90-day period by which provisions and proposed decisions must be issued by the Board. This provision will make the requirements consistent with the Administrative Procedures Act so that all time periods will now be 100 days.

IMPLEMENTATION:

- Newsletter Article
- Notify Board staff
- Notify Attorney General's Office and the Office of Administrative Hearings

October 15, 2007

Senate Bill No. 1048

CHAPTER 588

An act to amend Sections 337, 1209, 1701.1, 1725, 1750, 1750.1, 1750.2, 1750.3, 1750.4, 1751, 1752, 1752.1, 1752.2, 1752.5, 1752.6, 1753, 1753.1, 1754, 1756, 1757, 1770, 2177, 2225, 2313, 2335, 2416, 2497.5, 2570.7, 2717, 2732.05, 3057, 3527, 3634, 4068, 4084, 4101, 4160, 4161, 4162, 4162.5, 4200, 4200.1, 4200.2, 4208, 4314, 4315, 4980.01, 4980.38, 4980.40, 4980.44, 4980.54, 4980.57, 4980.80, 4980.90, 4982, 4984.1, 4984.4, 4989.36, 4989.42, 4989.54, 4992.3, 4996.4, 4996.6, 4996.18, and 4996.22 of, to add Sections 1672, 2471, 2570.8, 4984.01, 4984.72, 4992.10, and 4996.28 to, and to repeal and add Sections 3530, 4984.7, 4984.8, 4996.3, 4996.14, and 4997 of, the Business and Professions Code, and to amend Sections 11372, 12529, and 12529.5 of the Government Code, relating to healing arts, and making an appropriation therefor.

[Approved by Governor October 13, 2007. Filed with Secretary of State October 13, 2007.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1048, Committee on Business, Professions and Economic Development. Healing arts.

(1) Existing law provides for the regulation and licensure of clinical laboratories and clinical laboratory personnel, including laboratory directors.

This bill would prohibit a laboratory director from directing more than a specified number of laboratories.

(2) Existing law, the Dental Practice Act, establishes the Dental Board of California and provides for the licensure and regulation of the practice of dentistry. The act makes the willful practice, attempt to practice, or advertisement to practice without appropriate authorization in circumstances causing harm, as specified, a misdemeanor offense. The act also provides for the licensure of various types of dental auxiliaries and for their licensure fees to be established by board resolution, and requires the board to adopt regulations for the approval and recognition of specified dental education courses. The act also provides for the establishment by board resolution of fees for the review of radiation courses and specialty registration courses. The act defines the functions certain dental auxiliaries are authorized to perform and the requirements for such authorization, and, on and after January 1, 2008, revises the criteria for licensure and the functions certain dental auxiliaries are authorized to perform. Under the act, commencing on that date, the board is authorized to issue dental auxiliary licenses for a registered orthodontic, surgery, and restorative assistant, and a dentist is authorized to train and educate employees in those licensure categories pursuant to specified procedures. The act requires the board, commencing

January 1, 2008, to adopt regulations governing the procedures that dental auxiliaries are authorized to perform.

This bill would delay from January 1, 2008, to January 1, 2010, the operation of provisions revising the duties and licensure criteria for certain dental auxiliaries and requiring the board to adopt regulations governing the procedures dental auxiliaries are authorized to perform. The bill would similarly delay the board's licensure of the additional dental auxiliary categories and would revise the procedures applicable to a dentist training his or her employees in those categories. The bill would revise the board's requirement to adopt regulations for the approval and recognition of dental education courses, and would revise the licensure and examination fee provisions for dental auxiliaries and apply the fee provisions applicable to review of radiation courses or specialty registration courses to the review of any course approval application. The bill would revise educational requirements for a registered dental assistant with relation to the performance of specified registered surgery assistant duties and monitoring of patients during the preoperative, intraoperative, and postoperative phases. The bill would make other related changes to the dental auxiliary provisions of the Dental Practice Act. The bill would also increase the punishment for unauthorized practice under the Dental Practice Act in circumstances causing harm, as specified, by making it a felony offense. The bill would authorize the board to require a licensee to pay the costs of monitoring probationary terms or conditions imposed on his or her license and would prohibit the board from renewing or reinstating a license if those costs are unpaid.

(3) Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California (the medical board) and for the licensure and regulation of podiatrists by the California Board of Podiatric Medicine (the podiatric board), within the jurisdiction of the medical board. Existing law creates the Health Quality Enforcement Section within the Department of Justice with the primary responsibility of prosecuting proceedings against licensees and applicants within the jurisdiction of the medical board and various other boards. Under existing law, a panel of administrative law judges, the Medical Quality Hearing Panel within the Office of Administrative Hearings, conducts disciplinary proceedings against licensees of the medical board and of boards under its jurisdiction. Existing law requires the podiatric board and the Division of Medical Quality of the medical board to issue an order of nonadoption of a proposed decision by the Medical Quality Hearing Panel within 90 days of receipt of the decision. Existing law requires that all complaints or relevant information concerning licensees that are within the jurisdiction of the medical board or the Board of Psychology be made available to the Health Quality Enforcement Section and requires the Division of Medical Quality of the medical board to report annually specified information to the Legislature relating to its operations and to the licensees of the medical board.

This bill would specify that an applicant remains eligible for a physician and surgeon's certificate issued by the medical board after having obtained

a passing score on the licensure examination in more than 4 attempts. The bill would authorize the podiatric board to employ, within the limits of the funds received by the podiatric board and subject to specified limitations, all personnel necessary to carry out the licensing and regulatory provisions applicable to podiatrists. The bill also would clarify that the provisions concerning the responsibilities of the Health Quality Enforcement Section within the Department of Justice apply to complaints and proceedings concerning licensees of the podiatric board. The bill would extend to 100 days the time period within which the podiatric board and the Division of Medical Quality are required to issue an order of nonadoption of a proposed decision by the Medical Quality Hearing Panel and would revise the information the division is required to include in its annual report to the Legislature.

(4) Existing law, the Occupational Therapy Act, establishes the California Board of Occupational Therapy and makes it responsible for issuing an occupational therapist's license and an occupational therapy assistant certification. The act requires that licensure and certification examinations be given at least twice each year at a place determined by the board and that the board provide notice of the examinations.

This bill would delete these particular provisions relating to licensure and certification examinations and would specify that the information on the board's Internet Web site is adequate for licensure verification purposes.

(5) Existing law, the Nursing Practice Act, provides for the registration and regulation of nurses by the Board of Registered Nursing in the Department of Consumer Affairs. Existing law requires an employer of, or agent for, a registered nurse to ascertain that the nurse is authorized to practice as a registered professional nurse. A violation of the Nursing Practice Act is a crime.

This bill would require an employer of, or agent for, a registered nurse required to hold a board-issued certification, as specified, or a temporary licensee or interim permittee to practice nursing to ascertain that the person is currently authorized to practice pursuant to the board-issued certification or as a temporary licensee or interim permittee. Because this bill would impose new requirements under the Nursing Practice Act, the violation of which would be a crime, it would impose a state-mandated local program.

(6) Under existing law, the Optometry Practice Act, the State Board of Optometry licenses and regulates persons engaged in the practice of optometry and makes a violation of the act a crime. Existing law requires an applicant for licensure to meet certain requirements, including signing a release allowing disclosure of information from the National Practitioner Data Bank.

This bill would instead require an applicant for licensure to sign a release allowing disclosure of information from the Healthcare Integrity and Protection Data Bank.

(7) Existing law, the Physician Assistant Practice Act, provides for the licensing and regulation of physician assistants by the Physician Assistant Committee of the Medical Board of California. Existing law provides for

1770. (a) A licensed dentist may simultaneously utilize in his or her practice no more than two dental auxiliaries in extended functions licensed pursuant to Sections 1756 and 1768.

(b) This section shall remain in effect only until January 1, 2010, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2010, deletes or extends that date.

SEC. 25.5. Section 1770 of the Business and Professions Code, as amended by Section 22 of Chapter 621 of the Statutes of 2005, is amended to read:

1770. (a) A licensed dentist may simultaneously utilize in his or her practice no more than two dental assistants in extended functions or registered dental hygienists in extended functions licensed pursuant to Sections 1756 and 1918.

(b) This section shall remain in effect only until January 1, 2010, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2010, deletes or extends that date.

SEC. 26. Section 1770 of the Business and Professions Code, as amended by Section 23 of Chapter 621 of the Statutes of 2005, is amended to read:

1770. (a) A licensed dentist may simultaneously utilize in his or her practice no more than three dental auxiliaries in extended functions licensed pursuant to Sections 1753 and 1768.

(b) This section shall become operative on January 1, 2010.

SEC. 26.5. Section 1770 of the Business and Professions Code, as amended by Section 23 of Chapter 621 of the Statutes of 2005, is amended to read:

1770. (a) A licensed dentist may simultaneously utilize in his or her practice no more than three dental assistants in extended functions or registered dental hygienists in extended functions licensed pursuant to Sections 1753 and 1918.

(b) This section shall become operative on January 1, 2010.

SEC. 27. Section 2177 of the Business and Professions Code is amended to read:

2177. (a) A passing score is required for an entire examination or for each part of an examination, as established by resolution of the Division of Licensing.

(b) Applicants may elect to take the written examinations conducted or accepted by the division in separate parts.

(c) (1) An applicant shall have obtained a passing score on Part III of the United States Medical Licensing Examination within not more than four attempts in order to be eligible for a physician's and surgeon's certificate.

(2) Notwithstanding paragraph (1), an applicant who obtains a passing score on Part III of the United States Medical Licensing Examination in more than four attempts and who meets the requirements of Section 2135.5 shall be eligible to be considered for issuance of a physician's and surgeon's certificate.

SEC. 28. Section 2225 of the Business and Professions Code is amended to read:

2225. (a) Notwithstanding Section 2263 and any other provision of law making a communication between a physician and surgeon or a doctor of podiatric medicine and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted under this chapter. Members of the board, the Senior Assistant Attorney General of the Health Quality Enforcement Section, members of the California Board of Podiatric Medicine, and deputies, employees, agents, and representatives of the board or the California Board of Podiatric Medicine and the Senior Assistant Attorney General of the Health Quality Enforcement Section shall keep in confidence during the course of investigations, the names of any patients whose records are reviewed and may not disclose or reveal those names, except as is necessary during the course of an investigation, unless and until proceedings are instituted. The authority of the board or the California Board of Podiatric Medicine and the Health Quality Enforcement Section to examine records of patients in the office of a physician and surgeon or a doctor of podiatric medicine is limited to records of patients who have complained to the board or the California Board of Podiatric Medicine about that licensee.

(b) Notwithstanding any other provision of law, the Attorney General and his or her investigative agents, and investigators and representatives of the board or the California Board of Podiatric Medicine, may inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, whichever is applicable, and may inspect documents relevant to those investigations in accordance with the following procedures:

(1) Any document relevant to an investigation may be inspected, and copies may be obtained, where patient consent is given.

(2) Any document relevant to the business operations of a licensee, and not involving medical records attributable to identifiable patients, may be inspected and copied where relevant to an investigation of a licensee.

(c) In all cases where documents are inspected or copies of those documents are received, their acquisition or review shall be arranged so as not to unnecessarily disrupt the medical and business operations of the licensee or of the facility where the records are kept or used.

(d) Where documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of the board or the California Board of Podiatric Medicine, they shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and surgeon for any violation of this section. This remedy is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

(e) Searches conducted of the office or medical facility of any licensee shall not interfere with the recordkeeping format or preservation needs of any licensee necessary for the lawful care of patients.

SEC. 29. Section 2313 of the Business and Professions Code is amended to read:

2313. The Division of Medical Quality shall report annually to the Legislature, no later than October 1 of each year, the following information:

(a) The total number of temporary restraining orders or interim suspension orders sought by the board or the division to enjoin licensees pursuant to Sections 125.7, 125.8 and 2311, the circumstances in each case that prompted the board or division to seek that injunctive relief, and whether a restraining order or interim suspension order was actually issued.

(b) The total number and types of actions for unprofessional conduct taken by the board or a division against licensees, the number and types of actions taken against licensees for unprofessional conduct related to prescribing drugs, narcotics, or other controlled substances, including those related to the undertreatment or undermedication of pain.

(c) Information relative to the performance of the division, including the following: number of consumer calls received; number of consumer calls or letters designated as discipline-related complaints; number of complaint forms received; number of Section 805 reports by type; number of Section 801.01 and Section 803 reports; coroner reports received; number of convictions reported to the division; number of criminal filings reported to the division; number of complaints and referrals closed, referred out, or resolved without discipline, respectively, prior to accusation; number of accusations filed and final disposition of accusations through the division and court review, respectively; final physician discipline by category; number of citations issued with fines and without fines, and number of public reprimands issued; number of cases in process more than six months from receipt by the division of information concerning the relevant acts to the filing of an accusation; average and median time in processing complaints from original receipt of complaint by the division for all cases at each stage of discipline and court review, respectively; number of persons in diversion, and number successfully completing diversion programs and failing to do so, respectively; probation violation reports and probation revocation filings and dispositions; number of petitions for reinstatement and their dispositions; and caseloads of investigators for original cases and for probation cases, respectively.

"Action," for purposes of this section, includes proceedings brought by, or on behalf of, the division against licensees for unprofessional conduct that have not been finally adjudicated, as well as disciplinary actions taken against licensees.

(d) The total number of reports received pursuant to Section 805 by the type of peer review body reporting and, where applicable, the type of health care facility involved and the total number and type of administrative or disciplinary actions taken by the Medical Board of California with respect to the reports.

(e) The number of malpractice settlements in excess of thirty thousand dollars ($30,000) reported pursuant to Section 801.01. This information shall be grouped by specialty practice and shall include the total number of physicians and surgeons practicing in each specialty. For the purpose of this subdivision, "specialty" includes all specialties and subspecialties considered in determining the risk categories described in Section 803.1.

SEC. 30. Section 2335 of the Business and Professions Code is amended to read:

2335. (a) All proposed decisions and interim orders of the Medical Quality Hearing Panel designated in Section 11371 of the Government Code shall be transmitted to the executive director of the board, or the Executive Director of the California Board of Podiatric Medicine as to the licensees of that board, within 48 hours of filing.

(b) All interim orders shall be final when filed.

(c) A proposed decision shall be acted upon by a panel of the Division of Medical Quality or the California Board of Podiatric Medicine, as the case may be, in accordance with Section 11517 of the Government Code, except that all of the following shall apply to proceedings against licensees under this chapter:

(1) When considering a proposed decision, the division panel and the California Board of Podiatric Medicine shall give great weight to the findings of fact of the administrative law judge, except to the extent those findings of fact are controverted by new evidence.

(2) The Division of Medical Quality or the California Board of Podiatric Medicine shall poll the members of the division panel or California Board of Podiatric Medicine by written mail ballot concerning the proposed decision. The mail ballot shall be sent within 10 calendar days of receipt of the proposed decision, and shall poll each member on whether the member votes to approve the decision, to approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of additional evidence, to defer final decision pending discussion of the case by the panel or board as a whole, or to nonadopt the decision. No party to the proceeding, including employees of the agency that filed the accusation, and no person who has a direct or indirect interest in the outcome of the proceeding or who presided at a previous stage of the decision, may communicate directly or indirectly, upon the merits of a contested matter while the proceeding is pending, with any member of the panel or board, without notice and opportunity for all parties to participate in the communication. The votes of four members of a division panel, and a majority of the California Board of Podiatric Medicine, are required to approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of further evidence, or to nonadopt the decision. The votes of two members of the panel or board are required to defer final decision pending discussion of the case by the panel or board as a whole. If there is a vote by the specified number to defer final decision pending discussion of the case by the panel or board as a whole, provision

shall be made for that discussion before the 100-day period specified in paragraph (3) expires, but in no event shall that 100-day period be extended.

(3) If four members of a division panel, or a majority of the California Board of Podiatric Medicine vote to do so, the panel of the division and the California Board of Podiatric Medicine shall issue an order of nonadoption of a proposed decision within 100 calendar days of the date it is received by the board. If a panel of the division or the California Board of Podiatric Medicine does not refer the case back to the administrative law judge for the taking of additional evidence or issue an order of nonadoption within 100 days, the decision shall be final and subject to review under Section 2337. Members of a panel of the division or the California Board of Podiatric Medicine who review a proposed decision or other matter and vote by mail as provided in paragraph (2) shall return their votes by mail to the board within 30 days from receipt of the proposed decision or other matter.

(4) The division panel or California Board of Podiatric Medicine shall afford the parties the opportunity to present oral argument before deciding a case after nonadoption of the administrative law judge's decision.

(5) A vote of four members of a division panel, or a majority of the California Board of Podiatric Medicine, are required to increase the penalty from that contained in the proposed administrative law judge's decision. No member of the division panel or of the California Board of Podiatric Medicine may vote to increase the penalty except after reading the entire record and personally hearing any additional oral argument and evidence presented to the panel or board.

SEC. 30.5. Section 2335 of the Business and Professions Code is amended to read:

2335. (a) All proposed decisions and interim orders of the Medical Quality Hearing Panel designated in Section 11371 of the Government Code shall be transmitted to the executive director of the board, or the Executive Director of the California Board of Podiatric Medicine as to the licensees of that board, within 48 hours of filing.

(b) All interim orders shall be final when filed.

(c) A proposed decision shall be acted upon by the board or by any panel appointed pursuant to Section 2008 or by the California Board of Podiatric Medicine, as the case may be, in accordance with Section 11517 of the Government Code, except that all of the following shall apply to proceedings against licensees under this chapter:

(1) When considering a proposed decision, the board or panel and the California Board of Podiatric Medicine shall give great weight to the findings of fact of the administrative law judge, except to the extent those findings of fact are controverted by new evidence.

(2) The board's staff or the staff of the California Board of Podiatric Medicine shall poll the members of the board or panel or of the California Board of Podiatric Medicine by written mail ballot concerning the proposed decision. The mail ballot shall be sent within 10 calendar days of receipt of the proposed decision, and shall poll each member on whether the member votes to approve the decision, to approve the decision with an altered penalty,

to refer the case back to the administrative law judge for the taking of additional evidence, to defer final decision pending discussion of the case by the panel or board as a whole, or to nonadopt the decision. No party to the proceeding, including employees of the agency that filed the accusation, and no person who has a direct or indirect interest in the outcome of the proceeding or who presided at a previous stage of the decision, may communicate directly or indirectly, upon the merits of a contested matter while the proceeding is pending, with any member of the panel or board, without notice and opportunity for all parties to participate in the communication. The votes of a majority of the board or of the panel, and a majority of the California Board of Podiatric Medicine, are required to approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of further evidence, or to nonadopt the decision. The votes of two members of the panel or board are required to defer final decision pending discussion of the case by the panel or board as a whole. If there is a vote by the specified number to defer final decision pending discussion of the case by the panel or board as a whole, provision shall be made for that discussion before the 100-day period specified in paragraph (3) expires, but in no event shall that100-day period be extended.

(3) If a majority of the board or of the panel, or a majority of the California Board of Podiatric Medicine vote to do so, the board or the panel or the California Board of Podiatric Medicine shall issue an order of nonadoption of a proposed decision within 100 calendar days of the date it is received by the board. If the board or the panel or the California Board of Podiatric Medicine does not refer the case back to the administrative law judge for the taking of additional evidence or issue an order of nonadoption within 100 days, the decision shall be final and subject to review under Section 2337. Members of the board or of any panel or of the California Board of Podiatric Medicine who review a proposed decision or other matter and vote by mail as provided in paragraph (2) shall return their votes by mail to the board within 30 days from receipt of the proposed decision or other matter.

(4) The board or the panel or the California Board of Podiatric Medicine shall afford the parties the opportunity to present oral argument before deciding a case after nonadoption of the administrative law judge's decision.

(5) A vote of a majority of the board or of a panel, or a majority of the California Board of Podiatric Medicine, are required to increase the penalty from that contained in the proposed administrative law judge's decision. No member of the board or panel or of the California Board of Podiatric Medicine may vote to increase the penalty except after reading the entire record and personally hearing any additional oral argument and evidence presented to the panel or board.

SEC. 31. Section 2416 of the Business and Professions Code is amended to read:

2416. Physicians and surgeons and doctors of podiatric medicine may conduct their professional practices in a partnership or group of physician and surgeons or a partnership or group of doctors of podiatric medicine,

Medical Board of California
2007 Tracker II - Legislative Bills
10/22/2007

BILL	AUTHOR	TITLE	STATUS	AMENDED	POSITION
AB 14	Laird	Discrimination: Civil Rights Act	Chapter #568	08/27/07	
AB 34	Portantino	Umbilical Cord Blood Collection Program	Chapter #158	09/07/07	
AB 54	Dymally	Health Care Coverage: Acupuncture	Health	03/08/07	
AB 64	Berg	Uniform Emergency Volunteer Health Practitioners Act	Sen. Rules	07/11/07	
AB 139	Bass	Vehicles: Schoolbus Drivers: Medical Examinations	Chapter #158	07/10/07	
AB 158	Ma	Public Health	Approps. Susp.	05/01/07	
AB 249	Eng	Licensees: Healing Arts: Settlement Agreements	Vetoed		
AB 269	Eng	Dentists: License Renewal	Chapter #262	08/30/07	
AB 272	Garcia	HIV Tests	Health		
AB 295	Lieu	State Agencies: Collection of Demographic Data	Vetoed	08/23/07	
AB 309	Tran	State Boards and Commissions: Salaries: Suspension	B&P	04/12/07	
AB 325	Nava	Peace Officers: Recruitment	App-Susp.	03/19/07	
AB 374	Berg	California Compassionate Choices Act	Floor	05/25/07	
AB 436	Salas	Medical Records	Health	04/09/07	
AB 555	Nakanishi	Healing Arts: medical records	Introduced		Support concept
AB 632	Salas	Health Care Facilities: Whistleblower Protections	Chapter #683	09/05/07	
AB 636	Levine	Acupuncture	B&P	03/27/07	
AB 644	Dymally	Workers' Comp.: medical treatment utilization reivew	Insurance	04/09/07	
AB 682	Berg	HIV/AIDS Testing	Chapter #550	09/04/07	
AB 865	Davis	State Agencies: Live Customer Service Agents	B&P	04/23/07	
AB 871	Davis	Hypertension and Diabetes	Introduced		
AB 961	Hernandez	Diabetes	Appr. Susp.	05/01/07	
AB 1009	Benoit	Fetal Pain Prevention	Health		
AB 1039	Parra	Medical Referral Services	Introduced		
AB 1044	Strickland	Optometrists: Regulation	B&P	04/09/07	

Orange = Chaptered Bills **Green = Vetoed Bills** **Yellow = Bills with Board Positions**

Medical Board of California
2007 Tracker II - Legislative Bills
10/22/2007

BILL	AUTHOR	TITLE	STATUS	AMENDED	POSITION
AB 1057	Beall	Health Care: Traumatic Brain Injury: Pilot Program	Senate Health	07/03/07	
AB 1102	Nakanishi	Prescription Lenses: fitting of lenses	Introduced		
AB 1137	Eng	Chiropractors	Sen. B&P	06/04/07	
AB 1154	Leno	Diabetes	Health	04/10/07	Refer to Access to Care
AB 1178	Hernandez	Medical Information: Disclosures	Chapter #506	08/27/07	
AB 1198	Benoit	Law Enf. Response Costs: Driving Under the Influence	Judiciary		
AB 1276	Karnette	Pharmacies: Prescription Containers: Labels	B&P	04/17/07	Support
AB 1298	Jones	Personal Information: Disclosure	Chapter #699	08/23/07	
AB 1390	Huffman	Health Care Service Plans: Unfair Payment Patterns	Sen. Health		
AB 1393	Leno	Public Records	Vetoed	08/31/07	
AB 1399	Richardson	Pharmacies: Prescription Labels	Health		
AB 1429	Evans	Human Papillonavirus Vaccination	Vetoed	06/27/07	
AB 1436	Hernandez	Nurse Practitioners: Scope of Practice	B&P	05/30/07	Oppose
AB 1444	Emmerson	Physical Therapists: Scope of Practice	B&P	04/09/07	Oppose
AB 1468	Garrick	Hospitals: Patient Data	Health	04/10/07	
AB 1480	Mendoza	Physicians and Surgeons: Medical Board of CA	Introduced		
AB 1486	Calderon	Licensed Professional Counselors	Sen. B&P	06/26/07	
AB 1531	DeSaulnier	Vehicles: Disabled Parking	Chapter #413	09/07/07	
AB 1555	Lieber	Health Care Services: Chronic Care Model Task Force	Approps.	04/26/07	
AB 1643	Niello	Nurse Practitioners	B&P		Oppose unless amend
SB 136	Cedillo	Acupuncture: Tui Na	B&P	04/16/07	
SB 284	Lowenthal	Certified Athletic Trainers: Registration	Vetoed	07/10/07	
SB 320	Alquist	CA Health Care Information Infrastructure Program	Vetoed	06/26/07	
SB 356	Negrete McLeod	List of Reportable Diseases and Conditions	Inactive File	08/20/07	

Orange = Chaptered Bills **Green = Vetoed Bills** **Yellow = Bills with Board Positions**

Medical Board of California
2007 Tracker II - Legislative Bills
10/22/2007

BILL	AUTHOR	TITLE	STATUS	AMENDED	POSITION
SB 533	Yee	Health: Immunizations: Pneumococcus	Vetoed	08/31/07	
SB 557	Wiggins	Worker's Comp: Audiologists	Vetoed	08/30/07	
SB 615	Oropeza	Pharmacy Technicians: Scholarship & Loan Repayment Prog	Vetoed	08/27/07	
SB 618	Alquist	State Agencies: Electronic Records	Appr.-Susp		
SB 661	Maldonado	Healing Arts: Anatomic Pathology Services	Chapter #656	09/04/07	
SB 676	Ridley-Thomas	Health: Immunizations	Asm. Approps.	08/20/07	
SB 721	Ashburn	State Agencies: Succession Plans	Asm. Approps.		
SB 731	Oropeza	Massage Therapy	Asm. Approps.	07/09/07	
SB 743	Kuehl	Hospitals: Medical Errors	Floor	05/16/07	
SB 801	Ridley-Thomas	Chiropractors	Vetoed	09/12/07	
SB 809	Ashburn	Nurse Practitioners: Scope of Practice	B&P	03/26/07	Oppose
SB 822	Aanestad	Immunity: Evaluation of Practitioner of Healing Arts	Chapter #36	07/10/07	
SB 840	Kuehl	Single-Payer Health Care Coverage	Asm. Approps.	07/10/07	
SB 843	Calderon	Medical Information	Judiciary	04/18/07	
SB 850	Maldonado	Vital Statistics: Certificate of Still Birth	Chapter #661	08/30/07	
SB 907	Calderon	Physicians and Surgeons: Referrals	B&P		Oppose
SB 962	Migden	Umbilical Cord Blood: Research	Chapter #517	09/07/07	
SB 963	Ridley-Thomas	Regulatory Boards: Operations	Asm. B&P	06/25/07	
SB 971	McClintock	Government Reorganization: Realignment of Closure	G.O.		
SB 993	Aanestad	Psychologists: Scope of Practice: prescribing drugs	B&P	04/18/07	Oppose
SB 1014	Kuehl	Taxation: Single-Payer Health Care Coverage Tax	Rev.&Tax	04/23/07	
SB 1047	B&P Comm.	Professions and Vocations	Chapter #354	08/20/07	

Orange = Chaptered Bills **Green = Vetoed Bills** **Yellow = Bills with Board Positions**

ASSEMBLY BILL No. 555

Introduced by Assembly Member Nakanishi

February 21, 2007

An act relating to the healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 555, as introduced, Nakanishi. Healing arts: medical records.

Existing law, the Medical Practice Act, creates the Medical Board of California and makes it responsible for issuing a physician's and surgeon's certificate to qualified applicants and for regulating the practice of physicians and surgeons. Under existing law, a general acute care hospital is required to maintain a medical records system that organizes the records for each patient under a unique identifier but is not required to maintain the records in an electronic format.

This bill would express the Legislature's intent to require the board to work with interested parties to develop an electronic system that would allow any physician and surgeon in this state to access the medical records of the patient he or she requires in order to treat that patient.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. It is the intent of the Legislature to require the
2 Medical Board of California to work with all interested parties to
3 develop an electronic system that would allow any physician and

1 surgeon in the state to access the medical records of the patient
2 that the physician and surgeon requires in order to treat that patient.

O

AMENDED IN ASSEMBLY APRIL 10, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL No. 1154

Introduced by Assembly Member Leno

February 23, 2007

An act to add ~~Section 131086 to~~ *and repeal Section 131086 of* the Health and Safety Code, relating to diabetes.

LEGISLATIVE COUNSEL'S DIGEST

AB 1154, as amended, Leno. Diabetes.

Existing law authorizes the State Department of Health Services to perform studies, demonstrate innovative methods, and disseminate information relating to the protection, preservation, and advancement of public health. Effective July 1, 2007, these duties will be transferred to the State Department of Public Health.

This bill would ~~declare the intent of the Legislature to enact legislation that establishes a statewide pilot project to provide free diabetes medicines and supplies to specified public employees~~ *require the department, in consultation with the California Health Alliance Commission, to develop a diabetes risk reduction pilot program within 24 counties to analyze and report the outcomes from integrative care to the causes of diabetes through proactive prevention.*

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

The people of the State of California do enact as follows:

1 *SECTION 1. The Legislature finds and declares all of the*
2 *following:*

(a) Clear and substantial evidence indicates that a combination of better food and hydration, with prudent activity and a healthy attitude, promotes health and reduces the risk of chronic diseases, particularly diabetes. The benefits of this combination range from restorative sleep to enhanced hormone and neurochemical balance. All of these contribute to, and are synergistic in achieving, a healthy balance of sugar and energy in the body. As a result, effective habit modification is able to reduce the risk of diabetes, particularly in at-risk participants.

(b) Recent research confirms a rapid and accelerating increase in diabetes, particularly in California's children. The human and financial costs are staggering and avoidable. Access to healthier choices and resources facilitates the practice of healthy habits.

(c) Diabetes and its antecedents and consequences drain precious resources from the state.

(d) Diabetes negatively impacts productivity and quality of life, while increasing substantially the risk of complications ranging from heart attacks to kidney failure, stroke to blindness, and fragile blood vessels to amputation. The promotion of healthy habits that is reinforced with information and documentation of perceived and tangible benefits is more effective than communicating a general message of prevention while largely focusing on early disease detection and communicating the principles of prevention in the abstract rather than actionable terms.

(e) Proactive prevention in diabetes risk mitigation is a public health concept that supports community health promotion habits and practices that show evidence-based efficacy in at-risk populations. Proactive prevention programs include incentives for more whole foods, fruits, vegetables, pulses, nuts, seeds, and herbs along with adequate water, regular physical activity, and expression or receipt of appreciation and for the help we can be to ourselves and those in need. All this contributes to better weight maintenance by eating a balanced variety of nourishing foods and drinking adequate amounts of water and herbal teas, choosing moments in which to appreciate what we have, and enjoying the kind of regular activity appropriate to our functional age and abilities.

(f) A primary strategy of proactive prevention is to increase access to health enhancing practices, resources, and choices. Reinforcement of healthier choices and reduction of barriers

coupled with incentives for use are components of this approach. Incentives for health promoting actions are both financial and emotional.

(g) Existing law requires the State Department of Health Services to promote the public health and welfare.

(h) It is the intent of the Legislature that the program established pursuant to this act will document the program outcomes in rigorous tests and formal statistical measures, as well as by consumer quality of life outcome surveys performed by the California Health Alliance.

(i) It is the intent of the Legislature that the program established pursuant to this act will document the benefits of proactive prevention in diabetes risk mitigation at its cause.

(j) It is also the intent of the Legislature for the pilot program established pursuant to this act to improve the health and well-being of at-risk Californians by addressing the causes of diabetes and monitoring the benefits people enjoy through the application of proactive prevention.

SEC. 2. Section 131086 is added to the Health and Safety Code, to read:

131086. (a) As used in this section:

(1) "Commission" means the California Health Alliance Commission, a private nonprofit organization focused upon the health of the state's citizens.

(2) "Department" means the State Department of Public Health.

(3) "Director" means the state public health officer.

(b) The department shall, in consultation with the California Health Alliance, develop a diabetes risk reduction pilot program within 24 counties to analyze and report the outcomes from integrative care to the causes of diabetes through proactive prevention.

(c) The program shall include all of the following components:

(1) The use of information technology and media to facilitate and reinforce messages of the benefits of more nutritious whole foods, including fresh fruits and vegetables, seeds, nuts, and herbs along with good hydration. These messages and resources to increase physical activity shall be coupled with an appreciation of those who take these constructive steps. Specially trained pharmacists and nurses shall provide reminders that include, for example, the importance of mineral and water intake during

exercise or exposure to temperatures over 80°F or cold and dry conditions.

(2) The monitoring of risks that predict diabetes development or progression.

(3) Reporting, after review by the California Health Alliance Commission, to the director on the opportunities to improve quality of life outcomes and reduce lifetime costs through the application of the pilot program.

(4) Quarterly internal updates on how the program increases access, reinforces the benefits, and documents the results of the program. These quarterly updates shall be delivered to the commission no later than 30 days after the close of each quarter and to the department at least annually.

(5) Strategies to reduce diabetes risk within low-income, at-risk communities and populations.

(6) Strategies to promote the health of food stamp recipients and reduce health risk behaviors. These strategies shall be a priority of the program.

(7) Inclusion of the federal Centers for Disease Control and Prevention's Diabetes Prevention Guidelines to document the risk and harm reduction as well as to document the outcomes of this program.

(d) In communities selected to enroll in the pilot program, the department shall provide dedicated health professionals and support personnel to implement the pilot program, as recommended by the commission's Diabetes Risk Reduction Update.

(e) The department shall provide technical and logistical support as needed and predicated upon funding of the public-private partnership responsible for this pilot program.

(f) The department, in consultation with the State Department of Social Services, shall seek any necessary federal government approvals to allow the use of the Food Stamp Electronic Benefits Card, as provided in Chapter 3 (commencing with Section 10065) of Part 1 of Division 9 of the Welfare and Institutions Code, to provide incentives, and to implement this pilot program during the 2008–09 fiscal year.

(g) In developing the pilot program, the department shall include all of the following:

(1) At least two counties that have above the food stamp average county participation.

(2) At least two counties that have below the food stamp average county participation.

(3) At least two counties with above-average rates of diabetes.

(4) At least two counties with above-average rates of obesity.

(5) At least two counties with above-average rates of cardiovascular diseases.

(6) At least two counties with a predominantly Native American population.

(7) At least two counties with a predominantly African-American population.

(8) At least two counties with a predominantly Hispanic population.

(9) At least two urban counties.

(10) At least two rural counties.

(h) The department shall consider all of the following in choosing counties to participate in the program.

(1) The level of need in the community.

(2) The size of the food stamp population.

(3) The need for geographic diversity.

(4) The availability of technology in targeted counties and communities to implement the program and collect the data necessary to evaluate the pilot program.

(i) The department shall seek all necessary approvals to establish the pilot program, and shall apply for available, prequalified federal matching funds to support the work of the pilot program.

(j) The department shall develop, in consultation with the commission, a process for evaluating the effectiveness of the pilot program. The evaluation shall examine the impact of the various strategies employed in the pilot program on the use of healthier choices, particularly those aimed at diabetes risk reduction. The evaluation shall also test options that are appropriate to each community and implement those options with the highest likely benefit for that community. The department shall contract with the commission to conduct and perform real-time data collection and prompt data analysis of outcomes. The department shall make recommendations to the Legislature regarding the continuation of the pilot program, and any state or federal policy changes needed to support the goals of the pilot program.

(k) This section shall become inoperative on July 1 following the fourth fiscal year after the first appropriation is made in the annual Budget Act or other statute, and as of the following January 1 is repealed, unless a later enacted statute, that is enacted before that date deletes or extends that date.

~~SECTION 1. Section 131086 is added to the Health and Safety Code, to read:~~

~~131086. It is the intent of the Legislature enact legislation that establishes a statewide pilot project to provide free diabetes medicines and supplies to state, county, and municipal employees who have the disease, if the employee agree to undergo monthly counseling from specially trained pharmacists.~~

O

AMENDED IN ASSEMBLY MAY 30, 2007

AMENDED IN ASSEMBLY APRIL 17, 2007

AMENDED IN ASSEMBLY APRIL 9, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL No. 1436

Introduced by Assembly Member Hernandez
(~~Coauthors: Assembly Members Emmerson and Niello~~ *Coauthor: Assembly Member Niello*)

February 23, 2007

An act to amend Sections 2725, 2725.1, ~~2835.5, 2836.1, 3502.1, 3502.5, and 3516 of, to add Sections 2835.7 and 3502.01 to, and to repeal Section 3516.1 of,~~ *2835.5, and 2836.1 of, and to add Section 2835.7 to,* the Business and Professions Code, relating to the ~~healing arts~~ *nursing*.

LEGISLATIVE COUNSEL'S DIGEST

AB 1436, as amended, Hernandez. ~~Healing arts~~ *Nurse practitioners*: scope of practice.

~~(1)~~ Existing law, the Nursing Practice Act, provides for the certification and regulation of nurse practitioners and nurse-midwives by the Board of Registered Nursing and specifies requirements for certification as a nurse practitioner. Under the act, the practice of nursing is defined, in part, as providing direct and indirect patient care service ordered by specified healing arts practitioners, including dispensing of drugs or devices upon their order in a clinic setting, as defined.

This bill would specify that the practice of nursing includes those actions taken pursuant to an order by a nurse practitioner or a nurse-midwife. The bill would provide that a nurse practitioner is

authorized to perform comprehensive health care services for which he or she is educationally prepared and competent to perform and to admit and discharge patients from health facilities in collaboration, as defined, with specified healing arts practitioners. The bill would deem specified authorizations by a physician and surgeon to include authorizations provided by a certified nurse practitioner. The bill would require a certified nurse practitioner to consult or refer a patient to another health care provider if a situation or condition ~~occurred~~ *occurs* beyond the nurse practitioner's knowledge and experience. The bill would revise the educational requirements for certification as a nurse practitioner and would require a nurse practitioner to be certified by a nationally recognized certifying body approved by the board.

Because this bill would impose additional requirements under the Nursing Practice Act, the violation of which would be a crime, it would impose a state-mandated local program.

~~(2) Existing law, the Physician Assistant Practice Act, provides for the licensure of physician assistants by the Physician Assistant Committee of the Medical Board of California. Under the act, a physician assistant is authorized to perform medical services under the supervision of a physician and surgeon who is limited to supervising no more than 2 physician assistants at a time, except in certain circumstances. The act prohibits a physician assistant from administering, providing, or issuing a drug order for controlled substances, as specified, without approval by the supervising physician and surgeon.~~

~~This bill would require a physician assistant and his or her supervising physician and surgeon to establish written supervision guidelines, as specified, and would require the supervising physician and surgeon to review medical records of a sample of patients treated by the physician assistant. The bill would delete the requirement of advance approval by a supervising physician and surgeon prior to a physician assistant administering, providing, or issuing a drug order for a controlled substance, as specified, and would delete the limitation on the number of physician assistants that may be supervised by a physician and surgeon.~~

~~(3)~~ The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 2725 of the Business and Professions
2 Code is amended to read:
3 2725. (a) In amending this section at the 1973–74 session, the
4 Legislature recognizes that nursing is a dynamic field, the practice
5 of which is continually evolving to include more sophisticated
6 patient care activities. It is the intent of the Legislature in amending
7 this section at the 1973–74 session to provide clear legal authority
8 for functions and procedures that have common acceptance and
9 usage. It is the legislative intent also to recognize the existence of
10 overlapping functions between physicians and registered nurses
11 and to permit additional sharing of functions within organized
12 health care systems that provide for collaboration between
13 physicians and registered nurses. These organized health care
14 systems include, but are not limited to, health facilities licensed
15 pursuant to Chapter 2 (commencing with Section 1250) of Division
16 2 of the Health and Safety Code, clinics, home health agencies,
17 physicians' offices, and public or community health services.
18 (b) The practice of nursing within the meaning of this chapter
19 means those functions, including basic health care, that help people
20 cope with difficulties in daily living that are associated with their
21 actual or potential health or illness problems or the treatment
22 thereof, and that require a substantial amount of scientific
23 knowledge or technical skill, including all of the following:
24 (1) Direct and indirect patient care services that ensure the
25 safety, comfort, personal hygiene, and protection of patients; and
26 the performance of disease prevention and restorative measures.
27 (2) Direct and indirect patient care services, including, but not
28 limited to, the administration of medications and therapeutic agents,
29 necessary to implement a treatment, disease prevention, or
30 rehabilitative regimen ordered by and within the scope of licensure
31 of a physician, dentist, podiatrist, nurse practitioner, nurse-midwife,
32 or clinical psychologist, as defined by Section 1316.5 of the Health
33 and Safety Code.
34 (3) The performance of skin tests, immunization techniques,
35 and the withdrawal of human blood from veins and arteries.

(4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

(c) "Standardized procedures," as used in this section, means either of the following:

(1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses.

(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system that is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

The policies and protocols shall be subject to any guidelines for standardized procedures that the Division of Licensing of the Medical Board of California and the Board of Registered Nursing may jointly promulgate. If promulgated, the guidelines shall be administered by the Board of Registered Nursing.

(d) Nothing in this section shall be construed to require approval of standardized procedures by the Division of Licensing of the Medical Board of California, or by the Board of Registered Nursing.

(e) No state agency other than the board may define or interpret the practice of nursing for those licensed pursuant to the provisions of this chapter, or develop standardized procedures or protocols pursuant to this chapter, unless so authorized by this chapter, or specifically required under state or federal statute. "State agency" includes every state office, officer, department, division, bureau, board, authority, and commission.

SEC. 2. Section 2725.1 of the Business and Professions Code is amended to read:

2725.1. Notwithstanding any other provision of law, a registered nurse may dispense drugs or devices upon an order by

a licensed physician and surgeon, nurse practitioner, or ~~nurse midwife~~ *nurse-midwife* if the nurse is functioning within a licensed clinic as defined in paragraphs (1) and (2) of subdivision (a) of Section 1204 of, or within a clinic as defined in subdivision (b) or (c) of Section 1206, of the Health and Safety Code.

No clinic shall employ a registered nurse to perform dispensing duties exclusively. No registered nurse shall dispense drugs in a pharmacy or keep a pharmacy, open shop, or drugstore for the retailing of drugs or poisons. No registered nurse shall compound drugs. Dispensing of drugs by a registered nurse, except a certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51 or a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, shall not include substances included in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code). Nothing in this section shall exempt a clinic from the provisions of Article 13 (commencing with Section 4180) of Chapter 9.

SEC. 3. Section 2835.5 of the Business and Professions Code is amended to read:

2835.5. (a) A registered nurse who is holding himself or herself out as a nurse practitioner or who desires to hold himself or herself out as a nurse practitioner shall, within the time prescribed by the board and prior to his or her next license renewal or the issuance of an initial license, submit educational, experience, and other credentials and information as the board may require for it to determine that the person qualifies to use the title "nurse practitioner," pursuant to the standards and qualifications established by the board.

(b) Upon finding that a person is qualified to hold himself or herself out as a nurse practitioner, the board shall appropriately indicate on the license issued or renewed, that the person is qualified to use the title "nurse practitioner." The board shall also issue to each qualified person a certificate evidencing that the person is qualified to use the title "nurse practitioner."

(c) A person who has been found to be qualified by the board to use the title "nurse practitioner" prior to the effective date of this section, shall not be required to submit any further qualifications or information to the board and shall be deemed to have met the requirements of this section.

(d) On and after January 1, 2008, an applicant for initial qualification or certification as a nurse practitioner under this article who has not been qualified or certified as a nurse practitioner in California or any other state shall meet the following requirements:

(1) Hold a valid and active registered nursing license issued under this chapter.

(2) Possess a master's or doctoral degree in nursing.

(3) Satisfactorily complete a nurse practitioner program approved by the board.

(4) Be certified as a nurse practitioner by a nationally recognized certifying body approved by the board.

SEC. 4. Section 2835.7 is added to the Business and Professions Code, to read:

2835.7. (a) A certificate to practice as a nurse practitioner authorizes the holder to provide comprehensive health care services, including, but not limited to, diagnosis, psychosocial assessment, and management of health and illness needs, for which the nurse practitioner has been educationally prepared and is clinically competent to perform.

(b) Notwithstanding any other provision of law, a nurse practitioner in collaboration with a physician and surgeon or doctor of osteopathy, may admit patients to and discharge patients from hospitals, skilled nursing facilities, nursing facilities, home health care, hospice facilities, and other inpatient facilities. "Collaboration," for the purposes of this section, is defined as a relationship between a nurse practitioner and a physician and surgeon that includes both autonomous and cooperative decisionmaking, with the nurse practitioner and the physician and surgeon contributing their respective expertise.

(c) Notwithstanding any other provision of law, whenever any law or regulation requires a signature, certification, stamp, verification, affidavit, or endorsement by a physician and surgeon, it shall be deemed to include a signature, certification, stamp, verification, affidavit, or endorsement by a nurse practitioner.

(d) A nurse practitioner shall consult or refer a patient to a physician and surgeon or other health care provider if the referral will protect the health and welfare of the patient and a situation or condition occurs in a patient that is beyond the nurse practitioner's knowledge and experience.

(e) Nothing in this article shall be construed to limit, revise, or expand the current scope of practice of a registered nurse as defined in Section 2527.

(f) The board has sole authority to interpret the practice of nurse practitioners.

SEC. 5. Section 2836.1 of the Business and Professions Code is amended to read:

2836.1. Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing or ordering drugs or devices when all of the following apply:

(a) The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

(b) The nurse practitioner is functioning pursuant to standardized procedure, as defined by Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.

(c) (1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the provisions of the standardized procedure.

(2) In addition to the requirements in paragraph (1), for Schedule II controlled substance protocols, the provision for furnishing Schedule II controlled substances shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration, as defined in Section 2835.7, on the development

of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.

(e) For purposes of this section, no physician and surgeon shall supervise more than four nurse practitioners at one time.

(f) (1) Drugs or devices furnished or ordered by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and shall be further limited to those drugs agreed upon by the nurse practitioner and physician and surgeon and specified in the standardized procedure.

(2) When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner's standardized procedure relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order.

(g) (1) The board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed (1) at least six month's physician and surgeon-supervised experience in the furnishing or ordering of drugs or devices and (2) a course in pharmacology covering the drugs or devices to be furnished or ordered under this section.

(2) Nurse practitioners who are certified by the board and hold an active furnishing number, who are authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board. The board shall establish the requirements for satisfactory completion of this subdivision.

(h) Use of the term "furnishing" in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include (1) the ordering of a drug or device in accordance

with the standardized procedure and (2) transmitting an order of a supervising physician and surgeon.

