MEDICAL BOARD OF CALIFORNIA
Executive Office

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Janet Salomonson, M.D.
Ronald H. Wender, M.D.
Barbara Yaroslavsky
Frank V. Zerunyan, J.D.

QUARTERLY BOARD MEETING

January 31 – February 1, 2008

The Westin Los Angeles Airport
5400 West Century Blvd.
Los Angeles, CA 90045
(310) 216-5858

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

AGENDA

January 31, 2008 – 3:00 p.m. to 5:00 p.m.

February 1, 2008 – 9:00 a.m.
(or at the conclusion of the Application Review Committee meeting)

Thursday, January 31, 2008 3:00 p.m.

1. Call to Order/Roll Call

2. Approval of Minutes from the November 1 – 2, 2007 Meeting
   A. Full Board
   B. Division of Medical Quality
   C. Division of Licensing

3. President's Report
   A. Executive Committee Update
   B. Diversion Summit Update

4. Legislation – Ms. Whitney
   A. 2007 - 2008 Legislation and Proposals
   B. Licensing Issues Related to Restructuring
   C. Status of Regulatory Action

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, and to promote access to quality medical care through the Board's licensing and regulatory functions.

5. Executive Director's Report – Ms. Johnston
   A. Budget Overview and Staffing Update
   B. Update on Board Mandated Reports

6. Demonstration of MBC Web Site – Diane Ingram

7. California Physician Corps Program Update – Ms. Yaroslavsky

8. Cultural and Linguistic Physician Competency Workgroup Update – Ms. Chang

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

10. Education Committee Update – Ms. Yaroslavsky

11. Medical Errors Task Force Update – Dr. Aristeiguieta

12. Wellness Committee Update – Dr. Duruisseau

13. Public Comment on Items not on the Agenda

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Friday, February 1, 2008 - Meeting continues at 9:00 a.m. or at the conclusion of the Application Review Committee meeting.

14. Call to Order/Roll Call

15. REGULATIONS – PUBLIC HEARING – Mr. Qualset/Ms. Scuri
   A. Continuing Education Requirements – Amend Section 1336 in Article 11 of Chapter 1, Division 13, Title 16, California Code of Regulations. This proposal will change the time frame for continuing medical education from calendar year to the two-year period immediately preceding the license expiration date.
   B. Delegation of Services – Physician Assistants – Amend Section 1399.540 of Article 4 of Division 13.8, Title 16, California Code of Regulations. This proposal will formally recognize the document as a "delegation of services agreement" and require it be signed by both the supervising physician and the physician assistant.

16. Licensing Chief's Report – Mr. Qualset
   A. Physician Assistant Committee Update
   B. Midwifery Advisory Council Report
   C. Research Psychoanalytic Institution Equivalency Report
   D. Special Programs Update
   E. Licensing Program Update
   F. American Board of Cosmetic Surgery v. MBC Update – Ms. Scuri

17. Midwifery Advisory Council Appointments – Dr. Fantozzi

18. Action on Recommendations of Special Faculty Permit Review Committee – Dr. Gitnick

19. Enforcement Chief's Report – Ms. Threadgill
    A. Enforcement Program Update
    B. Medical Expert Program Survey
    C. Revised Expert Survey Form
    D. Expert Utilization Report
    E. Approval of Orders Restoring License Following Successful Completion of Probation, Orders Issuing Public Letter of Reprimand, and Orders for License Surrender During Probation

20. Vertical Enforcement Progress/Update – Ms. Threadgill/Mr. Ramirez
    A. Information Technology Integration Update
    B. Vertical Enforcement Statistics

21. Consideration of Proposal to Amend Disciplinary Guidelines Regulations – Ms. Kirchmeyer

22. Consideration of Proposal to Adjust Initial Licensing and Renewal Fees Pursuant to Sunset of Diversion – Ms. Kirchmeyer

23. Diversion Program Report – Mr. Valine
    A. Program/Transition Update
    B. Fiscal Report

24. Policy Statement on Access to Care/Healthcare Reform

25. Laser Forums' Summary – Dr. Moran/Dr. Salomonson/Ms. Cordray

26. Agenda Items for April 2008 Meeting

27. 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.