(i) "Drug order" or "order" for purposes of this section means an order for medication ~~which~~ *that* is dispensed to or for an ultimate user, issued by a nurse practitioner as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by nurse practitioners; and (3) the signature of a nurse practitioner on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

~~SEC. 6. Section 3502.01 is added to the Business and Professions Code, to read:~~

~~3502.01. (a) A physician assistant and his or her supervising physician and surgeon shall establish in writing, guidelines for the adequate supervision of the physician assistant. The supervising physician and surgeon may adopt protocols to satisfy this requirement for the performance of tasks by a physician assistant.~~

~~(b) The minimum content for a protocol governing diagnosis and management of a patient by a physician assistant shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, medications to recommend to the patient, and education to be provided to the patient. A protocol for procedures shall state the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the followup care for the patient.~~

~~(c) Protocols shall be developed by the physician and surgeon and adopted from, or referenced to, texts or other sources. The physician and surgeon and the physician assistant he or she supervises shall sign and date the protocols.~~

~~(d) The physician and surgeon shall review, countersign, and date a sample of medical records of patients treated within the last 30 days by the physician assistant he or she supervises and who functions under the protocols developed pursuant to this section.~~

~~The size of the sample shall be determined by the supervising physician and surgeon in his or her judgment. The physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.~~

~~SEC. 7. Section 3502.1 of the Business and Professions Code is amended to read:~~

~~3502.1. (a) In addition to the services authorized in the regulations adopted by the board, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).~~

~~(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.~~

~~(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. The drugs listed shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.~~

~~(b) "Drug order" for purposes of this section means an order for medication that is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their~~

~~supervising physicians, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.~~

~~(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician before it is filled or carried out.~~

~~(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.~~

~~(2) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.~~

~~(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and phone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant. The requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.~~

~~(e) The medical record of any patient cared for by a physician assistant for whom the supervising physician and surgeon's Schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven days.~~

~~(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA).~~

~~(g) The committee shall consult with the Medical Board of California and report during its sunset review required by Division 1.2 (commencing with Section 473) the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient.~~

~~SEC. 8. Section 3502.5 of the Business and Professions Code is amended to read:~~

~~3502.5. Notwithstanding any other provision of law, a physician assistant may perform those medical services permitted pursuant to Section 3502 during any state of war emergency, state of emergency, or state of local emergency, as defined in Section 8558 of the Government Code, and at the request of a responsible federal, state, or local official or agency, or pursuant to the terms of a mutual aid operation plan established and approved pursuant to the California Emergency Services Act (Chapter 7 (commencing with Section 8550) of Division 1 of Title 2 of the Government Code), regardless of whether the physician assistant's approved supervising physician is available to supervise the physician assistant, so long as a licensed physician is available to render the appropriate supervision. "Appropriate supervision" shall not require the personal or electronic availability of a supervising physician if that availability is not possible or practical due to the emergency. The local health officers and their designees may act as supervising physicians during emergencies without being subject to approval by the board. At all times, the local health officers or their designees supervising the physician assistants shall be licensed physicians and surgeons.~~

~~No responsible official or mutual aid operation plan shall invoke this section except in the case of an emergency that endangers the health of individuals. Under no circumstances shall this section~~

~~be invoked as the result of a labor dispute or other dispute concerning collective bargaining.~~

~~SEC. 9. Section 3516 of the Business and Professions Code is amended to read:~~

~~3516. Notwithstanding any other provision of law, a physician assistant licensed by the committee shall be eligible for employment or supervision by a physician and surgeon who is qualified to supervise physician assistants.~~

~~The board may restrict a physician and surgeon to supervising specific types of physician assistants including, but not limited to, restricting a physician and surgeon from supervising physician assistants outside of the field of specialty of the physician and surgeon.~~

~~SEC. 10. Section 3516.1 of the Business and Professions Code is repealed.~~

~~SEC. 11.~~

SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

AMENDED IN ASSEMBLY APRIL 9, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL No. 1444

Introduced by Assembly Member Emmerson
(Coauthor: Senator Alquist)

February 23, 2007

An act to amend Section 2620 of the Business and Professions Code, relating to physical therapists.

LEGISLATIVE COUNSEL'S DIGEST

AB 1444, as amended, Emmerson. Physical therapists: scope of practice.

Existing law, the Physical Therapy Practice Act, creates the Physical Therapy Board of California and makes it responsible for the licensure and regulation of physical therapists. The act defines the term "physical therapy" for its purposes and makes it a crime to ~~practice physical therapy without a license issued by the board~~ *violate any of its provisions.*

This bill would ~~make nonsubstantive changes to this provision that defines "physical therapy."~~ *revise the definition of "physical therapy" and would authorize a physical therapist to initiate treatment of conditions within the scope of physical therapist practice and require a physical therapist to refer his or her patient to another specified healing arts practitioner if the physical therapist has reason to believe the patient has a condition requiring treatment or services beyond that scope of practice.*

Because the bill would specify additional requirements under the Physical Therapy Practice Act, the violation of which would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

1 SECTION 1. Section 2620 of the Business and Professions
2 Code is amended to read:
3 ~~2620. (a) Physical therapy means the art and science of~~
4 *2620. (a) Physical therapy means examining, evaluating, and*
5 *testing a person with mechanical, physiological, and developmental*
6 *movement-related impairments, functional limitations, and*
7 *disabilities or other health and movement-related conditions in*
8 *order to develop a plan of therapeutic intervention and to initiate*
9 *treatment. Physical therapy is the art and science of* physical or
10 corrective rehabilitation or of physical or corrective treatment of
11 a bodily or mental condition of a person by the use of the physical,
12 chemical, and other properties of heat, light, water, electricity,
13 sound, massage, and active, passive, and resistive exercise, and
14 shall include physical therapy evaluation, treatment planning,
15 instruction, and consultative services. The practice of physical
16 therapy includes the promotion and maintenance of physical fitness
17 to enhance the bodily movement related health and wellness of
18 individuals through the use of physical therapy interventions. The
19 use of roentgen rays and radioactive materials, for diagnostic and
20 therapeutic purposes, and the use of electricity for surgical
21 purposes, including cauterization, are not authorized under the
22 term "physical therapy" as used in this chapter, and a license issued
23 pursuant to this chapter does not authorize the diagnosis of disease.
24 *(b) A physical therapist may initiate treatment of conditions*
25 *within the scope of practice of a physical therapist. If at any time,*
26 *the physical therapist has reason to believe that the patient he or*
27 *she is treating has signs or symptoms of a condition that requires*
28 *treatment or services beyond the scope of practice of a physical*
29 *therapist, the physical therapist shall refer the patient to a person*

holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California or by a person licensed to practice dentistry, podiatric medicine, or chiropractic.

~~(b)~~

(c) Nothing in this section shall be construed to restrict or prohibit other healing arts practitioners licensed or registered under this division from practice within the scope of their license or registration.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

ASSEMBLY BILL No. 1643

Introduced by Assembly Member Niello
(Coauthors: Assembly Members Benoit, Huff, Smyth, Strickland, Tran, and Villines)

February 23, 2007

An act to amend Sections 2836.1, 2836.3, and 3640.5 of the Business and Professions Code, relating to nurse practitioners.

LEGISLATIVE COUNSEL'S DIGEST

AB 1643, as introduced, Niello. Nurse practitioners.

Existing law does not prohibit a nurse practitioner from furnishing or ordering drugs or devices under conditions that require physician and surgeon supervision. For purposes of these conditions, a physician and surgeon is prohibited from supervising more than 4 nurse practitioners at one time.

This bill would repeal the prohibition against a physician and surgeon supervising more than 4 nurse practitioners at one time. It would also make conforming changes.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 2836.1 of the Business and Professions
2 Code is amended to read:
3 2836.1. Neither this chapter nor any other provision of law
4 shall be construed to prohibit a nurse practitioner from furnishing
5 or ordering drugs or devices when all of the following apply:

(a) The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

(b) The nurse practitioner is functioning pursuant to standardized procedure, as defined by Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.

(c) (1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the provisions of the standardized procedure.

(2) In addition to the requirements in paragraph (1), for Schedule II controlled substance protocols, the provision for furnishing Schedule II controlled substances shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.

~~(e) For purposes of this section, no physician and surgeon shall supervise more than four nurse practitioners at one time.~~

(e) (1) Drugs or devices furnished or ordered by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and shall be further limited to those drugs agreed

upon by the nurse practitioner and physician and surgeon and specified in the standardized procedure.

(2) When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner's standardized procedure relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order.

~~(g)~~

(f) (1) The board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed ~~(1)~~ *(A)* at least six ~~month's~~ *months'* physician and surgeon-supervised experience in the furnishing or ordering of drugs or devices and ~~(2)~~ *(B)* a course in pharmacology covering the drugs or devices to be furnished or ordered under this section.

(2) Nurse practitioners who are certified by the board and hold an active furnishing number, who are authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board. The board shall establish the requirements for satisfactory completion of this subdivision.

~~(h)~~

(g) Use of the term "furnishing" in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include (1) the ordering of a drug or device in accordance with the standardized procedure and (2) transmitting an order of a supervising physician and surgeon.

~~(i)~~

(h) "Drug order" or "order" for purposes of this section means an order for medication which is dispensed to or for an ultimate user, issued by a nurse practitioner as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law,

(1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by nurse practitioners; and (3) the signature of a nurse practitioner on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

SEC. 2. Section 2836.3 of the Business and Professions Code is amended to read:

2836.3. (a) The furnishing of drugs or devices by nurse practitioners is conditional on issuance by the board of a number to the nurse applicant who has successfully completed the requirements of subdivision ~~(g)~~ *(f)* of Section 2836.1. The number shall be included on all transmittals of orders for drugs or devices by the nurse practitioner. The board shall make the list of numbers issued available to the Board of Pharmacy. The board may charge the applicant a fee to cover all necessary costs to implement this section.

(b) The number shall be renewable at the time of the applicant's registered nurse license renewal.

(c) The board may revoke, suspend, or deny issuance of the numbers for incompetence or gross negligence in the performance of functions specified in Sections 2836.1 and 2836.2.

SEC. 3. Section 3640.5 of the Business and Professions Code is amended to read:

3640.5. Nothing in this chapter or any other provision of law shall be construed to prohibit a naturopathic doctor from furnishing or ordering drugs when all of the following apply:

(a) The drugs are furnished or ordered by a naturopathic doctor in accordance with standardized procedures or protocols developed by the naturopathic doctor and his or her supervising physician and surgeon.

(b) The naturopathic doctor is functioning pursuant to standardized procedure, as defined by subdivisions (a), (b), (d)~~,~~ ~~(e)~~ *(g)*, *and* (h),~~ and (i)~~ of Section 2836.1 and paragraph (1) of subdivision (c) of Section 2836.1, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the naturopathic doctor, and, where applicable, the facility administrator or his or her designee.

(c) The standardized procedure or protocol covering the furnishing of drugs shall specify which naturopathic doctors may furnish or order drugs, which drugs may be furnished or ordered under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the naturopathic doctor's competence, including peer review, and review of the provisions of the standardized procedure.

(d) The furnishing or ordering of drugs by a naturopathic doctor occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include all of the following:

(1) Collaboration on the development of the standardized procedure.

(2) Approval of the standardized procedure.

(3) Availability by telephonic contact at the time of patient examination by the naturopathic doctor.

(e) For purposes of this section, a physician and surgeon shall not supervise more than four naturopathic doctors at one time.

(f) Drugs furnished or ordered by a naturopathic doctor may include Schedule III through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and shall be further limited to those drugs agreed upon by the naturopathic doctor and physician and surgeon as specified in the standardized procedure. When Schedule III controlled substances, as defined in Section 11056 of the Health and Safety Code, are furnished or ordered by a naturopathic doctor, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the naturopathic doctor's standardized procedure relating to controlled substances shall be provided upon request, to a licensed pharmacist who dispenses drugs, when there is uncertainty about the naturopathic doctor furnishing the order.

(g) The bureau has certified that the naturopathic doctor has satisfactorily completed adequate coursework in pharmacology covering the drugs to be furnished or ordered under this section. The bureau shall establish the requirements for satisfactory completion of this subdivision.

(h) Use of the term "furnishing" in this section, in health facilities defined in subdivisions (b), (c), (d), (e), and (i) of Section 1250 of the Health and Safety Code, shall include both of the following:

(1) Ordering a drug in accordance with the standardized procedure.

(2) Transmitting an order of a supervising physician and surgeon.

(i) For purposes of this section, "drug order" or "order" means an order for medication which is dispensed to or for an ultimate user, issued by a naturopathic doctor as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations.

(j) Notwithstanding any other provision of law, the following apply:

(1) A drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician.

(2) All references to prescription in this code and the Health and Safety Code shall include drug orders issued by naturopathic doctors.

(3) The signature of a naturopathic doctor on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

O

AMENDED IN SENATE MARCH 26, 2007

SENATE BILL No. 809

Introduced by ~~Senator Ashburn~~ *Senators Ashburn and Runner*

February 23, 2007

~~An act relating to primary care services.~~ *An act to amend Sections 2725.1, 2835.5, 2836, 2836.1, 2836.2, 2836.3, 3640, 3640.5, 4024, 4040, 4060, 4061, 4076, 4170, and 4174 of, and to add Section 2835.7 to, the Business and Professions Code, to amend Sections 11150 and 120582 of the Health and Safety Code, and to amend Sections 14111, 14111.5, and 16952 of the Welfare and Institutions Code, relating to nursing.*

LEGISLATIVE COUNSEL'S DIGEST

SB 809, as amended, Ashburn. ~~Primary care clinics: underserved areas: improved access.~~ *Nurse practitioners: scope of practice.*

(1) Existing law, the Nursing Practice Act, provides for the certification and regulation of nurse practitioners and nurse-midwives by the Board of Registered Nursing and requires the board to establish categories of, and standards for, nurse practitioners in consultation with specified health care practitioners, including physicians and surgeons with expertise in the nurse practitioner field. Existing law requires nurse practitioners to meet certain requirements, including educational requirements, and authorizes a nurse practitioner who has been issued a board number for the furnishing or ordering of drugs to furnish or order drugs under certain conditions, including pursuant to standardized procedures or protocols and under the supervision of a physician and surgeon. Existing law prohibits a physician and surgeon from supervising more than 4 nurse practitioners at one time. A violation of the Nursing Practice Act is a crime.

This bill would set forth the activities that a nurse practitioner is authorized to engage in, and would delete the requirement that the board consult with physicians and surgeons in establishing categories of nurse practitioners. The bill would revise the educational requirements for certification as a nurse practitioner and would require a nurse practitioner to be certified by a nationally recognized certifying body approved by the board. The bill would allow a nurse practitioner to prescribe drugs and devices if he or she has been certified by the board to have satisfactorily completed at least 6 months of supervised experience in the prescribing of drugs and devices and if such prescribing is consistent with his or her education or established clinical competency, would delete the requirement of standardized procedures and protocols, and would delete the requirement of physician supervision. The bill would require that a nurse practitioner be issued a board number prior to prescribing drugs and devices and would allow revocation or suspension or denial of a board number for incompetence or gross negligence. The bill would delete the prohibition against a physician and surgeon supervising more than 4 nurse practitioners at one time.

Because this bill would impose additional requirements under the Nursing Practice Act, the violation of which would be a crime, it would impose a state-mandated local program.

(2) Existing law, the Medi-Cal Act, provides for the Medi-Cal program, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons. The act authorizes certain covered health care services provided under in a long-term health care facility to be delegated to a nurse practitioner if specified conditions are met, including mandatory supervision by a physician and surgeon.

This bill would remove the requirement of mandatory supervision of the nurse practitioner by a physician and surgeon in order for the services to be delegated to a nurse practitioner.

(3) Existing law, the Emergency Medical Services System and Prehospital Emergency Medical Care Personnel Act, authorizes a county to establish an emergency medical services fund for reimbursement of emergency medical service related costs. Existing law makes physician and surgeons eligible to receive payment from the fund for patient care services, as specified, performed by a nurse practitioner or nurse-midwife under the direct supervision of a physician and surgeon.

This bill would also make a nurse practitioner eligible to receive payment for those patient care services and would remove the requirement of supervision of the services by a physician and surgeon. The bill would authorize a nurse practitioner to receive reimbursement for emergency services and inpatient and outpatient obstetric pediatric services that the nurse practitioner determines to be medically necessary.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law provides for licensing of clinics by the State Department of Health Services, and establishes the Primary Clinic Revolving Fund for the purposes of providing payments to clinics. Effective July 1, 2007, these duties will be transferred to the State Department of Public Health.~~

~~This bill would declare the intent of the Legislature to subsequently amend this bill to include provisions that would improve access to primary care in underserved areas by encouraging establishment of additional clinics by allowing registered nurse practitioners greater flexibility to operate clinics.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

1 *SECTION 1. Section 2725.1 of the Business and Professions*
2 *Code is amended to read:*
3 2725.1. Notwithstanding any other provision of law, a
4 registered nurse may dispense drugs or devices upon an order by
5 a licensed physician and surgeon, *nurse practitioner, or nurse*
6 *midwife* if the nurse is functioning within a licensed clinic as
7 defined in paragraphs (1) and (2) of subdivision (a) of Section
8 1204 of, or within a clinic as defined in subdivision (b) or (c) of
9 Section 1206, of the Health and Safety Code.
10 No clinic shall employ a registered nurse to perform dispensing
11 duties exclusively. No registered nurse shall dispense drugs in a
12 pharmacy~~,~~ *or* keep a pharmacy, open shop, or drugstore for the

retailing of drugs or poisons. No registered nurse shall compound drugs. Dispensing of drugs by a registered nurse, except a certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51 or a nurse practitioner ~~who functions pursuant to a standardized procedure described in Section 2836.1, or protocol~~, shall not include substances included in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code). Nothing in this section shall exempt a clinic from the provisions of Article 13 (commencing with Section 4180) of Chapter 9.

SEC. 2. Section 2835.5 of the Business and Professions Code is amended to read:

2835.5. (a) A registered nurse who is holding himself or herself out as a nurse practitioner or who desires to hold himself or herself out as a nurse practitioner shall, within the time prescribed by the board and prior to his or her next license renewal or the issuance of an initial license, submit educational, experience, and other credentials and information as the board may require for it to determine that the person qualifies to use the title "nurse practitioner," pursuant to the standards and qualifications established by the board.

(b) Upon finding that a person is qualified to hold himself or herself out as a nurse practitioner, the board shall appropriately indicate on the license issued or renewed, that the person is qualified to use the title "nurse practitioner." The board shall also issue to each qualified person a certificate evidencing that the person is qualified to use the title "nurse practitioner."

(c) A person who has been found to be qualified by the board to use the title "nurse practitioner" prior to the effective date of this section, shall not be required to submit any further qualifications or information to the board and shall be deemed to have met the requirements of this section.

(d) On and after January 1, 2008, an applicant for initial qualification or certification as a nurse practitioner under this article who has not been qualified or certified as a nurse practitioner in California or any other state shall meet the following requirements:

(1) Hold a valid and active registered nursing license issued under this chapter.

(2) Possess a master's degree in nursing~~, a master's degree in a clinical field related to nursing,~~ or a ~~graduate~~ *doctoral* degree in nursing.

(3) Satisfactorily complete a nurse practitioner program approved by the board.

(4) Be certified as a nurse practitioner by a nationally recognized certifying body approved by the board.

SEC. 3. Section 2835.7 is added to the Business and Professions Code, to read:

2835.7. (a) A nurse practitioner may do all of the following:

(1) Perform a comprehensive history and physical examination.

(2) Establish diagnoses for physical, mental, or emotional ailments or potential ailments.

(3) Admit patients to hospitals and nursing facilities.

(4) Order, perform, and interpret laboratory, radiographic, and other diagnostic tests.

(5) Identify, develop, implement, and evaluate a plan of care for a patient to promote, maintain, and restore health.

(6) Perform therapeutic procedures that the nurse practitioner is qualified by education and experience to perform.

(7) Prescribe treatments.

(8) Prescribe and dispense medications when granted authority by the board.

(9) Refer patients to appropriate licensed physician and surgeons or other health care providers.

(10) Provide emergency care.

(11) Perform additional acts that the nurse practitioner is educationally prepared and clinically competent to perform.

(12) Sign death certificates, return-to-work, school certificates, and other related health certification forms.

(13) Certify incapacity for the purpose of activating durable power of attorney for health care.

(14) Sign handicapped parking applications.

(15) Order home health services.

(16) Order durable medical equipment.

(17) Order home schooling or tutoring.

(b) A nurse practitioner shall consult or refer a patient to a physician and surgeon or another health care provider if the referral will protect the health and welfare of the patient and if a

situation or condition occurs in a patient that is beyond the nurse practitioner's knowledge and experience.

SEC. 4. Section 2836 of the Business and Professions Code is amended to read:

2836. (a) The board shall establish categories of nurse practitioners and standards for nurses to hold themselves out as nurse practitioners in each category. Such standards shall take into account the types of advanced levels of nursing practice ~~which~~ *that* are or may be performed and the clinical and didactic education, experience, or both needed to practice safely at those levels. In setting ~~such~~ *the* standards, the board shall consult with nurse practitioners~~, physicians and surgeons with expertise in the nurse practitioner field,~~ and health care organizations utilizing nurse practitioners. Established standards shall apply to persons without regard to the date of meeting such standards. ~~If the board sets standards for use of nurse practitioner titles which include completion of an academically affiliated program, it shall provide equivalent standards for registered nurses who have not completed such a program.~~

(b) Any regulations promulgated by a state department*, board, commission, or bureau* that affect the scope of practice of a nurse practitioner shall be developed in consultation with the board.

SEC. 5. Section 2836.1 of the Business and Professions Code is amended to read:

~~2836.1. Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing or ordering drugs or devices when all of the following apply:~~

~~(a) The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon~~

2836.1. (a) A nurse practitioner may prescribe drugs and devices when the drugs or devices ~~furnished or ordered~~ *prescribed* are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

~~(b) The nurse practitioner is functioning pursuant to standardized procedure, as defined by Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.~~

~~(c) (1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the provisions of the standardized procedure.~~

~~(2) In addition to the requirements in paragraph (1), for Schedule II controlled substance protocols, the provision for furnishing Schedule II controlled substances shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.~~

~~(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.~~

~~(e) For purposes of this section, no physician and surgeon shall supervise more than four nurse practitioners at one time.~~

~~(f) (1)~~

(b) Drugs or devices ~~furnished or ordered~~ *prescribed* by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) ~~and shall be further limited to those drugs agreed upon by the nurse practitioner and physician and surgeon and specified in the standardized procedure~~.

~~(2) When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner's standardized procedure relating to controlled substances shall be provided, upon request, to any licensed~~

~~pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order.~~

~~(g) (1) The~~

(c) A nurse practitioner may not prescribe drugs or devices under this section unless the board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed ~~(1)~~ at least six ~~month's physician and surgeon-supervised~~ *months' supervised* experience in the ~~furnishing or ordering~~ *prescribing* of drugs ~~or~~ *and* devices ~~and (2) a course in pharmacology covering the drugs or devices to be furnished or ordered under this section~~.

~~(2) Nurse practitioners who are certified by the board and hold an active furnishing number, who are authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board. The board shall establish the requirements for satisfactory completion of this subdivision.~~

~~(h) Use of the term "furnishing" in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include (1) the ordering of a drug or device in accordance with the standardized procedure and (2) transmitting an order of a supervising physician and surgeon.~~

~~(i) "Drug order" or "order" for purposes of this section means an order for medication which is dispensed to or for an ultimate user, issued by a nurse practitioner as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by nurse practitioners; and (3) the signature of a nurse practitioner on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.~~

SEC. 6. Section 2836.2 of the Business and Professions Code is amended to read:

2836.2. ~~Furnishing or ordering of drugs or devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure.~~ All nurse practitioners who are authorized pursuant to Section ~~2831.1~~ *2836.1* to ~~furnish or issue drug orders~~ *prescribe* for controlled substances shall register with the United States Drug Enforcement Administration.

SEC. 7. Section 2836.3 of the Business and Professions Code is amended to read:

2836.3. (a) The ~~furnishing~~ *prescribing* of drugs or devices by nurse practitioners is conditional on issuance by the board of a number to the nurse *practitioner* applicant who has successfully completed the requirements of subdivision ~~(g)~~ *(c)* of Section 2836.1. The number shall be included on all ~~transmittals of orders~~ *prescriptions* for drugs or devices by the nurse practitioner. The board shall make the list of numbers issued available to the Board of Pharmacy. The board may charge the applicant a fee to cover all necessary costs to implement this section.

(b) The number shall be renewable at the time of the applicant's registered nurse license renewal.

(c) The board may revoke, suspend, or deny issuance of the numbers for incompetence or gross negligence in the performance of functions specified in Sections 2836.1 and 2836.2.

SEC. 8. Section 3640 of the Business and Professions Code is amended to read:

3640. (a) A naturopathic doctor may order and perform physical and laboratory examinations for diagnostic purposes, including, but not limited to, phlebotomy, clinical laboratory tests, speculum examinations, orificial examinations, and physiological function tests.

(b) A naturopathic doctor may order diagnostic imaging studies, including X-ray, ultrasound, mammogram, bone densitometry, and others, consistent with naturopathic training as determined by the bureau, but shall refer the studies to an appropriately licensed health care professional to conduct the study and interpret the results.

(c) A naturopathic doctor may dispense, administer, order, and prescribe or perform the following:

(1) Food, extracts of food, ~~nutraceuticals~~ *neutraceuticals*, vitamins, amino acids, minerals, enzymes, botanicals and their

extracts, botanical medicines, homeopathic medicines, all dietary supplements and nonprescription drugs as defined by the federal Food, Drug, and Cosmetic Act, consistent with the routes of administration identified in subdivision (d).

(2) Hot or cold hydrotherapy; naturopathic physical medicine inclusive of the manual use of massage, stretching, resistance, or joint play examination but exclusive of small amplitude movement at or beyond the end range of normal joint motion; electromagnetic energy; colon hydrotherapy; and therapeutic exercise.

(3) Devices, including, but not limited to, therapeutic devices, barrier contraception, and durable medical equipment.

(4) Health education and health counseling.

(5) Repair and care incidental to superficial lacerations and abrasions, except suturing.

(6) Removal of foreign bodies located in the superficial tissues.

(d) A naturopathic doctor may utilize routes of administration that include oral, nasal, auricular, ocular, rectal, vaginal, transdermal, intradermal, subcutaneous, intravenous, and intramuscular.

(e) The bureau may establish regulations regarding ocular or intravenous routes of administration that are consistent with the education and training of a naturopathic doctor.

(f) Nothing in this section shall exempt a naturopathic doctor from meeting applicable licensure requirements for the performance of clinical laboratory tests.

~~(g) The authority to use all routes for furnishing prescription drugs as described in Section 3640.5 shall be consistent with the oversight and supervision requirements of Section 2836.1.~~

SEC. 9. Section 3640.5 of the Business and Professions Code is amended to read:

3640.5. Nothing in this chapter or any other provision of law shall be construed to prohibit a naturopathic doctor from furnishing or ordering drugs when all of the following apply:

(a) The drugs are furnished or ordered by a naturopathic doctor in accordance with standardized procedures or protocols developed by the naturopathic doctor and his or her supervising physician and surgeon.

(b) The naturopathic doctor is functioning pursuant to standardized procedure~~, as defined by subdivisions (a), (b), (d), (e), (h), and (i) of Section 2836.1 and paragraph (1) of subdivision~~

~~(c) of Section 2836.1,~~ or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the naturopathic doctor, and, where applicable, the facility administrator or his or her designee.

(c) The standardized procedure or protocol covering the furnishing of drugs shall specify which naturopathic doctors may furnish or order drugs, which drugs may be furnished or ordered under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the naturopathic doctor's competence, including peer review, and review of the provisions of the standardized procedure.

(d) The furnishing or ordering of drugs by a naturopathic doctor occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include all of the following:

(1) Collaboration on the development of the standardized procedure.

(2) Approval of the standardized procedure.

(3) Availability by telephonic contact at the time of patient examination by the naturopathic doctor.

(e) For purposes of this section, a physician and surgeon shall not supervise more than four naturopathic doctors at one time.

(f) Drugs furnished or ordered by a naturopathic doctor may include Schedule III through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and shall be further limited to those drugs agreed upon by the naturopathic doctor and physician and surgeon as specified in the standardized procedure. When Schedule III controlled substances, as defined in Section 11056 of the Health and Safety Code, are furnished or ordered by a naturopathic doctor, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the naturopathic doctor's standardized procedure relating to controlled substances shall be provided upon request, to a licensed pharmacist who dispenses drugs, when there is uncertainty about the naturopathic doctor furnishing the order.

(g) The bureau has certified that the naturopathic doctor has satisfactorily completed adequate coursework in pharmacology

covering the drugs to be furnished or ordered under this section. The bureau shall establish the requirements for satisfactory completion of this subdivision.

(h) Use of the term "furnishing" in this section, in health facilities defined in subdivisions (b), (c), (d), (e), and (i) of Section 1250 of the Health and Safety Code, shall include both of the following:

(1) Ordering a drug in accordance with the standardized procedure.

(2) Transmitting an order of a supervising physician and surgeon.

(i) For purposes of this section, "drug order" or "order" means an order for medication which is dispensed to or for an ultimate user, issued by a naturopathic doctor as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations.

(j) Notwithstanding any other provision of law, the following apply:

(1) A drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician.

(2) All references to prescription in this code and the Health and Safety Code shall include drug orders issued by naturopathic doctors.

(3) The signature of a naturopathic doctor on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

SEC. 10. Section 4024 of the Business and Professions Code is amended to read:

4024. (a) Except as provided in subdivision (b), "dispense" means the furnishing of drugs or devices upon a prescription from a physician *and surgeon*, dentist, optometrist, podiatrist, veterinarian, *nurse practitioner,* or naturopathic doctor pursuant to Section 3640.7, or upon an order to furnish drugs or transmit a prescription from a certified nurse-midwife, ~~nurse practitioner,~~ physician assistant, naturopathic doctor pursuant to Section 3640.5, or pharmacist acting within the scope of his or her practice.

(b) "Dispense" also means and refers to the furnishing of drugs or devices directly to a patient by a physician *and surgeon*, dentist, optometrist, podiatrist, or veterinarian, or by a certified

nurse-midwife, nurse practitioner, naturopathic doctor, or physician assistant acting within the scope of his or her practice.

SEC. 11. Section 4040 of the Business and Professions Code is amended to read:

4040. (a) "Prescription" means an oral, written, or electronic transmission order that is both of the following:

(1) Given individually for the person or persons for whom ordered that includes all of the following:

(A) The name or names and address of the patient or patients.

(B) The name and quantity of the drug or device prescribed and the directions for use.

(C) The date of issue.

(D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification, and his or her federal registry number, if a controlled substance is prescribed.

(E) A legible, clear notice of the condition for which the drug is being prescribed, if requested by the patient or patients.

(F) If in writing, signed by the prescriber issuing the order, or the certified nurse-midwife, ~~nurse practitioner,~~ physician assistant, or naturopathic doctor who issues a drug order pursuant to Section 2746.51, ~~2836.1,~~ 3502.1, or 3640.5, respectively, or the pharmacist who issues a drug order pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

(2) Issued by a physician *and surgeon*, dentist, optometrist, podiatrist, veterinarian, *nurse practitioner,* or naturopathic doctor pursuant to Section 3640.7 or, if a drug order is issued pursuant to Section 2746.51, ~~2836.1,~~ 3502.1, or 3460.5, by a certified nurse-midwife, ~~nurse practitioner,~~ physician assistant, or naturopathic doctor licensed in this state, or pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 by a pharmacist licensed in this state.

(b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug, except for any Schedule II controlled substance, that contains at least the name and signature of the prescriber, the name and address of the patient in a manner consistent with paragraph (3) of subdivision (b) of Section 11164 of the Health and Safety Code, the name and quantity of the drug

prescribed, directions for use, and the date of issue may be treated as a prescription by the dispensing pharmacist as long as any additional information required by subdivision (a) is readily retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164 of the Health and Safety Code, Section 11164 of the Health and Safety Code shall prevail.

(c) "Electronic transmission prescription" includes both image and data prescriptions. "Electronic image transmission prescription" means any prescription order for which a facsimile of the order is received by a pharmacy from a licensed prescriber. "Electronic data transmission prescription" means any prescription order, other than an electronic image transmission prescription, that is electronically transmitted from a licensed prescriber to a pharmacy.

(d) The use of commonly used abbreviations shall not invalidate an otherwise valid prescription.

(e) Nothing in the amendments made to this section (formerly Section 4036) at the 1969 Regular Session of the Legislature shall be construed as expanding or limiting the right that a chiropractor, while acting within the scope of his or her license, may have to prescribe a device.

SEC. 12. Section 4060 of the Business and Professions Code is amended to read:

4060. No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician *and surgeon*, dentist, podiatrist, optometrist, veterinarian, *nurse practitioner,* or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, ~~a nurse practitioner pursuant to Section 2836.1,~~ a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052. This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician *and surgeon*, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer.

Nothing in this section authorizes a certified nurse-midwife, ~~a nurse practitioner,~~ a physician assistant, or a naturopathic doctor~~,~~ to order his or her own stock of dangerous drugs and devices.

SEC. 13. Section 4061 of the Business and Professions Code is amended to read:

4061. (a) No manufacturer's sales representative shall distribute any dangerous drug or dangerous device as a complimentary sample without the written request of a physician *and surgeon*, dentist, podiatrist, optometrist, veterinarian, *nurse practitioner,* or naturopathic doctor pursuant to Section 3640.7. However, a certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, ~~a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol,~~ a physician assistant who functions pursuant to a protocol described in Section 3502.1, or a naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5~~,~~ may sign for the request and receipt of complimentary samples of a dangerous drug or dangerous device that has been identified in the standardized procedure, protocol, or practice agreement. Standardized procedures, protocols, and practice agreements shall include specific approval by a physician *and surgeon*. A review process, consistent with the requirements of Section 2725, 3502.1, or 3640.5, of the complimentary samples requested and received by a ~~nurse practitioner,~~ certified nurse-midwife, physician assistant, or naturopathic doctor~~,~~ shall be defined within the standardized procedure, protocol, or practice agreement.

(b) Each written request shall contain the names and addresses of the supplier and the requester, the name and quantity of the specific dangerous drug desired, the name of the certified nurse-midwife, ~~nurse practitioner,~~ physician assistant, or naturopathic doctor, if applicable, receiving the samples pursuant to this section, the date of receipt, and the name and quantity of the dangerous drugs or dangerous devices provided. These records shall be preserved by the supplier with the records required by Section 4059.

(c) Nothing in this section is intended to expand the scope of practice of a certified nurse-midwife, ~~nurse practitioner,~~ physician assistant, or naturopathic doctor.

SEC. 14. Section 4076 of the Business and Professions Code is amended to read:

4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except where the prescriber or the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, ~~the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol,~~ the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.

(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, ~~the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol,~~ the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition for which the drug was prescribed if requested by the patient and the condition is indicated on the prescription.

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.

(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in any commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, ~~the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol,~~ the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a

policy, procedure, or protocol pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.

SEC. 15. Section 4170 of the Business and Professions Code is amended to read:

4170. (a) No prescriber shall dispense drugs or dangerous devices to patients in his or her office or place of practice unless all of the following conditions are met:

(1) The dangerous drugs or dangerous devices are dispensed to the prescriber's own patient, and the drugs or dangerous devices are not furnished by a nurse or physician attendant.

(2) The dangerous drugs or dangerous devices are necessary in the treatment of the condition for which the prescriber is attending the patient.

(3) The prescriber does not keep a pharmacy, open shop, or drugstore, advertised or otherwise, for the retailing of dangerous drugs, dangerous devices, or poisons.

(4) The prescriber fulfills all of the labeling requirements imposed upon pharmacists by Section 4076, all of the recordkeeping requirements of this chapter, and all of the packaging requirements of good pharmaceutical practice, including the use of childproof containers.

(5) The prescriber does not use a dispensing device unless he or she personally owns the device and the contents of the device, and personally dispenses the dangerous drugs or dangerous devices to the patient packaged, labeled, and recorded in accordance with paragraph (4).

(6) The prescriber, prior to dispensing, offers to give a written prescription to the patient that the patient may elect to have filled by the prescriber or by any pharmacy.

(7) The prescriber provides the patient with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice.

(8) A certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, ~~a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol,~~ a physician assistant who functions pursuant to Section 3502.1, or a naturopathic doctor who functions pursuant to Section 3640.5, may hand to a patient of the supervising physician and surgeon *or nurse practitioner* a properly labeled prescription drug prepackaged by a physician and surgeon, a manufacturer as defined in this chapter, *a nurse practitioner,* or a pharmacist.

(b) The Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, the Veterinary Medical Board, and the Physician Assistant Committee shall have authority with the California State Board of Pharmacy to ensure compliance with this section, and those boards are specifically charged with the enforcement of this chapter with respect to their respective licensees.

(c) "Prescriber," as used in this section, means a person, who holds ~~a physician's~~ *physician* and surgeon's certificate, a license to practice optometry, a license to practice naturopathic medicine, a license to practice dentistry, a license to practice veterinary medicine, ~~or~~ a certificate to practice podiatry, *or a license and certification as a nurse practitioner,* and who is duly registered by the Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Veterinary Medical Board, ~~or~~ the Board of Osteopathic Examiners, *or the Board of Registered Nursing* of this state.

SEC. 16. Section 4174 of the Business and Professions Code is amended to read:

4174. Notwithstanding any other provision of law, a pharmacist may dispense drugs or devices upon the drug order of ~~a nurse practitioner functioning pursuant to Section 2836.1 or~~ a certified nurse-midwife functioning pursuant to Section 2746.51, ~~a drug~~

~~order of~~ a physician assistant functioning pursuant to Section 3502.1, or a naturopathic doctor functioning pursuant to Section 3640.5, or the order of a pharmacist acting under Section 4052.

SEC. 17. Section 11150 of the Health and Safety Code is amended to read:

11150. No person other than a physician *and surgeon*, dentist, podiatrist, or veterinarian, or naturopathic doctor acting pursuant to Section 3640.7 of the Business and Professions Code, or pharmacist acting within the scope of a project authorized under Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107 or within the scope of either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 of the Business and Professions Code, a registered nurse acting within the scope of a project authorized under Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107, a certified nurse-midwife acting within the scope of Section 2746.51 of the Business and Professions Code, a nurse practitioner acting within the scope of ~~Section~~ *Sections 2835.7 and* 2836.1 of the Business and Professions Code, a physician assistant acting within the scope of a project authorized under Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107 or Section 3502.1 of the Business and Professions Code, a naturopathic doctor acting within the scope of Section 3640.5 of the Business and Professions Code, or an optometrist acting within the scope of Section 3041 of the Business and Professions Code, or an out-of-state prescriber acting pursuant to Section 4005 of the Business and Professions Code shall write or issue a prescription.

SEC. 18. Section 120582 of the Health and Safety Code is amended to read:

120582. (a) Notwithstanding any other provision of law, a physician and surgeon *or a nurse practitioner* who diagnoses a sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the department, in an individual patient may prescribe, dispense, furnish, or otherwise provide prescription antibiotic drugs to that patient's sexual partner or partners without examination of that patient's partner or partners. The department may adopt regulations to implement this section.

(b) Notwithstanding any other provision of law, ~~a nurse practitioner pursuant to Section 2836.1 of the Business and~~

~~Professions Code,~~ a certified nurse-midwife pursuant to Section 2746.51 of the Business and Professions Code~~,~~ and a physician assistant pursuant to Section 3502.1 of the Business and Professions Code may dispense, furnish, or otherwise provide prescription antibiotic drugs to the sexual partner or partners of a patient with a diagnosed sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the department, without examination of the patient's sexual partner or partners.

SEC. 19. Section 14111 of the Welfare and Institutions Code is amended to read:

14111. (a) As permitted by federal law or regulations, for health care services provided in a long-term health care facility that are reimbursed by Medicare, a physician and surgeon may delegate any of the following to a nurse practitioner:

(1) Alternating visits required by federal law and regulations with a physician and surgeon.

(2) Any duties consistent with federal law and regulations within the scope of practice of nurse practitioners, so long as all of the following conditions are met:

(A) A physician and surgeon approves, in writing, the admission of the individual to the facility.

~~(B) The medical care of each resident is supervised by a physician and surgeon.~~

~~(C)~~

(B) A physician and surgeon performs the initial visit and alternate required visits.

(b) This section does not authorize benefits not otherwise authorized by federal law or regulation.

~~(c) All responsibilities delegated to a nurse practitioner pursuant to this section shall be performed under the supervision of the physician and surgeon and pursuant to a standardized procedure among the physician and surgeon, nurse practitioner, and facility.~~

~~(d)~~

(c) No task that is required by federal law or regulation to be performed personally by a physician *and surgeon* may be delegated to a nurse practitioner.

~~(e)~~

(d) Nothing in this section shall be construed as limiting the authority of a long-term health care facility to hire and employ

nurse practitioners so long as that employment is consistent with federal law and within the scope of practice of a nurse practitioner.

SEC. 20. Section 14111.5 of the Welfare and Institutions Code is amended to read:

14111.5. (a) As permitted by federal law or regulations, for health care services provided in a long-term health care facility that are reimbursed under this chapter, a nurse practitioner may, to the extent consistent with his or her scope of practice, perform any of the following tasks otherwise required of a physician and surgeon:

(1) With respect to visits required by federal law or regulations, making alternating visits, or more frequent visits if the physician and surgeon is not available.

(2) Any duty or task that is consistent with federal and state law or regulation within the scope of practice of nurse practitioners, so long as all of the following conditions are met:

(A) A physician and surgeon approves, in writing, the admission of the individual to the facility.

~~(B) The medical care of each resident is supervised by a physician and surgeon.~~

~~(C)~~

(B) A physician and surgeon performs the initial visit and alternate required visits.

(b) This section does not authorize benefits not otherwise authorized by federal or state law or regulation.

~~(c) All responsibilities undertaken by a nurse practitioner pursuant to this section shall be performed in collaboration with the physician and surgeon and pursuant to a standardized procedure among the physician and surgeon, nurse practitioner, and facility.~~

~~(d)~~

(c) Except as provided in subdivisions (a)~~ to (c), inclusive~~ *and (b)*, any task that is required by federal law or regulation to be performed personally by a physician *and surgeon* may be delegated to a nurse practitioner who is not an employee of the long-term health care facility.

~~(e)~~

(d) Nothing in this section shall be construed as limiting the authority of a long-term health care facility to hire and employ nurse practitioners so long as that employment is consistent with federal law and with the scope of practice of a nurse practitioner.

SEC. 21. Section 16952 of the Welfare and Institutions Code is amended to read:

16952. (a) (1) Each county shall establish within its emergency medical services fund a Physician Services Account. Each county shall deposit in the Physician Services Account those funds appropriated by the Legislature for the purposes of the Physician Services Account of the fund.

(2) (A) Each county may encumber sufficient funds to reimburse physician *and surgeon* losses incurred during the fiscal year for which bills will not be received until after the fiscal year.

(B) Each county shall provide a reasonable basis for its estimate of the necessary amount encumbered.

(C) All funds that are encumbered for a fiscal year shall be expended or disencumbered prior to the submission of the report of actual expenditures required by Sections 16938 and 16980.

(b) (1) Funds deposited in the Physician Services Account in the county emergency medical services fund shall be exempt from the percentage allocations set forth in subdivision (a) of Section 1797.98. However, funds in the county Physician Services Account shall not be used to reimburse for physician *and surgeon* services provided by ~~physicians~~ *physician and surgeons* employed by county hospitals.

(2) No physician *and surgeon* who provides physician *and surgeon* services in a primary care clinic which receives funds from this act shall be eligible for reimbursement from the Physician Services Account for any losses incurred in the provision of those services.

(c) The county ~~physician services account~~ *Physician Services Account* shall be administered by each county, except that a county electing to have the state administer its medically indigent adult program as authorized by Section 16809, may also elect to have its county physician services account administered by the state in accordance with Section 16954.

(d) Costs of administering the account, whether by the county or by the department through the emergency medical services contract-back program, shall be reimbursed by the account based on actual administrative costs, not to exceed 10 percent of the amount of the account.

(e) For purposes of this article "administering agency" means the agency designated by the board of supervisors to administer

this article, or the department, in the case of those CMSP counties electing to have the state administer this article on their behalf.

(f) The county Physician Services Account shall be used to reimburse ~~physicians~~ *physician and surgeons* for losses incurred for services provided during the fiscal year of allocation due to patients who do not have health insurance coverage for emergency services and care, who cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(g) Nurse practitioners shall be eligible to receive payment for patient care services. Payment shall be limited to those claims that are substantiated by a medical record.

~~(g) Physicians~~

(h) Physician and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a ~~properly credentialed nurse practitioner or~~ *licensed* physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of ~~nurse practitioners, and~~ physician assistants in California.

~~(h)~~

(i) (1) Reimbursement for losses shall be limited to emergency services as defined in Section 16953, obstetric, and pediatric services as defined in Sections 16905.5 and 16907.5, respectively.

(2) It is the intent of this subdivision to allow reimbursement for all of the following:

(A) All inpatient and outpatient obstetric services ~~which~~ *that* are medically necessary, as determined by the attending physician *and surgeon or nurse practitioner.*

(B) All inpatient and outpatient pediatric services ~~which~~ *that* are medically necessary, as determined by the attending physician *and surgeon or nurse practitioner.*

~~(i)~~

(j) Any physician *and surgeon or nurse practitioner* may be reimbursed for up to 50 percent of the amount claimed pursuant to Section 16955 for the initial cycle of reimbursements made by the administering agency in a given year. All funds remaining at the end of the fiscal year shall be distributed proportionally, based on the dollar amount of claims submitted and paid to all ~~physicians~~ *physician and surgeons and nurse practitioners* who submitted qualifying claims during that year. The administering agency shall not disburse funds in excess of the total amount of a qualified claim.

SEC. 22. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~SECTION 1. It is the intent of the Legislature to subsequently amend this act to include provisions that would improve access to primary care in underserved areas by encouraging establishment of additional clinics by allowing registered nurse practitioners greater flexibility to operate clinics.~~

O

SENATE BILL No. 907

Introduced by Senator Calderon

February 23, 2007

An act to add Section 650.03 to the Business and Professions Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

SB 907, as introduced, Calderon. Physicians and surgeons: referrals.

Existing law, with certain exceptions, prohibits the offer, delivery, receipt, or acceptance by any healing arts licensee regulated by the Business and Professions Code or under the Chiropractic Initiative Act, of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, as compensation or an inducement for referring patients, clients, or customers to any person.

This bill would provide that it is not unlawful for a physician and surgeon to provide consideration for a referral for an elective cosmetic procedure if specified conditions are met.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 650.03 is added to the Business and
2 Professions Code, to read:
3 650.03. Notwithstanding Section 650, or any other provision
4 of law, it shall not be unlawful for a physician and surgeon licensed
5 under this division to provide consideration for a referral if all of
6 the following conditions are satisfied:
7 (a) The referral is made by an employee of the physician and
8 surgeon.

1 (b) The referral is for an elective cosmetic procedure performed
2 under local anesthetic.
3 (c) The individual referred made the initial contact or inquiry.
4 (d) The physician and surgeon charges no more than his or her
5 usual and customary fee for the elective cosmetic procedure
6 performed.
7 (e) The consideration does not exceed two hundred fifty dollars
8 ($250).
9 (f) The physician and surgeon discloses the referral arrangement
10 to the individual referred.

O

AMENDED IN SENATE APRIL 18, 2007

SENATE BILL No. 993

Introduced by ~~Senator Calderon~~ *Senators Aanestad and Calderon*
(Principal coauthors: Senators Lowenthal and Romero)
(Coauthor: Senator Scott)

February 23, 2007

~~An act to amend Section 2904 of, and to add Article 1.5 (commencing with Section 2919.10) to Chapter 6.6 of Division 2 of, the Business and Professions Code, relating to healing arts.~~ *An act to amend Sections 2902, 2904, 2960, 4040, 4502, 4502.1, and 4502.2 of, and to add Sections 2949, 2949.2, 2949.3, and 2949.4 to, the Business and Professions Code, relating to psychology.*

LEGISLATIVE COUNSEL'S DIGEST

SB 993, as amended, ~~Calderon~~ *Aanestad.* Psychologists: scope of practice: prescribing drugs.

The Psychology Licensing Law provides for the licensure and regulation of psychologists by the Board of Psychology, and the Pharmacy Law provides for the regulation of prescription drug and medical device dispensing by the State Board of Pharmacy. The Psychology Licensing Law provides that the practice of psychology does not include the prescribing of drugs and does not authorize a psychologist to prescribe drugs or write prescriptions. Existing law additionally makes a violation of its provisions a crime and unprofessional conduct, constituting grounds for disciplinary action by the Board of Psychology.

This bill would revise these provisions to authorize a certified prescribing psychologist, as defined, to prescribe drugs for the treatment of specified disorders if certain requirements are met. This bill would

require the Board of Psychology to establish and administer a certification process to grant licensed psychologists the authority to write prescriptions, and would require an applicant for certification as a prescribing psychologist to meet specified education and training requirements, including requirements of clinical competency, and passing a nationally recognized examination approved and administered by the board. The bill would require the board to charge fees for the issuance and renewal of a certificate to cover the costs of administering the certification process and the examination, and would provide for the deposit of these fees in the Psychology Fund. The bill would require the board to establish requirements for the renewal of a certificate, including continuing education requirements, and to provide certain information to the State Board of Pharmacy, including a list of psychologists certified to prescribe drugs. The bill would also require an approved program to meet specified requirements, including providing certain reports to the board.

This bill would include as unprofessional conduct, subject to disciplinary action by the board, a violation of particular provisions of law relating to the prescribing of drugs.

By adding these provisions, this bill would impose a state-mandated local program by creating new crimes.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law, the Psychology Licensing Law, provides for the licensure and regulation of the practice of psychology by the Board of Psychology in the Department of Consumer Affairs. Existing law excludes prescribing drugs from the scope of practice of a licensed psychologist.~~

~~This bill would, with certain exceptions, authorize the board to grant a prescription certificate or a conditional prescription certificate to a licensed psychologist authorizing, within the scope of practice of a psychologist, the prescription of certain drugs if certain conditions are met.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

1 *SECTION 1. The Legislature hereby finds and declares all of*
2 *the following:*
3 *(a) In September 2006 the California Department of Corrections*
4 *and Rehabilitation (CDCR) reported a systemwide vacancy rate*
5 *for psychiatrists of 67 percent. In February 2007, the State*
6 *Department of Mental Health reported a vacancy rate for*
7 *psychiatrists of 40 percent.*
8 *(b) As a result of the severe shortages, patient care has been*
9 *compromised and CDCR, with over 32,000 mentally ill patients,*
10 *is in federal receivership. Further, there are several outstanding*
11 *lawsuits against the State of California alleging that inmates and*
12 *patients at state mental hospitals are not receiving constitutionally*
13 *adequate mental health care due to the severe shortage of*
14 *competent psychiatrists and state-employed psychiatrists' salaries*
15 *have been raised to nearly $300,000 annually.*
16 *(c) Busy nonpsychiatrist, primary care and other physicians,*
17 *with little training in mental health, prescribe 80 percent of all*
18 *psychotropic medications in patient visits that average 8 to 10*
19 *minutes with typical followup of months into the future for another*
20 *brief appointment. A change in law is required so that prescribing*
21 *psychologists are available to those patients who need more than*
22 *a few minutes and a prescription from a primary care physician.*
23 *(d) According to the National Institute for Mental Health, one*
24 *in four individuals suffers from a diagnosable mental illness in a*
25 *given year, and one in 17 suffers from a severe mental illness.*
26 *(e) Families with members who have a serious mental illness*
27 *would benefit by being free to choose, if desired, a psychologist*
28 *with the comprehensive training to prescribe not only needed*
29 *medication but also provide the additional treatments that are*
30 *necessary to improve the mentally ill person's quality of life, which*
31 *the National Institute of Mental Health says is beyond what*
32 *antipsychotic medications are able to do.*
33 *(f) Psychologists are authorized to prescribe medication in New*
34 *Mexico, Louisiana, and the United States territory of Guam, and*
35 *have written over 40,000 prescriptions with no deaths and no*
36 *adverse outcomes.*
37 *(g) Psychologists with appropriate training and credentials*
38 *have been prescribing medications to active duty personnel and*

their families in military facilities since 1991. These prescribing psychologists have consulted and treated over 160,000 patients with no deaths and no adverse outcomes.

(h) Research data soundly demonstrates that there is not enough mental health care available to serve the needs of all people in California due to the severe shortages of psychiatrists. According to the American Board of Medical Specialties Directory of Board Certified Medical Specialists, there are 11 California counties with no psychiatrist and an additional 17 California counties with five or fewer psychiatrists in residence.

(i) Since 2001 and 2002, psychologists in California have been allowed to discuss and recommend psychotropic medications to both patients and physicians. California psychologists routinely collaborate with primary care physicians to provide combined therapy and psychopharmacological care for their patients. Since 1978, California psychologists have held independent hospital privileges.

(j) The American Psychological Association has a model curriculum used by training programs around the country for the education and training of prescribing psychologists. In order to meet the increasing demands for services to mentally ill and disordered persons in California, it is the intent of the Legislature to grant prescriptive authority to California licensed psychologists who choose to receive the appropriate education and training.

SEC. 2. Section 2902 of the Business and Professions Code is amended to read:

2902. As used in this chapter, unless the context clearly requires otherwise and except as in this chapter expressly otherwise provided, the following definitions apply:

(a) "Licensed psychologist" means an individual to whom a license has been issued pursuant to the provisions of this chapter, which license is in force and has not been suspended or revoked.

(b) "Board" means the Board of Psychology.

(c) A person represents himself or herself to be a psychologist when the person holds himself or herself out to the public by any title or description of services incorporating the words "psychology," "psychological," "psychologist," "psychology consultation," "psychology consultant," "psychometry," "psychometrics" or "psychometrist," "psychotherapy," "psychotherapist," "psychoanalysis," or "psychoanalyst," or when

the person holds himself or herself out to be trained, experienced, or an expert in the field of psychology.

(d) "Accredited," as used with reference to academic institutions, means the University of California, the California State University, *an institution that is accredited under Section 94712 of the Education Code,* or an institution that is *located in another state and that is* accredited by a national or an applicable regional accrediting agency recognized by the United States Department of Education.

(e) "Approved," as used with reference to academic institutions, means an institution ~~having "approval to operate", as defined in Section 94718~~ *approved under Section 94800* of the Education Code.

(f) "Prescriptive authority" means the authority to prescribe, discontinue, order, administer or dispense without charge, drugs or controlled substances, excluding narcotics, recognized for, or customarily used in, the inpatient or outpatient diagnosis, treatment, or evaluation and management of individuals with psychiatric, mental, cognitive, nervous, emotional, addictive, developmental, or behavioral disorders, and to order or utilize other procedures, consultations, devices, and tests related thereto.

(g) "Health service provider" means a licensed psychologist who is duly trained and experienced in the delivery of preventive, assessment, diagnostic, and therapeutic intervention services relative to the psychological and physical health of consumers and who has done both of the following:

(1) Completed an internship and supervised experience in health care settings.

(2) Been licensed as a psychologist at the independent practice level.

(h) "Prescribing psychologist" means a health service provider who has received from the board, pursuant to Section 2949, a valid certificate granting prescriptive authority, and whose certificate has not been revoked or suspended.

(i) "Drug" has the same meaning as provided in Section 4025, and includes controlled substances and dangerous drugs, as defined in Sections 4021 and 4022, respectively.

(j) "Device" has the same meaning as provided in Section 4023, and includes dangerous devices, as defined in Section 4022.

(k) "Prescription" has the same meaning as provided in Sections 4040 and 4070.

SEC. 3. Section 2904 of the Business and Professions Code is amended to read:

2904. The practice of psychology shall not include ~~prescribing drugs, performing surgery or administering electroconvulsive therapy.~~ *any of the following:*

(a) Prescribing drugs or devices, except for those prescribed by prescribing psychologists, as defined in Section 2902.

(b) Performing surgery.

(c) Administering electroconvulsive therapy.

SEC. 4. Section 2949 is added to the Business and Professions Code, to read:

2949. (a) The board shall establish and administer a certification process to grant licensed psychologists prescriptive authority. The board shall also develop a procedure for prescribing-psychologists-in-training to prescribe under the supervision and license of a qualified prescriber. The board shall develop procedures for the administration of an appropriate, valid, nationally recognized examination, such as the American Psychological Association Practice Organization's College of Professional Psychology examination, approved by the board. The board shall charge applicants reasonable fees for the issuance of, and renewal of, a certificate in order to cover the costs of administering the certification process and the examination. These fees shall be deposited in the Psychology Fund.

(b) Each applicant for certification as a prescribing psychologist, as defined in subdivision (h) of Section 2902, shall show by official transcript or other official evidence satisfactory to the board that he or she has successfully completed both of the following:

(1) An organized and planned sequence of psychopharmacological training deemed by the board to be consistent with this chapter and with the American Psychological Association's (APA) training guidelines for prescriptive authority in effect at the time the coursework was completed. The board may certify a psychologist from a federal or other state jurisdiction to practice as a prescribing psychologist if that jurisdiction has authorized the psychologist to prescribe and if the board determines that the psychologist has practiced with competence.

Also, the board may certify a psychologist to practice as a prescribing psychologist if the psychologist has lawfully prescribed under another professional license that authorizes prescribing and the training and experience under the other license is consistent with the training standards required for a prescribing psychologist. Approved programs may give credit for required didactic science courses taken at other educational institutions that would meet the educational requirements of their program. Coursework shall be consistent with the most current APA training guidelines, and shall include education in all of the following subjects:

(A) Basic science, including anatomy, physiology, and biochemistry.

(B) Neurosciences, including neuroanatomy, neurophysiology, and neurochemistry.

(C) Physical assessment and laboratory examinations, including the following:

(i) Physical assessment.

(ii) Laboratory and radiological assessment.

(iii) Medical terminology and documentation.

(iv) Integration of the subjects in clauses (i) to (iii), inclusive, through supervised clinical experience or laboratory experience in conducting physical examinations, ordering psychometric and laboratory tests, and understanding results and interpretation.

(D) Clinical medicine and pathophysiology, including the following:

(i) Pathophysiology, with particular emphasis on cardiac, renal, hepatic, neurologic, gastrointestinal, hematologic, dermatologic, and endocrine systems.

(ii) Clinical medicine, with particular emphasis on signs, symptoms, and treatment of disease states with behavioral and psychiatric manifestations or comorbidities.

(iii) Differential diagnosis.

(iv) Clinical correlations. The illustration of the content of this domain through case study.

(v) Chemical dependency and chronic pain management.

(vi) Integration of the subjects in clauses (i) to (v), inclusive, through supervised clinical experience or laboratory experience in taking medical history, assessment for differential diagnosis, and review of systems.

(E) Clinical and research pharmacology and psychopharmacology, including the following:

(i) Pharmacology.

(ii) Clinical pharmacology.

(iii) Pharmacogenetics.

(iv) Psychopharmacology.

(v) Developmental psychopharmacology.

(vi) Integration of the subjects in clauses (i) to (v), inclusive, through supervised clinical experience or laboratory experience in clinical medicine and ongoing treatment monitoring and evaluation.

(F) Clinical pharmacotherapeutics, including the following as related to pharmacotherapeutics:

(i) Professional, ethical, and legal issues.

(ii) Combined therapies, such as psychotherapy and pharmocotherapy interactions.

(iii) Computer-based aids to practice.

(iv) Pharmacoepidemiology.

(v) Integration of clauses (i) to (iv), inclusive, through supervised clinical experience or laboratory experience in integrated treatment planning and consultation and the implications of treatment.

(G) Research, including the following:

(i) Methodology and design of psychopharmacological research.

(ii) Interpretation and evaluation of research.

(iii) Federal Food and Drug Agency drug development and other regulatory processes.

(2) Relevant supervised clinical experience, in accordance with APA guidelines, to obtain competency in prescribing and the psychopharmacological treatment of a diverse patient population under the direction of qualified prescribers, as determined by the board.

(A) The supervised clinical experience is intended to be an intensive, closely supervised experience. Approved programs shall commit to providing training courses and experiences that encourage sensitivity to the interactions between pharmacological and psychological interventions with the developmental status, gender, health status, culture, and ethnicity of patients. The supervised experience shall be an organized sequence of education and training that provides an integrative approach to learning,

as well as the opportunity to assess competencies in skills and applied knowledge. The intent of the supervised clinical experience shall be both of the following:

(i) To provide ongoing integration of didactic and applied clinical knowledge throughout the learning sequence, including ample opportunities for practical learning and clinical application of skills.

(ii) To provide opportunity for programs to assess formative and summative clinical competency in skills and applied knowledge.

(B) The clinical competencies targeted by this experience shall include all of the following:

(i) Physical examination and mental status evaluation, including knowledge and execution of elements and sequence of both comprehensive and focused physical examination and mental status evaluation, proper use of instruments used in physical examination, such as stethoscopes and blood pressure measurement devices, and scope of knowledge gained from physical examination and mental status examination.

(ii) Review of systems, including knowledge and ability to systematically describe the process of integrating information learned from patient reports, signs, symptoms, and a review of each of the major body systems.

(iii) Medical history interview and documentation, including the ability to systematically conduct a patient clinical interview producing a personal and family medical history, and to communicate the findings in written and verbal form.

(iv) Assessment indications and interpretation, including the ability to order and interpret appropriate tests, such as psychometric, laboratory, and radiological tests, for the purpose of making a differential diagnosis and for monitoring therapeutic and adverse effects of treatment.

(v) Differential diagnosis, including use of appropriate processes, including established diagnostic criteria such as ICD-9 and DSM-IV, to determine primary and alternate diagnoses.

(vi) Integrated treatment planning, including the ability to identify and select, using all available data, the most appropriate treatment alternatives and to sequence treatment within the larger biopsychosocial context.

(vii) Consultation and collaboration, including understanding of the parameters of the role of the prescribing psychologist or medical psychologist and working with other professionals in an advisory or collaborative manner to effect treatment of a patient.

(viii) Treatment management, including application, monitoring, and modification, as needed, of treatment.

(C) The supervised clinical experience should also meet the following requirements:

(i) The range of diagnostic categories, settings, and developmental status, gender, health status, and ethnicity reflected in the patients seen in connection with the supervised clinical experience should be appropriate to the current and anticipated practice of the trainee. It should allow the trainee to gain exposure to acute, short-term, and maintenance medication strategies.

(ii) Prior to being granted certification as a prescribing psychologist, a trainee shall obtain supervised clinical experience with a sufficient range and number of patients in order to demonstrate threshold performance levels for each of the competency areas. In order to achieve the complex clinical competency skills required for independent prescribing, a minimal number of supervised patient contact hours shall be completed. The program shall report the total number of supervised clinical experience hours that students experience. These hours shall be specified as either face-to-face patient contacts or other clinical experiences and this shall be done for each clinical competency.

(iii) The program shall provide the board with a report for each applicant that includes a description of the method and appropriate benchmarks for assuring each clinical competency. Methods may include performing basic physical examinations, case presentations, or patient simulations based on actual patients and patients for whom the trainee assumes direct psychological responsibility. The trainee shall recommend or prescribe in consultation with or under the supervision of someone with demonstrated skills and experience in clinical psychopharmacology and in accordance with the prevailing law.

(iv) The program shall provide final approval of the supervised clinical experience of an applicant.

(D) Supervised clinical experience may be integrated into each level of a trainee's education and training, provided in a final

summative practical experience, or provided in a combination of those methods according to the design of the program.

(E) A trainee shall demonstrate competency in his or her ability to integrate didactic learning and applied clinical skill.

(c) A prescribing psychologist shall maintain competency through continuing education over the lifespan of maintaining and practicing in prescriptive authority or collaborative activities with other prescribers.

SEC. 5. Section 2949.2 is added to the Business and Professions Code, to read:

2949.2. (a) The board, shall set forth the requirements for renewal of a certificate of a prescribing psychologist for each license renewal period.

(b) Each applicant for renewal of a certificate for prescriptive authority shall present evidence of having completed approved mandatory continuing education in the area of psychopharmacology and related prescribing practice as set forth by the board.

SEC. 6. Section 2949.3 is added to the Business and Professions Code, to read:

2949.3. (a) Each prescribing psychologist shall comply with all state and federal rules and regulations relating to the prescribing, dispensing, and recordkeeping for drugs or devices, as defined in Sections 4021, 4022, 4023, 4025, and 4055, and other applicable provisions of law. If the board determines that it would facilitate administration of the provisions governing prescribing psychologists to identify a prescribing psychologist by another name that is consistent with other jurisdictions, it may do so.

(b) A written order of a prescribing psychologist shall include his or her prescribing identification number, which shall be assigned by the board to any certified prescribing psychologist.

(c) A prescribing psychologist shall not delegate the prescribing of medication to any other person except for a supervised trainee in a recognized training program for prescribing psychologists.

(d) Records of all prescriptions shall be maintained in a prescribing psychologists client records.

SEC. 7. Section 2949.4 is added to the Business and Professions Code, to read:

2949.4. (a) The board shall annually transmit to the State Board of Pharmacy a list of prescribing psychologists containing, at a minimum, all of the following information:

(1) The name of the prescribing psychologist.

(2) The unique identification number indicating certification of the prescribing psychologist to prescribe.

(3) The effective date of prescribing psychologist's prescriptive authority.

(b) The board shall promptly forward to the State Board of Pharmacy the names and identification numbers of prescribing psychologists added to or deleted from the annual list of psychologists certified to prescribe.

(c) The board shall notify the State Board of Pharmacy in a timely manner upon termination, suspension, or reinstatement of a psychologist's authority to prescribe.

SEC. 8. Section 2960 of the Business and Professions Code is amended to read:

2960. The board may refuse to issue any registration, *certification,* or license, or may issue a registration or license with terms and conditions, or may suspend or revoke the registration or license of any registrant or licensee if the applicant, registrant, or licensee has been guilty of unprofessional conduct. Unprofessional conduct shall include, but not be limited to, *all of the following*:

(a) Conviction of a crime substantially related to the qualifications, functions or duties of a psychologist or psychological assistant.

(b) Use of any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or dangerous drug, or any alcoholic beverage to an extent or in a manner dangerous to himself or herself, any other person, or the public, or to an extent that this use impairs his or her ability to perform the work of a psychologist with safety to the public.

(c) Fraudulently or neglectfully misrepresenting the type or status of license or registration actually held.

(d) Impersonating another person holding a psychology license or allowing another person to use his or her license or registration.

(e) Using fraud or deception in applying for a license or registration or in passing the examination provided for in this chapter.

(f) Paying, or offering to pay, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of clients.

(g) Violating Section 17500.

(h) Willful, unauthorized communication of information received in professional confidence.

(i) Violating any rule of professional conduct promulgated by the board and set forth in regulations duly adopted under this chapter.

(j) Being grossly negligent in the practice of his or her profession.

(k) Violating any of the provisions of this chapter or regulations duly adopted thereunder.

(l) The aiding or abetting of any person to engage in the unlawful practice of psychology.

(m) The suspension, revocation or imposition of probationary conditions by another state or country of a license or certificate to practice psychology or as a psychological assistant issued by that state or country to a person also holding a license or registration issued under this chapter if the act for which the disciplinary action was taken constitutes a violation of this section.

(n) The commission of any dishonest, corrupt, or fraudulent act.

(o) Any act of sexual abuse, or sexual relations with a patient or former patient within two years following termination of therapy, or sexual misconduct that is substantially related to the qualifications, functions or duties of a psychologist or psychological assistant or registered psychologist.

(p) Functioning outside of his or her particular field or fields of competence as established by his or her education, training, and experience.

(q) Willful failure to submit, on behalf of an applicant for licensure, verification of supervised experience to the board.

(r) Repeated acts of negligence.

(s) Violating Section 2949.3 relating to prescribing or dispensing drugs.

SEC. 9. Section 4040 of the Business and Professions Code is amended to read:

4040. (a) "Prescription" means an oral, written, or electronic transmission order that is both of the following:

(1) Given individually for the person or persons for whom ordered that includes all of the following:

(A) The name or names and address of the patient or patients.

(B) The name and quantity of the drug or device prescribed and the directions for use.

(C) The date of issue.

(D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification, and his or her federal registry number, if a controlled substance is prescribed.

(E) A legible, clear notice of the condition for which the drug is being prescribed, if requested by the patient or patients.

(F) If in writing, signed by the prescriber issuing the order~~, or the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor who issues a drug order pursuant to Section 2746.51, 2836.1, 3502.1, or 3640.5, respectively, or the pharmacist who issues a drug order pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052~~.

(2) Issued by a physician, dentist, optometrist, podiatrist, *prescribing psychologist,* veterinarian, or naturopathic doctor pursuant to Section 3640.7 or, if a drug order is issued pursuant to Section 2746.51, 2836.1, 3502.1, or 3460.5, by a certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor licensed in this state, or pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 by a pharmacist licensed in this state.

(b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug, except for any Schedule II controlled substance, that contains at least the name and signature of the prescriber, the name *or names* and address of the patient *or patients* in a manner consistent with paragraph (3) of subdivision (b) of Section 11164 of the Health and Safety Code, the name and quantity of the drug prescribed, directions for use, and the date of issue may be treated as a prescription by the dispensing pharmacist as long as any additional information required by subdivision (a) is readily retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164 of the Health and

Safety Code, Section 11164 of the Health and Safety Code shall prevail.

(c) "Electronic transmission prescription" includes both image and data prescriptions. "Electronic image transmission prescription" means any prescription order for which a facsimile of the order is received by a pharmacy from a licensed prescriber. "Electronic data transmission prescription" means any prescription order, other than an electronic image transmission prescription, that is electronically transmitted from a licensed prescriber to a pharmacy.

(d) The use of commonly used abbreviations shall not invalidate an otherwise valid prescription.

(e) Nothing in the amendments made to this section (formerly Section 4036) at the 1969 Regular Session of the Legislature shall be construed as expanding or limiting the right that a chiropractor, while acting within the scope of his or her license, may have to prescribe a device.

SEC. 10. Section 4502 of the Business and Professions Code is amended to read:

4502. As used in this chapter, "psychiatric technician" means any person who, for compensation or personal profit, implements procedures and techniques which involve understanding of cause and effect and which are used in the care, treatment, and rehabilitation of mentally ill, emotionally disturbed, or mentally retarded persons and who has one or more of the following:

(a) Direct responsibility for administering or implementing specific therapeutic procedures, techniques, treatments, or medications with the aim of enabling recipients or patients to make optimal use of their therapeutic regime, their social and personal resources, and their residential care.

(b) Direct responsibility for the application of interpersonal and technical skills in the observation and recognition of symptoms and reactions of recipients or patients, for the accurate recording of such symptoms and reactions, and for the carrying out of treatments and medications as prescribed by a licensed physician and surgeon ~~or a~~, psychiatrist, *or prescribing psychologist.*

The psychiatric technician in the performance of such procedures and techniques is responsible to the director of the service in which his duties are performed. The director may be a licensed physician

and surgeon, psychiatrist, psychologist, rehabilitation therapist, social worker, registered nurse, or other professional personnel.

Nothing herein shall authorize a licensed psychiatric technician to practice medicine or surgery or to undertake the prevention, treatment or cure of disease, pain, injury, deformity, or mental or physical condition in violation of the law.

SEC. 11. Section 4502.1 of the Business and Professions Code is amended to read:

4502.1. A psychiatric technician, working in a mental health facility or developmental disability facility, when prescribed by a physician and surgeon *or prescribing psychologist*, may administer medications by hypodermic injection.

SEC. 12. Section 4502.2 of the Business and Professions Code is amended to read:

4502.2. A psychiatric technician, when prescribed by a physician and surgeon *or prescribing psychologist*, may withdraw blood from a patient with a mental illness or developmental disability if the psychiatric technician has received certification from the board that the psychiatric technician has completed a prescribed course of instruction approved by the board or has demonstrated competence to the satisfaction of the board.

SEC. 13. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

All matter omitted in this version of the bill appears in the bill as introduced in Senate, February 23, 2007 (JR11)

O

MEDICAL BOARD OF CALIFORNIA
Executive Office

TO: **MEMBERS**
MEDICAL BOARD OF CALIFORNIA

FROM; **Linda Whitney**
Chief of Legislation

SUBJECT: **2008 PROPOSED LEGISLATION**

The following are legislative proposals staff would like to develop for 2008 Legislation.

1. Allow for a "cap" on the initial and renewal license fee instead of having a "fixed" amount prescribed in law.

Prior to SB 231, the fees were set in law as ". . . shall be fixed by the board at an amount not to exceed . . ." This language allowed the board to set and revise the fee by regulation. This enabled the board to lower (to any level below the cap) or increase (to the cap) the fee depending upon the fund condition. Current language fixes the fee by using the language ". . . fee shall be . . ." which requires the board to set the fee at the amount prescribed in law ($790). The recent fiscal audit report recommended that the board seek authorization to amend law to give the board flexibility to revise the fees.

Recommendation: Authorize staff to begin discussions and seek legislation to allow for a "cap" on the current ($790) physician initial and renewal fees by inserting the "fixed by the board" language in law. This will allow the board to set and revise the fee by regulatory action.

2. Extend Vertical Enforcement-Prosecution as an ongoing program (no sunset date), using the language from the final version of SB 797, that only included the extension, but continue to require the board to report, on a regular basis, regarding the effectiveness of the program.

There is ongoing discussion by various entities of extending the pilot program. The funding for the additional Attorney General staff (seven positions) expires on July 1, 2008, thus if the board wants to continue operating the program at the staffing currently authorized, this legislation (effective date of 1/1/09) or a budget request (effective date of 7/1/09) must be made during calendar year 2008.

Recommendation: Authorize staff to continue discussions regarding extension of the pilot and seek either legislation and/or budget authorization to continue the VE-P AG positions.

3. Address the outstanding sections of law related to the Diversion Program that have not been addressed with the sunset of the program. These sections have to do with the peer review process as used by reporting entities. The underlined portions of the following two sections are those that need to be revised as they refer to the diversion program/administrator and the confidentiality protections provided for in that program.

821.5. (a) A peer review body, as defined in Section 805, that reviews physicians and surgeons, shall, within 15 days of initiating a formal investigation of a physician and surgeon's ability to practice medicine safely based upon information indicating that the physician and surgeon may be suffering from a disabling mental or physical condition that poses a threat to patient care, report to the diversion program of the Medical Board the name of the physician and surgeon under investigation and the general nature of the investigation. A peer review body that has made a report to the diversion program under this section shall also notify the diversion program when it has completed or closed an investigation.

(b) The diversion program administrator, upon receipt of a report pursuant to subdivision (a), shall contact the peer review body that made the report within 60 days in order to determine the status of the peer review body's investigation. The diversion program administrator shall contact the peer review body periodically thereafter to monitor the progress of the investigation. At any time, if the diversion program administrator determines that the progress of the investigation is not adequate to protect the public, the diversion program administrator shall notify the chief of enforcement of the Division of Medical Quality of the Medical Board of California, who shall promptly conduct an investigation of the matter. Concurrently with notifying the chief of enforcement, the diversion program administrator shall notify the reporting peer review body and the chief executive officer or an equivalent officer of the hospital of its decision to refer the case for investigation by the chief of enforcement.

(c) For purposes of this section "formal investigation" means an investigation ordered by the peer review body's medical executive committee or its equivalent, based upon information indicating that the physician and surgeon may be suffering from a disabling mental or physical condition that poses a threat to patient care. "Formal investigation" does not include the usual activities of the well-being or assistance committee or the usual quality assessment and improvement activities undertaken by the medical staff of a health facility in compliance with the licensing and certification requirements for health facilities set forth in Title 22 of the California Code of Regulations, or preliminary deliberations or inquiries of the executive committee to determine whether to order a formal investigation. For purposes of this section, "usual activities" of the well-being or assistance committee are activities to assist medical staff members who may be impaired by chemical dependency or mental illness to obtain necessary evaluation and rehabilitation services that do not result in referral to the medical executive committee.

(d) Information received by the diversion program pursuant to this section shall be governed by, and shall be deemed confidential to the same extent as program records under, Section 2355. The records shall not be further disclosed by the diversion program, except as provided in subdivision (b).

(e) Upon receipt of notice from a peer review body that an investigation has been closed and that the peer review body has determined that there is no need for further action to protect the public, the diversion program shall purge and destroy all records in its possession pertaining to the investigation unless the diversion program administrator has referred the matter to the chief of enforcement pursuant to subdivision (b).

(f) A peer review body that has made a report under subdivision (a) shall not be deemed

to have waived the protections of Section 1157 of the Evidence Code. It is not the intent of the Legislature in enacting this subdivision to affect pending litigation concerning Section 1157 or to create any new confidentiality protection except as specified in subdivision (d). "Pending litigation" shall include Arnett v. Dal Cielo (No. S048308), pending before the California Supreme Court.

(g) The report required by this section shall be submitted on a short form developed by the board. The board shall develop the short form, the contents of which shall reflect the requirements of this section, within 30 days of the effective date of this section. The board shall not require the filing of any report until the short form is made available by the board.

(h) This section shall become operative on January 1, 1997, unless the regulations required to be adopted pursuant to Section 821.6 are adopted prior to that date, in which case this section shall become operative on the effective date of the regulations. 821.6. The board shall adopt regulations to implement the monitoring responsibility of the diversion program administrator described in subdivision (b) of Section 821.5, and the short form required to be developed pursuant to subdivision (g), on or before January 1, 1997.

Recommendation: Authorize staff to meet with interested parties to develop language that will be consistent with existing law, continuation of reporting this information to the board, and that will ensure the confidentiality of the reports as currently ensured by the diversion program. Appoint a board member to be participate in this discussion.

4. Develop an initial licensing category for disabled physicians.

The board authorized staff to work on this issue late in the 2007 legislative session. There were too many questions that arose regarding how this would be implemented, thus the proposal did not move forward. The law currently allows a California licensed physician, who is disabled, to go into disabled license status, not practice, and have fees waived (section 2441 is below). This physician may request to exit the disabled status and practice medicine again by certifying to the board that the disability no longer exists or that he/she will limit the practice of medicine as prescribed by the reviewing physician. In essence, this has authorized the board to issue a limited license to a physician who is licensed in California. There is no similar law that allows the board to issue an initial limited license, other than a probationary license for a cause that relates to an action on which the board could take disciplinary action. There are significant issues related to how the board would makes its determination on issuing an initial limited license. That is part of the reason this proposal did not move forward in 2007.

2441. Any licensee who demonstrates to the satisfaction of the board that he or she is unable to practice medicine due to a disability may request a waiver of the license renewal fee. The granting of a waiver shall be at the discretion of the board and may be terminated at any time. Waivers shall be based on the inability of a licensee to practice medicine. A licensee whose renewal fee has been waived pursuant to this section shall not engage in the practice of medicine unless and until the licensee pays the current renewal fee and does either of the following:

(a) Establishes to the satisfaction of the board, on a form prescribed by the board and signed under penalty of perjury, that the licensee's disability either no longer exists or does not affect his or her ability to practice medicine safely.

(b) Signs an agreement on a form prescribed by the board, signed under penalty of

perjury, in which the licensee agrees to limit his or her practice in the manner prescribed by the reviewing physician.

Recommendation: Authorize staff to reopen discussions regarding this proposal for an initial limited license to determine if it is feasible for introduction into legislation. Appoint a board member to participate in this discussion.

5. The Division of Licensing has numerous proposals for legislation. These will be fully discussed in the Division meeting.

Recommendation: Allow the Division of Licensing to review the legislative proposals and make recommendations back to the full board in its report.

6. Allow for the requirement of training when issuing a Public Letter of Reprimand.

Currently the Executive Director has authorization to issue to an individual a Public Letter of Reprimand in lieu of filing of an Accusation for minor violations (B&P Code section 2233). There are times when an individual who receives a Public Letter of Reprimand in lieu of an Accusation being filed, should also be required to take an educational course, such as a "medical records" or "prescribing practices" course. This required course of instruction would enhance consumer protection. However, pursuant to statute only a Public Letter of Reprimand can be issued, because the Board cannot negotiate a settlement proposal without an accusation being filed. Therefore, in order to require additional training, the Board must first file an accusation, then ask for a public reprimand pursuant to B&P Code section 2227 that could include an education course. This process takes more time to conclude, and adds an expense to both the Board and the physician that is unnecessary when the concerns could be resolved at a lower level of enforcement.

Recommendation: Direct staff to fully examine pros and cons of an amendment to section 2233 to allow the Executive Director to ask for an education course with the public letter of reprimand. Appoint a Board member to work with staff and interested parties on this concept.

7. Omnibus or technical clean up language.

Board staff has identified a number of sections that need to be edited. These will be proposed as amendments in a Business and Professions omnibus bill. Because these are not substantive changes, must have NO objections from interested parties, and are added to as the session progresses, they are not included in this report.

Recommendation: No Action.

Governor's Health Care Proposal

The Governor's vision for health reform is an accessible, efficient, and affordable health care system that promotes a healthier California through prevention and wellness and universality of coverage. For the Governor's vision to be realized, health care reform must reflect a "systems" approach that incorporates three essential building blocks in an integrated manner. These building blocks are:

Prevention, health promotion, and wellness
Coverage for all Californians
Affordability and cost containment

A. PREVENTION, HEALTH PROMOTION, AND WELLNESS

Preventable disease and disability have a profound impact on the health of California residents and communities as well as on the continued growth in health care costs. An increased emphasis on disease prevention, health promotion and healthy lifestyles will improve health outcomes and help contain health care costs. To promote a healthier California and achieve long term cost containment, the Governor's action steps include:

Structuring benefits and providing incentives/rewards to promote prevention, wellness and healthy lifestyles through the implementation of "Healthy Actions Incentives/Rewards" programs in both the public and private sector: Implement "Healthy Action Incentives/Rewards" programs in both the public and private sectors to encourage the adoption of healthy behaviors. Californians who take personal responsibility to increase healthy practices and behaviors, thereby reducing their risk of chronic medical conditions and the incidence of infectious diseases, will benefit from participation in this groundbreaking program. The Healthy Action Rewards/Incentives program will reward Californians for participation in evidence-based practices and behaviors that have been shown to both reduce the burden of disease and are cost-effective. Individuals in public programs, such as Medi-Cal and Healthy Families, will earn rewards that may include gym memberships or weight management programs. Participants enrolled in commercial plans, including CalPERS, will earn rewards and incentives, including premium reductions, for engaging in healthy activities. The Governor's plan includes the creation of a new insurance subsidy pool administered by MRMIB through which low income adults will be provided with subsidized coverage. The pool's coverage will also include a Healthy Action Incentive/Rewards program. All health plans and insurers will be required to offer a health benefit package(s) that includes incentives/rewards programs, including premium reduction, in the event that an employer wishes to make them available to their employees. All of the Healthy Actions programs are linked to the completion of a Health Risk Assessment and follow-up doctor visit.

Establishing a national model for the prevention and treatment of diabetes: Over 2 million Californians currently have diabetes, and the number of Californians with diabetes is expected to

double by 2025. Over one quarter of people with diabetes do not know they have the disease. To better prevent, target and manage this high-cost chronic condition, Medi-Cal and the California Diabetes Program, in collaboration with community organizations, will jointly develop a comprehensive statewide initiative to institute proven interventions for pre-diabetes and diabetes screening, primary prevention, and self-management to reduce the number of people with diabetes or improve the health of those with the disease while reducing costly care within California's health care system.

Preventing medical errors and health care acquired infections: Medical errors and health care acquired infections unnecessarily compromise the health status of patients, lower health care quality and significantly contribute to health care costs. Patient harm due to such lapses causes an estimated 23,000 hospital deaths and untold numbers of injuries each year in California and costs over $4 billion annually. To combat this problem and significantly improve patient safety throughout California the Governor will: (1) Require electronic prescribing by all providers and facilities by 2010 to substantially reduce adverse drug events; (2) Require new health care safety measures and reporting requirements in California's health facilities to reduce medical errors and hospital acquired infections by 10% over 4 years; (3) Call upon the leadership of California's health facilities to implement evidence-based measures to prevent harm to patients and provide state technical assistance; and (4) Create a university-based academic "re-engineering" curriculum designed to improve patient safety and streamline costs within the health care delivery system.

Reversing obesity trends through nation-leading innovative and comprehensive strategies: Obesity threatens to surpass tobacco as the leading cause of preventable death among Californians and costs the state $28.5 billion in health care costs, lost productivity and workers' compensation. California can lead the nation in tackling obesity with the same success demonstrated in the state's anti-tobacco campaign. Based on the Governor's 10-Step Vision for a Healthy California, the Governor's proposal includes a sustained media campaign to encourage healthy choices; community-based activities to increase access to healthy food and physical activity in stores, schools, and neighborhoods; employee wellness programs; and school-based strategies that engage the broader community in obesity prevention activity.

Continuing the battle against tobacco use: Smoking is the leading preventable cause of death in California. California has led the nation in effective smoking control activities, achieving the second lowest rate of smoking among adults in the nation. Still, an estimated 3.8 million adults and 200,000 youth smoke. California can maintain its leadership role in tobacco control and further reduce smoking rates by increasing access to cessation services offered through the highly effective California Smokers' Helpline and maximizing utilization of cessation benefits.

B. COVER ALL CALIFORNIANS

According to the UCLA California Health Interview Survey, 6.5 million Californians were uninsured at some point during last year, representing 20% of children and non-elderly adults. 75% of the uninsured were in working families, with the majority having no health coverage through their employers.

Addressing the "hidden tax" benefits everyone: A recent report by the New America Foundation estimated that a "hidden tax" on California health premiums has driven prices 10%

higher to help cover the costs of caring for the state's large numbers of uninsured. The study indicated that this annual "hidden tax" is $1,186 per California family and $455 for individual health insurance policies. This tax is even higher when underpayments from government purchasers such as Medi-Cal are added in.

Source: Dobson, Allen et al. (2006). The Cost-Shift Payment 'Hydraulic': Foundation, History, And Implications. Health Affairs, 25, no. 1: 22-33.

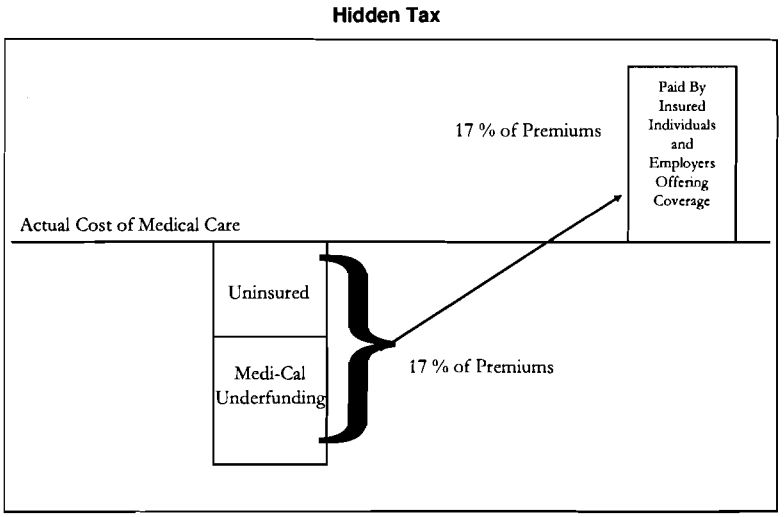


Figure 1: The effect of the hidden tax on insured individuals and employers offering coverage.

Ensuring availability of emergency rooms and trauma centers is essential: According to the Office of Statewide Health Planning and Development 65 emergency rooms (ERs) in California have closed in the last decade. In Los Angeles County, one fifth of emergency rooms have closed since 1995, leaving only 75 ERs open to the county's10 million residents. A new study by the federal Centers for Disease Control and Prevention indicates that between 40 percent and 50 percent of emergency departments experienced overcrowding during 2003 and 2004. A major source of this overcrowding, especially in metropolitan areas, is the uninsured and persons who have problems accessing physicians through government programs such as Medi-Cal, which also contributes to emergency department and trauma center closures across California. As a result, the well-being and life of many Californians is threatened by longer drives to fewer ER facilities, longer waiting times, and compromised hospital capacity to cope with a major emergency, such as a disease outbreak or earthquake.

Availability of insurance affects not only the physical but the financial health of the community: A 2002 synthesis of 25 years of research on the uninsured conducted by the Kaiser Commission on Medicaid and the Uninsured found that the uninsured receive less preventive care, are diagnosed at more advanced stages of illness, have reduced annual earnings from work and achieve reduced educational attainment. A National Institute of Medicine study indicated that the lack of insurance has resulted in a lost national economic productivity of $65 billion to $130 billion annually.

A February 2005 article in Health Affairs indicated that about half of the approximately 1.5 million American families that filed for bankruptcy in 2001 cited medical bills as the cause, which indicates that 1.9–2.2 million Americans (filers plus dependents) experienced bankruptcy due to lack of funds for medical expenses. The lack of insurance and underinsurance (less comprehensive medical policies) were major contributors to the bankruptcies for the two years

prior to 2005 as well. Numerous other articles have chronicled the sometimes catastrophic financial difficulties that individual families have encountered when facing uncovered health care costs.

To achieve coverage for all of California's uninsured, the Governor's action steps include:

Requiring all individuals to have a minimum level of coverage (individual mandate): Requiring people to carry coverage is the most effective strategy for fixing the broken health care system. The core problem for California is that those with insurance pay the cost of health care delivered to 6.5 million uninsured. Everyone must participate equally. An employer mandate will not achieve universal coverage because it fails to address the needs of part-time, seasonal and unemployed uninsured Californians.

Providing low-income individuals affordable coverage: Low-income Californians will be provided expanded access to public programs, such as Medi-Cal and Healthy Families, and lower-income working residents will be provided financial assistance to help with the cost of coverage through a new state-administered purchasing pool.

Requiring insurers to issue health insurance: Insurers will be required to guarantee coverage, with limits on how much they can charge based on age or health status, so that all individuals have access to affordable products.

Increasing Medi-Cal rates significantly: To reduce the "hidden tax" associated with low Medi-Cal reimbursement and to encourage greater provider participation in the Medi-Cal program, Medi-Cal rates for providers, hospitals and health plans will be increased.

Facilitating and enforcing the individual mandate: Systems will be established to facilitate enrollment of uninsured persons who use the health care system. Providers will play an important role in supporting enrollment by instituting such strategies as on-site enrollment at provider locations, as well as by underscoring the expectation that everyone present a coverage card at the point of service. In addition, the salary tax withholding and payment process with the Employment Development Department and the state income tax filing process will be utilized to promote compliance with the individual mandate.

Coverage Proposal Overview

6.5 million Californians are uninsured for all or part of a year; 4.8 million Californians are uninsured at any given time. Governor Arnold Schwarzenegger's health care initiative identifies sufficient funds to cover all Californians through a variety of mechanisms. Jon Gruber, Ph.D., an MIT economist and health care expert has assisted the Administration in estimating individual and employee behavior in the coverage model outlined below based upon coverage for all 4.8 million uninsured residents.

Coverage for uninsured children (approximately 750,000):

- All uninsured children below 300% of the federal poverty level (FPL), regardless of residency status, will be eligible for state-subsidized coverage. 220,000 uninsured

children below 100% of the FPL will enroll in Medi-Cal, while 250,000 uninsured children between 101-300% of the FPL will enroll in the Healthy Families Program.

- 210,000 uninsured children will enroll in employer-sponsored coverage and an additional 50,000 uninsured children above 300% of the FPL would be covered by private insurance by their parents or responsible adult. Parents of these children will be responsible for purchasing at least the minimum level of coverage for their children.

Coverage for uninsured adults (approximately 4.1 Million)

- 630,000 uninsured legal resident adults with incomes below 100% of the FPL will be eligible for and enroll in no-cost Medi-Cal. This population has little discretionary income and purchasing Medi-Cal is a cost-effective coverage option.
- Approximately 1.2 million uninsured legal resident adults with incomes between 100-250% of the FPL will be eligible for coverage through a state purchasing pool operated by the Managed Risk Medical Insurance Board. Approximately 1 million are expected to enroll with the remaining 200,000 opting for employer-sponsored coverage.
- Consistent with the principle of shared responsibility, the individual's/family's contribution toward the premium will be as follows:

  100-150%: 3% of gross income
  151-200%: 4% of gross income
  201-250%: 6% of gross income

- Approximately 1.1 million uninsured legal resident adults above 250% percent of the FPL will not receive a subsidy and will be required to purchase and maintain coverage under the individual mandate. Of this amount, 370,000 are expected to opt for employer-sponsored coverage and 730,000 are expected to purchase individual coverage.
- There are approximately 1 million uninsured persons without a "green card" (primarily undocumented persons and persons with temporary visas). Of this amount, approximately 40,000 are expected to opt for employer-sponsored coverage and 160,000 are expected to purchase individual coverage. The remaining 750,000 under 250% of the FPL are expected to receive health coverage provided, coordinated or arranged by county government in coordination, where applicable, with county and University of California hospitals. Counties would retain $1 billion in current funding (primarily for outpatient services) and county and UC hospitals will retain $1 billion in federal Disproportionate Share Hospital (DSH) funds and in addition, some "safety net" funds for primarily inpatient services. The state will also continue to fund emergency Medi-Cal which provides certain vital services such as prenatal care and maternity for this population.

Payment assistance will be available for low-income insured adults: In order to maintain equity for low-income persons who are already contributing towards the cost of their care, persons with individual or employer-sponsored coverage who are between 100-250% of the poverty level will be eligible for state financial assistance through the purchasing pool. Approximately 700,000 persons are expected to utilize this option. Persons with employer sponsored coverage are eligible for state financial assistance through the purchasing pool for the employee share of the premium only if the employer contributes to the cost of coverage for those employees.