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For additional information call (916) 263-2389.

MEDICAL BOARD OF CALIFORNIA

Executive Office

AGENDA ITEM 2A

Hilton San Diego Mission Valley
Carmel 3 Room
901 Camino Del Rio South
San Diego, CA 92108

November 1 – 2, 2007

MINUTES

Agenda Item 1 Call to Order/Roll Call

Dr. Fantozzi called the meeting to order on November 1, 2007 at 2:30 pm. A quorum was present and notice had been sent to interested parties.

Members Present:

Richard 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.

Members Absent: None

Staff Present:

Barbara Johnston, Executive Director
Kimberly Kirchmeyer, Deputy Director
Stacie Berumen, Staff Services Manager
Kathi Burns, Manager, Licensing Unit
Candis Cohen, Public Information Officer
Janie Cordray, Research Specialist
Nancy Edwards, Supervising Investigator, San Diego Office
Kurt Heppler, Staff Counsel, DCA Legal Office
Valerie Moore, Associate Analyst
Kelly Nelson, Legislative Analyst
Cindi Oseto, Associate Analyst

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
Lori Taul, Office Technician
Frank Valine, Diversion Program Administrator
Linda K. Whitney, Chief of Legislation

Members of the Audience:

Sandra Bressler, California Medical Association
Michelle Butler, Center for Public Interest Law
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law
James Hay, M.D., California Medical Association
Sara Huchel, Senate Office of Research
Tara Kittle, General Public
MaryAgnes Matyszewski, Deputy Attorney General
Brett Michelin, California Medical Association
Janet Mitchell, General Public
Carlos Ramirez, Senior Assistant Attorney General
Carmen Rodriguez, General Public
Jesus Rodriguez, M.D., General Public
Carolyn Sam, Center for Public Interest Law
Antonette Sorrick, Deputy Director, Department of Consumer Affairs

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

It was M/S/C (Alexander/Wender) to approve the minutes from the July 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 November 1 - 2, 2007 meeting.

Agenda Item 3 Discussion on Fiscal Audit Report

Dr. Fantozzi asked that any discussion or motions related to potential legislation regarding the audit be deferred until Linda Whitney's legislative report.

Barbara Johnston, Executive Director, reported on the California State Auditor's Report and directed the members' attention to page 19 thru 33 of their board packet for further information regarding the auditor's recommendation to reduce or refund fees to maintain the mandated fund balance not to exceed two months; with an amendment to allow flexibility to adjust fees. Ms. Johnston referred the members' to Tab 7 of their board packet for comparison of the Board's Fund balance to other DCA Boards' Fund balances, most of which have balances of two or more years. Ms. Johnston explained the proposed fund condition also reflects future projected spending, as well as what will happen to our fund balance if we refund or reduce the licensing fees.

Agenda Item 4 Legislation Update

Linda Whitney, Chief of Legislation, provided an update on 2007 Legislation and implementation.

The board took the following positions on legislation:

AB3 (Bass)	Physician Assistants	**Support**
AB 253 (Eng)	MBC: Restructuring	**Sponsor/Support**
AB 329 (Nakanishi)	Chronic Diseases: Telemedicine	**Sponsor/Support**
AB 1025 (Bass)	Professions: Denial of Licensure	**Oppose**
AB 1073 (Nava)	Work Comp: CA lic. Physicians on Utiliz. Review	**Support**
AB 1224 (Hernandez)	Telemedicine (Optometrists)	**Support**
SB 102 (Migden)	Blood Transfusions: Brochure	**Support**
SB 472 (Corbett)	Prescription Drugs: Labeling Req. & Panel	**Support**
SB 620 (Correa)	Anesthesia Permit for Physicians in Dental Offices	**Support**
SB 761 (Ridley-Thomas)	Diversion & Vertical Enforcement	**Sponsor/Support**
SB 764 (Migden)	MBC Reporting Licensee Information to OSHPD	**Support w/conditions**
SB 767 (Ridley-Thomas)	Drug Overdose Treatment: Liability	**Neutral**
SB 797 (Ridley-Thomas)	Professions & Vocations	**Support**
SB 1048 (Comm. B,P&ED)	Healing Arts: Omnibus	**Support**

It was M/S (Aristeiguieta/Alexander) to assign AB 329 to the Access of Care Committee.