Anti crowd-out provisions are included to disincentivize employers and employees from dropping current coverage. These include the 4% employer "in-lieu" fee for non-offering employers with 10 or more employees, purchasing pool premium contribution levels which are slightly higher than employee-only premium contribution levels, and a proposed provision that will be added to the Labor Code making it an unfair business practice for an employer to

differentiate the employer premium contribution by class of employee, except pursuant to a collective bargaining agreement.

In order to establish a more organized system of state-subsidized coverage that simplifies the eligibility system and maintains family unity of coverage, a "bright line" will be established between the Medi-Cal program and other subsidized programs (except for pregnant women). This would affect 680,000 children and 215,000 adult Medi-Cal enrollees above 100% of the Federal Poverty Level who would switch coverage to either the Healthy Families Program or the purchasing pool.

Source: Governor Schwarzenegger's health care team.

California's Family Health Insurance Programs

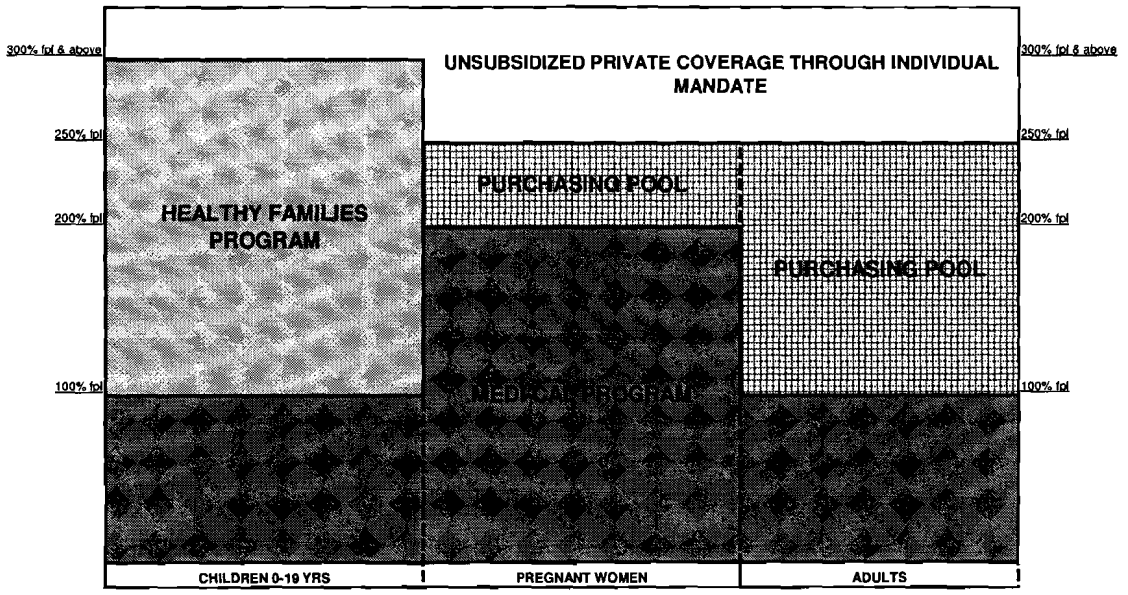


Figure 2: Proposed state coverage programs.

Everyone must maintain a minimum level of insurance:

- All Californians will be required to have health insurance coverage. Coverage must be substantial enough to protect families against catastrophic costs as well as minimize the "cost shift" that occurs when large numbers of persons are receiving care without paying the full cost of that care.
- The *minimum* health insurance benefit that must be maintained will be a $5,000 deductible plan with maximum out-of-pocket limits of $7,500 per person and $10,000 per family. For the majority of uninsured individuals, such coverage can be purchased today for $100 or less per month for an individual and $200 or less for two persons. Uninsured persons at any income level can purchase their own health coverage that meets the above requirement or, if income eligible, may obtain coverage with a state subsidy.
- Coverage through the new purchasing pool will fulfill an individual's obligation to obtain health coverage. The subsidized coverage through the purchasing pool is expected to be at the level of Knox-Keene medical benefits plus prescription drugs. Deductibles and/or co-payments that encourage the use of preventive benefits and discourage unnecessary use of emergency rooms will also be a part of the benefit package. The design of the

subsidized benefit package will be the responsibility of the Managed Risk Medical Insurance Board. Although dental and vision benefits will not be included in the subsidized benefits, the pool will also offer non-subsidized products so that members can purchase richer benefits at their own expense. Persons between 100-250% FPL will have the option to purchase this subsidized coverage through the pool.

- Medi-Cal and Healthy Families Program benefits are expected to remain the same.
- Persons not eligible for a subsidy can purchase coverage that meets the minimum requirements in the private individual market. They can also access the mandated minimum $5,000 deductible product in the purchasing pool. Individuals will also be able to take advantage of the federal pre-tax premium deductions in either place if eligible.

Under shared responsibility, financing for expanded public programs, the subsidized health plan, increased Medi-Cal rates, and programs to promote prevention, health and wellness will be achieved through the following structure:

- Employers with 10 or more employees who choose not to offer health coverage will contribute an amount equal to 4% of payroll toward the cost of employees health coverage.
- The plan will direct $10-$15 billion to hospitals and doctors, who will then return a portion of this coverage dividend associated with universal coverage; hospitals will contribute 4% of gross revenues and physicians will contribute 2% of gross revenues.
- The redirection of $2 billion in medically indigent care funding, which includes health care safety net, realignment and other funding sources.
- Additional federal reimbursements for Healthy Families Program expansion, Medi-Cal rate increases, Medi-Cal coverage of parents as well as single adults through a Medi-Cal Section 1115 Waiver.

The proceeds from these revenue sources will be deposited into a newly established Health Care Services Fund. These funds will be segregated from the state general fund and will be the source for payments for health care coverage under the initiative.

Under the proposal, counties, county and University of California hospitals, will retain $2 billion in current funding for the uninsured. The State will continue to fund emergency Medi-Cal, which provides certain vital services, including emergency care, prenatal care and maternity services for this population.

C. AFFORDABILITY AND COST CONTAINMENT

Cost and coverage must be addressed together: without short- and long-term cost containment measures, the current system of health care delivery is not sustainable for employers and employees. With health care costs rising faster than general inflation, even more employers and employees will discontinue coverage and reliance on state health care programs will increase if health care affordability is not addressed. Cost containment becomes even more important with an individual mandate so individuals can afford to purchase and maintain comprehensive benefits.

Reduction of the "Hidden Tax":

- Once more Californians have coverage, providers won't need to continue loading their insurance charges with extra funds to make up for the cost of caring for those without coverage.
- Increased Medi-Cal reimbursement will further reduce the need of providers to shift uncompensated Medi-Cal costs to other payers.
- Employers will finally see an end to the annual premium cost-spikes they are currently experiencing. Providing health coverage to their employees will be more affordable.

Enhanced tax breaks for individuals and employers for the purchase of insurance:

- Align state tax laws with federal laws by allowing persons to make pre-tax contributions to individual health care insurance Health Savings Accounts.
- Require employers to establish "Section 125" plans so that employees can make tax-sheltered contributions to health insurance and save employers additional FICA contributions.

Enhance insurer and hospital efficiency:

- Require health plans (HMO's), insurers and hospitals to spend 85% of every dollar in premium and health spending on patient care.
- Revise the amount an insurer must pay a hospital when insured persons need treatment outside of their network so insurers don't need "defensive contracting" to protect against high daily rates from out-of-network providers.

Reduce regulatory barriers to more efficient health care delivery:

- Implement a new federal classification system for hospital construction and establish a new structural performance category to adopt a "worst first" system of hospital conformity to California's seismic safety requirements.
- Implement a "24-Hour Coverage" program that combines and coordinates the health care component of workers' compensation with traditional group health coverage. The proposed five-year pilot program for Cal-PERS (state and local agency employees) will ensure that health care services are delivered by the same set of providers used in the Cal-PERS managed care/HMO program for work and non-work-related health care. The private sector will be allowed to opt into the pilot.
- Remove statutory and regulatory barriers to expansion of lower-cost models of health care delivery such as retail-based medical clinics by making scope of practice changes for "physician extenders" such as nurse practitioners and physician assistants.

Reduce cost for delivering HMO products to employers and individuals:

- Review health/plan benefit, provider and procedural mandates in order to reduce the cost of health care.
- Allow electronic submission of documents between insurers and their enrollees.
- Eliminate unnecessary health plan reporting requirements, such as the report on late grievances, antifraud and arbitration reports, which are confusing and result in incomplete and/or not useful information.
- Streamline health insurance product approval.
- Develop a technology assessment process that will promote evidence-based care.

Prevention, health promotion and wellness represent critical long-term cost containment strategies, as described above. Other key components for achieving long-term affordability include:

Health Information Technology (HIT): Health Information Technology offers great promise as one means to achieve more affordable, safe, and accessible health care for Californians while inside and outside of the state . Governor Schwarzenegger proposes the following action steps to advance the adoption of HIT throughout California:

- Providing state leadership and coordination by appointing a Deputy Secretary of HIT to lead and coordinate the state's HIT-related efforts to achieve 100 percent electronic health data exchange in the next 10 years.
- Improving patient safety through universal e-prescribing by 2010.
- Accelerating HIT by leveraging state purchasing, including support for uniform interoperability standards and HIT adoption, such as e-prescribing.
- Supporting consumer empowerment through use of standardized Personal Health Records (PHR)in the shorter-term within the public and private sectors that: are accessible via the internet and smart cards, are portable between health plan, and provide consumers with access to the core set of data in their PHR for their use and the use of their providers.
- At the county level, a pilot of an Electronic Medical Record system will be implemented, utilizing requirements under the Mental Health Services Act, creating an integrated network of care for mental health clients.
- Facilitating the use of innovative financing mechanisms, guided by a State HIT Financing Advisory Committee, to ensure the development of public/private partnerships and to meet capital needs for important HIT-related projects.
- Expanding broadband capabilities to facilitate the use of telemedicine and tele-health, particularly in underserved areas throughout the state and stimulating the adoption of e-health technologies throughout the state through engagement of early tele-health adopters, communities in which they serve, technology firms, and community stakeholders.

Leverage state purchasing power through Medi-Cal:

- Increase Medi-Cal physician, hospital outpatient and inpatient, and health plan rates to promote a stable and sizeable provider network and assure continued timely access to health care for Medi-Cal beneficiaries and the broader population.
- Link future Medi-Cal provider and plan rate increases to specific performance improvements measures, including measuring and reporting quality information, improvements in health care efficiency and safety, and health information technology adoption.
- Pursue a federal Medicaid 1115 waiver to maximize federal financing and support innovations in the financing and delivery of services through Medi-Cal. Such innovations can include the use of incentives and rewards for healthy behaviors, new strategies for diabetes prevention and management, adoption of health information technology, and strategies to rebalance the state's current system of long term care services in support of home and community-based services.

Enhance health care quality and efficiency:

- Provide a one-stop resource for information on health plan performance through the Office of the Patient Advocate website (www.opa.ca.gov) to increase the transparency of quality of care and access to other information to help inform consumers.
- Expand and strengthen the ability of the Office of Statewide Health Planning and Development to collect, integrate and distribute data on health outcomes, costs, utilization and pricing for use by providers, purchasers and consumers so that additional health care data is available to inform and drive decision-making.
- Partner with private and public sector purchasers to promote the measurement and reporting of provider performance and the aggregation of data for quality improvement, pay for performance and consumer choice.

We have a social, economic and moral imperative to fix California's broken health care system and improve health care for all. Health care reform is essential to a healthy, productive and economically competitive California. The foundation of the Governor's plan to expand health coverage and contain costs is shared responsibility. Just as society as a whole shares in the benefits of universal coverage and health care affordability, so too is there a shared responsibility to secure universal coverage and contain health care costs. Over the course of the next year, the Governor and his Administration will work collaboratively with the Legislature, employers, health care insurers and providers, and all Californians to create a national model for health care.

Source: Governor Schwarzenegger's health care team.

State Fiscal Impact Summary
(Dollars in Millions)

COSTS	STATE	LOCAL	FEDERAL	TOTAL COSTS	INDIVIDUAL TAX REDUCTION	SAFETY NET CARE POOL[1]
Increased Medi-Cal/Healthy Families Program Coverage	$1,283		$1,357	$2,638		
Subsidy for Persons 100% -250% of FPL	$1,135		$1,135	$2,270		$542
Persons w/o Green Cards Provided Coverage by Counties		$1,000	$1,000	$2,000		
Prevention and Wellness Measures	$150		$150	$300		
Section 125 Tax Treatment (State Income Tax Reduction)	$900			$900	$900	
Section 125 Tax Treatment (Federal Income Tax and FICA Reduction)					$7,500	
Medi-Cal Rate Increase	$2,208		$1,832	$4,039		$224
TOTAL COSTS	**$5,675**	**$1,000**	**$5,474**	**$12,147**	**$8,400**	**$766**

REVENUES	
Employer 4% of Social Security Wages Payroll In-Lieu Fee (employers with <10 employees excluded)	$1,000
Provider Coverage Dividend (4% Gross Revenues from Hospitals and 2% from Physicians)	$3,472
County Funds Available from Relief of County Obligations	$1,000
Savings from the elimination of State Programs[2]	$203
TOTAL REVENUES	**$5,675**

NET SURPLUS/SHORTFALL	**$0**

[1] Safety Net Care pool funding is included in the federal fund cost column and is split out in this column to show how these funds are being used.
[2] The Access for Infants and Mothers program, Managed Risk Medical Insurance Program and Medi-Cal Share-of-Cost will no longer be needed.

Figure 3: Fiscal impact of Governor's proposal.

Medical Board of California
Tracker - Legislative Bill File
10/24/2007

BILL	AUTHOR	TITLE	STATUS
ABX1 1	Nunez	Healthcare Reform	Introduced 09/11/07
ABX1 2	Nunez	Healthcare Reform	Introduced 09/11/07
ABX1 3	Dymally	Healthcare Coverage: MRMIP	Introduced 09/13/07
ABX1 4	Nakanishi	Income Tax: Health Savings Accounts	Introduced 09/18/07
ABX1 5	Nakanishi	Income/Corp Taxes: Credits: Health Savings Account	Introduced 09/18/07
ABX1 6	Nakanishi	Physician Assistants: Educational Loan Program	Introduced 09/18/07
ABX1 7	Nakanishi	Calif. Major Risk Medical Ins. Program: Eligibility	Introduced 09/18/07
SBX1 1	Perata	Healthcare Reform	Introduced 09/11/07
SBX1 2	Perata	Healthcare Reform	Introduced 09/11/07
SBX1 3	Hollingsworth	Healthcare Coverage	Introduced 10/11/07
SBX1 4	Dutton	Employment/Incentives	Introduced 10/11/07
SBX1 5	Cox	Calif. Children and Families Program: Funding	Introduced 10/11/07
SBX1 6	Runner	Hospitals: Preventative Medical Services	Introduced 10/11/07
SBX1 7	Aanestad	Medi-Cal: Reimbursement Rates	Introduced 10/11/07
SBX1 8	Aanestad	Personal Income Taxes: Physician Credit	Introduced 10/11/07
SBX1 9	Runner	Medi-Cal: Clinic Funding	Introduced 10/11/07
SBX1 10	Maldonado	Income Tax: Health Savings Account	Introduced 10/11/07
SBX1 11	Harman	Income/Corp. Tax: Credit: Health Savings Account	Introduced 10/11/07
SBX1 12	Runner	Healthcare Providers: Incentives: Leg Intent	Introduced 10/11/07
SBX1 13	Maldonado	Public Health: Tech. Systems:Tax Credit/Loans	Introduced 10/11/07
SBX1 14	Runner	Medi-Cal Benefits	Introduced 10/11/07
SBX1 15	Cogdill	Health Facility Financing: Appeals Procedure	Introduced 10/11/07
SBX1 16	McClintock	Out-of-State Carriers	Introduced 10/11/07
SBX1 17	Cogdill	Healthcare Coverage: Small Group Market	Introduced 10/11/07
SBX1 18	Cogdill	Employee Health Benefits: Health Savings Acct.	Introduced 10/11/07

Medical Board of California
Tracker - Legislative Bill File
10/24/2007

SBX!	19	Cogdill	Medical Corporations: Repeal Prohibition	Introduced 10/11/07
SBX1	20	Runner	Personal Income Taxes: Credit: Primary Care	Introduced 10/11/07
SBX1	21	Cogdill	Personal Income Taxes/Credits: Rural Areas: Med. Professionals	Introduced 10/11/07
SBX1	22	Battin	For-Profit Clinic Facility Financing: Revenue Bonds	Introduced 10/11/07
SBX1	23	Ashburn	Taxation: Cafeteria Plans: Credits	Introduced 10/11/07
SBX1	24	Ashburn	Nurse Practitioners: Scope of Practice	Introduced 10/11/07
SBX1	25	Cox	Healthcare Coverage	Introduced 10/11/07
SBX1	26	McClintock	Insurance: Multiple Employer Welfare Arrangements	Introduced 10/11/07

SENATE BILL No. 6

Introduced by Senator Runner

October 11, 2007

An act relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 6, as introduced, Runner. Hospitals: preventative medical services.

Existing law regulates the establishment and operation of hospitals, including emergency rooms.

This bill would set forth the intent of the legislature to enact legislation that would allow hospitals to offer preventive medical services delivered through the hospital's primary care or community-based clinic.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. It is the intent of the Legislature to enact
2 legislation that would relieve the overutilization of hospital
3 emergency rooms by allowing hospitals to offer preventative
4 medical services delivered through the hospital's primary care or
5 community-based clinic.

O

SENATE BILL No. 12

Introduced by Senator Runner
(Coauthor: Senator Harman)

October 11, 2007

An act relating to health care incentives.

LEGISLATIVE COUNSEL'S DIGEST

SB 12, as introduced, Runner. Health care providers: incentives: legislative intent.

Existing law requires the State Department of Public Health and the State Department of Health Care Services to implement and administer various public health programs in the state, provides for the regulation and licensing of health care professionals and health care facilities, and prescribes requirements for health care service plans.

This bill would declare the intent of the Legislature to enact legislation that would establish incentives for health care providers, including hospitals, clinics, physician groups, physicians, health care service plans, and health insurers, that are designed to improve the quality of health and medical services for health care consumers in this state.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. It is the intent of the Legislature to enact
2 legislation that would establish incentives for health care providers,
3 including hospitals, clinics, physician groups, physicians, health
4 care service plans, and health insurers, that are designed to improve

1 the quality of health and medical services for health care consumers
2 in this state.

O

SENATE BILL No. 12

Introduced by Senator Runner
(Coauthor: Senator Harman)

October 11, 2007

An act relating to health care incentives.

LEGISLATIVE COUNSEL'S DIGEST

SB 12, as introduced, Runner. Health care providers: incentives: legislative intent.

Existing law requires the State Department of Public Health and the State Department of Health Care Services to implement and administer various public health programs in the state, provides for the regulation and licensing of health care professionals and health care facilities, and prescribes requirements for health care service plans.

This bill would declare the intent of the Legislature to enact legislation that would establish incentives for health care providers, including hospitals, clinics, physician groups, physicians, health care service plans, and health insurers, that are designed to improve the quality of health and medical services for health care consumers in this state.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. It is the intent of the Legislature to enact
2 legislation that would establish incentives for health care providers,
3 including hospitals, clinics, physician groups, physicians, health
4 care service plans, and health insurers, that are designed to improve

1 the quality of health and medical services for health care consumers
2 in this state.

O

SENATE BILL No. 19

Introduced by Senator Cogdill
(Coauthor: Senator Harman)

October 11, 2007

An act to amend Section 2400 of, and to repeal Sections 2401, 2401.1, and 2402 of, the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

SB 19, as introduced, Cogdill. Medical corporations.

Existing law, the Medical Practice Act, provides for the licensing and regulation of physicians and surgeons. The Medical Practice Act prohibits corporations and other artificial legal entities from having professional rights, privileges, or powers, except as specified.

This bill would delete the prohibition, and related exceptions, and would instead authorize corporations and artificial legal entities to have professional rights, privileges, or powers.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 2400 of the Business and Professions
2 Code is amended to read:
3 2400. Corporations and other artificial legal entities ~~shall have~~
4 ~~no~~ *may have* professional rights, privileges, or powers. ~~However,~~
5 ~~the Division of Licensing may in its discretion, after such~~
6 ~~investigation and review of such documentary evidence as it may~~
7 ~~require, and under regulations adopted by it, grant approval of the~~

~~employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic.~~

SEC. 2. Section 2401 of the Business and Professions Code is repealed.

~~2401. (a) Notwithstanding Section 2400, a clinic operated primarily for the purpose of medical education by a public or private nonprofit university medical school, which is approved by the Division of Licensing or the Osteopathic Medical Board of California, may charge for professional services rendered to teaching patients by licensees who hold academic appointments on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made.~~

~~(b) Notwithstanding Section 2400, a clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code may employ licensees and charge for professional services rendered by those licensees. However, the clinic shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.~~

~~(c) Notwithstanding Section 2400, a narcotic treatment program operated under Section 11876 of the Health and Safety Code and regulated by the State Department of Alcohol and Drug Programs, may employ licensees and charge for professional services rendered by those licensees. However, the narcotic treatment program shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.~~

~~(d) Notwithstanding Section 2400, a hospital owned and operated by a health care district pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code may employ a licensee pursuant to Section 2401.1, and may charge for professional services rendered by the licensee, if the physician and surgeon in whose name the charges are made approves the charges. However, the hospital shall not interfere with, control, or otherwise direct the physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other provision of law.~~

SEC. 3. Section 2401.1 of the Business and Professions Code is repealed.

~~2401.1. (a) The Legislature finds and declares as follows:~~

~~(1) Due to the large number of uninsured and underinsured Californians, a number of California communities are having great difficulty recruiting and retaining physicians and surgeons.~~

~~(2) In order to recruit physicians and surgeons to provide medically necessary services in rural and medically underserved communities, many district hospitals have no viable alternative but to directly employ physicians and surgeons in order to provide economic security adequate for a physician and surgeon to relocate and reside in their communities.~~

~~(3) The Legislature intends that a district hospital meeting the conditions set forth in this section be able to employ physicians and surgeons directly, and to charge for their professional services.~~

~~(4) The Legislature reaffirms that Section 2400 provides an increasingly important protection for patients and physicians and surgeons from inappropriate intrusions into the practice of medicine, and further intends that a district hospital not interfere with, control, or otherwise direct a physician and surgeon's professional judgment.~~

~~(b) A pilot project to provide for the direct employment of a total of 20 physicians and surgeons by qualified district hospitals is hereby established in order to improve the recruitment and retention of physicians and surgeons in rural and other medically underserved areas.~~

~~(c) For purposes of this section, a qualified district hospital means a hospital that meets all of the following requirements:~~

~~(1) Is a district hospital organized and governed pursuant to the Local Health Care District Law (Division 23 (commencing with Section 32000) of the Health and Safety Code).~~

~~(2) Provides a percentage of care to Medicare, Medi-Cal, and uninsured patients that exceeds 50 percent of patient days.~~

~~(3) Is located in a county with a total population of less than 750,000.~~

~~(4) Has net losses from operations in fiscal year 2000-01, as reported to the Office of Statewide Health Planning and Development.~~

~~(d) In addition to the requirements of subdivision (c), and in addition to other applicable laws, a qualified district hospital may~~

~~directly employ a licensee pursuant to subdivision (b) if all of the following conditions are satisfied:~~

~~(1) The total number of physicians and surgeons employed by all qualified district hospitals under this section does not exceed 20.~~

~~(2) The medical staff and the elected trustees of the qualified district hospital concur by an affirmative vote of each body that the physician and surgeon's employment is in the best interest of the communities served by the hospital.~~

~~(3) The licensee enters into or renews a written employment contract with the qualified district hospital prior to December 31, 2006, for a term not in excess of four years. The contract shall provide for mandatory dispute resolution under the auspices of the board for disputes directly relating to the licensee's clinical practice.~~

~~(4) The total number of licensees employed by the qualified district hospital does not exceed two at any time.~~

~~(5) The qualified district hospital notifies the board in writing that the hospital plans to enter into a written contract with the licensee, and the board has confirmed that the licensee's employment is within the maximum number permitted by this section. The board shall provide written confirmation to the hospital within five working days of receipt of the written notification to the board.~~

~~(e) The board shall report to the Legislature not later than October 1, 2008, on the evaluation of the effectiveness of the pilot project in improving access to health care in rural and medically underserved areas and the project's impact on consumer protection as it relates to intrusions into the practice of medicine.~~

~~(f) Nothing in this section shall exempt the district hospital from any reporting requirements or affect the board's authority to take action against a physician and surgeon's license.~~

~~(g) This section shall remain in effect only until January 1, 2011, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2011, deletes or extends that date.~~

SEC. 4. Section 2402 of the Business and Professions Code is repealed.

~~2402. The provisions of Section 2400 do not apply to a medical or podiatry corporation practicing pursuant to the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section~~

1 ~~13400) of Division 3 of Title 1 of the Corporations Code) and this~~
2 ~~article, when such corporation is in compliance with the~~
3 ~~requirements of these statutes and all other statutes and regulations~~
4 ~~now or hereafter enacted or adopted pertaining to such corporations~~
5 ~~and the conduct of their affairs.~~

O

SENATE BILL No. 24

Introduced by Senator Ashburn

October 11, 2007

An act to amend Sections 2725.1, 2835.5, 2836, 2836.1, 2836.2, 2836.3, 3640, 3640.5, 4024, 4040, 4060, 4061, 4076, 4170, and 4174 of, and to add Section 2835.7 to, the Business and Professions Code, to amend Sections 11150 and 120582 of the Health and Safety Code, and to amend Sections 14111, 14111.5, and 16952 of the Welfare and Institutions Code, relating to nursing.

LEGISLATIVE COUNSEL'S DIGEST

SB 24, as introduced, Ashburn. Nurse practitioners: scope of practice.

(1) Existing law, the Nursing Practice Act, provides for the certification and regulation of nurse practitioners and nurse-midwives by the Board of Registered Nursing and requires the board to establish categories of, and standards for, nurse practitioners in consultation with specified health care practitioners, including physicians and surgeons with expertise in the nurse practitioner field. Existing law requires nurse practitioners to meet certain requirements, including educational requirements, and authorizes a nurse practitioner who has been issued a board number for the furnishing or ordering of drugs to furnish or order drugs under certain conditions, including pursuant to standardized procedures or protocols and under the supervision of a physician and surgeon. Existing law prohibits a physician and surgeon from supervising more than 4 nurse practitioners at one time. A violation of the Nursing Practice Act is a crime.

This bill would set forth the activities that a nurse practitioner is authorized to engage in, and would delete the requirement that the board

consult with physicians and surgeons in establishing categories of nurse practitioners. The bill would revise the educational requirements for certification as a nurse practitioner and would require a nurse practitioner to be certified by a nationally recognized certifying body approved by the board. The bill would allow a nurse practitioner to prescribe drugs and devices if he or she has been certified by the board to have satisfactorily completed at least 6 months of supervised experience in the prescribing of drugs and devices and if such prescribing is consistent with his or her education or established clinical competency, would delete the requirement for standardized procedures and protocols, and would delete the requirement of physician supervision. The bill would require that a nurse practitioner be issued a board number prior to prescribing drugs and devices and would allow revocation or suspension or denial of a board number for incompetence or gross negligence. The bill would delete the prohibition against a physician and surgeon supervising more than 4 nurse practitioners at one time.

Because this bill would impose additional requirements under the Nursing Practice Act, the violation of which would be a crime, it would impose a state-mandated local program.

(2) Existing law, the Medi-Cal Act, provides for the Medi-Cal program, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons. The act authorizes certain covered health care services provided under in a long-term health care facility to be delegated to a nurse practitioner if specified conditions are met, including mandatory supervision by a physician and surgeon.

This bill would remove the requirement of mandatory supervision of the nurse practitioner by a physician and surgeon in order for the services to be delegated to a nurse practitioner.

(3) Existing law, the Emergency Medical Services System and Prehospital Emergency Medical Care Personnel Act, requires a county to establish a Physician Services Account within its emergency medical services fund. Existing law makes a physician and surgeon eligible to receive payment from the fund for patient care services, as specified, performed by a nurse practitioner or nurse-midwife under the direct supervision of the physician and surgeon.

This bill would also make a nurse practitioner eligible to receive payment for those patient care services and would remove the requirement of supervision of the services by a physician and surgeon. The bill would authorize a nurse practitioner to receive reimbursement

for emergency services and inpatient and outpatient obstetric pediatric services that the nurse practitioner determines to be medically necessary.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 2725.1 of the Business and Professions
2 Code is amended to read:
3 2725.1. Notwithstanding any other provision of law, a
4 registered nurse may dispense drugs or devices upon an order by
5 a licensed physician and surgeon, *nurse practitioner, or nurse*
6 *midwife* if the nurse is functioning within a licensed clinic as
7 defined in paragraphs (1) and (2) of subdivision (a) of Section
8 1204 of, or within a clinic as defined in subdivision (b) or (c) of
9 Section 1206, of the Health and Safety Code.
10 No clinic shall employ a registered nurse to perform dispensing
11 duties exclusively. No registered nurse shall dispense drugs in a
12 pharmacy~~;~~ *or* keep a pharmacy, open shop, or drugstore for the
13 retailing of drugs or poisons. No registered nurse shall compound
14 drugs. Dispensing of drugs by a registered nurse, except a certified
15 nurse-midwife who functions pursuant to a standardized procedure
16 or protocol described in Section 2746.51 or a nurse practitioner
17 ~~who functions pursuant to a standardized procedure described in~~
18 ~~Section 2836.1, or protocol~~, shall not include substances included
19 in the California Uniform Controlled Substances Act (Division 10
20 (commencing with Section 11000) of the Health and Safety Code).
21 Nothing in this section shall exempt a clinic from the provisions
22 of Article 13 (commencing with Section 4180) of Chapter 9.
23 SEC. 2. Section 2835.5 of the Business and Professions Code
24 is amended to read:
25 2835.5. (a) A registered nurse who is holding himself or herself
26 out as a nurse practitioner or who desires to hold himself or herself
27 out as a nurse practitioner shall, within the time prescribed by the
28 board and prior to his or her next license renewal or the issuance

of an initial license, submit educational, experience, and other credentials and information as the board may require for it to determine that the person qualifies to use the title "nurse practitioner," pursuant to the standards and qualifications established by the board.

(b) Upon finding that a person is qualified to hold himself or herself out as a nurse practitioner, the board shall appropriately indicate on the license issued or renewed, that the person is qualified to use the title "nurse practitioner." The board shall also issue to each qualified person a certificate evidencing that the person is qualified to use the title "nurse practitioner."

(c) A person who has been found to be qualified by the board to use the title "nurse practitioner" prior to the effective date of this section, shall not be required to submit any further qualifications or information to the board and shall be deemed to have met the requirements of this section.

(d) On and after January 1, 2008, an applicant for initial qualification or certification as a nurse practitioner under this article who has not been qualified or certified as a nurse practitioner in California or any other state shall meet the following requirements:

(1) Hold a valid and active registered nursing license issued under this chapter.

(2) Possess a master's degree in nursing~~, a master's degree in a clinical field related to nursing,~~ or a ~~graduate~~ *doctoral* degree in nursing.

(3) Satisfactorily complete a nurse practitioner program approved by the board.

(4) Be certified as a nurse practitioner by a nationally recognized certifying body approved by the board.

SEC. 3. Section 2835.7 is added to the Business and Professions Code, to read:

2835.7. (a) A nurse practitioner may do all of the following:

(1) Perform a comprehensive history and physical examination.

(2) Establish diagnoses for physical, mental, or emotional ailments or potential ailments.

(3) Admit patients to hospitals and nursing facilities.

(4) Order, perform, and interpret laboratory, radiographic, and other diagnostic tests.

(5) Identify, develop, implement, and evaluate a plan of care for a patient to promote, maintain, and restore health.

(6) Perform therapeutic procedures that the nurse practitioner is qualified by education and experience to perform.

(7) Prescribe treatments.

(8) Prescribe and dispense medications when granted authority by the board.

(9) Refer patients to appropriate licensed physician and surgeons or other health care providers.

(10) Provide emergency care.

(11) Perform additional acts that the nurse practitioner is educationally prepared and clinically competent to perform.

(12) Sign death certificates, return-to-work, school certificates, and other related health certification forms.

(13) Certify incapacity for the purpose of activating durable power of attorney for health care.

(14) Sign handicapped parking applications.

(15) Order home health services.

(16) Order durable medical equipment.

(17) Order home schooling or tutoring.

(b) A nurse practitioner shall consult or refer a patient to a physician and surgeon or another health care provider if the referral will protect the health and welfare of the patient and if a situation or condition occurs in a patient that is beyond the nurse practitioner's knowledge and experience.

SEC. 4. Section 2836 of the Business and Professions Code is amended to read:

2836. (a) The board shall establish categories of nurse practitioners and standards for nurses to hold themselves out as nurse practitioners in each category. Such standards shall take into account the types of advanced levels of nursing practice ~~which~~ *that* are or may be performed and the clinical and didactic education, experience, or both needed to practice safely at those levels. In setting ~~such~~ *the* standards, the board shall consult with nurse practitioners~~, physicians and surgeons with expertise in the nurse practitioner field,~~ and health care organizations utilizing nurse practitioners. Established standards shall apply to persons without regard to the date of meeting ~~such~~ *those* standards. ~~If the board sets standards for use of nurse practitioner titles which include completion of an academically affiliated program, it shall provide equivalent standards for registered nurses who have not completed such a program.~~

(b) Any regulations promulgated by a state department, *board, commission, or bureau* that affect the scope of practice of a nurse practitioner shall be developed in consultation with the board.

SEC. 5. Section 2836.1 of the Business and Professions Code is amended to read:

~~2836.1. Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing or ordering drugs or devices when all of the following apply:~~

~~(a) The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon~~

2836.1. (a) A nurse practitioner may prescribe drugs and devices when the drugs or devices ~~furnished or ordered~~ *prescribed* are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

~~(b) The nurse practitioner is functioning pursuant to standardized procedure, as defined by Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.~~

~~(c) (1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the provisions of the standardized procedure.~~

~~(2) In addition to the requirements in paragraph (1), for Schedule II controlled substance protocols, the provision for furnishing Schedule II controlled substances shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.~~

~~(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by~~

~~telephonic contact at the time of patient examination by the nurse practitioner.~~

~~(e) For purposes of this section, no physician and surgeon shall supervise more than four nurse practitioners at one time.~~

~~(f) (1)~~

(b) Drugs or devices ~~furnished or ordered~~ *prescribed* by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) ~~and shall be further limited to those drugs agreed upon by the nurse practitioner and physician and surgeon and specified in the standardized procedure~~.

~~(2) When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner's standardized procedure relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order.~~

~~(g) (1) The~~

(c) A nurse practitioner may not prescribe drugs or devices under this section unless the board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed ~~(1)~~ at least six ~~month's physician and surgeon-supervised~~ *months' supervised* experience in the ~~furnishing or ordering~~ *prescribing* of drugs ~~or~~ *and* devices ~~and (2) a course in pharmacology covering the drugs or devices to be furnished or ordered under this section~~.

~~(2) Nurse practitioners who are certified by the board and hold an active furnishing number, who are authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board. The board shall establish the requirements for satisfactory completion of this subdivision.~~

~~(h) Use of the term "furnishing" in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include (1) the ordering of a drug or device in accordance with the standardized procedure and (2) transmitting an order of a supervising physician and surgeon.~~

~~(i) "Drug order" or "order" for purposes of this section means an order for medication which is dispensed to or for an ultimate user, issued by a nurse practitioner as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by nurse practitioners; and (3) the signature of a nurse practitioner on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.~~

SEC. 6. Section 2836.2 of the Business and Professions Code is amended to read:

2836.2. ~~Furnishing or ordering of drugs or devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure.~~ All nurse practitioners who are authorized pursuant to Section ~~2831.1~~ *2836.1* to ~~furnish or issue drug orders for~~ *prescribe* controlled substances shall register with the United States Drug Enforcement Administration.

SEC. 7. Section 2836.3 of the Business and Professions Code is amended to read:

2836.3. (a) The ~~furnishing~~ *prescribing* of drugs or devices by nurse practitioners is conditional on issuance by the board of a number to the nurse *practitioner* applicant who has successfully completed the requirements of subdivision ~~(g)~~ *(c)* of Section 2836.1. The number shall be included on all ~~transmittals of orders~~ *prescriptions* for drugs or devices by the nurse practitioner. The board shall make the list of numbers issued available to the Board of Pharmacy. The board may charge the applicant a fee to cover all necessary costs to implement this section.

(b) The number shall be renewable at the time of the applicant's registered nurse license renewal.

(c) The board may revoke, suspend, or deny issuance of the numbers for incompetence or gross negligence in the performance of functions specified in Sections 2836.1 and 2836.2.

SEC. 8. Section 3640 of the Business and Professions Code is amended to read:

3640. (a) A naturopathic doctor may order and perform physical and laboratory examinations for diagnostic purposes, including, but not limited to, phlebotomy, clinical laboratory tests, speculum examinations, orificial examinations, and physiological function tests.

(b) A naturopathic doctor may order diagnostic imaging studies, including X-ray, ultrasound, mammogram, bone densitometry, and others, consistent with naturopathic training as determined by the bureau, but shall refer the studies to an appropriately licensed health care professional to conduct the study and interpret the results.

(c) A naturopathic doctor may dispense, administer, order, and prescribe or perform the following:

(1) Food, extracts of food, ~~nutraceuticals~~ *neutraceuticals*, vitamins, amino acids, minerals, enzymes, botanicals and their extracts, botanical medicines, homeopathic medicines, all dietary supplements and nonprescription drugs as defined by the federal Food, Drug, and Cosmetic Act, consistent with the routes of administration identified in subdivision (d).

(2) Hot or cold hydrotherapy; naturopathic physical medicine inclusive of the manual use of massage, stretching, resistance, or joint play examination but exclusive of small amplitude movement at or beyond the end range of normal joint motion; electromagnetic energy; colon hydrotherapy; and therapeutic exercise.

(3) Devices, including, but not limited to, therapeutic devices, barrier contraception, and durable medical equipment.

(4) Health education and health counseling.

(5) Repair and care incidental to superficial lacerations and abrasions, except suturing.

(6) Removal of foreign bodies located in the superficial tissues.

(d) A naturopathic doctor may utilize routes of administration that include oral, nasal, auricular, ocular, rectal, vaginal, transdermal, intradermal, subcutaneous, intravenous, and intramuscular.

(e) The bureau may establish regulations regarding ocular or intravenous routes of administration that are consistent with the education and training of a naturopathic doctor.

(f) Nothing in this section shall exempt a naturopathic doctor from meeting applicable licensure requirements for the performance of clinical laboratory tests.

~~(g) The authority to use all routes for furnishing prescription drugs as described in Section 3640.5 shall be consistent with the oversight and supervision requirements of Section 2836.1.~~

SEC. 9. Section 3640.5 of the Business and Professions Code is amended to read:

3640.5. Nothing in this chapter or any other provision of law shall be construed to prohibit a naturopathic doctor from furnishing or ordering drugs when all of the following apply:

(a) The drugs are furnished or ordered by a naturopathic doctor in accordance with standardized procedures or protocols developed by the naturopathic doctor and his or her supervising physician and surgeon.

(b) The naturopathic doctor is functioning pursuant to standardized procedure~~, as defined by subdivisions (a), (b), (d), (e), (h), and (i) of Section 2836.1 and paragraph (1) of subdivision (c) of Section 2836.1,~~ or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the naturopathic doctor, and, where applicable, the facility administrator or his or her designee.

(c) The standardized procedure or protocol covering the furnishing of drugs shall specify which naturopathic doctors may furnish or order drugs, which drugs may be furnished or ordered under what circumstances, the extent of physician and surgeon supervision, *and* the method of periodic review of the naturopathic doctor's competence, including peer review~~,~~ and review of the provisions of the standardized procedure.

(d) The furnishing or ordering of drugs by a naturopathic doctor occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include all of the following:

(1) Collaboration on the development of the standardized procedure.

(2) Approval of the standardized procedure.

(3) Availability by telephonic contact at the time of patient examination by the naturopathic doctor.

(e) For purposes of this section, a physician and surgeon shall not supervise more than four naturopathic doctors at one time.

(f) Drugs furnished or ordered by a naturopathic doctor may include Schedule III through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and shall be further limited to those drugs agreed upon by the naturopathic doctor and physician and surgeon as specified in the standardized procedure. When Schedule III controlled substances, as defined in Section 11056 of the Health and Safety Code, are furnished or ordered by a naturopathic doctor, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the naturopathic doctor's standardized procedure relating to controlled substances shall be provided upon request, to a licensed pharmacist who dispenses drugs, when there is uncertainty about the naturopathic doctor furnishing the order.

(g) The bureau has certified that the naturopathic doctor has satisfactorily completed adequate coursework in pharmacology covering the drugs to be furnished or ordered under this section. The bureau shall establish the requirements for satisfactory completion of this subdivision.

(h) Use of the term "furnishing" in this section, in health facilities defined in subdivisions (b), (c), (d), (e), and (i) of Section 1250 of the Health and Safety Code, shall include both of the following:

(1) Ordering a drug in accordance with the standardized procedure.

(2) Transmitting an order of a supervising physician and surgeon.

(i) For purposes of this section, "drug order" or "order" means an order for medication which is dispensed to or for an ultimate user, issued by a naturopathic doctor as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations.

(j) Notwithstanding any other provision of law, the following apply:

(1) A drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician.

(2) All references to prescription in this code and the Health and Safety Code shall include drug orders issued by naturopathic doctors.

(3) The signature of a naturopathic doctor on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

SEC. 10. Section 4024 of the Business and Professions Code is amended to read:

4024. (a) Except as provided in subdivision (b), "dispense" means the furnishing of drugs or devices upon a prescription from a physician *and surgeon*, dentist, optometrist, podiatrist, veterinarian, *nurse practitioner,* or naturopathic doctor pursuant to Section 3640.7, or upon an order to furnish drugs or transmit a prescription from a certified nurse-midwife, ~~nurse practitioner,~~ physician assistant, naturopathic doctor pursuant to Section 3640.5, or pharmacist acting within the scope of his or her practice.

(b) "Dispense" also means and refers to the furnishing of drugs or devices directly to a patient by a physician *and surgeon*, dentist, optometrist, podiatrist, or veterinarian, or by a certified nurse-midwife, nurse practitioner, naturopathic doctor, or physician assistant acting within the scope of his or her practice.

SEC. 11. Section 4040 of the Business and Professions Code is amended to read:

4040. (a) "Prescription" means an oral, written, or electronic transmission order that is both of the following:

(1) Given individually for the person or persons for whom ordered that includes all of the following:

(A) The name or names and address of the patient or patients.

(B) The name and quantity of the drug or device prescribed and the directions for use.

(C) The date of issue.

(D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification, and his or her federal registry number, if a controlled substance is prescribed.

(E) A legible, clear notice of the condition for which the drug is being prescribed, if requested by the patient or patients.

(F) If in writing, signed by the prescriber issuing the order, or the certified nurse-midwife, ~~nurse practitioner,~~ physician assistant, or naturopathic doctor who issues a drug order pursuant to Section 2746.51, ~~2836.1,~~ 3502.1, or 3640.5, respectively, or the pharmacist who issues a drug order pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

(2) Issued by a physician *and surgeon*, dentist, optometrist, podiatrist, veterinarian, *nurse practitioner,* or naturopathic doctor pursuant to Section 3640.7 or, if a drug order is issued pursuant to Section 2746.51, ~~2836.1,~~ 3502.1, or ~~3460.5~~ *3640.5*, by a certified nurse-midwife, ~~nurse practitioner,~~ physician assistant, or naturopathic doctor licensed in this state, or pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 by a pharmacist licensed in this state.

(b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug, except for any Schedule II controlled substance, that contains at least the name and signature of the prescriber, the name and address of the patient in a manner consistent with paragraph (3) of subdivision (b) of Section 11164 of the Health and Safety Code, the name and quantity of the drug prescribed, directions for use, and the date of issue may be treated as a prescription by the dispensing pharmacist as long as any additional information required by subdivision (a) is readily retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164 of the Health and Safety Code, Section 11164 of the Health and Safety Code shall prevail.

(c) "Electronic transmission prescription" includes both image and data prescriptions. "Electronic image transmission prescription" means any prescription order for which a facsimile of the order is received by a pharmacy from a licensed prescriber. "Electronic data transmission prescription" means any prescription order, other than an electronic image transmission prescription, that is electronically transmitted from a licensed prescriber to a pharmacy.

(d) The use of commonly used abbreviations shall not invalidate an otherwise valid prescription.

(e) Nothing in the amendments made to this section (formerly Section 4036) at the 1969 Regular Session of the Legislature shall

be construed as expanding or limiting the right that a chiropractor, while acting within the scope of his or her license, may have to prescribe a device.

SEC. 12. Section 4060 of the Business and Professions Code is amended to read:

4060. No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician *and surgeon*, dentist, podiatrist, optometrist, veterinarian, *nurse practitioner,* or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, ~~a nurse practitioner pursuant to Section 2836.1,~~ a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052. This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician *and surgeon*, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant~~,~~ when in stock in containers correctly labeled with the name and address of the supplier or producer.

Nothing in this section authorizes a certified nurse-midwife, ~~a nurse practitioner,~~ a physician assistant, or a naturopathic doctor~~,~~ to order his or her own stock of dangerous drugs and devices.

SEC. 13. Section 4061 of the Business and Professions Code is amended to read:

4061. (a) No manufacturer's sales representative shall distribute any dangerous drug or dangerous device as a complimentary sample without the written request of a physician *and surgeon*, dentist, podiatrist, optometrist, veterinarian, *nurse practitioner,* or naturopathic doctor pursuant to Section 3640.7. However, a certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, ~~a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol,~~ a physician assistant who functions pursuant to a protocol described in Section 3502.1, or a naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5~~,~~ may sign for the request and receipt of complimentary samples of

a dangerous drug or dangerous device that has been identified in the standardized procedure, protocol, or practice agreement. Standardized procedures, protocols, and practice agreements shall include specific approval by a physician *and surgeon*. A review process, consistent with the requirements of Section 2725, 3502.1, or 3640.5, of the complimentary samples requested and received by ~~a nurse practitioner,~~ certified nurse-midwife, physician assistant, or naturopathic doctor~~,~~ shall be defined within the standardized procedure, protocol, or practice agreement.

(b) Each written request shall contain the names and addresses of the supplier and the requester, the name and quantity of the specific dangerous drug desired, the name of the certified nurse-midwife, ~~nurse practitioner,~~ physician assistant, or naturopathic doctor, if applicable, receiving the samples pursuant to this section, the date of receipt, and the name and quantity of the dangerous drugs or dangerous devices provided. These records shall be preserved by the supplier with the records required by Section 4059.

(c) Nothing in this section is intended to expand the scope of practice of a certified nurse-midwife, ~~nurse practitioner,~~ physician assistant, or naturopathic doctor.

SEC. 14. Section 4076 of the Business and Professions Code is amended to read:

4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except where the prescriber or the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, ~~the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol,~~ the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients

may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.

(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, ~~the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol,~~ the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition for which the drug was prescribed if requested by the patient and the condition is indicated on the prescription.

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.

(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in any commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, ~~the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol,~~ the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.

SEC. 15. Section 4170 of the Business and Professions Code is amended to read:

4170. (a) No prescriber shall dispense drugs or dangerous devices to patients in his or her office or place of practice unless all of the following conditions are met:

(1) The dangerous drugs or dangerous devices are dispensed to the prescriber's own patient, and the drugs or dangerous devices are not furnished by a nurse or physician attendant.

(2) The dangerous drugs or dangerous devices are necessary in the treatment of the condition for which the prescriber is attending the patient.

(3) The prescriber does not keep a pharmacy, open shop, or drugstore, advertised or otherwise, for the retailing of dangerous drugs, dangerous devices, or poisons.

(4) The prescriber fulfills all of the labeling requirements imposed upon pharmacists by Section 4076, all of the recordkeeping requirements of this chapter, and all of the packaging requirements of good pharmaceutical practice, including the use of childproof containers.

(5) The prescriber does not use a dispensing device unless he or she personally owns the device and the contents of the device, and personally dispenses the dangerous drugs or dangerous devices to the patient packaged, labeled, and recorded in accordance with paragraph (4).

(6) The prescriber, prior to dispensing, offers to give a written prescription to the patient that the patient may elect to have filled by the prescriber or by any pharmacy.

(7) The prescriber provides the patient with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice.

(8) A certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, ~~a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol,~~ a physician assistant who functions pursuant to Section 3502.1, or a naturopathic doctor who functions pursuant to Section 3640.5, may hand to a patient of the supervising physician and surgeon *or nurse practitioner* a properly labeled prescription drug prepackaged by a physician and surgeon, a manufacturer as defined in this chapter, *a nurse practitioner,* or a pharmacist.

(b) The Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, the Veterinary Medical Board, and

the Physician Assistant Committee shall have authority with the California State Board of Pharmacy to ensure compliance with this section, and those boards are specifically charged with the enforcement of this chapter with respect to their respective licensees.

(c) "Prescriber," as used in this section, means a person~~,~~ who holds a ~~physician's~~ *physician* and surgeon's certificate, a license to practice optometry, a license to practice naturopathic medicine, a license to practice dentistry, a license to practice veterinary medicine, ~~or~~ a certificate to practice podiatry, *or a license and certification as a nurse practitioner,* and who is duly registered by the Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Veterinary Medical Board, ~~or~~ the Board of Osteopathic Examiners*, or the Board of Registered Nursing* of this state.

SEC. 16. Section 4174 of the Business and Professions Code is amended to read:

4174. Notwithstanding any other provision of law, a pharmacist may dispense drugs or devices upon the drug order of ~~a nurse practitioner functioning pursuant to Section 2836.1 or~~ a certified nurse-midwife functioning pursuant to Section 2746.51, ~~a drug order of~~ a physician assistant functioning pursuant to Section 3502.1, or a naturopathic doctor functioning pursuant to Section 3640.5, or the order of a pharmacist acting under Section 4052.

SEC. 17. Section 11150 of the Health and Safety Code is amended to read:

11150. No person other than a physician *and surgeon*, dentist, podiatrist, or veterinarian, or naturopathic doctor acting pursuant to Section 3640.7 of the Business and Professions Code, or pharmacist acting within the scope of a project authorized under Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107 or within the scope of either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 of the Business and Professions Code, a registered nurse acting within the scope of a project authorized under Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107, a certified nurse-midwife acting within the scope of Section 2746.51 of the Business and Professions Code, a nurse practitioner acting within

the scope of ~~Section~~ *Sections 2835.7 and* 2836.1 of the Business and Professions Code, a physician assistant acting within the scope of a project authorized under Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107 or Section 3502.1 of the Business and Professions Code, a naturopathic doctor acting within the scope of Section 3640.5 of the Business and Professions Code, or an optometrist acting within the scope of Section 3041 of the Business and Professions Code, or an out-of-state prescriber acting pursuant to Section 4005 of the Business and Professions Code shall write or issue a prescription.

SEC. 18. Section 120582 of the Health and Safety Code is amended to read:

120582. (a) Notwithstanding any other provision of law, a physician and surgeon *or a nurse practitioner* who diagnoses ~~a~~ sexually transmitted chlamydia, gonorrhea, or ~~other~~ *another* sexually transmitted infection, as determined by the department, in an individual patient may prescribe, dispense, furnish, or otherwise provide prescription antibiotic drugs to that patient's sexual partner or partners without examination of that patient's partner or partners. The department may adopt regulations to implement this section.

(b) Notwithstanding any other provision of law, ~~a nurse practitioner pursuant to Section 2836.1 of the Business and Professions Code,~~ a certified nurse-midwife pursuant to Section 2746.51 of the Business and Professions Code~~,~~ and a physician assistant pursuant to Section 3502.1 of the Business and Professions Code may dispense, furnish, or otherwise provide prescription antibiotic drugs to the sexual partner or partners of a patient with a diagnosed sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the department, without examination of the patient's sexual partner or partners.

SEC. 19. Section 14111 of the Welfare and Institutions Code is amended to read:

14111. (a) As permitted by federal law or regulations, for health care services provided in a long-term health care facility that are reimbursed by Medicare, a physician and surgeon may delegate any of the following to a nurse practitioner:

(1) Alternating visits required by federal law and regulations with a physician and surgeon.

(2) Any duties consistent with federal law and regulations within the scope of practice of nurse practitioners, so long as ~~all~~ *both* of the following conditions are met:

(A) A physician and surgeon approves, in writing, the admission of the individual to the facility.

~~(B) The medical care of each resident is supervised by a physician and surgeon.~~

~~(C)~~

(B) A physician and surgeon performs the initial visit and alternate required visits.

(b) This section does not authorize benefits not otherwise authorized by federal law or regulation.

~~(c) All responsibilities delegated to a nurse practitioner pursuant to this section shall be performed under the supervision of the physician and surgeon and pursuant to a standardized procedure among the physician and surgeon, nurse practitioner, and facility.~~

~~(d)~~

(c) No task that is required by federal law or regulation to be performed personally by a physician *and surgeon* may be delegated to a nurse practitioner.

~~(e)~~

(d) Nothing in this section shall be construed as limiting the authority of a long-term health care facility to hire and employ nurse practitioners so long as that employment is consistent with federal law and within the scope of practice of a nurse practitioner.

SEC. 20. Section 14111.5 of the Welfare and Institutions Code is amended to read:

14111.5. (a) As permitted by federal law or regulations, for health care services provided in a long-term health care facility that are reimbursed under this chapter, a nurse practitioner may, to the extent consistent with his or her scope of practice, perform any of the following tasks otherwise required of a physician and surgeon:

(1) With respect to visits required by federal law or regulations, making alternating visits, or more frequent visits if the physician and surgeon is not available.

(2) Any duty or task that is consistent with federal and state law or regulation within the scope of practice of nurse practitioners, so long as ~~all~~ *both* of the following conditions are met:

(A) A physician and surgeon approves, in writing, the admission of the individual to the facility.

~~(B) The medical care of each resident is supervised by a physician and surgeon.~~

~~(C)~~

(B) A physician and surgeon performs the initial visit and alternate required visits.

(b) This section does not authorize benefits not otherwise authorized by federal or state law or regulation.

~~(c) All responsibilities undertaken by a nurse practitioner pursuant to this section shall be performed in collaboration with the physician and surgeon and pursuant to a standardized procedure among the physician and surgeon, nurse practitioner, and facility.~~

~~(d)~~

(c) Except as provided in subdivisions (a)~~ to (c), inclusive~~ *and (b)*, any task that is required by federal law or regulation to be performed personally by a physician *and surgeon* may be delegated to a nurse practitioner who is not an employee of the long-term health care facility.

~~(e)~~

(d) Nothing in this section shall be construed as limiting the authority of a long-term health care facility to hire and employ nurse practitioners so long as that employment is consistent with federal law and with the scope of practice of a nurse practitioner.

SEC. 21. Section 16952 of the Welfare and Institutions Code is amended to read:

16952. (a) (1) Each county shall establish within its emergency medical services fund a Physician Services Account. Each county shall deposit in the Physician Services Account those funds appropriated by the Legislature for the purposes of the Physician Services Account of the fund.

(2) (A) Each county may encumber sufficient funds to reimburse physician *and surgeon* losses incurred during the fiscal year for which bills will not be received until after the fiscal year.

(B) Each county shall provide a reasonable basis for its estimate of the necessary amount encumbered.

(C) All funds that are encumbered for a fiscal year shall be expended or disencumbered prior to the submission of the report of actual expenditures required by Sections 16938 and 16980.

(b) (1) Funds deposited in the Physician Services Account in the county emergency medical services fund shall be exempt from the percentage allocations set forth in subdivision (a) of Section 1797.98. However, funds in the county Physician Services Account shall not be used to reimburse for physician *and surgeon* services provided by ~~physicians~~ *physician and surgeons* employed by county hospitals.

(2) No physician *and surgeon* who provides physician *and surgeon* services in a primary care clinic which receives funds from this act shall be eligible for reimbursement from the Physician Services Account for any losses incurred in the provision of those services.

(c) The county ~~physician services account~~ *Physician Services Account* shall be administered by each county, except that a county electing to have the state administer its medically indigent adult program as authorized by Section 16809, may also elect to have its county physician services account administered by the state in accordance with Section 16954.

(d) Costs of administering the account, whether by the county or by the department through the emergency medical services contract-back program, shall be reimbursed by the account based on actual administrative costs, not to exceed 10 percent of the amount of the account.

(e) For purposes of this article "administering agency" means the agency designated by the board of supervisors to administer this article, or the department, in the case of those CMSP counties electing to have the state administer this article on their behalf.

(f) The county Physician Services Account shall be used to reimburse ~~physicians~~ *physician and surgeons* for losses incurred for services provided during the fiscal year of allocation due to patients who do not have health insurance coverage for emergency services and care, who cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(g) Nurse practitioners shall be eligible to receive payment for patient care services. Payment shall be limited to those claims that are substantiated by a medical record.

~~(g) Physicians~~

(h) Physician and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a ~~properly credentialed nurse practitioner or~~ *licensed* physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of ~~nurse practitioners and~~ physician assistants in California.

~~(h)~~

(i) (1) Reimbursement for losses shall be limited to emergency services as defined in Section 16953, obstetric, and pediatric services as defined in Sections 16905.5 and 16907.5, respectively.

(2) It is the intent of this subdivision to allow reimbursement for all of the following:

(A) All inpatient and outpatient obstetric services ~~which~~ *that* are medically necessary, as determined by the attending physician *and surgeon or nurse practitioner*.

(B) All inpatient and outpatient pediatric services ~~which~~ *that* are medically necessary, as determined by the attending physician *and surgeon or nurse practitioner*.

~~(i)~~

(j) Any physician *and surgeon or nurse practitioner* may be reimbursed for up to 50 percent of the amount claimed pursuant to Section 16955 for the initial cycle of reimbursements made by the administering agency in a given year. All funds remaining at the end of the fiscal year shall be distributed proportionally, based on the dollar amount of claims submitted and paid to all ~~physicians~~ *physician and surgeons and nurse practitioners* who submitted qualifying claims during that year. The administering agency shall not disburse funds in excess of the total amount of a qualified claim.

SEC. 22. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty

1 for a crime or infraction, within the meaning of Section 17556 of
2 the Government Code, or changes the definition of a crime within
3 the meaning of Section 6 of Article XIII B of the California
4 Constitution.

O

Standing Committees, Task Forces & Councils of the Medical Board of California

Committee	*Members*		*Staff Assigned*	*Minutes*
Executive Committee	**Richard Fantozzi, M.D. , Chair** Steve Alexander Cesar Aristeiguieta, M.D. Gary Gitnick, M.D.	 Hedy Chang Barbara Yaroslavsky	Barbara Johnston Linda Whitney	Chris Valine
Access to Care Committee	**Steve Alexander, Co-Chair** **Gary Gitnick, M.D., Co-Chair** Hedy Chang Shelton Duruisseau, Ph.D.	 **Gerrie Schipske, RN, JD** Barbara Yaroslavsky **Frank V. Zerunyan, JD**	Kevin Schunke	
Diversion Committee	**Janet Salomonson, M.D., Co-Chair** **Ronald H.Wender, M.D., Co-Chair** Cesar Aristeiguieta, M.D. Shelton Duruisseau, Ph.D.		Frank Valine	
International Medical Education Committee	**Janet Salomonson, M.D., Chair** Cesar Aristeiguieta, M.D. Gary Gitnick, M.D. Mary Lynn Moran, M.D.	 Gerrie Schipske, RN, JD Frank V. Zerunyan, JD	Gary Qualset	
Midwifery Committee	**Hedy Chang, Chair** Mary Lynn Moran, M.D. Barbara Yaroslavsky		Kathi Burns	
Physician Recognition Committee	**Mary Lynn Moran, M.D., Chair** Frank V. Zerunyan, JD		Candis Cohen	
Public Education Committee	**Steve Alexander, Chair** Hedy Chang Mary Lynn Moran, M.D. Gerrie Schipske, RN, JD	 Janet Salomonson, M.D. **Barbara Yaroslavsky**	Candis Cohen	Candis Cohen
Strategic Planning Committee	Gary Gitnick, M.D. Frank V. Zerunyan, J.D.		Kim Kirchmeyer	
Special Faculty Permit Review Committee	**Gary Gitnick, M.D., Chair** Hedy Chang Neal Cohen, M.D. Daniel Giang, M.D. James Nuovo, M.D.	 Lawrence Opas, M.D. Neil Parker, M.D. Andrew Ries, M.D. Lawrence Shuer, M.D. Jeremiah Tilles, M.D.	Gary Qualset	
Cultural & Linguistic Competency Work Group	Hedy Chang Dorene Dominguez Shelton Duruisseau, Ph.D.		Gary Qualset Kathi Burns	
Medical Errors Task Force	**Cesar Aristeiguieta, M.D., Chair** Reginald Low, M.D. Mary Lynn Moran, M.D. Barbara Yaroslavsky		Janie Cordray	
Oral Argument Task Force	Cesar Aristeiguieta, M.D. Frank V. Zerunyan, JD		Kim Kirchmeyer	
Wellness Committee	**Shelton Duruisseau, Ph.D., Chair** John Chin, M.D. Ronald H. Wender, M.D. William Norcross, M.D. .	 Loma Linda Representative Laurie C. Gregg, M.D. Well-being Comm. Rep.	Kevin Schunke	

Revised 10/07

Standing Committees, Task Forces & Councils of the Medical Board of California Cont'd.

Diversion Advisory Council	Shannon Chavez, M.D. Marvin Firestone, M.D., J.D. Janet Salomonson, M.D.	Bruce Kaldor, M.D. David Pating, M.D. Stephanie Shaner, M.D. Lee Snook, M.D.	Frank Valine	
Midwifery Advisory Council	Faith Gibson, L.M., Chair. Ruth Haskins, M.D. Karen Ehrlich, L.M.	Carrie Sparrevohn, L.M. Guillermo Valenzuela, M.D. Barbara Yaroslavsky	Kathi Burns	

Revised 10/07

MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

	EXEC	ENFORCE	LICENSING	ADMIN SERVICES	DIVERSION	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 04/05								
$ Budgeted	1,504,000	28,428,000	3,482,000	1,750,000	1,194,000	2,548,000	2,117,000	41,023,000
$ Spent*	1,419,000	27,264,000	3,151,000	1,774,000	1,054,000	2,298,000	1,340,000	38,300,000 *
Positions Authorized	8.0	137.6	37.2	20.0	12.0	15.0	23.0	252.8
FY 05/06								
$ Budgeted	1,531,000	29,371,000	3,567,000	1,814,000	1,189,000	2,711,000	2,399,000	42,582,000
$ Spent *	1,412,000	26,380,000	3,170,000	1,756,000	1,148,000	2,438,000	1,406,000	37,710,000 *
Positions Authorized	8.0	137.6	37.2	20.0	12.0	15.0	23.0	252.8
FY 06/07								
$ Budgeted	1,534,000	34,693,000	3,949,000	3,089,000	1,747,000	2,857,000	2,591,000	50,460,000
$ Spent *	1,555,000	30,572,000	3,517,000	2,756,000	1,683,000	2,393,000	1,495,000	43,971,000 *
Positions Authorized	8.8	141.6	40.5	19.4	14.0	16.0	25.0	265.3
FY 07/08								
$ Budgeted	1,825,000	34,598,000	4,209,000	2,907,000	1,389,000	3,056,000	2,730,000	50,714,000
$ Spent thru 8/31*	221,000	5,837,000	700,000	368,000	246,000	814,000	338,000	8,524,000 *
Positions Authorized	8.0	141.6	40.5	19.0	14.0	16.8	25.0	264.9

* net expenditures (includes unscheduled reimbursements)

9/27/2007
Budget Overview by Program.xls

0758 - Medical Board
Analysis of Fund Condition
(Dollars in Thousands)

#1: Planned Budget

	ACTUAL 2006-07	2007-08	2008-09	2009-10	2010-11
BEGINNING BALANCE	$ 12,199	$ 18,467	$ 17,972	$ 16,497	$ 10,726
Prior Year Adjustment	$ 576	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 12,775	$ 18,467	$ 17,972	$ 16,497	$ 10,726
REVENUES AND TRANSFERS					
Revenues:					
125600 Other regulatory fees	$ 348	$ 354	$ 366	$ 366	$ 366
125700 Other regulatory licenses and permits	$ 5,703	$ 5,693	$ 5,707	$ 5,707	$ 5,707
125800 Renewal fees	$ 42,415	$ 42,834	$ 43,233	$ 43,639	$ 44,038
Reduced fees per elim of Diversion Program			$ (1,400)	$ (1,400)	$ (1,400)
125900 Delinquent fees	$ 94	$ 92	$ 100	$ 100	$ 100
141200 Sales of documents	$ -	$ -	$ -	$ -	$ -
142500 Miscellaneous services to the public	$ 25	$ 25	$ 25	$ 25	$ 25
150300 Income from surplus money investments	$ 1,088	$ 352	$ 323	$ 210	$ 100
160400 Sale of fixed assets		$ -	$ -	$ -	$ -
161000 Escheat of unclaimed checks and warrants	$ 11	$ -	$ -	$ -	$ -
161400 Miscellaneous revenues	$ 4	$ 6	$ 6	$ 6	$ 6
164300 Penalty assessments - Probation Monitoring		$ 900	$ 900	$ 900	$ 900
Totals, Revenues	$ 49,688	$ 50,256	$ 49,260	$ 49,553	$ 49,842
Totals, Revenues and Transfers					
Totals, Revenues and Transfers	$ 49,688	$ 50,256	$ 49,260	$ 49,553	$ 49,842
Total Resources	$ 62,463	$ 68,723	$ 67,233	$ 66,050	$ 60,568
EXPENDITURES					
0840 State Controller (State Operations)	$ 25	$ 37	$ -	$ -	$ -
1110 Program Expenditures (State Operations)	$ 43,971	$ 50,714	$ 52,136	$ 53,179	$ 54,242
Elimination of Diversion Program			$ (1,400)	$ (1,400)	$ (1,400)
Proposed BCP: Operation Safe Medicine				$ 1,924	$ 1,620
Proposed BCP: Probation Program Expansion				$ 621	$ 514
Proposed BCP: Replace IT Infrastructure				$ 1,000	$ 500
Total Expenditures and Expenditure Adjustments	$ 43,996	$ 50,751	$ 50,736	$ 55,324	$ 55,476
FUND BALANCE					
Reserve for economic uncertainties	$ 18,467	$ 17,972	$ 16,497	$ 10,726	$ 5,092
Months in Reserve	4.4	4.3	3.6	2.3	1.1

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED.

B. EXPENDITURE GROWTH PROJECTED AT 2% BEGINNING FY 2008-09.

10/16/2007

0758 - Medical Board
Analysis of Fund Condition

(Dollars in Thousands)

#2: Current Budget

		ACTUAL 2006-07	2007-08	2008-09	2009-10	2010-11
BEGINNING BALANCE		$ 12,199	$ 18,467	$ 17,972	$ 16,497	$ 14,342
Prior Year Adjustment		$ 576	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 12,775	$ 18,467	$ 17,972	$ 16,497	$ 14,342
REVENUES AND TRANSFERS						
Revenues:						
125600	Other regulatory fees	$ 348	$ 354	$ 366	$ 366	$ 366
125700	Other regulatory licenses and permits	$ 5,703	$ 5,693	$ 5,707	$ 5,707	$ 5,707
125800	Renewal fees	$ 42,415	$ 42,834	$ 43,233	$ 43,639	$ 44,038
	Reduced fees per elim of Diversion Program			$ (1,400)	$ (1,400)	$ (1,400)
125900	Delinquent fees	$ 94	$ 92	$ 100	$ 100	$ 100
141200	Sales of documents	$ -	$ -	$ -	$ -	$ -
142500	Miscellaneous services to the public	$ 25	$ 25	$ 25	$ 25	$ 25
150300	Income from surplus money investments	$ 1,088	$ 352	$ 323	$ 281	$ 225
160400	Sale of fixed assets		$ -	$ -	$ -	$ -
161000	Escheat of unclaimed checks and warrants	$ 11	$ -	$ -	$ -	$ -
161400	Miscellaneous revenues	$ 4	$ 6	$ 6	$ 6	$ 6
164300	Penalty assessments - Probation Monitoring		$ 900	$ 900	$ 900	$ 900
Totals, Revenues		$ 49,688	$ 50,256	$ 49,260	$ 49,624	$ 49,967
Totals, Revenues and Transfers						
Totals, Revenues and Transfers		$ 49,688	$ 50,256	$ 49,260	$ 49,624	$ 49,967
Total Resources		$ 62,463	$ 68,723	$ 67,233	$ 66,121	$ 64,309
EXPENDITURES						
0840 State Controller (State Operations)		$ 25	$ 37	$ -	$ -	$ -
1110 Program Expenditures (State Operations)		$ 43,971	$ 50,714	$ 52,136	$ 53,179	$ 54,242
	Elimination of Diversion Program			$ (1,400)	$ (1,400)	$ (1,400)
	NO CHANGE IN AUTHORITY FOR PLANNED PROGRAMS					
Total Expenditures and Expenditure Adjustments		$ 43,996	$ 50,751	$ 50,736	$ 51,779	$ 52,842
FUND BALANCE						
Reserve for economic uncertainties		$ 18,467	$ 17,972	$ 16,497	$ 14,342	$ 11,467
Months in Reserve		4.4	4.3	3.8	3.3	2.6

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED.

B. EXPENDITURE GROWTH PROJECTED AT 2% BEGINNING FY 2008-09.

10/16/2007

0758 - Medical Board
Analysis of Fund Condition
(Dollars in Thousands)

#3: Planned Budget with Decreased Fees for 2 years

		ACTUAL 2006-07	2007-08	2008-09	2009-10	2010-11
BEGINNING BALANCE		$ 12,199	$ 18,467	$ 17,972	$ 14,006	$ 5,695
Prior Year Adjustment		$ 576	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 12,775	$ 18,467	$ 17,972	$ 14,006	$ 5,695
REVENUES AND REFUNDS						
Revenues:						
125600	Other regulatory fees	$ 348	$ 354	$ 366	$ 366	$ 366
125700	Other regulatory licenses and permits	$ 5,703	$ 5,693	$ 5,707	$ 5,707	$ 5,707
125800	Renewal fees	$ 42,415	$ 42,834	$ 43,233	$ 43,639	$ 44,038
	Reduced fees per elim of Diversion Program			$ (1,400)	$ (1,400)	$ (1,400)
125900	Delinquent fees	$ 94	$ 92	$ 100	$ 100	$ 100
141200	Sales of documents	$ -	$ -	$ -	$ -	$ -
142500	Miscellaneous services to the public	$ 25	$ 25	$ 25	$ 25	$ 25
150300	Income from surplus money investments	$ 1,088	$ 352	$ 323	$ 161	$ -
160400	Sale of fixed assets		$ -	$ -	$ -	$ -
161000	Escheat of unclaimed checks and warrants	$ 11	$ -	$ -	$ -	$ -
161400	Miscellaneous revenues	$ 4	$ 6	$ 6	$ 6	$ 6
164300	Penalty assessments - Probation Monitoring		$ 900	$ 900	$ 900	$ 900
Totals, Revenues		$ 49,688	$ 50,256	$ 49,260	$ 49,504	$ 49,742
Refund to Physicians via decreased fee for 2 years (full renewal cycle) 53,000 x $47				$ (2,491)	$ (2,491)	
Totals, Revenues and Refunds		$ 49,688	$ 50,256	$ 46,769	$ 47,013	$ 49,742
Total Resources		$ 62,463	$ 68,723	$ 64,742	$ 61,018	$ 55,437
EXPENDITURES						
0840 State Controller (State Operations)		$ 25	$ 37	$ -	$ -	$ -
1110 Program Expenditures (State Operations)		$ 43,971	$ 50,714	$ 52,136	$ 53,179	$ 54,242
	Elimination of Diversion Program			$ (1,400)	$ (1,400)	$ (1,400)
	Proposed BCP: Operation Safe Medicine				$ 1,924	$ 1,620
	Proposed BCP: Probation Program Expansion				$ 621	$ 514
	Proposed BCP: Replace IT Infrastructure				$ 1,000	$ 500
Total Expenditures and Expenditure Adjustments		$ 43,996	$ 50,751	$ 50,736	$ 55,324	$ 55,476
FUND BALANCE						
Reserve for economic uncertainties		$ 18,467	$ 17,972	$ 14,006	$ 5,695	$ (40)
Months in Reserve		4.4	4.3	3.0	1.2	0.0

NOTES:
A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED
B EXPENDITURE GROWTH PROJECTED AT 2% BEGINNING FY 2008-09

10/16/2007

0758 - Medical Board
Analysis of Fund Condition
(Dollars in Thousands)

#4: Current Budget with Decreased Fees for 2 years

		ACTUAL 2006-07	2007-08	2008-09	2009-10	2010-11
BEGINNING BALANCE		$ 12,199	$ 18,467	$ 17,972	$ 14,006	$ 9,311
Prior Year Adjustment		$ 576	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 12,775	$ 18,467	$ 17,972	$ 14,006	$ 9,311
REVENUES AND REFUNDS						
Revenues:						
125600	Other regulatory fees	$ 348	$ 354	$ 366	$ 366	$ 366
125700	Other regulatory licenses and permits	$ 5,703	$ 5,693	$ 5,707	$ 5,707	$ 5,707
125800	Renewal fees	$ 42,415	$ 42,834	$ 43,233	$ 43,639	$ 44,038
	Reduced fees per elim of Diversion Program			$ (1,400)	$ (1,400)	$ (1,400)
125900	Delinquent fees	$ 94	$ 92	$ 100	$ 100	$ 100
141200	Sales of documents	$ -	$ -	$ -	$ -	$ -
142500	Miscellaneous services to the public	$ 25	$ 25	$ 25	$ 25	$ 25
150300	Income from surplus money investments	$ 1,088	$ 352	$ 323	$ 231	$ 124
160400	Sale of fixed assets		$ -	$ -	$ -	$ -
161000	Escheat of unclaimed checks and warrants	$ 11	$ -	$ -	$ -	$ -
161400	Miscellaneous revenues	$ 4	$ 6	$ 6	$ 6	$ 6
164300	Penalty assessments - Probation Monitoring		$ 900	$ 900	$ 900	$ 900
Totals, Revenues		$ 49,688	$ 50,256	$ 49,260	$ 49,574	$ 49,866
Refund to Physicians via decreased fee for 2 years (full renewal cycle) 53,000 x $47				$ (2,491)	$ (2,491)	
Totals, Revenues and Refunds		$ 49,688	$ 50,256	$ 46,769	$ 47,083	$ 49,866
Total Resources		$ 62,463	$ 68,723	$ 64,742	$ 61,089	$ 59,177
EXPENDITURES						
0840 State Controller (State Operations)		$ 25	$ 37	$ -	$ -	$ -
1110 Program Expenditures (State Operations)		$ 43,971	$ 50,714	$ 52,136	$ 53,179	$ 54,242
	Elimination of Diversion Program			$ (1,400)	$ (1,400)	$ (1,400)
Total Expenditures and Expenditure Adjustments		$ 43,996	$ 50,751	$ 50,736	$ 51,779	$ 52,842
FUND BALANCE						
Reserve for economic uncertainties		$ 18,467	$ 17,972	$ 14,006	$ 9,311	$ 6,334
Months in Reserve		4.4	4.3	3.2	2.1	1.4

NOTES:
A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED
B. EXPENDITURE GROWTH PROJECTED AT 2% BEGINNING FY 2008-09.

10/16/2007

Medical Board of California
FY 06/07
Budget Expenditure Report
(As of June 30, 2007)
(100.0% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE 6/30/07
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	14,912,628	13,224,280	88.7	1,688,348
DEC	24,000	27,400	114.2	(3,400)
Board Members	31,500	34,100	108.3	(2,600)
Phy Fitness Incentive Pay	29,623	29,445	99.4	178
Temp Help	1,144,410	1,269,508	110.9	(125,098)
Allocated Proctor	0	113		(113)
Overtime	12,143	76,842	632.8	(64,699)
Staff Benefits	6,191,597	5,066,437	81.8	1,125,160
Salary Savings	(1,006,512)			(1,006,512)
TOTALS, PERS SERVICES	21,339,389	19,728,125	92.4	1,611,264
OPERATING EXP & EQUIP				
General Expense	732,769	368,614	50.3	364,155
Fingerprint Reports	373,448	379,748	101.7	(6,300)
Printing	777,587	465,153	59.8	312,434
Communications	528,698	318,939	60.3	209,759
Postage	413,084	337,532	81.7	75,552
Insurance	35,277	25,900	73.4	9,377
Travel In-State	390,383	376,794	96.5	13,589
Travel Out-of-State	3,600	2,864	79.6	736
Training	58,469	79,116	135.3	(20,647)
Facilities Operation (Rent)	3,002,789	2,814,604	93.7	188,185
Consult/Prof Services	1,191,310	1,397,528	117.3	(206,218)
Departmental Prorata	3,890,812	3,670,075	94.3	220,737
Consolidated Data Ctr (Teale)	532,215	238,000	44.7	294,215
Data Processing	98,762	128,566	130.2	(29,804)
Central Admin Svcs (Statewide Prorata)	1,376,086	1,376,086	100.0	0
Attorney General Services	12,419,270	11,247,042	90.6	1,172,228
Office of Administrative Hearings	1,551,595	1,199,711	77.3	351,884
Court Reporter Services	125,000	143,202	114.6	(18,202)
Evidence/Witness	1,557,983	1,214,680	78.0	343,303
Major Equipment	369,000	375,184	101.7	(6,184)
Minor Equipment	164,300	320,779	195.2	(156,479)
Vehicle Operation/Other Items	225,261	349,940	155.3	(124,679)
Special Items of Expense (Tort, etc.)	0	12,517		(12,517)
Special Adjustments (Peer Review)	400,000	0	0.0	400,000
TOTALS, OE&E	30,217,698	26,842,574	88.8	3,375,124
TOTALS, EXPENDITURES	51,557,087	46,570,699	90.3	4,986,388
Scheduled Reimbursements	(384,000)	(392,595)	102.2	8,595
Distributed Costs	(713,000)	(711,456)	99.8	(1,544)
NET TOTAL, EXPENDITURES	50,460,087	45,466,648	90.1	4,993,439
Unscheduled Reimbursements		(1,495,579)		
		43,971,069		

Budget Expenditure Report.xls
Date: August 9, 2007

Medical Board of California

FY 07/08
Budget Expenditure Report
(As of August 31, 2007)
(16.7% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	14,731,824	2,306,593	15.7	12,425,231
DEC	24,000	2,600	10.8	21,400
Board Members	31,500	0	0.0	31,500
Phy Fitness Incentive Pay	29,623	2,015	6.8	27,608
Temp Help	1,144,410	114,126	10.0	1,030,284
Overtime	12,143	3,998	32.9	8,145
Staff Benefits	6,240,972	1,335,879	21.4	4,905,093
Salary Savings	(774,914)			(774,914)
TOTALS, PERS SERVICES	21,439,558	3,765,211	17.6	17,674,347
OPERATING EXP & EQUIP				
General Expense	891,585	28,555	3.2	863,030
Fingerprint Reports	373,448	58,164	15.6	315,284
Printing	835,648	293,266	35.1	542,382
Communications	567,855	1,102	0.2	566,753
Postage	444,459	35,360	8.0	409,099
Insurance	37,956	0	0.0	37,956
Travel In-State	421,039	14,101	3.3	406,938
Travel Out-of-State	2,800	0	0.0	2,800
Training	62,910	199	0.3	62,711
Facilities Operation (Rent)	2,784,152	1,624,372	58.3	1,159,780
Consult/Prof Services	969,919	186,676	19.2	783,243
Departmental Prorata	3,921,804	0	0.0	3,921,804
Interagency Services	4,672	0	0.0	4,672
Consolidated Data Ctr (Teale)	572,639	418,000	73.0	154,639
Data Processing	106,263	3,132	2.9	103,131
Central Admin Svcs (Statewide Prorata)	1,793,449	0	0.0	1,793,449
Attorney General Services	12,419,270	2,090,696	16.8	10,328,574
Office of Administrative Hearings	1,643,939	191,585	11.7	1,452,354
Court Reporter Services	160,000	8,061	5.0	151,939
Evidence/Witness	1,676,318	81,650	4.9	1,594,668
DOI-Investigative	2,347	0	0.0	2,347
Major Equipment	232,300	0	0.0	232,300
Minor Equipment	182,300	0	0.0	182,300
Vehicle Operation/Other Items	242,370	12,975	5.4	229,395
TOTALS, OE&E	30,349,442	5,047,894	16.6	25,301,548
TOTALS, EXPENDITURES	51,789,000	8,813,105	17.0	42,975,895
Scheduled Reimbursements	(384,000)	(60,293)	15.7	(323,707)
Distributed Costs	(691,000)	(106,131)	15.4	(584,869)
NET TOTAL, EXPENDITURES	50,714,000	8,646,681	17.0	42,067,319
Unscheduled Reimbursements		(123,092)		
		8,523,589		

Budget Expenditure Report.xls
Date: September 25, 2007

ENFORCEMENT/PROBATION RECEIPTS
MONTHLY PROFILE: JULY 2005 - AUGUST 2007

	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	FYTD Total
Invest Cost Recovery	50,749	89,190	48,074	92,811	64,158	51,605	79,797	44,058	32,282	51,377	25,267	12,829	642,197
*Invest Cost Recovery Ordered**	*43,797*	*49,467*	*140,574*	*46,665*	*75,155*	*72,133*	*59,294*	*11,500*	*29,500*	*10,000*	*0*	*0*	*538,085*
Criminal Cost Recovery	1,350	16,822	746	1,151	8,570	760	586	5,661	5,489	690	600	730	43,155
Probation Monitoring	36,707	14,612	7,909	46,661	97,709	111,055	239,827	229,080	31,782	41,281	30,624	27,579	914,826
Exam	2,611	825	4,057	11,997	4,111	360	3,936	2,089	602	2,713	1,793	4,600	39,694
Cite/Fine	1,350	1,450	0	5,175	9,100	175	4,150	7,900	3,850	850	5,300	5,000	44,300
MONTHLY TOTAL	92,767	122,899	60,786	157,795	183,648	163,955	328,296	288,788	74,005	96,911	63,584	50,738	1,684,172
FYTD TOTAL	92,767	215,666	276,452	434,247	617,895	781,850	1,110,146	1,398,934	1,472,939	1,569,850	1,633,434	1,684,172	

	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	FYTD Total
Invest Cost Recovery	21,173	30,787	19,692	22,508	22,790	10,741	26,503	6,342	13,891	18,577	11,064	6,789	210,857
*Invest Cost Recovery Ordered**	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Criminal Cost Recovery	450	704	57,971	1,100	840	373	1,213	750	100	10,200	18,704	2,689	95,094
Probation Monitoring	28,503	30,868	8,857	14,327	123,405	112,580	332,202	155,028	33,356	42,898	27,181	22,842	932,047
Exam	4,456	5,843	3,093	1,065	2,440	1,561	7,215	1,505	3,858	3,105	515	6,256	40,912
Cite/Fine	4,675	3,600	3,750	7,420	8,150	4,350	5,000	4,700	2,950	10,960	5,700	650	61,905
MONTHLY TOTAL	59,257	71,802	93,363	46,420	157,625	129,605	372,133	168,325	54,155	85,740	63,164	39,226	1,340,815
FYTD TOTAL	59,257	131,059	224,422	270,842	428,467	558,072	930,205	1,098,530	1,152,685	1,238,425	1,301,589	1,340,815	

	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	FYTD Total
Invest Cost Recovery	15,074	12,725											27,799
Criminal Cost Recovery	0	0											0
Probation Monitoring	31,949	49,534											81,483
Exam	3,545	4,227											7,772
Cite/Fine	1,200	9,100											10,300
MONTHLY TOTAL	51,768	75,586	0	0	0	0	0	0	0	0	0	0	127,354
FYTD TOTAL	51,768	127,354	127,354	127,354	127,354	127,354	127,354	127,354	127,354	127,354	127,354	127,354	

**not included in monthly and FYTD totals*

excel:enfreceiptsmonthlyprofile.xls.revised 10/3/07.

NOTE: cost recovery shown ordered after 1/1/06 was ordered in stipulations prior to 1/1/06

Medical Board of California
Board Members' Expense Report
July 1, 2007 - August 31, 2007

	Per Diem*			Travel Expenses*	Total July-Aug	Total FYTD
	JULY	AUG	TOTAL			
DMQ						
Mr. Alexander	500	300	800	486.47	1,286.47	1,286.47
Dr. Aristeiguieta	0	0	0	0.00	0.00	0.00
Dr. Chin	200	0	200	311.25	511.25	511.25
Dr. Corday	300	0	300	428.50	728.50	728.50
Dr. Duruisseau	500	200	700	380.50	1,080.50	1,080.50
Dr. Low	0	0	0	0.00	0.00	0.00
Dr. Moran	0	0	0	0.00	0.00	0.00
Dr. Salomonson	500	300	800	481.54	1,281.54	1,281.54
Dr. Wender	200	100	300	306.35	606.35	606.35
Ms. Yaroslavsky	0	0	0	0.00	0.00	0.00
Mr. Zerunyan	700	600	1,300	0.00	1,300.00	1,300.00
SUB TOTAL	2,900	1,500	4,400	2,394.61	6,794.61	6,794.61
LICENSING						
Ms. Chang	0	0	0	0.00	0.00	0.00
Dr. Fantozzi	1,100	1,000	2,100	1,534.80	3,634.80	3,634.80
Dr. Gitnick	0	0	0	0.00	0.00	0.00
Dr. Gregg	1,100	0	1,100	477.50	1,577.50	1,577.50
Ms. Schipske	0	0	0	403.78	403.78	403.78
SUB TOTAL	2,200	1,000	3,200	2,416.08	5,616.08	5,616.08
BOARD TOTAL	5,100	2,500	7,600	4,810.69	12,410.69	**12,410.69**

*includes claims paid/submitted through September 28, 2007

Board Members Expense Report.xls
Date: October 3, 2007

MEDICAL BOARD OF CALIFORNIA
EXECUTIVE PROGRAM
BUDGET REPORT
JULY 1, 2007 - AUGUST 31, 2007

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	589,865	93,043	current
Staff Benefits	247,264	47,877	current
TOTAL PERSONAL SERVICES	837,129	140,920	
OPERATING EXPENSE & EQUIPMENT			
General Expense 1/	70,000	11,332	1-2
Printing	300,000	0	1-2
Communications	26,292	176	1-2
Postage	181,375	261	1-2
Travel In-State	105,455	3,602	1-2
Travel Out-of-State	800	0	current
Training	5,000	0	1-2
Facilities Operations 2/	70,000	53,623	current
Consultant & Professional Services	24,000	10,894	1-2
Departmental Services 3/	140,008	0	current
Interagency Services	167	0	current
Data Processing	1,000	0	1-2
Central Administrative Services 4/	64,026	0	current
TOTAL OPERATING EXPENSES & EQUIPMENT	988,123	79,888	
TOTAL BUDGET/EXPENDITURES	**1,825,252**	**220,808**	

See footnotes on next page

9/26/07
g/admin/execbud.xls

1/ costs for employee relocation, miscellaneous office supplies, freight and drayage, General Services administration overhead (charges levied by the Department of General Services for purchase orders, contracts, traffic management, fleet administration, and confidential destruction; charges levied by the State Controller's Office for the processing of disability insurance claims, late payroll document costs; by EDD for unemployment insurance and by DPA Admininstration; charges levied by any other state agency for services provided not under contract), meetings and conferences, library purchases and subscriptions, photography, and office equipment rental, maintenance and repairs.

2/ rent, security, maintenance, facility planning, waste removal, purchase of building supplies and materials.

3/ Department of Consumer Affairs prorata assessments for support of the following:

a/ Public Affairs Division
b/ Consumer and Community Relations Division
c/ Administrative & Information Services Division
d/ Division of Investigation Special Operations Unit

4/ Charges for support of the State Personnel Board, Department of Finance, State Controller, State Treasurer, Legislature, Governor's Office, etc.

9/26/07
g/admin/execbud.xls

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2007 - AUGUST 31, 2007

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	8,692,467	1,331,977	current
Staff Benefits	3,417,710	738,791	current
TOTAL PERSONAL SERVICES	12,110,177	2,070,768	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	255,604	5,086	1-2
Printing	373,148	278,710	1-2
Communications	310,994	856	1-2
Postage	101,806	18,192	1-2
Insurance	29,930	0	current
Travel In-State	122,358	1,860	1-2
Travel Out-of-State	900	0	current
Training	21,806	199	1-2
Facililties Operations	1,622,789	1,121,347	current
Consultant/Professional Services	350,000	110,821	1-2
Departmental Services	2,685,258	0	current
Interagency Services	3,199	0	current
Data Processing	12,000	3,132	1-2
Central Administrative Services	1,227,975	0	current
Attorney General 1/	12,229,270	2,059,767	current
OAH	1,643,939	191,585	1
Evidence/Witness Fees	1,606,750	81,237	1-2
DOI-Investigative	2,347	0	current
Court Reporter Services	160,000	8,061	1-2
Major Equipment	112,800	0	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	72	8,227	1-2
Vehicle Operations	184,098	2,575	1-2
Minor Equipment	65,500	0	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	23,122,543	3,891,655	
DISTRIBUTED COSTS	(634,562)	(106,131)	
TOTAL BUDGET/EXPENDITURES	**34,598,158**	**5,856,292**	
Unscheduled Reimbursements		(19,572)	
		5,836,720	

1/See next page for monthly billing detail

9/26/07
g/admin/enfrcbud.exl

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 07/08
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

		Number of Hours	Rate	Amount
July	Attorney Services	6,180.75	158.00	976,558.50
	Paralegal Services	134.00	101.00	13,534.00
	Auditor/Analyst Services	4.00	63.00	252.00
	Cost of Suit			
				990,344.50
August	Attorney Services	6,722.75	158.00	1,062,194.50
	Paralegal Services	65.25	101.00	6,590.25
	Auditor/Analyst Services	1.00	63.00	63.00
	Cost of Suit			575.00
				1,069,422.75
September	Attorney Services		158.00	0.00
	Paralegal Services		101.00	0.00
	Auditor/Analyst Services		63.00	0.00
	Cost of Suit			
				0.00
October	Attorney Services		158.00	0.00
	Paralegal Services		101.00	0.00
	Auditor/Analyst Services		63.00	0.00
	Cost of Suit			
				0.00
November	Attorney Services		158.00	0.00
	Paralegal Services		101.00	0.00
	Auditor/Analyst		63.00	0.00
	Cost of Suit			
				0.00
December	Attorney Services		158.00	0.00
	Paralegal Services		101.00	0.00
	Auditor/Analyst		63.00	0.00
	Cost of Suit			
				0.00

Enforcement AG Expenditures July - August = 2,059,767.25

Revised 9/17/07

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2007 - AUGUST 31, 2007

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,778,140	302,951	current
Staff Benefits	786,160	175,897	current
TOTAL PERSONAL SERVICES	2,564,300	478,848	
OPERATING EXPENSES & EQUIPMENT			
General Expense	43,960	401	1-2
Fingerprint Reports*	369,948	57,762	current
Printing	100,000	5,174	1-2
Communications	73,816	41	1-2
Postage	137,446	16,530	1-2
Travel In-State	25,000	1,145	1-2
Training	4,000	0	1-2
Facilities Operation	185,000	146,258	current
Consult/Professional Services	448,919	59,611	1-2
Departmental Services	322,765	0	current
Interagency Services	385	0	current
Data Processing	500	0	1-2
Central Administrative Services	147,601	0	current
Attorney General	190,000	30,929	current
Evidence/Witness Fees	5,000	0	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	2,054,340	317,851	
SCHEDULED REIMBURSEMENTS	(384,000)	(60,293)	
DISTRIBUTED COSTS	(26,089)	0	
TOTAL BUDGET/EXPENDITURES	**4,208,551**	**736,406**	
Unscheduled Reimbursements		(36,439)	
		699,967	

*Department of Justice invoices for fingerprint reports, name checks, and subsequent arrest reports

g/admin/licensn2.xls
9/27/2007

MEDICAL BOARD OF CALIFORNIA
ADMINISTRATIVE SERVICES PROGRAM
BUDGET REPORT
JULY 1, 2007 - AUGUST 31, 2007

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	901,731	154,403	current
Staff Benefits	396,073	87,570	current
TOTAL PERSONAL SERVICES	1,297,804	241,973	
OPERATING EXPENSE & EQUIPMENT			
General Expense	432,621	1,763	1-2
Printing	30,000	2,145	1-2
Communications	80,435	0	1-2
Postage	10,131	72	1-2
Travel In-State	20,000	1,416	1-2
Training	3,000	0	1-2
Facilities Operations	695,363	120,255	current
Consultant & Professional Services	37,000	750	1-2
Departmental Services	223,151	0	current
Interagency Services	266	0	current
Data Processing	1,000	0	1-2
Central Administrative Services	102,047	0	current
Vehicle Operations/Insurance/Other	2,445	0	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	1,637,459	126,401	
DISTRIBUTED COSTS	(28,357)	0	
TOTAL BUDGET/EXPENDITURES	**2,906,906**	**368,374**	

9/26/07
g/admin/ADMINserv.xls

MEDICAL BOARD OF CALIFORNIA
DIVERSION PROGRAM
BUDGET REPORT
JULY 1, 2007 - AUGUST 31, 2007

	FY 07/08 BUDGET	EXPEND/ ENCUMB YR-TO-DATE	PERCENT OF BUDGET EXP/ENCUMB	LAG TIME (MONTHS)
PERSONAL SERVICES				
Salaries & Wages	720,121	130,673	18.1	current
Staff Benefits	308,770	64,843	21.0	current
TOTAL PERSONAL SERVICES	1,028,891	195,516	19.0	
OPERATING EXPENSES & EQUIPMENT				
General Expense	25,000	9,805	39.2	1-2
Printing	10,000	5,174	51.7	1-2
Communications	22,822	0	0.0	1-2
Postage	5,255	253	4.8	1-2
Insurance	1,702	0	0.0	current
Travel In-State	75,000	5,222	7.0	1-2
Travel Out-of-State	1,100	0	0.0	current
Training	4,418	0	0.0	1-2
Facilities Operation	32,000	28,290	88.4	current
Departmental Services	106,672	0	0.0	current
Interagency Services	127	0	0.0	current
DP Maint/Supplies	500	0	0.0	1-2
Central Administrative Services	48,782	0	0.0	current
Major Equipment	16,000	0	0.0	current
Vehicle Operations	11,000	1,448	13.2	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	360,378	50,192	13.9	
TOTAL BUDGET/EXPENDITURES	**1,389,269**	**245,708**	17.7	

g/admin/diverprg.xls
9/26/2007

MEDICAL BOARD OF CALIFORNIA
INFORMATION SYSTEMS PROGRAM
BUDGET REPORT
JULY 1, 2007 - AUGUST 31, 2007

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,036,519	179,809	current
Staff Benefits	458,800	90,733	current
TOTAL PERSONAL SERVICES	1,495,319	270,542	
OPERATING EXPENSE & EQUIPMENT			
General Expense	37,900	442	1-2
Printing	15,000	1,808	1-2
Communications	21,503	45	1-2
Postage	5,255	258	1-2
Travel In-State	21,441	0	1-2
Training	20,186	0	1-2
Facililties Operations	138,000	118,083	current
Consultant/Professional Services	110,000	4,600	1-2
Departmental Services	234,523	0	current
Interagency Services	279	0	current
Consolidated Data Centers (Teale)	572,639	418,000	current
Data Processing	90,763	0	1-2
Central Administrative Services	107,248	0	current
Major Equipment	71,500	0	1-2
Minor Equipment	116,800	0	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	1,563,037	543,236	
DISTRIBUTED COSTS	(1,992)	0	
TOTAL BUDGET/EXPENDITURES	**3,056,364**	**813,778**	

9/26/07
g/admin/datasyst.xls

MEDICAL BOARD OF CALIFORNIA
PROBATION MONITORING
BUDGET REPORT
JULY 1, 2007 - AUGUST 31, 2007

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,479,742	236,475	current
Staff Benefits	626,195	130,166	current
TOTAL PERSONAL SERVICES	2,105,937	366,641	
OPERATING EXPENSES & EQUIPMENT			
General Expense	30,000	128	1-2
Printing	7,500	253	1-2
Communications	31,993	29	1-2
Postage	3,191	7	1-2
Insurance	6,079	0	current
Travel In-State	51,785	598	1-2
Training	4,500	0	1-2
Facilities Operation	41,000	36,516	current
Departmental Services	209,424	0	current
Interagency Services	249	0	current
Data Processing	500	0	1-2
Central/Administrative Services	95,770	0	current
Evidence/Witness Fees	64,568	413	1-2
Major Equipment	32,000	0	1-2
Vehicle Operations/Other Items	45,000	725	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	623,559	38,669	
TOTAL BUDGET/EXPENDITURES	**2,729,496**	**405,310**	
Unscheduled Reimbursements*		(67,081)	
		338,229	

---

*no authority to spend

g/admin/probamon.xls
9/26/2007

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
MEDICAL BOARD OF CALIFORNIA– Executive Office
1434 Howe Avenue, Suite 92, Sacramento, CA 95825
(916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

October 17, 2007

To: Members,
Medical Board of California

From: Barb Johnston
Executive Director

Subject: Proposed 2008 Meeting Dates

At the July Board meeting the board voted to approve meeting dates for 2008. It was recently brought to my attention that the date for the May 1, 2, 2008 meeting date conflicts with the FSMB Annual meeting. Therefore, I am proposing the May meeting date be changed to allow members and staff the opportunity to attend the FSMB Annual meeting.