Sandra Bressler, California Medical Association (CMA), requested to comment on the fiscal audit. She stated the CMA does not have a position but indicated if the board were to maintain a two-year reserve, due to the size of its budget, there would be a $100,000,000 reserve. She also indicated the Board has been able to operate on a two month reserve in the past.

Dr. Fantozzi called for the vote on the motion regarding AB 329. The motion carried by unanimous vote.

Ms. Whitney reported AB 253 combines the two divisions of the board into one board effective January 1, 2008, revises the decision-making authority of the board by allowing the Executive Director

the authority to adopt default decisions and stipulations to surrender a license, and reduces the board membership from 21 to 15 members.

Ms. Whitney reported the board will need to elect officers for President, Vice President and a Secretary for the new restructured board and recommended the board hold elections at this meeting.

It was M/S/C (Yaroslavsky/Aristeiguieta) to hold elections to establish officers effective January 1, 2008.

Ms. Whitney stated the board also needed to determine whether to hold elections again in May or to restructure the terms for the calendar year and hold elections in November. She stated the board must establish and appoint the panels and committees for 2008 pursuant to restructuring.

Ms. Whitney advised the board needed to delegate the authority to the Executive Director to adopt default decisions and stipulations to surrender license. She recommended the board have the Secretary review and report back to the board on the delegation of this authority on January 1, 2009.

It was M/S/C to delegate the authority to the Executive Director.

Ms. Whitney reported SB 761 was held in the Assembly Appropriations Committee. The bill was held in committee due to concerns about legislating classifications. Consequently, the provisions of SB 761 regarding Vertical Enforcement/Prosecution were incorporated into SB 797, which was held on the assembly floor.

Ms. Whitney discussed implementation of the following legislation:

Sunset Diversion Program – Ms. Whitney deferred discussion on this issue to the full board meeting on Friday.

Sunset of the Vertical Prosecution Pilot Program – As reported SB 761 and SB 797 failed to move forward to extend the pilot program and the current legislation will become inoperative on July 1, 2008. Ms. Whitney advised senior management staff and Health Quality Enforcement Staff (HQES) have met and committed to a plan that aligns with the VE model as recommended by the board. Additionally, staff will continue to move forward with consideration of the feasibility of co-location between HQES and District offices, where appropriate, and implementation of an information technology system interoperable with the current system used at DOJ. Ms. Whitney asked for a motion authorizing staff to continue discussions and any necessary budget augmentation for the Attorney General positions that were added to the program.

It was M/S/C (Wender/Chang) to authorize staff to continue discussions regarding the extension of the pilot program and pursue budget augmentation as necessary.

Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL) and former enforcement monitor, strongly urged the board to support reintroducing a version of SB 797.

Ms. Whitney asked for a motion to authorize a study within existing resources to determine the correct classification and level of pay for board investigators.

A motion was moved and seconded to approve this study. The motion carried.

Next Ms. Whitney referred the members' to the orange-highlighted bills on the Tracker II list in their legislative packet and explained these bills were signed, the green-highlighted bills were vetoed, white and yellow highlighted bills are in a two-year status and could move forward in 2008. Additionally, she noted the board has taken a position on the yellow-highlighted bills.

The following proposed legislation for the 2008 legislative session was presented to the board for consideration and recommendation:

- Allow for a "cap" on the initial and renewal license fee instead of having a "fixed" amount prescribed by law.

It was M/S/C (Yaroslavsky/Wender) to authorize staff to begin discussions and seek legislation to allow for a cap on the current $790 physician initial and renewal fees.

- Revise the fund reserve language from two months to not more than four or six months.