The following dates are proposed for your review and consideration:

April 24, 25, 2008
or,
May 8, 9, 2008

JULY 2007 MEETING

7 Members responded – On all the ratings, the overall response average was that the Board members **agree** that they have the information necessary, the discussion items are relevant, enough time is allowed to discuss agenda items, and they feel they are open to public input.

Comments per item:

Board meeting packet:

- Consider packets online or scanning and putting in pdf format.
- New Executive Director's information was not given in advance of meeting.
- Regardless that the materials come in enough time, are complete, and relevant, it should be gone over during the meeting (because not everyone seems to be reading).

Committee meetings:

No Comments

Division meetings:

- The table/chair set up makes it hard (impossible) to see the chair and members. It's fine for "hearing" format but not great for discussion.

Full board meetings:

- I could not read the slides or most of the poorly printed handout for the presentation.
- Having a full board meeting the 1st day is an excellent method to ensure total engagement!
- Need to use motions to move the board – long discussion without action isn't effective meeting management.
- Quality of presentation – Could not read Power Point or handouts.

Further comments:

- The more everyone knows and the more fully engages the board is, the better knowledge every member has and can, in turn, be more engaged in the process and the work of the board.

2008

Medical Board of California

Strategic Plan 2008

MEDICAL BOARD OF CALIFORNIA

STRATEGIC PLAN 2008

Developed 2008

Richard D. Fantozzi, M.D., President
Steve Alexander
Cesar Aristeiguieta, M.D.
Hedy Chang
John Chin, M.D.
Shelton Duruisseau, Ph.D.
Gary Gitnick, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.
Ronald H. Wender, M.D.
Barbara Yaroslavsky
Frank V. Zerunyan, J.D.

Barb Johnston, Executive Director

Protecting the Public
Promoting Wellness

INTRODUCTION

The Medical Board of California (Board) is mandated to make public protection its first priority. This mandate is articulated in Business and Professions Code Section 2001.1, which states:

> ***Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions.***

While the mandated functions of the Board generally fall into two categories, licensing and discipline, there are other, more broadly defined issues relating to healthcare that impact the protection of the public. Acknowledging that California's healthcare landscape is ever changing, that the current environment of healthcare delivery is under great strain, and that the business of medicine may contribute to preventing access to healthcare or promote substandard care, this plan addresses issues beyond the simple issuing of licenses and rendering of disciplinary actions.

MISSION

The Mission of the Medical Board of California is to protect healthcare consumers through proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practices Act, and, to promote access to quality medical care through the Board's licensing and regulatory functions.

GOALS AND OBJECTIVES

Professional Qualifications
Promote the professional qualifications of medical practitioners by setting requirements for education, experience, and examinations, taking into account the states needs for more physicians, particularly in underserved populations; and promoting physician wellness.

Regulations and Enforcement
Protect the public by effectively enforcing laws and standards to deter violations.

Consumer Education
Increase public awareness of Board's Mission, activities and services.

Organizational Relationships
Improve effectiveness of relationships with related organizations to further Board's Mission and goals.

Organizational Effectiveness
Enhance organizational effectiveness and systems to improve service.

Goal 1: Professional Qualifications

Promote the professional qualifications of medical practitioners by setting requirements for education, experience, and examinations, taking into account the state's need for more physicians, particularly in underserved populations; and promoting physician wellness.

Objectives

- Assure greater compliance of CME requirements.
  Measure: Audits will show improved compliance with CME requirements.

- Develop a plan for addressing access to care and the shortage of doctors that is appropriate to the Board's Mission and resources.
  Measure: Determine impact of the Board's plan to address access to healthcare.

- Create a plan to assist in addressing medical errors as appropriate to the Board's Mission and resources.
  Measure: Development of an educational program to inform medical students and physicians of medical errors and consequences which may be used as curriculum or CME.

  Develop an on-line educational program on cultural and linguistic competency
  Measure: Determine the number of physicians using this program to enhance their skills and satisfaction with the course.

  Ensure that qualified internationally trained physicians are allowed to obtain license exemption under Business and Professions Code 2168 through the work of the Special Programs Review Committee.
  Measure: Site audits will indicate these physicians are compliant with regulation and there is a decrease of complaints about this group.

  Ensure international medical schools meet the Board's requirements for recognition.
  Measure: Site inspections will indicate compliance.

- Promote physician wellness by providing an on-line educational program and links to other resources.
  Measure: Determine the number of physicians using these resources.

Goal 2: Regulation and Enforcement

Protect the public by effectively enforcing laws and standards to deter violations.

Objectives

- Submit vertical enforcement report to the Legislature by December 2007 and implement the vertical enforcement model long term.
  Measure: Report submitted and vertical enforcement model fully integrated including implementation of fully interoperable information technology software used by the Department of Justice.

- Evaluation of peer review study of California hospitals and to address the issues identified.
  Measure: Study is completed and recommendations are provided to the Board for review and possible action.

  Re-establish the Board's Operation Safe Medicine Unit to target unlicensed activity, corporate practice of medicine, and lack of supervision violations.
  Measure: Program re-established and tracking the number of complaints to and outcomes from this unit.

- Restructure the Board's Probation Unit to transfer the monitoring of probations from investigators to inspectors. The investigators will be reassigned to the District Offices to decrease the number of cases assigned per investigator.
  Measure: A decrease in the length of time to conduct investigations.

Goal 3: Consumer Education

Increase public awareness of the Board's Mission, activities and services.

Objectives

- Complete a study of the public disclosure laws and take actions necessary to address issues identified.
  Measure: Study completed, with a report made available to the public via the Board's Web site and any recommendations that have been identified be presented to the Board.

  Recognition of excellence in medicine by California physicians
  Measure: Ensure annual award of recognition for excellence in medicine given to recipient and publicized on the Board's Web site.

  Improve education about the Board and its services to consumers including obtaining information on physicians.
  Measure: High levels of satisfaction reported by consumers who access educational material and other information on the Board's Web site.

Goal 4: Organizational Relationships

Improve effectiveness of relationships with related organizations to further the Board's Mission and goals.

Objectives

Establish a plan to include board members in meetings with legislators and other key stakeholders on various legislative proposals.
Measure: Increased support of the Board's legislative proposals.

Develop a plan for Executive Team or Supervising Investigators when appropriate to meet with legislative staff in district offices.
Measure: Increased awareness of the Board, its mission and services by legislative district offices.

Goal 5: Organizational Effectiveness

Enhance organizational effectiveness and systems to improve service to constituents.

Objectives

- Develop better ways of assessing Board "customer satisfaction" and implement changes that would better serve applicants, licensees and the public.
  Measure: High levels of satisfaction reported by customers who receive services or who access information on the Board's Web site.

- Reverse loss of investigators by identifying and addressing factors that are contributing to investigator retention problems. Perform a study to determine the difference in work performed and compensation between Board investigators and investigators from other State boards/agencies.
  Measure: Improve recruitment and retention of Board investigators.

  Implement the restructuring of the Board to ensure greater communication and synergy between enforcement and licensing divisions of the Board.
  Measure: Implementation is completed and all board members are educated regarding all Board issues.

  Perform a complete evaluation of the Licensing Program to identify areas for improvement.
  Measure: Evaluation completed and any recommendations for efficiency are implemented.

- Coordinate relocation of the Board's headquarters facilities and staff to improve operational efficiencies and to improve customer service.
  Measure: Consumers and other interested parties have improved access to the Board's services. Staff reports work environment more efficient.

  Develop consumer and licensee focused educational programs made available on-line from the Board's Web site to improve access statewide.
  Measure: Determine the number of individuals using these services and satisfaction with the courses.

  Improve organizational business processes through replacement of current information technology systems with state of the art user-friendly information technology (IT) software.
  Measure: When fully implemented staff reports significant improvement in business processes.

Conclusion

This plan seeks improve the efficiency and effectiveness of the Board to assure protection of the public and provide better service to licensees and consumers. This Board is also committed to including wellness of physicians as a priority for the Medical Board of California.

DRAFT

MEDICAL BOARD STAFF REPORT

AGENDA ITEM 8

DATE REPORT ISSUED:	November 2, 2007
ATTENTION:	Board Members
DEPARTMENT:	Medical Board of California (MBC)
SUBJECT:	Vertical Enforcement Report to Legislature
STAFF CONTACT:	Renee Threadgill

REQUESTED ACTION:
Board members approve submission of the report to the legislature regarding vertical enforcement as required by SB 231.

STAFF RECOMMENDATION:
Staff recommends the Vertical Enforcement (VE) model be fully and permanently integrated into MBC operations. Additionally, MBC should move forward with consideration of the feasibility of co-location between Health Quality Enforcement Section (HQES) and District Offices, where appropriate, and implementation of an information technology system interoperable with the current system used at Department of Justice (DOJ). The MBC and HQES of DOJ work together to create a manual similar to the MBC Enforcement Operations Manual that is modified to incorporate the VE model from the receipt of complaint until the resolution of any administrative action.

EXECUTIVE SUMMARY:
Statistical data collected by MBC during the pilot has shown a decrease in all of the time periods related to the investigation and prosecution of cases under the VE model. Staff concludes that significant benefits to both consumers and licensees are achieved under a VE model. Current pending legislation to extend the pilot and address issues of co-location and implementation of an interoperable information technology system is uncertain. If the legislature fails to pass legislation to extend the pilot program, the current statutes will become inoperative on July 1, 2008 and are repealed on January 1, 2009. With this in mind, senior management from MBC and HQES have met and committed to a plan that aligns with the above recommendations.

FISCAL CONSIDERATIONS:
There are no fiscal implications related to submitting this report.

However, there are fiscal implications associated with the implementation of an information technology system (IT) and co-location. Multifactor cost analysis regarding IT and co-location to be determined and in process.

PREVIOUS MBC AND/OR COMMITTEE ACTION:
SB 231 requires the Board to submit a report to the legislature regarding Vertical Enforcement. At the last MBC meeting in July 2007, the Members rejected the draft report to the legislature citing objections to the recommendations. At that time the Board approved the recommendation to seek legislation that would continue the VE pilot for another two years while strengthening the pilot by amending the enabling statute to eliminate confusion caused by the current statute as it relates to the ability of the deputy attorneys general to "direct" the investigator. Additionally the statute was to be amended to allow MBC to establish an MBC investigator series to include pay commensurate with the DOJ Special Agent classification. The legislation sought in compliance with this directive from the Board failed. This report is intended to fulfill the requirement pursuant to SB 231.

Draft

Report to the Legislature

Vertical Enforcement

November 2, 2007

Medical Board of California

Report to the Legislature
Vertical Enforcement

November 2, 2007

Table of Contents

Executive Summary 1

Introduction 4

Implementation 5

Findings and Analysis 8

APPENDIX A, History 23

APPENDIX B, Government Code Section 44

APPENDIX C, Vertical Prosecution Manual 48

Executive Summary

Over the years, the Legislature has periodically reviewed the MBC's performance and taken important steps to refine its operations to further improve public protection. (*Refer to Appendix A for detailed history).* Notably, in 1990, major reforms were initiated by SB 2375 (Presley, ch.1597, Statutes of 1990), including the establishment of the Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ). In so doing, the legislature consistently has sought to bring investigators and prosecutors together to investigate allegations of misconduct by physicians and surgeons. During the 2005-2006 session, the Legislature took yet another important step in this process by directing the MBC and HQES to implement the "vertical prosecution model" (herein referred to as vertical enforcement or VE) for such investigations (SB 231 (2005 Reg. Sess.), § 28). The legislative goal of this two-year VE pilot is to bring MBC investigators and HQES deputy attorneys general together from the beginning of an investigation with the goal of increasing public protection by improving coordination and teamwork, increasing efficiency, and reducing investigative completion delays.

The MBC and HQES have worked closely to implement the VE model. The statistical data collected by the MBC during the first 16 months of the VE pilot shows, when modified to exclude cases prior to implementation of the pilot, an overall decrease of 10 days in the average time to complete an investigation. This decrease was even more significant when consideration is given to fact that the MBC had continued to operate without sufficient investigator staffing and, while it was working to implement the VE model, MBC investigators were saddled with over 1,000 pending pre-2006 investigations. While data is limited, the VE pilot showed significant promise in the following areas:

1. Cases Closed Without Prosecution – The average number of days to close pre-VE cases was 145 days; after VE, it was reduced to 139 days.

2. Obtaining Medical Records – Prior to the VE pilot, it took an average of 74 days to obtain medical records; after VE, it was reduced to 36 days.

3. Obtaining Physician Interviews – Prior to the VE pilot, the average time between the initial request for an interview and the actual interview was 60 days; after VE, it was reduced to 40 days.

4. Obtaining Medical Expert Opinions – Prior to the VE pilot, the average number of days to obtain a medical expert opinion was 69 days; after VE, it was reduced to 36 days.

5. Obtaining HQES Filing – Prior to the VE pilot, the average number of days from investigative completion to the filing of an accusation was 241 days; after VE, it was reduced to 212 days.

6. Interim Suspension Order (ISO) or Temporary Restraining Order (TRP) – Prior to the VE pilot, it took 91 days from the receipt of the investigation to the granting of an ISO or TRO; after VE, it was reduced to 30 days.

Reducing investigative completion delays, however, is only one method of measuring improved public protection. The VE pilot was implemented by the Legislature in recognition of "...the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons," [and because of] "...the evidentiary burden in the board's disciplinary cases... (Gov. Code, §12529.6, subd. (a).)While difficult to objectively measure through statistics, improving coordination and teamwork between investigators and prosecutors significantly improves the quality of the investigation of these complex cases. Implementation of the VE pilot mandated by SB 231 has resulted in improvement in all of these areas.

During much of the 2005 legislative process, SB 231 contained provisions that provided for the transfer of MBC investigators to the DOJ, with the goal of creating a pure VE model where investigators and prosecutors were employed by the same agency, and worked together under a single chain-of-command in a common location. Ultimately, however, the legislature elected not to take this final step and, instead, established VE as a two-year pilot with investigators continuing to be employed by the MBC. The decision not to transfer MBC investigators to the DOJ has presented significant challenges to both agencies as they have worked together to implement the VE pilot. It also has resulted in the loss of experienced MBC investigators who, uncertain over their careers, have elected to seek employment with other law enforcement agencies offering higher salaries and lower caseloads of lesser complexity. Although the Board recommended legislation to allow co-location, implementation of a new information technology system that is interoperable with the same system used by the Attorney General's office, and to increase MBC investigator salaries to align with the salaries of DOJ investigative staff, the legislation failed. Legislation currently pending to address the issues of co-location, and implementation of the

interoperable information technology system is uncertain. If the legislature fails to pass legislation to extend the pilot program, the current statutes will become inoperative on July 1, 2008 and are repealed on January 1, 2009. Nonetheless, MBC and HQES met and have committed to continue VE absent enabling statutes as VE has been determined to be a more efficient and effective means of investigating MBC complaints. The lack of enabling statutes may challenge how MBC and HQES moves forward with VE. Moreover, this issue of two investigation tracking systems would be resolved immediately as DAGs and investigators would use the current information technology system (ProLaw) used by DOJ.

With the change in dynamics, senior management from MBC and HQES have met and committed to a plan that includes the following elements:

- Where practical, agree to co-locate DAGs in MBC district offices or Investigators in HQES offices. MBC and HQES continue to discuss the challenges of co-location including the fact that it may impact recruitment and retention of investigator staff at each field office. Historically the MBC established the location of district offices to encourage recruitment and retention, which was challenged by cost of living issues, the impact of heavy traffic patterns, and geographic barriers. MBC and HQES have agreed to review each MBC lease renewal opportunity to determine the appropriateness of co-location at each office location.
- MBC should purchase the current information technology system used by DOJ as soon as possible and convert from CAS to this interoperable system. Converting to this interoperable system will eliminate two incompatible complaint/investigation tracking systems and allow ease of interface between the two agencies.
- The current Vertical Prosecution Manual should be eliminated and replaced by a manual similar to the MBC Enforcement Operations Manual that is modified to incorporate the VE model from the receipt of complaint until the resolution of any administrative action. This should be accomplished on or before December 31, 2008.

Introduction

This report addresses the provisions of SB 231 (Figueroa, ch. 674, Statutes of 2005) that require the Medical Board of California (MBC or Board), in consultation with the Departments of Justice, Consumer Affairs, Finance and Personnel Administration, to make recommendations to the Governor and Legislature on the vertical prosecution pilot. (Gov. Code, § 12529.6) This landmark piece of legislation contained a number of legal and practical improvements to the Board's enforcement program, following a two-year study by the MBC's Enforcement Monitor.

Under SB 231, effective January 1, 2006, the MBC and the Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ) were required to implement a vertical prosecution (VP) model to conduct its investigations and prosecutions. Under this legislatively defined VP model, each complaint referred to a MBC district office for investigation is simultaneously and jointly assigned to a MBC investigator ***and*** an HQES deputy. The goal of this model is to increase public protection by improving the quality of investigations, increasing teamwork and efficiency, and shortening the time to resolve assigned cases. Additionally, the Board hoped this new relationship between MBC and DOJ would enhance the Board's ability to recruit and retain experienced investigators.

Throughout much of the legislative process, SB 231 contained a provision which specified that MBC investigators would be transferred to the DOJ, thus creating a more streamlined and centralized enforcement system to achieve the public protection goal. However, shortly before it was enacted, SB 231 was amended and this proposed transfer of investigators was deleted. Instead, as amended, SB 231 created a VP pilot under which investigators continued to be employed and supervised by the MBC while, at the same time, they are responsible for conducting investigations under the direction of HQES deputy attorneys general. While implementation of this unanticipated hybrid VP pilot has presented significant challenges to both agencies, based on the statistical data collected over the first 16 months of this pilot, it appears that the legislative goal of increasing public protection through faster and more efficient case resolution is being achieved. By law, this VP pilot becomes inoperative on July 1, 2008, and is repealed on January 1, 2009, unless a later enacted statute deletes or extends it.

This report presents:

- the significant steps taken by both MBC and HQES in the implementation of the VP pilot;
- the overall findings and statistical data showing the results of the VP pilot for the period of January 1, 2006 to April 9, 2007;
- recommendations of the MBC regarding the VP pilot; and
- summarizes an historical overview of the MBC enforcement program.

NOTE: The new vertical prosecution model impacts both the ***investigative*** and the ***prosecutorial*** phases of enforcement. Unlike a county district attorney's office, which is solely engaged in criminal prosecution, not all MBC cases lead to prosecution; therefore, vertical prosecution is a misnomer. MBC refers to the new model as a **vertical *enforcement* (VE) model**. Throughout this report, the vertical prosecution model will be referred to as the vertical enforcement (VE) model.

Implementation

On January 1, 2006, the Medical Board of California (MBC) and Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ) implemented the vertical prosecution model, as mandated by section 12529.6 of the Government Code (*Refer to Appendix B).* This model, a two-year pilot program, is a new concept never before implemented by another state agency. Implementation of this unique model, where members of the team are from two different governmental agencies with separate hiring authorities, communications systems, and chains-of-command, has presented significant challenges. To meet those challenges, MBC and HQES have taken significant steps, both individually and jointly, to successfully implement the program.

Vertical Enforcement as Defined in SB 231

Throughout much of the 2005 legislative process, SB 231 contained provisions, which specified that MBC investigators would be transferred to the DOJ, thus creating a more streamlined and centralized enforcement system. Since HQES is already statutorily responsible for prosecuting MBC cases, having the investigators under its jurisdiction seemed a logical choice. However, shortly before it was enacted, SB 231 was amended and this proposed transfer of MBC investigators was deleted. Instead, as amended, SB 231 created a pilot under which investigators continue to be employed and supervised by

MBC while, at the same time, they are responsible for conducting investigations under the direction of HQES deputy attorneys general. While the MBC investigative process is essentially unchanged under the VE model, the changes within HQES, both structurally and procedurally, have been more dramatic. For example, under the new VE model, HQES has been required to:

Develop a database for all cases referred for investigation, not just those that are prosecuted

Develop familiarity with all MBC policies pertaining to investigations

Become responsible for all elements of the investigative process on cases resulting in closure or prosecution

Provide case direction from the investigative stage through the prosecutorial stage

Prioritize a new workload, which included investigative and prosecutorial tasks

Implementation of this unique VE model mandated by SB 231 has proved challenging, with authority to direct investigators coming under HQES jurisdiction while, at the same time, authority for investigator supervision remaining with MBC. Both the MBC and HQES continue their efforts to meet and overcome these challenges, in a spirit of cooperation, to achieve the legislative goals of SB 231.

HQES and MBC met throughout calendar years 2005 and 2006 to discuss issues, such as: how to handle the large volume of pending pre-VE cases, protocols the agencies would utilize, how communication by the VE teams would be undertaken, and how success of the pilot would be measured. Senior management from both agencies discussed the global issues impacting the pilot, while task forces were established to examine pre-VE policies, create new procedures and select reporting formats.

Both agencies agreed the VE pilot included three basic elements. First, each complaint of alleged misconduct by a physician and surgeon referred to an MBC office for investigation must be simultaneously and jointly assigned to an MBC investigator and HQES deputy attorney general. Second, that joint assignment must exist for the duration of the case. Third, under the direction of a deputy attorney general, the assigned MBC investigator is responsible for obtaining the evidence required to permit the Attorney General to advise the MBC on legal matters such as whether a formal accusation should be file, dismiss the complaint, or take other appropriate legal action. (Gov. Code, § 12529.6.)

The MBC's Enforcement Operations Manual, a compilation of Enforcement Program policies and procedures, required modifications to comport with SB 231. After the revisions were made, they were carefully reviewed by both the MBC and HQES to ensure consistency and agreement. Because the Enforcement Monitor highlighted MBC's inability to meet the 180-day legislative goal for non-complex investigations and the one-year goal for complex investigations (Bus. & Prof. Code, §2319), efforts were undertaken to assess the MBC's policies. Consequently, new policies were developed to address delays encountered when seeking to obtain medical records and conducting physician interviews. MBC staff also defined the criteria for a "complex" investigation.[1] After applying this criteria to the current caseload, 40% of the caseload met the definition of "complex." SB 231 stated that investigations were under the "direction" of HQES; however, the statute did not define "direction" or provide guidance on how to implement the VE model. While initially unable to reach agreement on a joint manual, HQES, in January 2006, published its "Vertical Prosecution Manual for Investigations Conducted by Medical Board Investigators (First Edition, January 2006)," and both HQES and MBC published their "Joint HQE/MBC Vertical Prosecution Protocol (First Edition, January 2006)." HQES and MBC renewed their efforts to develop a joint manual and, in November 2006 successfully and jointly published their "Vertical Prosecution Manual (Second Edition, November 2006)." *(Refer to Appendix C.)*

The DOJ has also made significant modification to its ProLaw computer software used to track investigations and prosecutions. In an effort to overcome co-location barriers, HQES also installed upgraded computers in each MBC district office for use by the deputy attorneys general. A new investigative report format was instituted at the beginning of the VE model to enable investigators to advise DAGs of case progress on an ongoing basis. Minimally, the investigator and the assigned DAG will confer at three stages of an investigation: 1) upon initial case assignment; 2) prior to the interview with the subject physician, and 3) prior to the submission of case documents for an expert review.

Generally, new governmental programs are rarely implemented in a vacuum and the VE model was no exception to this rule. All new complaints received in MBC offices after January 1, 2006 have been investigated under the new VE model. However, as of December 31, 2005, there were 1,014 pending physician and surgeon cases under investigation. Thus, while HQES and MBC were in the process of

[1] On December 31, 2005, there were 140 allied health investigations in the MBC workload. This is also part of the MBC investigator workload from other DCA licensing boards and committees, in addition to the physician and surgeon cases which were the focus of the VE pilot.

implementing the VE model, they continued to handle this large volume of cases primarily under the former HQES Deputy-in-District-Office ("DIDO")[2] model, where, upon completion, the investigation was transmitted to HQES for prosecution. At the present time, the majority of these pre-VE cases have been resolved.

Findings and Analysis

SB 231 created a vertical enforcement (VE) pilot with investigative and prosecutorial team members in two separate agencies. While considerable progress has been made in developing new policies and procedures, defining participants' roles, and creating a team environment to implement the VE model, the fundamental structural barrier of having investigators employed by one agency, while their workload is being directed by employees of another agency, still remains. Notwithstanding those challenges, statistical data demonstrate that under the VE pilot, cases that should be closed are more quickly identified and egregious complaints are being handled more expeditiously – both resulting in a greater measure of public protection.

The statistical data collected by the MBC for the first 16 months of the VE pilot, when modified to exclude pending pre-2006 cases, shows an overall decrease of 10 days (from 146 to 136 days) in the average time to complete an investigation. Significantly, this decrease has been accomplished with existing staff, with no augmentation to restore the investigator positions lost during the FY 2002-2003.

The Legislature has established a goal that "...an average of no more than six months will elapse from the receipt of the complaint to the completion of the investigation." (Bus. & Prof. Code, § 2319.) That period is increased to one year for cases involving "...complex medical or fraud issues or complex recommendations to reduce investigative time lines, MBC identified those cases which would fit the definition of "complex" as discussed in the "Implementation" section of this report.

[2] Under the former Deputy-in-District-Office ("DIDO") program, which existed prior to the enactment of SB 231, a deputy attorney general was required to "frequently be available on location at each of the working offices at the major investigation centers of the Board, to provide consultation and related services and engage in case review with the Board's investigative, medical advisory, and intake staff." (Former Gov. Code, § 12529.5(b))

Initial statistical data from the pilot period identify trends which suggest the VE model can more quickly identify cases for closure and certain egregious complaints can be handled more expeditiously. The data also suggested progress in reducing the time frames to complete investigations. However, the pilot time frame was insufficient to address the Enforcement Monitor's concerns regarding the time to complete prosecutions. Since certain MBC investigations can take one year to conduct, the pilot time frame did not provide adequate time to measure the prosecutorial time line of such cases. It is anticipated that the time frame for the litigation phase will be lessened with the earlier involvement of the deputy attorney general in the case and the continuing availability of the investigator to assist at the hearing.

The MBC's Annual Reports and statistical data reported by the Enforcement Monitor were used to draw comparisons to the data accumulated during the VE pilot (January 1, 2006 through April 9, 2007).

MBC Annual Report Data Re: Time to Complete Investigations

The MBC's computerized data system, Consumer Affairs System (CAS), is used by the Board to gather data for its publications and Annual Report. As reported, the average number of days to complete an investigation was: 208 in FY 2002-03; 220 in FY 2003-04; 259 in FY 2004-05 and 277 in FY 2005-06. While this data shows an increase in the number of days to complete investigations, several significant factors which directly impact these numbers must be considered:

- Vacant and lost investigator positions lead to longer time lines to complete investigations. In FY 2002-03, the Governor's mandated staffing reduction lowered the number of investigators by 19.

- Beginning in FY 2002-03, and continuing to the present, MBC implemented changes pursuant to SB 1950 (Figueroa, ch. 1085, Statutes of 2002) which provided the Board with a new prioritization of complaints and investigations. The Board staff also took steps to reduce the number of cases sent to the district offices for investigation without impacting public safety concerns. Some complaints were resolved in the MBC Central Complaint Unit (CCU) via "cease and desist" letters; some complaints resulted in the issuance of citations: while other complaints e.g., violations involving criminal conviction, were forwarded directly to HQES. Elimination these simpler investigations from the district office workload has resulted in the field receiving only the more time-intensive and complex cases. Thus, the apparent increase in length of time necessary to complete investigations

appears to be the result, at least in part, the elimination of these less-complex investigations from the statistical data base.

- SB 1950, implemented in FY 2003-04, added section 2220.08 to the Business and Professions Code which requires CCU to have all quality-of -care complaints reviewed by a medical expert who is in the same specialty as the subject physician before these complaints were sent to the MBC district offices for formal investigation. This resulted in fewer cases being sent to the district offices. Some of these cases were marginal and often those cases were completed quickly when sent to the district office. With this procedural change, these cases were closed in CCU and impacted the average time for completion of investigations.

- Beginning in FY 2004-05, MBC instituted another procedural change to the way data was collected and reported. All citations initiated from CCU, including those stemming from a physician's failure to notify MBC of a change of address, were no longer reported as a complaint or an investigation. (They were only reported in the annual statistics as citations issued.) Previously these had been reported as cases opened and closed the same day, and impacted the average time for completed cases.

Monitor's Report: Cycle Time for Completed Investigations

The Enforcement Monitor focused attention on MBC's case cycle time (the time that elapses between receipt of a complaint to completion of the investigation related to that complaint). The Monitor's Initial Report presented time frames for completion of investigations by disposition and day range. Table 1 below indicates that, in FY 2003-04, the average elapsed time from receipt of an investigation to case resolution was 261 days, as reflected in the following chart:

Table 1 FY 2003-2004 Investigative Time Frames by Disposition and Day Range

Day Range	Non-Legal Closure		Referred for Legal Action		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	83	7.0	144	23.8	227	12.7
1 to 3 Months	133	11.2	36	6.0	169	9.4
3 to 6 Months	239	20.2	80	13.2	319	17.8
6 to 9 Months	248	20.9	69	11.4	317	17.7
9 to 12 Months	195	16.5	80	13.2	275	15.4
12 to 18 Months	206	17.4	110	18.2	316	17.7
18 to 24 Months	67	5.7	67	11.1	134	7.5
More than 24 Months	14	1.2	19	3.1	33	1.8
Total	1185	100.0	605	100.00	1790	100.00
Average Time Frame	256 days		269 days		261 days	

To contrast the Monitor's data, the same criteria was applied to the CAS data, for calendar year 2006 (the VE pilot period). On December 31, 2005, 1,014 physician and surgeon investigations were pending in the MBC district offices. In calendar year 2006, 1,090 physician and surgeon cases were referred to the field. Thus, 2,104 cases were in varying stages of investigation during this pilot period and the average elapsed time from receipt of an investigation to case resolution was 282 days, as reflected in Table 2 below.

Table 2 **CY 2006 Investigative Time Frames by Disposition and Day Range**

Day Range	Non-Legal Closure		Referred for Legal Action		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	25	3.3	107	24.7	132	11.0
1 to 3 Months	61	8.0	19	4.3	80	6.7
3 to 6 Months	128	16.7	68	15.7	196	16.4
6 to 9 Months	142	18.6	65	15.0	207	17.3
9 to 12 Months	164	21.4	44	10.1	208	17.3
12 to 18 Months	181	23.7	82	18.9	263	21.9
18 to 24 Months	52	6.8	36	8.3	88	7.3
More than 24 Months	12	1.5	13	3.0	25	2.1
Total	765	100.0	434	100.0	1199	100.0
Average Time Frame	296 days		256 days		282 days	

A comparison of Table 1 to Table 2 appears to reflect an increase in average case investigation time from 261 days (FY 03-04) to 282 days (CY 06). However, data modifications are necessary to both charts because they include a significant number of cases that were in the workload ***prior*** to the start of the time period under analysis. The 2003-04 chart also included workload that is no longer sent to the district offices, due to changes in MBC and CCU policies.

Table 3 below reflects these modifications. For cases that were initiated ***and*** completed during FY 2003-04, the average time to complete investigations was 146 days.

Table 3 **FY 2003-04 Investigative Time Frames by Disposition and Day Range for Investigations Initiated and Completed in FY 2003-2004 (This excludes out-of-state and headquarters cases.)**

Day Range	Non-Legal Closure		Referred for Legal Action		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	24	6.8	29	24.2	53	11.1
1 to 3 Months	76	21.3	17	14.2	93	19.5
3 to 6 Months	128	36.0	30	25.0	158	33.2
6 to 9 Months	99	27.8	31	25.8	130	27.3
9 to 12 Months	29	8.1	13	10.8	42	8.8
12 to 18 Months	0	0	0	0	0	0
18 to 24 Months	0	0	0	0	0	0
More than 24 Months	0	0	0	0	0	0
Total	356	100.0	120	100.0	476	100.0
Average Time Frame	148 days		139 days		146 days	

Table 4 below reflects investigative time frames for cases referred for investigation in 2006. Table 4 reveals that, under the VE model the average time to complete an investigation is 136 days.

Table 4 **CY 2006 Investigative Time Frames by Disposition and Day Range for Investigations Initiated and Completed in CY 2006 (This excluded out-of – state and headquarters cases.)**

Day Range	Non-Legal Closure		Referred for Legal Action		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	22	11.0	19	24.0	41	14.7
1 to 3 Months	47	23.5	13	26.5	60	21.5
3 to 6 Months	73	36.5	19	24.1	92	33.0
6 to 9 Months	38	19.0	22	27.8	60	21.5
9 to 12 Months	20	10.0	6	7.6	26	9.3
12 to 18 Months	0	0	0	0	0	0
18 to 24 Months	0	0	0	0	0	0
More than 24 Months	0	0	0	0	0	0
Total	200	100.0	79	100.0	279	100.0
Average Time Frame	136 days		133 days		136 days	

Table 4 data clearly indicates a reduced time for the disposition of all cases under the jurisdiction of the district offices.

Overview of Investigative Workload During the VE Pilot

The CAS data can be viewed in a different format to assess how investigations progressed during the VE pilot. Table 5 chart represents investigations that were in the system on January 1, 2006, as well as investigations which were added through December 31, 2006. The chart reflects the disposition of these investigations between January 1, 2006 and April 9, 2007:

Table 5 Investigation Dispositions CY 2006

Physician & Surgeon Investigations	Cases Closed with No Action			Citations Issued			Referred for Criminal Action			Referred for Prosecution				Investigations Pending	
	#	%	Avg Days	#	%	Avg days	#	%	Avg Days	# Primary Referral	# Consolidated Referrals	%	Avg Days	#	%
1014 pending on 1-1-07	569	56%	378	37	4%	380	17	2%	461	191	51	24%	447	149	14%
1090 opened between 1-1-06 & 12-31-06	305	28%	169	11	1%	198	9	1%	218	80	42	11%	186	643	59%

Investigations Pending on December 31, 2005

1,014 investigations were in the investigators' workload at the inception of the pilot. These investigations were in varying stages of development and may have had significant legal involvement under the former HQES DIDO program. While VE was being piloted, these cases also required attention from the newly formed VE teams. Table 5 above reveals that, of the 1,014 investigations, 569 or 56% of these investigations were closed, with an average completion time of 378 days. Of the remaining 445 investigations, action was taken as follows: 37 citations (4%) were issued; 17 investigations (2%) were referred for criminal action: and 242 investigations (51%) were identified for potential administrative action. Effective April 9, 2007, there were 149 pre-2006 investigations pending.

Investigations Opened After January 1, 2006

Table 5 above reveals that 1,090 investigations were opened and assigned to the VP teams during 2006 calendar year. The VE protocols were utilized in processing these investigations. Of the 1,090 investigations, 305 investigations (28%) were closed, with an average completion time of 169 days. Of the remaining 785 investigations, 13% resulted in the following actions: 11 citations (1%) were issued; nine investigations (1%) were referred for criminal action; and 122 investigations (11%) were accepted for administrative action. The data reveals that the average number of days from receipt of the investigation to the investigation completion and acceptance for administrative action averaged 186 days. Effective April 9, 2007, there were 643 investigations (59%) pending.

The data in Table 5 suggests that a large body of work was processed by the team members during this period of time. Of the 2,104 investigations, 874 investigations were closed, 48 citations were issued, 26 investigations were referred for criminal action, and 364 investigations were referred for administrative action. The VE teams worked on the older investigations in the system, as well as focused attention on the newer investigations.

In addition to decreased investigation completion and accusation filing times, the VE model has led to significant improvements in other areas that were the subject of concern by the Enforcement Monitor.

Comparison of Case Closure Data

Within the 2006 calendar year, it took an average of 135 days to close an investigation, which was determined to have "no violation," for those investigations opened during this same year. In FY 2003-04, it took 154 days. This data suggests the VE team is able to identify those investigations which should be removed from the investigative workload earlier in the time line.

During the VE pilot period, it took 139 days to close an investigation that had insufficient evidence to result in a prosecution, whereas in FY 2003-04 it took 145 days. This also suggests these types of investigations are being pulled out of the workload more quickly.

Delays in Obtaining Medical Records

The Enforcement Monitor reported there were significant delays in the time it took for MBC to obtain medical records. In FY 2003-04, the average time from a request for records by MBC to the receipt of all records was 74 days. Subsequently, the Enforcement Program instituted a zero-tolerance policy change for failure to provide medical records in a timely manner pursuant to Bus. & Prof. Code, § 2225 and § 2225.5. The policy was vetted through MBC and HQES, revised in the MBC Enforcement Operations Manual, and distributed to all investigative staff. For cases in the VE pilot assigned in calendar year 2006, the average time to retrieve records was 36 days.

MBC and HQES staff have been diligent to ensure the zero-tolerance policy is enforced and citations have been issued for failure to provide records in a timely manner. The VE pilot has enabled increased

participation by DAGs in record acquisition. It appears the involvement of the Department of Justice also has been instrumental in garnering cooperation from law offices, hospitals, physician offices and governmental entities in providing medical records expeditiously.

Delays in Physician Interviews

The Enforcement Monitor reported there were inconsistent MBC policies and, therefore, delays in conducting interviews with subject physicians. The average time between the initial request for an interview and the actual subject interview was 60 days. For investigations in the VE pilot assigned in calendar year 2006, the average time to request an interview with a physician to the completion of the physician interview was 40 days. The MBC and HQES staff have used their subpoena authority to compel a physician to appear for an interview when there have been delays in appearances.

Delays in Obtaining Medical Expert Opinions

The Enforcement Monitor reported MBC had a policy and a goal of obtaining the expert opinion in 30 days. In FY 03-04, the number of days between the time a completed investigation was sent to an expert reviewer and the time the expert opinion was returned to the investigator was 69 days. MBC data for the request and receipt of an expert opinion in the VE pilot is 36 days.

As part of the VE pilot, HQES DAGs were encouraged to interact with the medical consultants to ensure the appropriate medical expert was selected. This has reduced the number of times a subsequent expert opinion was necessary. The involvement of DAGs earlier in the investigation has served to identify the materials essential for the expert's review, thus elimination the need for the expert's review of unnecessary documents. When the expert opinion is returned, the DAG can quickly assess the opinion to determine if the expert has followed the guidelines and if the opinion has addressed all the substantive issues referenced in the complaint. If the expert opinion requires clarification, the DAG can readily request clarifying information, rather than waiting for the issue to be resolved at the time of trial. This also can eliminate the unnecessary filing of administrative charges.

Number of Accusations and Elapsed Time for HQES Filing

The Enforcement Monitor had concerns about the delays in filing accusations from the date HQES received the investigation. Table 6 below compares cases investigated from calendar year 2006 and accepted by HQES for administrative action between January 1, 2006 through April 9, 2007.

Table 6 Average days to file Accusation

	Accusations Filed				Number of accusations filed where the info from consolidated case is in Accusation (incl in Accusations filed also)	Amended Accusation filed based upon consolidated case information	Disciplinary Actions Taken	
	#	% of referred	Average days from completion of investigation to filing	Average days from completion of investigation to filing			#	Average days from completion of investigation to outcome
1014 investigations pending as of 1-1-06	102	53	569	110	23	9	36	217
1090 investigations were opened between 1-1-06 and 12-31-06	36	45	212	80	14	8	8	130

Investigations Pending on December 31, 2005[3]

Of the 1,014 (pre-VE) investigations pending in the MBC investigator workload, 242 investigations were accepted by HQE with an average of 447 days from the start of the investigation to the acceptance of the case. (Note: These include 191 primary referrals and 51 consolidated case referrals, which are subsequent cases on the same physician.) Table 6 above indicates that of the 242 investigations, 102 investigations (53% of the 191 primary referrals) resulted in the filing of an accusation by the end of CY 2006. The average number of days from the start of the investigation to this filing date was 569 days. The average time from investigation completion to the filing of administrative charges was 110 days. Final outcome was achieved for 36 investigations in an average of 217 days from the completion of the investigation to the final outcome.

[3] On December 31, 2005, there were 140 allied health investigations in the MBC workload. This is also part of the MBC investigator workload from other DCA licensing boards and committees, in addition to the physician and surgeon cases which were the focus of the VE pilot.

Investigations Opened After January 1, 2006[4]

Of the 1,090 investigations opened after January 1, 2006, 122 VE investigations were accepted by HQES for administrative action (80 primary referrals and 42 consolidated case referrals), with an average of 186 days from the start of the investigation to the acceptance of the case. Table 6 above indicates that of the 122 investigations, 36 investigations (45% of 80 primary referrals) resulted in the filing of an accusation by the end of CY 2006. The average time from the start of the investigation to this filing date was 212 days. (Note: As a comparison, for investigations opened in FY 2003-04 with filings within 15 months, it took an average of 241 days.) During the VE pilot, the average time from investigation completion to the filing of administrative charges was 80 days. (Note: In contrast, the FY 2003-04 Annual Report reflected 107 days for an investigation to progress to this point.) In the VE pilot, final outcome was achieved for eight investigations, in an average of 130 days form the completion of the investigation to the final outcome. (Note: As a comparison, for the investigations opened and resolved in calendar year 2004, with outcomes within 15 months, 161 was the average number of days.)

During the pilot, all prosecutorial time frames have decreased. It is significant to note that of the investigations initiated during calendar year 2006 which were accepted by HQES for the filing of an accusation, 45% already have an accusation filed. This suggests that having the legal review earlier in the investigation has led to quicker action on those cases that are filed.

ISO/TRO filings and Elapsed time for filing

The Enforcement Monitor was critical that MBC appeared to have underutilized the Interim Suspension Order (ISO) and Temporary Restraining Order, (TRO) tools that provide extraordinary relief from those physicians who may pose an imminent threat to public safety. Although the monitor did not measure elapsed time to obtain these orders, the time frame in FY 2003-04 from the receipt of the investigation to the granting of the orders was 283 days. In calendar year 2006, the elapsed time from the receipt of the investigation to the granting of these orders was 274 days. In FY 2003-04, the monitor noted 22 ISOs/TROs were granted, regardless of the date of when the investigation was initiated. From January

[4] During calendar year 2006, 183 new allied health investigations were opened. This is also part of the MBC investigative workload from other DCA licensing boards and committees, in addition to the physician and surgeon cases which were the focus of the VE pilot.

1, 2006 through December 31, 2006, 23 ISOs/TROs were obtained regardless of when the investigation was initiated. The numbers alone do not represent a significant increase. Upon further examination of the underlying case data, it was determined that six ISOs/TROs were granted in FY 2003-04 based upon investigations initiated during that same time frame and these took an average of 91 days. In contrast, in calendar year 2006, eight ISOs/TROs were granted based upon investigations initiated during this period, which took an average of 30 days. This data reflects a 67% reduction in the amount of time to obtain an ISO/TRO, thereby demonstrating enhanced public protection.

Successes, Challenges and Recommendations

Over the years, the Legislature has periodically reviewed the MBC's performance and taken important steps to refine its operations to further improve public protection. The implementation of the VE model mandated by SB 231 was another important step in that effort. The preliminary data suggests there have been decreases in all time frames relating to the investigation and prosecution of VE cases. This improvement has occurred even thought the MBC has experienced investigator retention and recruitment issues associated with the uncertainty of this pilot. HQES also had to fill nine vacancies and there is a learning curve associated with new employees. This suggests that in the future a full complement of experienced team members may lead to further decreases in the time frames of enforcement activities. There are positive and negative factors which impact the success of the current pilot, as detailed in the following pages:

Successes:

- 2,104 pending investigations were in process during the VE pilot period. 1,014 cases were pending prior to the VE pilot and 1,090 investigations were assigned during calendar year 2006. Of those, 1,312 reached disposition (865 pre-VE and 447 post-VE): 874 investigations were closed (569 pre-VE and 305 post-VE); 48 citations were issued (37 pre-VE and 11 post-VE); 26 investigations were referred for criminal action (17 pre-VE and nine post-VE); and 364 investigations were referred for disciplinary action (242 pre-VE and 122 post-VE).

- Investigations that result in a finding of no violation or insufficient evidence are being closed more quickly. In FY 03-04, it took 154 days to close "no violation" cases, while in calendar year 2006, it

took 135 days. In FY 03-04, it took 145 days to close "insufficient evidence" cases, while in calendar year 2006, it took 139 days. Both consumers and physicians directly benefit when such investigations are quickly resolved.

- Medical records are being obtained more quickly. In FY 03-04, it took an average of 74 days to obtain medical records. In calendar year 2006, it took an average of 36 days. Some of this reduction in time may be the result of law passed in 2005 giving MBC citation and fine authority for failure to provide records in 15 days. (Bus. & Prof. Code, § 2225 (d)).

- Physician interviews are occurring in a more timely manner. In FY 03-04, it took an average of 60 days to conduct interviews with subject physicians. In calendar year 2006, it took 40 days.

- The average time for receipt of a medical expert opinion has been reduced by 40%. In FY 03-04, it took an average of 69 days to obtain the medical expert opinion. In calendar year 2006, it took 36

  days. Implementation of a new policy compelling physicians to appear through use of subpoena power may have contributed to this time savings along with the attorney participation in the VE pilot.

- Accusations are being filed faster. In FY 03-04 it took an average of 241 days from the date the case was initiated to the date an accusation was filed. In 45% of the investigations initiated during calendar year 2006 through April 9, 2007 and approved for filing by HQES, accusations were filed within an average time of 212 days.

- Petitions for Interim Suspension Orders (ISOs) and Temporary Restraining Orders (TROs) in emergency cases are being filed faster. ISOs/TROs initiated in FY 03-04 took an average of 91 days. In calendar year 2006, they took an average of 30 days. Clearly, the assumption is that early involvement of a DAG reduces the time to initiate these actions.

While the VE pilot has plainly demonstrated substantial public protection benefits, it is unclear whether further significant improvements can be obtained under the present model. The loss of experienced MBC investigators as a result of continuing the pilot in its present state may ultimately undermine the

very public protection goals it was originally enacted to achieve. In this regard, the MBC presents the following.

Challenges:

There are retention problems with MBC investigative staff which have existed for many years due to factors common in many law enforcement agencies. Recruitment of entry level personnel followed by a number of years of training and experience creates a work force eligible for and interested in jobs found elsewhere outside of the MBC that, for a variety of reasons, including higher pay, may be more attractive. This problem may have been exacerbated recently with MBC investigators who were led to believe they might soon be transferred to DOJ (and receive a higher salary) and instead were engaged in a "pilot" study.

(Note: On January 1, 2006, MBC had 92 sworn staff position comprised of 71 investigators and 21 supervisors. On July 1, 2006, SB 231 augmented staff by four investigator positions, bringing the total to 96. Of the 96 authorized positions, there was an average statewide vacancy rate of 12.3% during calendar year 2006, which equates to 11.6 positions being vacant thereby resulting in an increased workload for the remaining investigators. From January 2006 to present, there were 19 investigator separations [six retired, two resigned, and 11 transferred]. Of the 11 transfers, two went to DOJ; two went to Corrections; five went to D of I; one went to Lottery; and one went to DHS. Although this vacancy rate may be consistent with other state agencies, when it is coupled with the time required for backgrounds and training, the impact is magnified.)

- In conducting exit interviews, many investigators have cited the major reason for such a high rate of exodus as due to MBC's lower salaries and more complex workload than other agencies. In addition, many retired investigators indicated that they may have chosen to work for more years if the workload were reduced and the pay increased.

- Some experienced MBC investigators also have been attracted to the DOJ special agent classification due to the prestige and enhanced benefits associated with that classification.

There is reason to believe the VE pilot may have hindered the recruitment efforts of MBC investigators. New applicants have questioned the future of the MBC investigator position and have been reluctant to join an investigative agency with such an uncertain future.

- Supervisory investigator positions have remained vacant for longer periods of time. Two supervisors chose to voluntarily demote and some investigators were reluctant to promote due to the changing environment and greater demands of VE.

- The VE pilot has led to some role confusion by DAGs and investigators as the terms "direction" and supervision," as used in the statute, were not clearly defined and are subject to interpretation.

Recommendation:

The statistical data collected by the MBC, while limited, has shown a decrease in all of the time periods related to the investigation and prosecution of cases under the VE model. MBC concludes that significant benefits to both consumers and licensees are achieved under a VE model and that this model should be fully and permanently integrated into the MBC operations. Additionally, the MBC should move forward with co-location, where appropriate, and implementation of an information technology system interoperable with the current system used at DOJ. The MBC and HQES should also work together to create a manual similar to the MBC Enforcement Operations Manual that is modified to incorporate the VE model from the receipt of complaint until the resolution of any administrative action.

Draft

Appendix A

History

Vertical Enforcement Defined

The term, "vertical prosecution" (VP), as defined in the Enforcement Monitor's Initial Report[4] refers to the continuous involvement of attorney and investigator team members as a case works its way through the investigative and prosecutorial process. Investigators and prosecutors work together in teams from the date a case is assigned for investigation. The purpose of this combined effort is to prepare complex investigations for trial or some other legal disposition. It is often visualized as a vertical chain of events beginning with investigation and proceeding to pleadings, preliminary examinations, pre-trial motions, trials and appeals. While these terms are common to criminal proceedings where VP is used, the majority of MBC cases will result in a disposition other than prosecution. The term "vertical enforcement" (VE) term more accurately describes the process of investigating MBC cases and includes those cases that will be closed without formal action.

In the VE model, the investigation benefits from having legal guidance and assistance from the HQES deputy attorney general at the initial assignment of the case. Under this model, the trial attorney and the investigator are assigned as a team to handle a complex case as soon as it is opened as a formal investigation. The team approach refers to the team assembled for a particular case, allowing for experts or certain specialists to be added to the case, as may be required. In some agencies, different teams are formed for different types of cases, thus maximizing training and the development of different working relationships.

While the prosecutor and the investigator work together during the investigative phase to develop the investigative plan and ensure the gathering of necessary evidence to prove the elements of the offense, they have very different roles. The prosecutor brings the expertise to anticipate legal defenses; provides legal analysis of the incoming evidence to help shape the direction of the case; assists with uncooperative subjects or third-party witnesses; deals directly with defense attorneys when issues arise; and addresses settlement or plea matters, which often arise early in such cases. In turn, the investigator contributes a peace officer's experience and insight into the investigative plan and case strategy; performs the

[4]Enforcement Monitor *Initial Report,* page 134 (including footnote #172)

Draft

field investigative tasks, including identification and location of witnesses and subjects; interviews witnesses and subjects; obtains and participates in the review of documentary and technical evidence; assesses criminal histories and other databases; identifies and assists with experts; plans and executes undercover operations; prepares affidavits and specifications for search warrants; serves warrants; makes arrests; assists with witnesses and evidence during the trial phase; prepares investigative reports; and conducts other tasks usually associated with the work of trained peace officers and professional investigators.

Enforcement Monitor's Recommendation

SB 1950 (Figueroa, c. 1085, Statutes of 2002) appointed an Enforcement Monitor to study the Medical Board of California's Enforcement Program. The study began in November 2003 and occurred over two years. During the first year, the study was devoted to 10 areas including: mission; resources; management structure; complaint, investigation and disciplinary processes; and the use of medical consultants and medical experts.

During the second year, emphasis was placed on measuring any changes implemented by the MBC during year one, analyzing the last year's fiscal year data and assistance with the drafting and advocacy of legislation introduced as a result of the Enforcement Monitor's recommendations. The Enforcement Monitor's Initial Report, released November 1, 2004, included 55 recommendations relevant to the Board's enforcement program. ***(Refer to http://www.mbc.ca.gov/Pubs_Enforcementrept.htm for the full Initial Report.)***

The Enforcement Monitor's report concluded that the board's enforcement program was impeded by: time delays in the investigative process; inadequate coordination and teamwork between MBC investigators and HQES prosecutors; delays in procurement of medical records; ineffective policies relating to physician interviews; inadequate medical consultant availability and utilization; weaknesses in the medical expert program; need for ongoing training for MBC investigative staff; need for improved coordination with state and local prosecutors; ongoing problems with recruitment and retention of MBC investigators; need to update existing MBC training manuals; and, MBC investigators could benefit from improved access to various databases. While some of these issues were addressed immediately as the MBC implemented new policies and procedures, others could not be addressed without legislation.

Draft

The Enforcement Monitor recognized how MBC cases might benefit from the VE model. The Enforcement Monitor envisioned early and continuing attorney/investigator teamwork that is typically utilized by many other prosecutorial offices when handling complicated cases. Certain complex and difficult law enforcement investigations naturally lend themselves to this model and many MBC investigations involve highly technical medical issues, complicated facts, and multiple victims and witnesses.

The monitor envisioned elements of the vertical enforcement model to include:

- Early coordination of the efforts of attorneys, investigators, and other staff;
- Continuity of teamwork throughout the case;
- Mutual respect for the importance of the professional contributions of both attorneys and investigators and the value of having both available in all stages of the case; and
- Early designation of trial counsel, recognizing that the prosecutor who ultimately puts on the case must be assigned from the case's inception to help shape and guide it because any investigation may have a trial as its ultimate outcome.

The Enforcement Monitor described concerns affecting the existing inadequate attorney-investigator coordination and teamwork. "The performance of the MBC's investigative staff and HQES prosecutors, and the nature of the working relationship between the HQES and MBC, have been studied closely in this project. MBC investigators and HQES prosecutors are hard-working and skilled professionals, and much good disciplinary work is done every day by these dedicated public servants. All parties acknowledge good faith and good efforts on all sides. However, there is clearly room for improvement in the cost, speed, and effectiveness of the administrative enforcement system as presently constituted, as indicated by the lengthy case cycle times and comparatively modest case outputs noted by the state Legislature and other critiques."[5]

[5]Enforcement Monitor's *Initial Report*, page 129

Draft

Vertical Enforcement as Defined in SB 231

Throughout much of the 2005 legislative process, SB 231 contemplated that MBC investigators would be transferred to the DOJ, thus creating a more streamlined and centralized enforcement system. Since HQES is already statutorily responsible for prosecuting MBC cases, having the investigators under its jurisdiction seemed a logical choice. However, shortly before it was enacted, SB 231 was amended and this proposed transfer of MBC investigators was deleted from the bill. Instead, as amended, SB 231 created a pilot under which investigators continue to be employed and supervised by MBC while, at the same time, are responsible for conducting investigations under the direction of HQES deputy attorneys general. While the MBC investigative process is essentially unchanged under the VE model, the changes within HQES, both structurally and procedurally, have been more dramatic. For example, under the new VE model, HQES has been required to:

- Develop a database for all cases referred for investigation, not just those that are prosecuted
- Develop familiarity with all MBC policies pertaining to investigations
- Become responsible for all elements of the investigative process on cases resulting in closure or prosecution
- Provide case direction from the investigative stage through the prosecutorial stage
- Prioritize a new workload, which included investigative and prosecutorial tasks

Implementation of this unique VE model mandated by SB 231 has proved challenging, with authority to direct investigators coming under HQES jurisdiction while, at the same time, authority for investigator supervision remaining with MBC. Both the MBC and HQES continue their efforts to meet and overcome these challenges, in a spirit of cooperation, to achieve the legislative goals of SB 231.

Draft

Historical Review: MBC Investigations and Prosecutions

The Medical Board of California is a semi-autonomous occupational licensing agency located within the state Department of Consumer Affairs (DCA). It has been in existence since 1876 when the Legislature first passed the Medical Practice Act. From its inception, there existed a need for the MBC to protect healthcare consumers through the vigorous, objective enforcement of the Medical Practice Act. This remains the MBC's mission today. The MBC has two fundamental responsibilities: licensing applicants under the Division of Licensing (DOL) and the investigation of complaints against its licensees, under the Division of Medical Quality (DMQ). The Enforcement Program, housed under DMQ, has made many improvements over the years to maximize efficiency. This historical review will highlight major events which led to the current structure of the MBC's Enforcement Program with an emphasis on the evolving relationship between the MBC investigative staff and the HQES prosecutors.

MBC Investigations During the Early Years

From 1876 to 1913, the Board of Medical Examiners (later renamed MBC) spent most of its energies trying to establish itself as a legal entity with jurisdiction over the medical profession. Little was done to discipline the physician community during this time. The MBC's Enforcement Program was not created until 1913 and initially consisted of one chief counsel and two special agents.

In the decades of the 1920s and 1930s many MBC investigations focused on fraudulent diploma "mills" which issued medical credentials, diplomas and licenses for a price. The Enforcement Program staff of four grew to a force of 10 individuals during this period. The state was divided in half with a Northern and a Southern Department. Little change occurred during the next two decades.

In the 1960s, the MBC Enforcement Program was responsible for investigating physician licensees as well as certain allied health licensees, as there was a similarity in the types of violations that were investigated. Common offenses involved improper use of prescription drugs, intemperance, illegal abortions and practicing medicine without a license.

Under Governor Ronald Reagan, a proposal was made and approved to centralize the investigative staff from all the licensing boards into one pool of investigators who were assigned to the newly created Division of Investigation under the renamed Department of Consumer Affairs (DCA). This included all the MBC

Draft

investigators. The restructuring would allow better organization and training of investigators, and the number of field offices could be expanded to certain geographic parts of the state which were under-served. With this reorganization, the Governor appointed a new chief over the Division of Investigation.

During this time, investigator caseloads often ranged from 75 to 100 cases, with a mix of violations. Cases involving physician misconduct could be discussed with the one medical consultant, who was available to the investigators periodically. In addition there was difficulty in monitoring the progress of investigations. By 1975, the number of DCA licensees had exceeded one million and the number of investigators had increased to more than 100. MBC complaints became backlogged over time and the Board was concerned about inadequate public protection.

MICRA and AB 1xx - 1975

In 1975, AB 1xx (Keene, 2nd Ex Sess., c.1, Statutes of 1975), known as the Medical Injury Compensation Reform Act of 1975 (MICRA), was created to provide relief from high malpractice insurance premiums and also included provisions for a massive reorganization of MBC. The Board's name was changed from the Board of Medical Examiners to the Board of Medical Quality Assurance. The new name was intended to better reflect the goal of assuring quality medicine to the citizens of California. Most important, it bolstered the Enforcement Program by increasing its staff by 54 additional technical, consultant, investigative and support positions.

Draft

In 1975, biennial physician licensing fees were increased to $175. MBC had sufficient funds to hire investigators who would again specialize in medical investigations. By 1976, approximately half of the investigators from the Division of Investigation were transferred, with their existing caseloads, to MBC, thus forming a new investigative unit.

In 1977, the Chief of Enforcement position was created. Under the direction of a supervising investigator, investigators worked with medical consultants who were now staffed in all field offices. If the evidence revealed a violation of law, the completed investigation was then transmitted, or "handed off," to a deputy attorney general (DAG) in the Department of Justice's Licensing Section. These deputies were located in four major metropolitan areas within the state. The DAGs were not specialized and received assignments involving all licensees under the DCA. MBC cases were commingled with the cases from the Division of Investigation and MBC investigations often received the same priority as cases involving licensed hairdressers, tax preparers and security guards.

The assigned DAGs reviewed the case file to determine if the evidence supported the filing of administrative action against a physician's license. Typically, the investigator and the prosecutor performed their roles separately. The workload volume was high, discussion of case evidence on individual cases was often limited and, in some cases, only occurred if the case went forward to hearing.

Reduced Board Investigator Staffing and Increased Workload

In July 1988, MBC had 700 complaints awaiting investigation. The Chief of Enforcement reported that since the creation of the Enforcement Program in 1977, all efforts to increase the staff had been denied by the Department of Finance, with the exception of two new investigator positions assigned to the probation surveillance program in 1979. He reminded the Board that three program audits, conducted by the Little Hoover Commission, the Department of Finance and Arthur Young International, had all recommended increasing the staffing of the enforcement program. Because the number of MBC investigators was not increased, annual complaints climbed from 4,265 in 1977 to 6,293 in 1988. In 1977, 2,539 investigations were opened and 2,089 were closed, while in 1988, 2,658 cases were opened with 2,561 closed.

Draft

The investigator staffing situation was further complicated in 1988, when the Governor authorized a "golden handshake" retirement option. A significant number of tenured investigators exercised this option to retire early with enhanced benefits and reduced the number of MBC investigators to 40. Faced with a significant number of vacant investigator positions, MBC made a focused effort to recruit, hire and train investigator replacements. The timing of this effort, however, was difficult, as all other state investigative agencies were also faced with vacant positions. Enforcement Program managers also recognized that some state agencies offered investigators caseloads of fewer than 10 cases while MBC investigators averaged 30 cases. Other state agencies were able to offer investigators significantly higher pay and some Board investigators took these offers of employment. Recruitment efforts, coupled with background investigations, also impacted the time span when a selected applicant could begin employment. It was generally recognized that basic training for a new MBC investigator required close supervision for a minimum of one year before the new employee could undertake independent work. The combination of these factors led MBC to take a different approach to address the staffing problem.

In April 1989, when responding to the Legislature on the issue of creating a toll-free number for consumers, the Board took the opportunity to inform the Legislature of its staffing needs to safely protect the public. The Board submitted a report to the Joint Legislative Budget Committee entitled, "*Special Budget Report: Curing the Backlog.*" The report detailed complaint increases over a five-year period and noted that during this same period, MBC had submitted budget requests for 30 additional positions to handle the case growth and resulting backlog. The report recommended 18 permanent new investigator and support staff positions to accommodate case growth, eight limited-term investigator positions, and two limited-term Complaint Analyst positions to eliminate the backlog.

At this same time, the Center for Public Interest Law (CPIL) released its report, *Physician Discipline in California: A Code Blue Emergency*. The report reviewed the MBC Enforcement Program and observed that while more complaints were received, fewer actions were filed and fewer physicians had been disciplined.

Draft

The CPIL report was critical of the existing structure whereby MBC had no control over the Licensing Section or the Office of Administrative Hearings, and expressed concern about the time necessary to complete some disciplinary actions. The report offered suggestions for change, including the creation of a unit of prosecutors within the Office of the Attorney General to specialize in medical disciplinary cases. All of these suggestions required legislation.

In May 1989, the Chief of Enforcement advised the Board of the need for additional investigators and detailed efforts by the Enforcement Program to increase MBC investigator's salaries, to be in parity with other comparable state investigative agencies. Based on this discussion, MBC agreed to increase its licensing renewal fees from $175 (1976) to $360 biennially. Later in the year, 18 permanent positions and 10 limited-term positions were added to the enforcement program and two new district offices were created in areas where most of the backlogged cases existed.

AB 184 (Speier c. 886, Statutes of 1989) changed the Board's name to the Medical Board of California, effective January 1, 1990. At this same time, a toll-free phone line was installed to make it more accessible to consumers and a Centralized Complaint and Investigation Control Unit (later referred to as CCU) was created for more efficient processing of complaints. This new structure allowed for improved communication with consumers on the status of their complaints and eliminated the backlog of unprocessed complaints. The centralized handling of complaints eventually led to redistribution and even workload assignments to the various district offices and allowed for consistency in the types of complaints that were formally investigated.

Significance of SB 2375

In 1990, SB 2375 (Presley, c. 1597, Statutes of 1990), also known as the Medical Judicial Procedure Improvement Act, was passed. This bill changed MBC's disciplinary process. It added Government Code § 12529 *et seq.* creating the Health Quality Enforcement Section (HQES) within the Department of Justice to specialize in prosecuting physicians and other health care practitioners. HQES was required to be "staffed with a sufficient number of experienced and able employees capable of handling the most complex and varied type of disciplinary actions against the licensees of the division or board." (Bus. & Prof. Code § 12529) HQES was also required to assign attorneys "to work closely with each major intake and investigatory unit... to assist in the evaluation and

screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations." (Bus. & Prof. Code §12529.5)

Bus. & Prof. Code § 2319 was added, requiring MBC to establish a goal that an average of no more than six months would elapse from receipt of a complaint to the completion of an investigation. Cases involving "complex medical or fraud issues or complex business or financial arrangements" had a goal of not more than one year from receipt to completion. A significant part of SB 2375 was devoted to amending Bus. & Prof. Code § 2229, redirecting the Board's primary priority from physician rehabilitation to public protection.

Recognizing the staff recruitment and retention difficulties of MBC, SB 2375 contained language stating, "It is also the intent of the Legislature that the pay scales for investigators of the Medical Board of California be equivalent to the pay scales for special investigative agents of the Department of Justice, in order to attract and retain experienced investigators." On April 20, 1990, MBC members voted to support SB 2375 with a specified amendment, which stated in part, "Add statutory provisions to raise Medical Board of California investigator salaries to prevent loss of experienced investigators to higher-paying agencies." The objective of the amendment was to get legislative intent recorded to say that the pay scales of the investigators of the Medical Board of California be increased to within 5% of the pay scales for the special agents of the Department of Justice in order to stem the loss of experienced investigators to higher paying state agencies, and to attract new investigators. This amendment was not incorporated, but the intent language stayed in the bill.

Draft

Efforts to Increase MBC Investigators' Salaries

Consistent with the intent language, in June 1990, the MBC took more action to increase investigators' salaries and provided detailed documentation to DCA outlining investigator vacancies and transfers. Analysis reflected that the duties and level of responsibility of the DCA Special Investigator series were comparable to the DOJ Attorney General investigator, who conducted Medi-Cal fraud investigations. However, in January 1991, DCA proposed that the salary level for the new DCA investigator classification series be aligned to the Department of Corporations investigator series. Three months later, the State Personnel Board established a new series for Investigator, DCA with a salary consistent with the Department of Corporations Investigator series. This represented a 10% salary increase, although MBC investigator salaries were still not aligned with the DOJ Special Agent series.

Response to SB 2375

In early 1991, all backlogged cases were assigned to MBC investigators. The MBC renewed its efforts to increase investigator staffing and received the support of both the Department of Finance and the State and Consumer Services Agency. Fourteen additional investigator positions and 10 support staff positions were requested. These positions were added to the new district offices and reduced caseloads from the 27-30 level, to the 20-23 level.

During this same year, the Office of the Attorney General implemented the provisions of Government Code §12529 and created the specialized HQES to handle disciplinary actions against physicians. Initially, the 22 deputies assigned to HQES set a goal of filing accusations within 60 days of receipt of a referred case. However, HQES was initially understaffed and cases became backlogged in its office.

In April 1991, an Auditor General report found that the MBC would be unable to complete investigations in a six-month period, noting that an average investigation took 14 months. This was attributed to an unusually high vacancy rate in MBC investigator positions and excessive caseloads. The report also found that HQES was taking approximately six months to file an accusation in a fully investigated case.

Draft

In the Fall of 1991, the MBC raised its licensing renewal fees to $400 biennially, and agreed to consider another fee increase to finance additional HQES staff.

In 1992, HQES experienced significant delays in filing accusations (486 days). There appeared to be a miscalculation on the number of hours it would require a DAG to review a case, draft pleadings, litigate and follow up on a case. The discussion resulted in an agreement by MBC to fund 27 additional DAG positions and four paralegal positions. To fund these DAG positions as well as more time for administrative law judges, the Board increased its biennial licensing renewal fee to $500.

SB 916

In 1993, SB 916 (Presley, c. 1267, Statutes of 1993) was passed and again revised the MBC's Enforcement Program. It included a number of provisions and authorized the MBC to increase its biennial licensing renewal fee from $500 to $600.

Investigator staffing problems were exacerbated in 1994 when DPA established a $200 recruitment and retention pay differential for Los Angeles County for incumbents in the Special Investigator and Senior Special classifications for the Department of Motor Vehicles and Employment Development Department. In 1995, the Department of Health Services was added. This same year, DCA submitted a request to DPA for investigator recruitment and differential pay; however, it was denied in 1996.

In March 1995, the Auditor General report, required by SB 916, noted that HQES deputies were assigned caseloads of 30. A backlog of unfiled cases was growing and HQES had requested funding to hire additional attorneys.

During this time, the MBC's Chief of Enforcement reported a 23% increase in complaint volume the prior two years, with no corresponding increase in staff. Investigator caseloads were growing, and there was a 10% vacancy rate in investigator positions because trained MBC investigators were leaving for other

Draft

agencies with higher pay and lower workload of lesser complexity. The Chief of Enforcement urged a fee increase to finance investigator positions and attorney positions, but this was denied. In 1996, when the complaint volume further increased and the time for completed investigations increased, the Board voted to seek legislation to increase the biennial licensing renewal fees. At this time, the Board's new executive director sought other fiscal efficiencies in the program and avoided the need for increased fees.

Creation of the "DIDO" Program

In 1997, the "Deputy In the District Office" or "DIDO" program was implemented. This program required a DAG to work in the MBC Central Complaint Unit and in the 12 offices one or more days a week to provide legal assistance and guidance throughout the "lifetime" of a complaint. Conceptually, the DAG would interact with board investigators, and give legal advice on a variety of matters. In CCU, the part-time DAG was primarily involved in the review of complaints and was asked to provide an opinion if a formal investigation was necessary. In the offices, the DAG assisted with active investigations (e.g., subpoena enforcement to help investigators obtain requested medical records; reviewing medical expert opinions to determine if the medical issues were sufficiently described; and reviewing all active cases before they were formally referred to HQES for prosecution).

HQES hoped the accusation filing time would drop from 134 days (in 1996) to 90 days as a result of the earlier involvement by an attorney in the investigative design and in the records procurement process. HQES met its goal of filing accusations in a more timely manner. However, the limited interaction allowed by the DIDO program was not always sufficient to match the time and complexity of the MBC investigations. The DAGs assigned to the DIDO Program also had other duties and responsibilities that sometimes prevented them from dedicating all their time to active MBC investigations. The DAGs were assigned active prosecution caseloads, which required them to review the case evidence, prepare legal correspondence, interact with defense counsel, prepare witnesses for testimony, draft subpoenas, prepare for settlement conferences and litigate cases. They were also required to present all cases through the appeals process before the Board, Superior Courts, Courts of Appeal, and Supreme Court. While balancing their trial calendar, DAGs would also provide legal assistance and guidance to investigators on active cases. However, when cases were formally transmitted to HQES, often a different DAG, other than the DIDO was assigned to the case.

Draft

Legal strategies sometimes differed, and investigators were sometimes given new direction on these referred cases. As with any "hand-off" method that involves the transfer of a case from one attorney to another, the DIDO model often resulted in a duplication of efforts and delays.

In the Fall of 1997, the MBC underwent "sunset" review by the Joint Legislative Sunset Review Committee. The average investigative time cycle to complete a case was 336 days and HQES averaged 134 days of elapsed time from receipt of a case to the filing of an accusation. The MBC investigator caseloads were still high.

In October 2001, Governor Davis imposed a hiring freeze. Although MBC is a special funded agency where salary savings would not assist the general fund deficit, MBC was required to cease the filling of any position which became vacant including investigator positions. During this year, MBC's Enforcement Program reduced the investigative cycle time to 204 days, and an average of 112 days elapsed between HQES receipt of a case and the filing of an accusation.

In Fall 2002, as a result of the continuing budget freeze and budget control language, MBC lost 15.5 positions, which included eight enforcement positions. The hiring freeze continued through FY 2002-03 and FY 2003-04 and imposed an additional 12% budget reduction in personnel. MBC lost a total of 44.8 positions (29 enforcement positions, which included 19 investigators and supervisors). MBC's investigator positions were reduced from 90 in FY 2000-01 to 71 by June 30, 2004, a 24% loss. Due to these same freezes, HQES lost six prosecutor positions assigned to the Los Angeles area.

Draft

Enforcement Monitor

In September 2002, SB 1950 (Figueroa, c. 1085, Statutes of 2002) was signed and made a number of changes to the MBC Enforcement Program. It created an "Enforcement Monitor," who was to be appointed by the DCA Director for a two-year period to study the effectiveness of the MBC Enforcement Program and extended the existence of the MBC until the monitor's findings and recommendations could be evaluated. SB 1950 authorized the MBC to increase its biennial fees from $600 to $610.

In 2003, several changes were implemented in CCU, utilizing "cease & desist" letters and other mechanisms, which resulted in the field receiving only the more time-intensive and complex investigations.

In August 2003, the Enforcement Monitor was appointed pursuant to SB 1950, and provided two reports to the Legislature. The Monitor's Initial Report, released November 1, 2004, described the existing investigative process and contained 55 recommendations for improvement to the Board's enforcement program. MBC implemented many of these recommendations; however, certain changes could not be made without legislation.

SB 231

In April 2005, SB 231 (Figueroa, c. 674, Statutes of 2005) was introduced. It underwent a number of amendments until it was signed by the Governor on October 7, 2005. An important part of this new legislation declared that "the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state government. Because of the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons, and the evidentiary burden in the board's disciplinary cases, the Legislature finds and declares that using a vertical prosecution model for those investigations is in the best interest of the people of California." When the Legislature closely studied this situation, they envisioned a need to improve the communication between the MBC investigators and DAGs with the goal of creating more efficient investigations and quicker case resolution.

Draft

Throughout calendar year 2005, MBC and HQES managers discussed options for implementing VE. The initial language in SB 231 contemplated the transfer of MBC investigators to HQES. Consideration was given to whether VE could be piloted in a designated geographic area, however this option posed several obstacles including investigator inequity, i.e., permitting a limited number of investigators to transfer to DOJ as special agents may be perceived as unfair by those investigators not permitted to transfer.

MBC researched what other VE models existed in state service. One of the few agencies utilizing a VE models is the DOJ's, Bureau of Medi-Cal Fraud (BMF). MBC recognized that the MBC structure was compatible with BMF and thus MBC could incorporate the BMF model. Major similarities exist between the MBC and BMF, as follows:

- BMF employs 106 sworn special agents, 31 deputy attorneys general (DAGs), 25 auditors and support staff *(MBC employs approximately 100 sworn investigators, and approximately 16 medical consultant positions. HQES is presently staffed with approximately 53 DAGs.)*

- BMF special agents and auditors are housed in 11 offices; prosecutors are located in four separate offices statewide *(MBC has 11 offices and prosecutors are located in four separate offices statewide).*

- The BMF VE triangle "team" consists of an agent, attorney and auditor and the triangle "spins" to focus attention on the lead person who is most responsible for the case at a given juncture. *(MBC's triangle team could consist of an investigator, attorney and, as necessary, a medical consultant.)*

- BMF cases are assigned to an intake special agent and a DAG via a DOJ software program called ProLaw, where documents, photos, audit reports, etc. can be scanned. *(MBC cases could be assigned via the CAS system which could be adapted to exchange information with ProLaw.)*

- BMF special agents and DAGs use computer docking stations and access ProLaw from various offices. *(MBC could acquire the equipment to implement this system.)*

Draft

- BMF case discussions are ongoing among the team members, are usually in person, and often take place where the evidence is located. DOJ supervisors can participate in any of these meetings. As necessary, team members communicate via their cell phone or by ProLaw. *(MBC could adopt this method of operation.)*

- BMF disputes regarding case resolution are resolved at the lowest level; however, the special agents can raise their concerns to the BMF Chief. The DAGs can raise their concerns to the BMF Chief DAG. Final dispute resolution rests with the Medi-Cal Fraud Director. *(MBC could adopt this resolution process.)*

SB 231 did not contemplate how the transfer of MBC sworn staff to DOJ would occur, nor was the discrepancy in classification addressed. MBC's Chief of Enforcement met with DOJ labor-relations personnel and learned that DOJ only has one classification for its sworn staff: Special Agent.

In September 2005, the Board's Executive Director met with the Senior Assistant Attorney General for HQES to consider a design for the VE relationship. They envisioned the replacement of the DIDO program with a team of deputies being assigned to each MBC office. They recognized that a significant number of MBC cases result in closure without disciplinary action, and therefore, vertical enforcement of these cases would not be necessary. The HQES team leader was construed to be an "advice and consultation" deputy, who in conjunction with the supervising investigator, would be responsible for assessing every case for its potential for administrative action. If a case was thought to present potential for prosecution, it would be assigned to a deputy to whom prosecutorial responsibility was attached. The major concern regarding the implementation of this model was the lack of sufficient staffing within the Los Angeles metropolitan area. The Senior Assistant Attorney General for HQES believed this model would be phased into various areas of the state as vacant DAG positions were filled.

On October 7, 2005, SB 231 was signed by the Governor. The final version of the law differed dramatically from what either MBC or HQEs had envisioned. Throughout much of the legislative process, SB 231 contemplated MBC investigators would be transferred to the Department of Justice, thus creating a more streamlined and centralized enforcement system. However, shortly before it was enacted, SB 231 was amended and this proposed transfer of investigators was deleted from the bill. Instead, as amended, SB 231 created the VE model under which investigators continue to be employed and supervised by the MBC while, at

Draft

the same time, are responsible for conducting investigations under the direction of HQES deputy attorneys general. SB 231 created a two-year pilot and required this report on the VE model to be submitted to the Legislature by July 1, 2007.

At the November 4, 2005 DMQ meeting, the Chief of Enforcement reported that SB 231 had been signed and a two-year pilot would begin, effective January 1, 2006. This pilot was viewed as a "first step" in a process which would culminate when the investigators and prosecutors were in the same agency.

HQE created a Lead Prosecutor who would be assigned to each office to review all incoming cases and a Primary Deputy who would be assigned to cases where prosecution would go forward. Flexibility would be necessary when deputies were called into trial and to ensure urgent priorities were expeditiously handled. To ensure all members of the team understood their respective roles in the process, new joint operating protocols would be needed. The protocols would clearly define the roles and responsibility of each member while staying focused on the ultimate goal, which was the timely and efficient completion of investigations and, where violations were uncovered, prosecution of the case.

In December 2005, all HQES deputies and MBC investigators attended joint meetings to discuss the implementation of the pilot. The content of SB 231 was discussed, and all attendees were encouraged to be flexible to adapt to necessary changes as the pilot unfolded. New MBC policies, impacted by this new relationship, and which had been vetted by MBC and HQES, were distributed to all participants. HQES deputies were assigned to specific MBC offices and the new teams were introduced. Questions were raised regarding the handling of the pending caseload, which was created under the former DIDO model. There was general agreement that a phasing-in process would be necessary to resolve these cases.

Draft

Implementation

On January 1, 2006, the Medical Board of California (MBC) and Health Quality Enforcement Section (HQES) of the Department of Justice (DOJ) implemented the vertical prosecution model, as mandated by Gov. Code section 12529.6. This model, a two-year pilot program, is a new concept never before implemented by another state agency. Implementation of this unique model, where members of the team are from two different governmental agencies with separate hiring authorities, communications systems, and chains-of-command, has presented significant challenges. To meet those challenges, MBC and HQES have taken significant steps, both individually and jointly to successfully implement the program.

HQES and MBC met throughout calendar years 2005 and 2006 to discuss issues, such as: how to handle the large volume of pending pre-VE cases, protocols the agencies would utilize, how communication by the VE teams would be undertaken, and how success of the pilot would be measured. Senior management from both agencies discussed the global issues impacting the pilot, while task forces were established to examine pre-VE policies, create new procedures and select reporting formats.

Both agencies agreed the VE pilot included three basic elements. First, each complaint of alleged misconduct by a physician and surgeon referred to an MBC office for investigation must be simultaneously and jointly assigned to an MBC investigator and HQES deputy attorney general. Second, that joint assignment must exist for the duration of the case. Third, under the direction of a deputy attorney general, the assigned MBC investigator is responsible for obtaining the evidence required to permit the Attorney General to advise the MBC on legal matters such as whether a formal accusation should be filed, dismiss the complaint, or take other appropriate legal action. (Gov. Code § 12529.6.)

The MBC's Enforcement Operations Manual, a compilation of Enforcement Program policies and procedures, required modifications to comport with SB 231. After the revisions were made, they were carefully reviewed by both the MBC and HQES to ensure consistency and agreement.

Draft

Because the Enforcement Monitor highlighted MBC's inability to meet the 180-day legislative goal for non-complex investigations and the one-year goal for complex investigations (Bus. & Prof. Code § 2319), efforts were undertaken to assess the MBC's policies. Consequently, new policies were developed to address delays encountered when seeking to obtain medical records and conducting physician interviews.

MBC staff also defined the criteria for a "complex" investigation[6] After applying this criteria to the current caseload, 40% of the caseload met the definition of "complex."

SB 231 stated that investigations were under the "direction" of HQES, however, the statute did not define "direction" or provide guidance on how to implement the VE model. While initially unable to reach agreement on a joint manual, in January 2006, HQES published its "Vertical Prosecution Manual for Investigations Conducted by Medical Board Investigators (First Edition, January 2006)," and both HQES and MBC published their "Joint HQE/MBC Vertical Prosecution Protocol (First Edition, January 2006)." HQES and MBC renewed their efforts to develop a joint manual and, in November 2006 successfully and jointly published their "Vertical Prosecution Manual (Second Edition, November 2006)." ***(Refer to Appendix.)***

HQES has also significantly revised many of its policies and procedures. For example, as part of its implementation of the VE model, HQES created the position of a "Lead Prosecutor" to be assigned to each of the MBC district offices. Lead Prosecutors are assigned, along with a second deputy attorney general, to each complaint referred to an MBC district office. At the outset, Lead Prosecutors determine whether a complaint warrants further investigation or should be closed. Since the majority of complaints referred to MBC district offices do not result in a the filing of disciplinary charges, the Lead Prosecutor acts as the primary deputy attorney general for the duration of the investigation. Whenever a Lead Prosecutor determines, whether upon initial review of the complaint, or as the investigation progresses, it is likely that a violation of law may be found, the second deputy attorney general assumes primary responsibility for the case for all purposes.

---

[6]On December 31, 2005, there were 140 allied health investigations in the MBC workload. This is also part of the MBC investigator workload from other DCA licensing boards and committees, in addition to the physician and surgeon cases which were the focus of the VE pilot.

Draft

The DOJ has also made significant modification to its ProLaw computer software used to track investigations and prosecutions. In an effort to overcome co-location barriers, HQES also installed upgraded computers in each MBC district office for use by the deputy attorneys general.

A new investigation report format was instituted at the beginning of the VE model to enable investigators to advise DAGs of case progress on an ongoing basis. Minimally, the investigator and the assigned DAG will confer at three stages of an investigation: 1) upon initial case assignment; 2) prior to the interview with the subject physician and 3) prior to the submission of case documents for an expert review.

Generally, new governmental programs are rarely implemented in a vacuum and the VE model was no exception to this rule. All new complaints received in MBC offices after January1, 2006, have been investigated under the new VE model. However, as of December 31, 2005, there were 1,014 pending physician and surgeon cases under investigation. Thus, while HQES and MBC were in the process of implementing the VE model, they continued to handle this large volume of cases primarily under the "DIDO" model, where, upon completion, the investigation was transmitted to HQES for prosecution. At the present time, the majority of these pre-VE cases have been resolved.

Draft

APPENDIX B

Government Code Section

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California including all committees under the jurisdiction of the board or a division of the board, including the Board of Podiatric Medicine, and the Board of Psychology. (b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions. (c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the division or board. (d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, and the committees under the jurisdiction of the Medical Board of California or a division of the board, and the Board of Psychology, with the intent that the expenses be proportionally shared as to services rendered. (e) This section shall become inoperative on July 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed. **12529**. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California including all committees under the jurisdiction of the board or a division of the board, including the Board of Podiatric Medicine, and the Board of Psychology, and to provide ongoing review of the investigative activities conducted in support of those prosecutions, as provided in subdivision (b) of Section **12529**.5. (b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the

Draft

Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions. (c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the division or board. (d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, and the committees under the jurisdiction of the Medical Board of California or a division of the board, and the Board of Psychology, with the intent that the expenses be proportionally shared as to services rendered. (e) This section shall become operative July 1, 2008. **12529**.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California or the Board of Psychology shall be made available to the Health Quality Enforcement Section. (b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to work on location at the intake unit of the boards described in subdivision (d) of Section **12529** to assist in evaluating and screening complaints and to assist in developing uniform standards and procedures for processing complaints. (c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards, division, or allied health committees, including the Board of Podiatric Medicine, in designing and providing initial and in-service training programs for staff of the division, boards, or allied health committees, including, but not limited to, information collection and investigation. (d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, the board, or allied health committee, including the Board of Podiatric Medicine, or the Board of Psychology, as appropriate in consultation with the senior assistant. (e) This section shall become inoperative on July 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed. **12529**.5. (a) All complaints or relevant information concerning

Draft

licensees that are within the jurisdiction of the Medical Board of California or the Board of Psychology shall be made available to the Health Quality Enforcement Section. (b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to assist the division and the boards in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit of the boards, to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations. A deputy attorney general of the Health Quality Enforcement Section shall frequently be available on location at each of the working offices at the major investigation centers of the boards, to provide consultation and related services and engage in case review with the boards' investigative, medical advisory, and intake staff. The Senior Assistant Attorney General and deputy attorneys general working at his or her direction shall consult as appropriate with the investigators of the boards, medical advisors, and executive staff in the investigation and prosecution of disciplinary cases. (c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards, division, or allied health committees, including the Board of Podiatric Medicine, in designing and providing initial and in-service training programs for staff of the division, boards, or allied health committees, including, but not limited to, information collection and investigation. (d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, the board, or allied health committee, including the Board of Podiatric Medicine, or the Board of Psychology, as appropriate in consultation with the senior assistant. (e) This section shall become operative July 1, 2008. **12529**.6. (a) The Legislature finds and declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state **government**. Because of the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons, and the evidentiary burden in the board's disciplinary cases, the Legislature finds and declares that using a vertical prosecution model for those investigations is in the best interests of the people of California. (b) Notwithstanding any other provision of law, as of January 1, 2006, each complaint that is referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney

Draft

general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so assigned shall, under the direction of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action. (c) The Medical Board of California, the Department of Consumer Affairs, and the Office of the Attorney General shall, if necessary, enter into an interagency agreement to implement this section. (d) This section does not affect the requirements of Section **12529**.5 as applied to the Medical Board of California where complaints that have not been assigned to a field office for investigation are concerned. (e) This section shall become inoperative on July 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute, that is enacted before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed. **12529**.7. By July 1, 2007, the Medical Board of California, in consultation with the Department of Justice, the Department of Consumer Affairs, the Department of Finance, and the Department of Personnel Administration, shall report and make recommendations to the Governor and the Legislature on the vertical prosecution model created under Section **12529.6**.

Draft

APPENDIX C

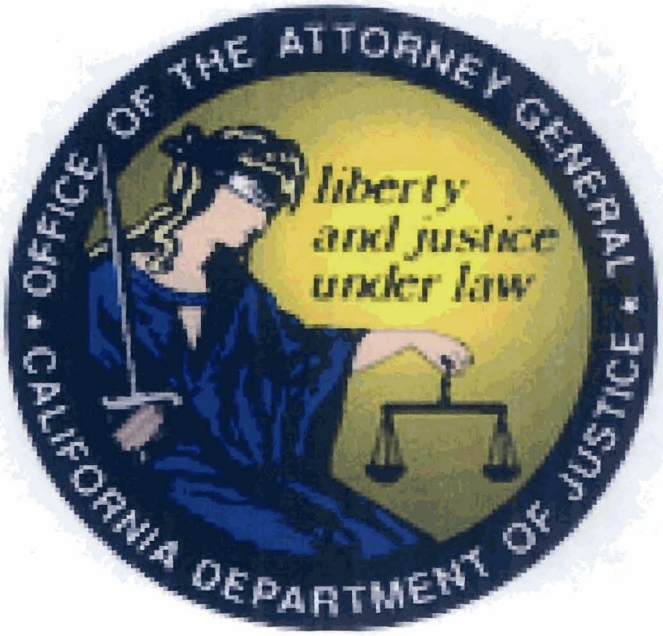
Vertical Prosecution Manual (Second Edition, November 2006)

Vertical Prosecution Manual

(Second Edition, November 2006)

Health Quality Enforcement Section
Office of the Attorney General
of the State of California

Medical Board of California
Department of Consumer Affairs



Carlos Ramirez
Senior Assistant Attorney General
Health Quality Enforcement Section

David T. Thornton
Executive Director
Medical Board of California

11-20-06

Table of Contents

Preface		**1**
I.	**The Vertical Prosecution Team**	**2**
II.	**Vertical Prosecution Under Senate Bill 231**	**3**
III.	**Cooperation and Consultation in Direction and Supervision**	**4**
IV.	**Direction of Investigation**	**4**
V.	**Lead Prosecutor**	**5**
VI.	**Receipt of Complaint and Assignment of Staff**	**6**
VII.	**Investigation Plan and Progress Report**	**7**
VIII.	**Documentation of Significant Communications**	**8**
IX.	**Investigation Reports**	**8**
X.	**Periodic Review of Ongoing Investigations**	**9**
XI.	**Witness Interviews**	**9**
XII.	**Pagination of Investigation Material Before Transmittal to Expert**	**9**
XIII.	**Acceptance of Cases for Prosecution**	**10**
XIV.	**Content of Investigation File**	**10**
XV.	**Approval of Proposed Closure of Investigation**	**10**
XVI.	**Submissions of Proposed Accusations for Filing**	**11**
XVII.	**Filing of Requests to Set with the Office of Administrative Hearings**	**11**
XVIII.	**Subpoena Review and Enforcement**	**11**
XIX.	**Interim Orders of Suspension and Penal Code Section 23 Appearances**	**11**
XX.	**Petitions for Competency, Physical and Mental Examinations**	**11**
XXI.	**Administrative Hearings**	**12**
XXII.	**Disagreements**	**12**
XXIII.	**Statistical Measure of Efficiency of the Vertical Prosecution Model**	**12**
XXIV.	**Implementation of the "Vertical Prosecution Model" with Existing Staff**	**13**
XXV.	**Future Revisions to this Manual**	**13**

The Vertical Prosecution Team:

Vertical prosecution is based on the team concept with each member working together with other members to achieve the common goal of greater public protection for the people of California. The development of a cohesive and positive team based on respect for the vital roles played by each team member is critical to the success of this pilot program. The following is a description of the duties, responsibilities and vital roles of each member of the vertical prosecution team.

- Investigators develop and update investigative plans, conduct fair, impartial and thorough investigations and participate in the administrative hearing process, all under the supervision of their Supervising Investigators I and II, Deputy Chiefs, and Chief of Enforcement, and direction of the assigned Primary Deputy Attorney General.

- District Medical Consultants provide medical input and assistance through review of medical records, participation in subject interviews, selection of expert reviewers and evaluation of expert opinions, all under the supervision of their Supervising Investigators I and II, Deputy Chiefs, and Chief of Enforcement, and direction of the assigned Primary Deputy Attorney General.

- Supervising Investigators I supervise a staff of assigned investigators, medical consultants, investigator assistants and clerical staff to ensure the forward progression of the caseloads for which they are responsible. Supervising Investigators I are responsible for ensuring that cases are investigated in a timely and efficient manner and in conjunction with directions from the Primary Deputy Attorney General and that investigator support continues through the prosecution of the case when disciplinary charges are filed. Supervising Investigators I also complete monthly reports, monitor case progress through quarterly case reviews and handle personnel matters as necessary.

- Supervising Investigators II supervise a staff of Supervising Investigators I assigned to a geographical area and oversee the general operation of that area. Supervising Investigators II develop and implement board policy, are the first-line resolution attempt at the citation and fine informal conference, sign subpoenas duces tecum, develop, coordinate and implement training, handle complex personnel matters and act as a liaison with other government entities.

- Deputy Chiefs directly manage a staff of Supervising Investigators II, as well as the overall enforcement operations program, including training, internal affairs, background investigations and probation.

- The Chief of Enforcement supervises the Deputy Chiefs and manages the overall enforcement program to facilitate its efficient operation.

Primary Deputy Attorneys General work closely with other team members and, in conjunction with Supervising Investigators I, direct investigators in the obtaining of evidence. Primary Deputy Attorneys General provide legal advice to the client and prosecute the case when disciplinary charges are filed.

- Lead prosecutors are assigned to specific Board district offices, act as the principal liaison to that office, are jointly assigned with another deputy on each case, act as the Primary Deputy Attorney General when so assigned and, when not so assigned, continue to monitor the progress of the investigation and appropriateness of directions from the Primary Deputy Attorneys General.

- Supervising Deputy Attorneys General supervise and provide support for their Deputy Attorneys General, oversee and monitor investigations within their respective geographical areas, and supervise the prosecution of cases when disciplinary charges are filed.

- Senior Assistant Attorney General, HQE, in conjunction with the Executive Director of the Medical Board, oversees and bears responsibility for all investigations and prosecutions within the jurisdiction of the Board's Enforcement Program.

II. Vertical Prosecution Under Senate Bill 231:

The three principle elements of the "vertical prosecution model" can be briefly summarized as follows:

> 1. Each physician and surgeon complaint referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation.
>
> 2. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter.[1]
>
> 3. During the assignment, the investigator so assigned shall, under the direction of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action. (Gov. Code, § 12529.6.)

While the Legislature has expressly limited the mandatory use of the "vertical prosecution model" to cases involving physicians and surgeons (Gov. Code, § 12529.6, subd. (a)), HQE and the Medical Board have determined that it shall be used in cases involving all licensees and applicants within the jurisdiction of the Board, except criminal cases.

III. Cooperation and Consultation in Direction and Supervision:

The fundamental purpose underlying the vertical prosecution pilot program is to bring investigators and deputy attorneys general together from the beginning of an investigation in order to improve coordination and teamwork, increase efficiency, and reduce investigation completion delays, all with the overall goal of increasing public protection. At the same time, however, it is important to recognize that the authority and responsibility to supervise investigators remains vested in Supervising Investigators I and II who continue to play an essential and vital role in both the Medical Board's Enforcement Program, as well as the success of this pilot program.

It is vitally important that Supervising Investigators I and II and deputy attorneys general cooperate and consult with each other in order to provide consistent, clear instructions to investigators. By doing so, Supervising Investigators I and II and deputy attorneys general will not only help achieve the legislative goals underlying this vertical prosecution pilot program but, at the same time, help reduce instances where an investigator is unsure whom he/she works for or feels torn between two sets of inconsistent instructions.

In exercising the statutory authority of direction under Government Code section 12529.6, deputies should be careful not to do so in a manner that undermines the supervision authority of Supervising Investigators I and II. Likewise, Supervising Investigators I and II should be careful not to exercise their supervision authority in an manner that undermines the direction authority of deputy attorneys general. Cooperation and consultation are the keys to ensuring these expectations are met.

IV. Direction of Investigation:

Teamwork is an essential component of the Legislature's new "Vertical Prosecution Model" which brings investigators and deputy attorneys general together from the very beginning of an investigation through closure or completion of the prosecution. The shared goal of both the Board and HQE in implementing the Legislature's new "Vertical Prosecution Model" is to improve the quality of both investigations and prosecutions of cases involving alleged misconduct by licensees.

Variations of vertical prosecution are employed by many law enforcement agencies. Such models generally rely on a team concept that typically involves the joint assignment of an investigator and prosecuting attorney, the latter with responsibility and authority to direct the investigator in the accumulation of evidence necessary to evaluate and, if violations of law are discovered, prosecute the case. The "Vertical Prosecution Model" enacted by the Legislature in Senate Bill 231 is such a model with the single notable exception that, here, the investigators are employed by the Board and the attorneys by the California Department of Justice. Prior to the enactment of Senate Bill 231, investigators worked at the direction of their Supervising Investigators I and II, Deputy Chiefs, and the Chief of Enforcement, when conducting an investigation. However, effective January 1, 2006, Senate Bill 231 requires that investigators work at the direction of their jointly assigned deputy attorney general. (Gov. Code, § 12529.6, subd. (b).)

"Direction," as that term is used in section 12529.6, includes, but is not limited to, the authority and responsibility to direct the assigned investigator to complete investigative tasks, obtain required testimonial and documentary evidence, make periodic reports regarding the progress of the investigation, and complete additional tasks necessary to prepare and present the case for hearing.[2] Such authority and responsibility also includes setting investigative priorities in conjunction with the Supervising Investigator I, monitoring the progress of the investigation to ensure its completion in a timely and efficient manner, determining when an investigation should be closed as well as when an investigation is completed such that the case is appropriate for acceptance by HQE for prosecution.

Investigators continue to work under the supervision of the Supervising Investigator I of the District Office.[3] It is anticipated that Supervising Investigators I and II, Deputy Chiefs, and the Chief of Enforcement will assist in ensuring that investigators complete investigative assignments, as directed by the assigned deputy attorney general, in a timely and efficient manner.

While the passage of Senate Bill 231 represents a significant change with regard to who makes the ultimate determination regarding the manner, extent and duration of each investigation, as a practical matter, deputy attorneys general and Board investigators will continue to work as a strong team with each member contributing his or her own unique talents to the investigation and prosecution of physician disciplinary matters.

V. Lead Prosecutor:

As part of the implementation of Senate Bill 231, the new position of Lead Prosecutor has been created. One Lead Prosecutor shall be assigned to each of the Board's District Offices.[4] The Lead Prosecutor shall be physically present at the assigned District Office to the extent that it is necessary to fully discharge his or her responsibilities, as described herein.

The Lead Prosecutor shall be assigned to, and shall review, each complaint referred to the District Office for investigation. In addition to the Lead Prosecutor, a second deputy attorney general shall be assigned by the Supervising Deputy Attorney General to each complaint as well. The Lead Prosecutor shall act as the primary deputy attorney general on the case for all purposes until and unless replaced by the second deputy attorney general, as described below.

An investigator shall be jointly assigned to the case by his or her Supervising Investigator, in consultation with the Lead Prosecutor. The investigator shall work with, and at the direction of, the Lead Prosecutor as the primary deputy attorney general on the case.

The Lead Prosecutor shall determine whether the complaint warrants further investigation or whether it should be closed without further investigation. If the Lead Prosecutor determines an investigation should be closed without further investigation, he or she should consult with the Supervising Investigator I. Disputes regarding whether a complaint merits further investigation should be handled in accordance with Section XXII, below.

If the Lead Prosecutor determines that the complaint warrants further investigation, he or she will so inform the assigned investigator who, in turn, shall prepare a plan of investigation. (See Section VII, below.) Except as noted below, the Lead Prosecutor shall review and approve, with or without modifications, the original plan of investigation submitted by the assigned investigator.

In some cases, the Lead Prosecutor will function as the primary deputy attorney general throughout the investigation and prosecution of the case. Whenever the Lead Prosecutor determines, either upon review of the original complaint or as the investigation progresses, that it is a likely a violation of law may be found, the second deputy attorney general shall replace the Lead Prosecutor as the primary deputy attorney general on the case for all purposes. The Lead Prosecutor will promptly notify the assigned investigator and his or her Supervising Investigator I, in writing, of any such transfer of primary responsibility. Copies of this new assignment shall be sent to the Supervising Deputy Attorney General, Supervising Investigator II, Deputy Chiefs and Chief of Enforcement. Following transfer of responsibility, the Lead Prosecutor shall continue to monitor the progress of the investigation and appropriateness of directions from the primary deputy attorney general.

It is anticipated that the second deputy attorney general shall immediately become the primary deputy attorney general in all cases involving allegations of sexual abuse or misconduct, mental or physical illness affecting competency to practice medicine, and complex criminal conviction cases.

VI. Receipt of Complaint and Assignment of Staff:

Upon receipt of a complaint from the Central Complaint Unit, the Supervising Investigator I will review and assign the complaint. The supervisor will enter the assigned investigator name into the CAS system. The Supervising Investigator I will notify the Lead Prosecutor of the assignment and provide the Lead Prosecutor with a hard or electronic copy of the complaint.

The Lead Prosecutor will enter the case into ProLaw and assign him or herself as the primary deputy attorney general, except for complaints involving sexual abuse or misconduct, mental or physical illness affecting competency to practice medicine, and complex criminal conviction cases. The Lead Prosecutor will insert in the Prolaw "Notes" tab (second tab in the Matters module), under the SYNOPSIS, the following additional information regarding the case: (a) the name of the investigator assigned to the case; (2) whether the case is appropriate for an ISO or other pre-accusation relief; and (3) any other information the Lead Prosecutor determines is significant. The Lead Prosecutor will then send an e-mail which includes all of the information in the Notes Tab to the Supervising Deputy Attorney General and Supervising Investigator I.

The Supervising Deputy Attorney General will assign a second deputy attorney general to the case. Even though a second deputy is assigned, the Lead Prosecutor will remain as the "primary" on the case, i.e., the deputy responsible at any given time for the direction of the investigation. However, when it appears likely that the investigation will result in the filing of an accusation, a petition for pre-accusation relief or a civil action, or when the investigation

involves allegations of sexual abuse or misconduct, mental or physical illness affecting competency to practice medicine or criminal conviction cases in a complex matter, the second deputy will be made the "primary." While the Lead Prosecutor will remain assigned to the case and will continue to monitor the case, only the primary deputy attorney general will direct the investigation.

The Supervising Deputy Attorney General will send an e-mail to the Lead Prosecutor, second DAG, and Supervising Investigator I notifying them that the case has been assigned and identifying who shall be the primary deputy on the case. If and when the primary deputy changes from the Lead Prosecutor to the second deputy, the Supervising Deputy Attorney General will send an e-mail to the investigator notifying him or her of the change and copy the Lead Prosecutor and the Supervising Investigator I.

The Supervising Deputy Attorney General will send an e-mail to his or her secretary with instructions to open the physical investigative file and to deliver that file to the primary deputy on the case. The secretary will deliver the physical investigative file to the primary deputy.

The Supervising Investigator I will enter the primary deputy attorney general assignment into the CAS Supervisor Notebook.

VII. Investigation Plan and Progress Report:

Each investigation shall begin with the development and approval of a plan of investigation. The plan shall be updated as significant events occur, as tasks are completed, and as the plan is changed. While it is expected that the primary deputy attorney general and investigator will regularly discuss all aspects of the case, all updates and changes to the plan are to be documented as provided below.

Within five (5) business days of an initial assignment of an investigation, the assigned investigator shall prepare, and submit to the primary deputy attorney general for review and approval, a proposed plan of investigation.[5]

In preparing the initial IPPR, the assigned investigator, should discuss the proposed investigative plan with his/her Supervising Investigator I, as necessary. The initial IPPR should contain the steps the investigator believes are most appropriate for the timely and efficient investigation of the case. Upon completion, the initial IPPR should be submitted by the assigned investigator to the primary deputy attorney general electronically as an e-mail attachment, with a copy sent to the Lead Prosecutor and Supervising Investigator I.

Within five (5) business days of receipt of the initial IPPR, the primary deputy attorney general shall review and approve the plan, with or without required changes or modifications, by way of a reply e-mail sent to the assigned investigator and copied to the Supervising Investigator I, Lead Prosecutor (if not the primary) and Supervising Deputy Attorney General. The primary deputy attorney general shall insure that a copy of the initial approved IPPR is placed in the Attorney General's ProLaw program.

The investigation is to be conducted pursuant to the IPPR. The assigned investigator and primary deputy attorney general should discuss proposed changes or modifications to the initial IPPR, as necessary and, if approved by the primary deputy attorney general, such changes or modifications should be confirmed in writing by e-mail.

The assigned investigator and primary deputy attorney general shall maintain a running e-mail thread, replying and communicating to each other by adding information to the e-mail thread as the investigation progresses which will then serve as ongoing documentation of the progress of the investigation. The primary deputy attorney general is charged with the responsibility of maintaining a copy of that running e-mail thread in the Attorney General's ProLaw program.[6]

As the investigation progresses, significant events occur and investigative tasks are completed, the assigned investigator shall keep the primary deputy attorney general informed by way of the running e-mail thread.

The assigned investigator shall inform the primary deputy attorney general in writing, by way of the running e-mail thread, of the dates of significant witness interviews, including the initial physician interview. The primary deputy attorney general shall notify the investigator if he or she will be participating in an interview. If so, the primary deputy attorney general, assigned investigator and District Medical Consultant (if he or she will be present for interview) should discuss the topics each will cover during the interview.

Finally, primary deputy attorneys general and investigators are reminded of the importance of sending copies of the initial IPPR and subsequent IPPR e-mails to both the Lead Prosecutor and Supervising Investigator I. This is essential since they are charged with insuring the overall efficient operation and timely completion of the investigation.

VIII. Documentation of Significant Communications:

All significant communications between the primary deputy attorney general and assigned investigator shall be reduced to writing by the originator of the communication. In addition to the initial IPPR and subsequent IPPR e-mails, it is recommended that these communications be documented by e-mail. Copies of all such e-mails shall be maintained by the primary deputy attorney general in the investigation case file. Documenting such significant communications will help avoid misunderstandings and allow Lead Prosecutors, Supervising Investigators and Supervising Deputy Attorneys General to monitor the progress of investigations.

IX. Investigation Reports:

Investigation reports are to be kept current. The investigator should keep the report of investigation current and record all events as soon as possible, and preferably no more than five (5) business days following the event.

X. Periodic Review of Ongoing Investigations:

The primary deputy attorney general and assigned investigator, and the Supervising Investigator I as necessary, should participate in the periodic review of ongoing investigations. While it is preferable that such reviews take place in person, participation electronically is permitted where necessary.

A case review, including the District Medical Consultant whenever possible, shall take place prior to referral of the matter to an expert. This review should, whenever possible, be conducted in person and include a review by the primary deputy attorney general of the investigation report and attachments. The primary attorney shall also insure the chosen expert is an appropriate expert to review the case, taking into consideration the expert's board certification and area of current active practice. Documents provided to the expert shall comply with the relevant provisions of the Board's Enforcement Operations Manual. Prior to submitting a case to an expert reviewer, the investigator should reference the Standards for Case Submission to Expert Reviewer (EOM section 7.4).

The assigned investigator should promptly provide a copy of the initial expert report to the primary deputy attorney general and District Medical Consultant. The primary deputy attorney general, District Medical Consultant and assigned investigator should determine whether all relevant matters have been reviewed and addressed by the expert, whether clarification of the expert's initial opinions and conclusions is needed, and whether additional further investigation (e.g., a second physician's interview) is required. After receipt of the initial expert report, the primary deputy attorney general is also strongly encouraged to consult with the District Medical Consultant to make this determination. If additional further investigation is required, the primary deputy attorney general shall inform the assigned investigator in writing, preferably by e-mail, with copies of that e-mail being sent to the investigator's Supervising Investigator I, Lead Prosecutor and Supervising Deputy Attorney General.

XI. Witness Interviews:

Throughout the course of the investigation, the primary deputy attorney general may elect to participate in witness interviews including the physician's interview. The primary deputy attorney general shall advise the assigned investigator if he or she will be participating in any witness interview. In such cases, prior to the commencement of the interview, the primary deputy attorney general should discuss the topics each will cover during the interview. If the District Medical Consultant will be present for the interview, he or she should be included in the pre-interview discussion as well.

XII. Pagination of the Investigation Material Before Transmittal to Expert:

Prior to transmittal of the investigation material to an expert for review, the assigned investigator, or his or her designee, shall paginate the investigation material. Page numbers shall be affixed to the investigation material in such a fashion as not to obscure any of the written information contained thereon. When referring to particular documents in the investigation material, the expert reviewer shall refer to specific page numbers in his or her expert report.

As of the date of the publication of this Second Edition of Vertical Prosecution Manual, the Medical Board does not presently have sufficient investigation support staff to paginate the investigation material as provided in this section. It is anticipated that, once sufficient investigation support staff have been retained by the Medical Board, the pagination of investigation material described in this section will be done prior to transmittal to an expert for review.

XIII. Acceptance of Cases for Prosecution:

Within five (5) business days of submission of the completed investigation, the primary deputy attorney general shall determine whether the case will be closed or accepted. If accepted for prosecution, the primary deputy attorney general shall communicate his or her acceptance of the case in writing by way of running e-mail thread which shall be sent to the assigned investigator, the Supervising Investigator I, the Lead Prosecutor and the Supervising Deputy Attorney General. The acceptance of the case by the primary deputy attorney general does not preclude the possibility that further investigation may be required.

XIV. Content of Investigation File:

Upon acceptance of the case by the primary deputy attorney general, the assigned investigator should deliver a copy of the entire investigation file, along with a memorandum documenting acceptance, to the Lead Prosecutor for delivery to the appropriate Supervising Deputy Attorney General. The entire investigation file shall consist of all documents related to the case, regardless of relevancy and regardless of the place where they are maintained (e.g., master file, investigator's copy of the file, or any other file, formal or not) beginning with and including the original complaint and related documents initially received by the District Office from the Board's Central Complaint Unit.

XV. Approval of Proposed Closure of Investigation:

In cases in which the report of investigation recommends closure, the primary deputy attorney general shall, within ten (10) business days, review the proposed closure and indicate either approval or disapproval. Any failure to comply with this time limitation shall be brought to the attention of the Supervising Deputy Attorney General.

If, at any stage in the investigation, the primary deputy attorney general concludes the investigation should be closed, he or she shall submit a proposal to close the investigation to the Lead Prosecutor by e-mail, with a copy of that e-mail being simultaneously sent to the assigned investigator, the Supervising Investigator I, and Supervising Deputy Attorney General. Within ten (10) business days, the Lead Prosecutor shall review the proposed closure and indicate in writing either approval or disapproval of the proposal. Any failure to comply with this time limitation shall be brought to the attention of the Supervising Deputy Attorney General. If approved, the Lead Prosecutor shall send notification of the case closure to the primary deputy attorney general, assigned investigator, and Supervising Investigator I. If disapproved, the Lead Prosecutor shall indicate in writing any additional investigative tasks that shall be completed.

If the Lead Prosecutor is the primary deputy attorney general at the time of the proposed closure, he or she shall close the case and notify, by e-mail, the assigned investigator, Supervising Investigator I, and Supervising Deputy Attorney General, of the closure. Disagreements regarding proposed closures of investigations shall be resolved as described in Section XXII, below.

XVI. Submission of Proposed Accusations for Filing:

The primary deputy attorney general should submit a proposed Accusation for filing to the Executive Director of the Board within thirty (30) calendar days of acceptance of the case for prosecution.

XVII. Filing of Requests to Set with the Office of Administrative Hearings:

Within fifteen (15) calendar days of receipt of the Notice of Defense, the primary deputy attorney general shall submit a request to set to the Office of Administrative Hearings.

XVIII. Subpoena Review and Enforcement:

Prior to issuance, all subpoenas requesting document production shall be supported by declarations which demonstrate that the particular records sought are relevant and material to the investigation. The declaration should be factually sufficient to permit a reviewing court to independently make a finding of good cause to order the documents disclosed. Within ten (10) business days after the determination that a subpoena will be necessary to compel document production, the assigned investigator shall submit the subpoena and supporting declaration for review and approval by the primary deputy attorney general. Preparation of the subpoena and supporting declaration shall be the responsibility of the assigned investigator. Subpoena enforcement actions shall be the responsibility of the primary deputy attorney general and shall be filed in the appropriate court within thirty (30) business days of acceptance of the subpoena enforcement request.

XIX. Interim Orders of Suspension and Penal Code Section 23 Appearances:

The Lead Prosecutor shall identify those cases in which an Interim Order of Suspension ("ISO") or Penal Code section 23 ("PC 23") appearance is necessary and shall so notify the Supervising Deputy Attorney General. In such cases, the Supervising Deputy Attorney General shall designate the second deputy attorney general as the primary deputy attorney general who shall be responsible for obtaining any necessary ISO or making any necessary PC 23 appearance. The Supervising Deputy Attorney General shall notify the assigned investigator, Lead Prosecutor, and Supervising Investigator I of such designations.

XX. Petitions for Competency, Physical and Mental Examinations:

The primary deputy attorney general shall be responsible for preparing and filing petitions for competency, physical and mental examinations.

XXI. Administrative Hearings:

After the filing of an Accusation, there are often additional investigative tasks that must be completed in order to prepare a case for an upcoming administrative hearing. When additional investigation is required post-accusation to prepare for, or present the case at, the administrative hearing, the primary DAG will notify the assigned investigator of the required additional investigation by e-mail, with a copy to the Supervising Investigator I, Lead Prosecutor (if not the primary) and Supervising Deputy Attorney General.

The assigned investigator is expected to attend the administrative hearing unless the primary deputy attorney general, in consultation with the Supervising Investigator I and Supervising Deputy Attorney General, releases the investigator. While such attendance necessarily takes time away from the investigator's other cases, the investigator's attendance and participation at the administrative hearing will ultimately benefit the prosecution of the case and the investigations and prosecutions of future cases.

XXII. Disagreements:

Occasionally, a disagreement may arise between an assigned investigator and primary deputy attorney general regarding an investigation. Whenever this occurs, the assigned investigator should first discuss his or her concerns directly with the primary deputy attorney general in an effort to resolve the disagreement. If the disagreement remains unresolved, the assigned investigator and primary deputy attorney general should discuss the matter with the Lead Prosecutor, Supervising Investigator I and/or Supervising Investigator II. If the disagreement remains unresolved, the matter shall be submitted to the Supervising Deputy Attorney General who, after consultation with the Chief of Enforcement, shall issue a determination.

It is the expectation of both the Senior Assistant Attorney General and the Executive Director of the Medical Board that, in the vast majority of cases, the determination of the Supervising Deputy Attorney General will resolve the disagreement. If, however, the disagreement remains unresolved, it shall be submitted to the Senior Assistant Attorney General who, after consultation with the Chief of Enforcement and the Executive Director of the Medical Board, shall issue a final determination.

XXIII. Statistical Measure of Efficiency of the Vertical Prosecution Model:

In addition to any other statistical measure that may be later identified, one statistical measure that shall be used to assess the efficiency of the vertical prosecution model, as described in Senate Bill 231, shall be the length of time from receipt by the Board's District Office of the original complaint from the Board's Central Complaint Unit to the date that the investigation is closed or a Request to Set is submitted to the Office of Administrative Hearings. Both Board investigators and HQE deputy attorneys general are jointly responsible for this statistical measure of efficiency. In its early stages, it is anticipated that use of the "vertical prosecution model" may extend the time it takes to complete some investigations.

XXIV. Implementation of the "Vertical Prosecution Model" with Existing Staff:

It is important to recognize that both the Board and HQE are presently in the process of recruiting, hiring and training additional personnel to fully implement the Vertical Prosecution Model contained in Senate Bill 231. This is a continuing process and, as the Board and HQE become fully staffed, there will be a far greater likelihood that the legislative goals of efficiency and enhanced public protection which underlie Senate Bill 231 will be achieved.

XXV. Future Revisions to this Manual:

It is anticipated that this "Vertical Prosecution Manual (Second Edition, November 2006)" will undergo future revisions and refinements as HQE and the Board continue on their joint mission to protect the public health, safety and welfare.

Endnotes:

1. Case reassignments, which are a routine occurrence in any law enforcement agency, including HQE, are necessitated for any number of reasons. For example, a case may be reassigned as a result of the illness or death of a deputy, the transfer of a deputy to another section or his/her termination of employment with the Attorney General's Office, the hiring of a new HQE deputy, a maternity leave, conflict of interest, and also for purposes of managing the case load of both individual deputies and the HQE section statewide. Likewise, an investigation may be reassigned from one investigator to another for similar reasons as well. While the presumption is that an original joint assignment will be maintained throughout the duration of a disciplinary matter, appropriate case reassignments will be made when necessary to insure the efficient, thorough and timely investigation and prosecution of cases.

2. The word "direction" has been defined as "[t]he act of governing; management; superintendence" (Black's Law Dictionary, 4th ed. (1968) at p. 547, col. 1) and "[t]hat which is imposed by directing; a guiding or authoritative instruction; order; command" (*Id.*). The word "superintend" means "[t]o have charge and direction of; to direct the course and oversee the details; to regulate with authority; to manage; to oversee with the power of direction; to take care of with authority." (*Id.*, at p. 1606, col. 1; cf. Gov. Code, § 12529.5, subd. (b) ["The Senior Assistant Attorney General and deputy attorneys general working at his or her direction . . ."].)

3. The word "supervise" has been defined as "[t]o have general oversight over, to superintend or to inspect." (Black's Law Dictionary, 4th ed. (1968) at p. 1607, col. 1.) The word "superintend" means "[t]o have charge and direction of; to direct the course and oversee the details; to regulate with authority; to manage; to oversee with the power of direction; to take care of with authority." (*Id.*, at p. 1606, col. 1.)

4. Until such time as HQE is fully staffed with a sufficient number of attorneys, it may be necessary for a Lead Prosecutor to be assigned to more than one of the Board's district offices.

5. In the vast majority of cases, the primary deputy attorney general shall be the Lead Prosecutor assigned to the District Office where the assigned investigator works.

6. This can be accomplished either by dropping and dragging updated copies of the entire e-mail thread into the ProLaw matter or by cutting and pasting the entirety of the e-mail thread text into the Case Diary in the matter.

MEDICAL BOARD STAFF REPORT

Agenda Item 16

DATE REPORT ISSUED:	October 10, 2007
ATTENTION:	Board Members
DEPARTMENT:	Medical Board of California (MBC)
SUBJECT:	Information Technology Replacement
STAFF CONTACT:	Diane Ingram

REQUESTED ACTION:
Board members approve MBC Information Technology replacement to improve interoperability with DOJ's information systems for vertical enforcement as required by SB 231.

STAFF RECOMMENDATION:
Staff recommends MBC should implement an information technology system which is fully interoperable with the current system used at Department of Justice (DOJ). This will require MBC moving away from the outdated and non-interoperable CAS system which is slowing down MBC business and which is now a high risk software environment for MBC because of the difficulty maintaining a 20 year old system. It is essential that MBC investigators and DOJ use fully interoperable systems for vertical enforcement.

EXECUTIVE SUMMARY:
A review by MBC staff has shown significant inefficiency and disruption to communication and business processes between MBC and DOJ investigators because of the lack of interoperability of the information systems of the two organizations. DOJ has already upgraded their system and have demonstrated its greatly increased effectiveness and efficiency. It is essential that MBC also replaces its IT system to become fully interoperable with DOJ. Staff concludes that significant benefits to both consumers and licensees will be achieved through this upgrade. Senior management from MBC and DOJ have met and agreed, subject to Board approval, a plan that aligns the information technology systems of the two organizations. MBC staff have met with DCA who have expressed support of this plan. A formal feasibility study to ascertain the scope, costs, timeline and risks of a proposed project to replace CAS is presently underway.

FISCAL CONSIDERATIONS:
All costs will be available at the conclusion of the feasibility study but initial estimates for the first year are for a cost of $1m for technology upgrades, data migration, consulting, training and programming of interfaces. The cost for maintenance and implementation during the second year is estimated at $500,000 with ongoing costs to be determined.

PREVIOUS MBC AND/OR COMMITTEE ACTION:
Improving the IT system (CAS) currently in use by MBC is an accepted longstanding need. At its July meeting the Board requested staff to investigate the benefits of making this change. Two previous feasibility studies have been conducted which both have concluded that the information technology upgrade should occur, but unfortunately neither was approved by the Department of Finance (oversight agency) for implementation.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
Medical Board of California | Information Systems Branch
1426 Howe Avenue, #48, Sacramento, CA 95825
P (916)263-2205 F (916) 263-2210 | www.mbc.ca.gov

ISSUE MEMORANDUM

DATE	October 5, 2007
TO	Kimberly Kirchmeyer Deputy Director
FROM	Diane Ingram Medical Board of California
SUBJECT	**Vertical Enforcement Communication**

The Medical Board's investigators and the Department of Justice's Deputy Attorneys General cannot communicate effectively due to having two separate information technology systems in use for vertical enforcement.

BACKGROUND
The mission of the Medical Board of California (Board) is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

On January 1, 2006, Government Code Sections 12529, 12529.5 and 12529.6 went into effect, requiring the Board investigators to work with the Department of Justice, Health Quality Enforcement Section (HQES), Deputy Attorneys General (DAG), from the start of all investigations in a "vertical prosecution model" through to closure, or if warranted, prosecution of the case. Vertical prosecution is based on the team concept with the investigator and attorney working together to achieve the common goal of greater public protection for the people of California. The Board and the HQES have worked closely together to implement the vertical enforcement model.

The Board's Central Complaint Unit reviews complaints at headquarters and then when investigation is appropriate, refers the complaint to the field office for investigation. The HQES has a DAG assigned to work in each Medical Board field office along side the investigators. The investigation of a complaint referred to the field office is assigned to both an investigator and a DAG at the same time.

The DAG has desktop computers set up at the field office. The DAGs working on Board cases use a separate network and an information technology system by Thomson Elite called ProLaw. The ProLaw system uses a dashboard to provide one-touch access to everything the DAG needs including their daily calendar, reminders, matters (or events),

contacts, documents, and more. ProLaw automates case management, tasks, deadlines, calendars, document management, reporting, time entry, and also provides comprehensive integration with Outlook, Word and Westlaw research and court rules. When a DAG creates a matter, ProLaw automates creation of file folders and organizes all subsequent documents and supporting materials within that matter. The events, docketing, and deadlines are integrated into ProLaw matter information into Outlook calendar. Complaints are logged in as "matters" into ProLaw as the tracking mechanism.

The investigator working on Medical Board cases uses WordPerfect 12, GroupWise email, the mainframe application Consumer Affairs Systems (CAS) Enforcement module, and the Investigator Activitiy Reporting (IAR) systems. There are additional enforcement databases used also by enforcement including Malpractice, 805, CCU Log, Medical Expert, Exhibits Log, and Criminal Activity Report. These databases perform additional tracking functions not available in the mainframe CAS.

The investigator uses a template form created in WordPerfect for the essential elements required from the DAG on a case. As an investigation progresses the updated documents are emailed to the DAG. Case numbers are used as the tracking mechanism for the investigation. Most communication on the investigations is performed with email for documentation along with updated case reports.

ANALYSIS AND RECOMMENDATIONS

The investigator and the DAG use different tools while working together in vertical enforcement. They additionally use different terminology for tracking and working on a investigation/matter. The multitude of applications used by the investigator is cumbersome and delays the investigation. The terminology differences used by both parties also impacts the communication while working thru the investigation to prosecution. The systems do not share the same structure or components and do not have the capacity to share information across platforms as they exist today.

The CAS is a natural program running on a Adabas database and the technical support for the system has traditionally had to go thru the Department of Consumer Affairs, Office of Information Services for completion. Additionally, as the years go by and technology evolves, programmers are getting harder and harder to find and contracting out for services is often necessary to complete enhancements. Currently the Board has only one qualified natural/Adabas programmer on staff.

To improve vertical enforcement the Board investigators needs to have a comprehensive all in one application available to them with similar tracking mechanisms and terminology used in the ProLaw application.

CONS

To move forward with an all in one comprehensive system will require the purchase of the one time off the shelf application ProLaw, three new servers, Microsoft Exchange, Microsoft Advanced Server, Cognos Reporting tool, and consultants to install for the Board. The ProLaw application would require several additional enhancements to

incorporate all of the components needed to make it an all in one application for the Board. Training and documentation will be absolutely necessary for all enforcement staff to use the system. Additionally, conversion of all complaints and current databases would be required and long term support by Department of Technology Services hosting the servers and ongoing yearly maintenance for the applications. These are unknown costs at this time.

PROS

Moving to ProLaw will allow the Board and the Department of Justice to work more efficiently at vertical enforcement. Sharing one terminology and the same system will improve work productivity by both agencies.

MEDICAL BOARD STAFF REPORT

Agenda Item 18

DATE REPORT ISSUED:	November 2, 2007
ATTENTION:	Board Members
DEPARTMENT:	Medical Board of California (MBC)
SUBJECT:	Transition Plan for Diversion Program Participants
STAFF CONTACT:	Kimberly Kirchmeyer

REQUESTED ACTION:
Board members approve the transition plan and policy statements for the Diversion Program in the attached memo.

STAFF RECOMMENDATION:
Staff recommends that the Board members approve the attached plan in order to transition the participants from the Diversion Program which will sunset on June 30, 2008.

EXECUTIVE SUMMARY:
Since there was no legislation approved to extend the Diversion Program, on June 30, 2008 the legislation authorizing the Diversion Program will become inoperative. However, as of September 21, 2007 there were 203 individuals participating in the Diversion Program and therefore a transition plan for those individuals needed to be developed. In addition, this plan would also need to include what to tell those individuals who are contacting the Board until June 30, 2008 requesting entrance into the Diversion Program. After input from staff and the Diversion Advisory Council, a transition plan was put together as follows:

Self referrals (75 participants)
New participants – The Board will no longer accept self referrals into the Diversion Program
Current participants – Those participants who have at least three years sobriety will be evaluated by the DEC and if in compliance will complete the Diversion Program (44 participants). Those participants without three years sobriety, and not deemed to be a danger to the public, will be released from the Program on June 30, 2008 but will be encouraged to seek another program to assist with sobriety (31 participants).
In lieu of discipline or Statements of Understanding (94 participants)
New participants – The Board will fully inform those individuals seeking entrance into the Diversion Program in lieu of discipline that they will not be able to successfully complete the Diversion Program and that on June 30, 2008 they will be referred to enforcement for further action.
Current participants – Those participants who have at least three years sobriety will be evaluated by the DEC and if in compliance will complete the Diversion Program (60 participants). Those participants without three years sobriety will need to locate a program similar to the Diversion Program that will monitor him or her until he or she reaches three years sobriety (34 participants). This program will be required to report participant activity to the Chief of Enforcement. Failure to obtain a program will result in the matter being referred to the Enforcement Unit.
Board ordered (27 participants)
Upon approval of the plan, the Board will no longer have the Diversion Program as a condition of a probationary order. However, each new decision will contain a condition stating that the probationer must abstain from drugs/alcohol and must submit to biological fluid testing.

Current probationers – The Diversion Program condition will become null and void on July 1, 2008 and probationers will no longer be required to comply with this condition. However, they must comply with abstaining from drugs/alcohol and must continue to submit to biological fluid testing. One staff member will be responsible for setting up biological fluid testing for probationers on a random schedule.
Out of State (7 participants)
Current participants – Board staff will continue to liaison with the other state's Diversion Programs to ensure the seven current participants successfully complete the other state's program.

FISCAL CONSIDERATIONS:
Pursuant to Business and Professions Code section 2435.2, the Board will need to reduce the initial and renewal license fees by the amount equal to the cost of operating the Diversion Program. However, the Board will need to maintain one full-time employee to perform the functions associated with the random biological fluid testing required for probationers. Since the funding will be taken from the Diversion Program, this position will be funded by the Board's Probation Unit.

PREVIOUS MBC AND/OR COMMITTEE ACTION:
At the July 2007 Board meeting, the Board members voted to allow the Diversion Program to sunset on June 30, 2008. Additionally, the Board requested a plan be developed to assist in the transition of the Diversion Program for the period between when the motion was made until June 30, 2008.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
MEDICAL BOARD OF CALIFORNIA – Executive Office
1434 Howe Avenue, Suite 92, Sacramento, CA 95825
(916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

Date: November 1, 2007

To: Diversion Committee Members

From: Kimberly Kirchmeyer
Deputy Director

Subject: Diversion Transition Plan

Based upon input from Board Executive Staff and the Diversion Advisory Council, a transition plan has been developed for participants who are currently in the Diversion Program. The Diversion Committee will need to approve staff's proposed policies. If the policies are approved at this committee meeting, the Diversion Committee co-chairs will present this plan to all Board Members for approval.

As of September 21, 2007, there were 203 individuals in the Diversion Program (with seven of the participants participating in similar out-of-state programs). Of those, 75 were self-referrals, 94 were in Diversion in lieu of discipline, and 27 were ordered into Diversion as a result of a disciplinary order. In developing a transition plan, staff recognized that each of these categories had to be treated differently. By way of background, individuals are considered a self referral if they enter the Diversion Program completely voluntarily (no action pending and no future action is brought forward). Pursuant to statute, an individual may enter the Diversion Program in lieu of discipline if the Board determines that the only issues that have been brought to the attention of the Board's investigative unit are substance abuse issues or mental illness (the individual signs a Statement of Understanding with the Enforcement Unit indicating that the Board will suspend its disciplinary process while the individual is in the Diversion Program and will cease the process if the individual successfully completes the Program). Lastly, an individual may enter the Diversion Program as a condition of a disciplinary order, which will also contain a period of probation. (The Board also has 2 individuals in Diversion as part of a Post Accusation Diversion Agreement. This agreement occurred after an Accusation had been filed against a physician, but it states that if the subject successfully completes the Diversion Program, then the accusation will be withdrawn and no action will be taken against the physician. Staff has placed these individuals into the same category as in lieu of discipline participants.)

To determine how to transition these participants, the Board will need to address the participants based upon how they were accepted into the program.

SELF REFERRALS

PROPOSED POLICY: Effective upon approval, the Board will inform individuals requesting participation in the Diversion Program that the program will be eliminated on June 30, 2008 and

therefore the individual will need to seek participation in another monitoring/treatment program. Information regarding other programs may be available via the Board's Web site.

Rationale: The Board cannot maintain its current program with a limited number of staff. Additionally, with the Diversion Program ending on June 30, 2008, it would not be substantially beneficial for these individuals to enter the program. Hence, physicians seeking to voluntarily enter the Diversion Program will be denied participation due to insufficient resources.

PROPOSED POLICY: Beginning immediately following the Board meeting and ongoing to June 30, 2008, those individuals who are self referrals and have at least three years of sobriety will be referred to a Diversion Evaluation Committee (DEC) for evaluation. If the DEC recommends, and the Program Administrator agrees, that the individual has been in compliance, the individual will be deemed to have completed the Diversion Program and will receive a letter informing them of such. The letter also will recommend that if the participant believes he/she needs assistance to maintain his/her sobriety that he/she seek entrance into another monitoring program. [As of September 21, 2007 there were 44 participants in this category.]

Rationale: Pursuant to Business and Professions (B&P) Code section 2350, three years sobriety and adoption of a lifestyle which will maintain a state of sobriety is to be used to determine completion of the program. In addition, as the Diversion Program continues to lose staff, this mechanism will assist in keeping the caseload down for each monitor.

PROPOSED POLICY: On June 30, 2008 those individuals who are self referrals but have less than three years sobriety will be sent a letter stating the Diversion Program is inoperative and there is no longer a monitoring program. The letter will highly encourage participants to seek entrance into another monitoring or treatment program that will assist him or her in maintaining his or her sobriety. [As of September 21, 2007 there were 31 participants in this category.]

Rationale: The Diversion Program will no longer be in existence after June 30, 2008 and will no longer be able to monitor these individuals.

IN LIEU OF DISCIPLINE (STATEMENTS OF UNDERSTANDING)

PROPOSED POLICY: Effective upon approval, the Board will inform those individuals seeking admission to the Diversion Program in lieu of discipline that they will be unable to complete the three year term of sobriety necessary for successful completion of the Diversion Program and therefore any contract signed would be limited to a term ending June 30, 2008, the date on which the program becomes inoperative. At that time, the Board will refer the matter to the Attorney General's office for further action. The participant will be made fully aware of this fact and be given the choice of either entering the program with the knowledge that on June 30, 2008 he or she will be referred to enforcement for further action, or that he or she can proceed through the enforcement process.

Rationale: While the Board cannot deny participation in the Program in lieu of discipline as long as the Program is still legally in operation (pursuant to B&P Code section 2350), it also

should not encourage participants to enter a program that will only be operational until June 30, 2008. With the knowledge that the program will be inoperable, it would not show good faith to have a physician enter the program only for seven months.

PROPOSED POLICY: Upon approval and ongoing to June 30, 2008 those individuals who are in the Program in lieu of discipline and have had at least three years of sobriety will be referred to a Diversion Evaluation Committee (DEC) for evaluation. If the DEC recommends, and the Program Administrator agrees, that the individual has been in compliance, the individual will be deemed to have completed the Diversion Program and will receive a letter informing them of such. The letter also will recommend that if the participant believes he/she needs assistance to maintain his/her sobriety that he/she seek entrance into another monitoring program. [currently 60 participants in this category.]

Rationale: Pursuant to Business and Professions (B&P) Code section 2350, three years sobriety and adoption of a lifestyle which will maintain a state of sobriety is to be used to determine completion of the program. In addition, as the Diversion Program loses its staff, this will assist in keeping the caseload down for each monitor.

PROPOSED POLICY: On January 1, 2008, those individuals who are in the Program in lieu of discipline, but have less than three years sobriety, will be sent a letter stating the Diversion Program will be inoperative as of June 30, 2008. The letter will further state that the participant must locate another program that will monitor the physician's recovery in order for the Board to honor the "diversion" provision. This other program must meet the requirements/protocols of the Board's current Diversion Program. This other program must be willing to report to the Chief of Enforcement on a regular basis and provide information as to whether or not the individual is complying and be willing to immediately notify the Board of any positive drug screening. The letter will further inform the individual that there is a "zero-tolerance" policy on positive drug screenings. Failure to enroll into another program or abstain from drugs/alcohol may subject him or her to discipline by the Board. [currently 34 participants in this category.]

Rationale: Since these participants are in the Diversion Program in lieu of discipline, the Board cannot just dissolve the contract as it will do for the self-referrals. These individuals were brought to the attention of the Enforcement Unit and must fit the criteria in B&P Code section 2350 for completion in order to avoid further action by the Board.

BOARD ORDERED (DISCIPLINARY ORDER)

PROPOSED POLICY: Upon approval the Board will not approve a stipulation that requires participation in the Diversion Program as a condition of a disciplinary order or as a condition to issuing a probationary license. Additionally, the Board will send a letter to the Director of the Office of Administrative Hearings requesting that, since the Diversion Program will become inoperable, the Administrative Law Judges (ALJ) no longer order participation in the Diversion Program as a condition of probation either for disciplinary action or for initial probationary licenses.

In lieu of a Diversion Program condition, all stipulations/ALJ decisions must contain a condition stating that the probationer must abstain from all drugs/alcohol and must submit to biological fluid testing. New language would state:

"*Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon request of the Board or its designee. Within 30 calendar days from the effective date of this decision respondent shall, at respondent's expense, contract with a laboratory or service - approved in advance by the Board or its designee - that will conduct random, unannounced, observed, urine testing a minimum of four times each month. The contract shall require results of the urine tests to be transmitted by the laboratory or service directly to Board or its designee within four hours of the results becoming available. Failure to maintain this laboratory or service during the period of probation is a violation of probation. A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and respondent. Failure to submit to or comply with the time frame for submitting to, or failure to complete the required biological fluid testing, is a violation of probation.*"

The Board will follow up with a regulatory amendment to codify this change in the disciplinary guidelines.

Rationale: With the Diversion Program becoming inoperative on June 30, 2008 it would not be appropriate for the Board to order a condition of probation that could not be fulfilled.

PROPOSED POLICY: On July 1, 2008 the Diversion Program condition in a disciplinary order will become null and void and will no longer be considered a condition of probation. However, the individuals will be required to fully comply with the conditions in their order that state the probationer must abstain from drugs/alcohol and must submit to biological fluid testing. The individuals will be required to obtain a drug screening service that will provide testing of the participant. Any refusal to submit to testing, failure either to comply with the time frame for the test or to complete the test, or failure to abstain from drugs/alcohol will be grounds to file a petition to revoke probation.

The Board will need to create a staff position that will provide the lab chosen by the participant with random dates to perform drug screening. This staff person will use the previous Random Drug Generator Program (used by the Diversion Program) to identify random dates to test the participant. This staff person will also liaison with the collectors and laboratories to receive notification of whether the individual is complying with the testing and the outcomes of the test.

Each probationer would be notified that strict adherence to these conditions will be required and any positive drug screening may result in further discipline. Additionally, the probationer will be notified that he/she may seek any monitoring/treatment program he chooses in order to remain in compliance with his probationary order.

Rationale: Since there will no longer be a Diversion Program, this condition can no longer be enforced. Additionally, each probationer knows that a condition of his/her probation is the abstinence of drugs/alcohol.

OUT OF STATE

PROPOSED POLICY: The Board will have staff continue to liaison with the other state to ensure these individuals are in compliance with that state's program until completion. Additionally, these participants will be notified that failure to complete the other state's program as required will result in referral of this matter to the Board's Enforcement Unit.

Rationale: The Board does not currently monitor these individuals (except to be in communication with the other state) and this is a very small workload. Because the other state's programs are still operative, it would be appropriate for the Board to remain in contact with this state until the individual completes the other state's program and no further action would be necessary.

HOSPITAL REPORTING

PROPOSED POLICY: B&P Code section 821.5 imposes a requirement on peer review bodies to report specified information to the Board's Diversion Program when they initiate and complete or close an investigation into a physician's ability to practice medicine safely that is based on information indicating that the physician may be suffering from a disabling mental or physical condition that poses a threat to patient care. However, B&P Code section 2358 provides that the laws authorizing the Diversion Program will become inoperative on July 1, 2008 and will be repealed as of January 1, 2009 unless those dates are deleted or extended.

Because B&P Code section 821.5 was not repealed, peer review reporting requirements must remain. Therefore, as of July 1, 2008, peer review bodies must continue to provide the reports required by section 821.5 even if the Diversion Program ceases to exist. At that time, peer review bodies will be asked to report to the Board's Deputy Director instead of reporting to the Diversion Program. The Deputy Director will follow the steps provided in B&P Code section 821.5 for resolution of the matter.