Mr. Alexander made a motion that, in light of the inconsistency in the board's fiscal reserve of only two months and the inherent risk such a minimum reserve poses to the successful long-term and ongoing operation of the board and its fulfillment of its consumer protection mission; and considering the board has programs and plans ready for implementation that will advance its critical consumer protection mission, the board seek authority to rectify this inconsistency in reserve fund balances and modify the reserve fund allocation to a minimum of six months or as otherwise recommend by the board's executive director to ensure the board's mission, vision and programs are no longer at risk based upon the inconsistency in fund balance requirements, and the board's licensing and enforcement programs can be properly implemented and maintained. A lengthy discussion by the board followed.

Mr. Alexander withdrew his motion.

It was M/S/C (Alexander/Wender) to modify the reserve fund allocation as recommended.

- Extend Vertical Enforcement as an ongoing program with no sunset date, using the language currently in SB 797.

It was M/S/C (Wender/Alexander) to authorize staff to continue discussions regarding the extension of the pilot and seek legislation or budgetary authority.

- Address the outstanding sections of law related to the diversion program that have not been addressed with the sunset of the program. Business and Professions Code section 821.5 references the diversion program administrator and includes confidentiality of reports.

It was M/S/C (Yaroslavsky/Wender) to authorize staff to meet with interested parties to develop language that would be consistent with existing law in terms of the reporting and confidentiality, continue reporting to this board, and appoint a member of the board to participate in these discussions. *Dr. Fantozzi asked Dr. Salomonson to represent the board in these discussions.*

- Develop an initial licensing category for disabled physicians.

It was M/S/C (Yaroslavsky/Wender) to authorize staff to re-open the discussion regarding an initial limited license and appoint a member of the board to be a part of the discussions. *Dr. Fantozzi asked Dr. Gitnick to represent the board in these discussions.*

Ms. Whitney stated the Division of Licensing had numerous legislative proposals that will be discussed at the Division meeting on Friday and brought back to the full board.

- Allow an educational course be required when issuing a public letter of reprimand.

It was M/S/C (Yaroslavsky/Wender) to authorize staff to fully examine pros and cons of an amendment to Business and Professions Code section 2233, allowing an education course be required with a public letter of reprimand and appoint a board member to work with staff. *Dr. Fantozzi asked Mr. Zerunyan to represent the board in these discussions.*

- Clarify Business and Professions Code section 801 reporting relating to multiple physicians and clarify cancelled license definition.

It was M/S/C (Yaroslavsky/Chang) to authorize staff to fully examine these clarifications. *Dr. Fantozzi asked Mr. Zerunyan to represent the board in these discussions.*

No action was taken on the omnibus bill which carries the technical clean up language for the board.

Ms. Whitney also provided a brief update on the Governor's Healthcare Proposal Plan and explained this is expected to be heard at the end of this year.

Ms. Whitney reported there are seven Assembly bills and twenty-six Senate bills in extraordinary session. The board took the following position on the following four bills presented for their review and consideration:

SB1X 6 (Runner)	**Watch**
SB1X 12 (Runner)	**Watch**
SB1X 19 (Harman)	**Oppose**
SB1X 24 (Ashburn)	**Oppose**

It was M/S (Gitnick/Yaroslavsky) to seek legislative authorization for the transfer of $500,000 per year for two years to the Stephen Thompson Physician Loan Repayment Program. Following discussion, Dr. Wender requested an amendment to the motion for a one-time allocation of $500,000. It was accepted.

Dr. Hay, CMA, stated the CMA does not have a position on whether the board should fund this program but supports funding it through the General Fund. CMA does not have financial resources to do this but would be happy to work with the board to assist in obtaining funding.

Tara Kittle, healthcare consumer, spoke in support of the motion and stated there is a great need for this funding.

Mr. Alexander requested an amendment to the motion that board funds be spent only if there are matching funds from other sources up to $500,000. Dr. Gitnick rejected this amendment. The motion carried (7-4) for a one-time allocation of $500,000 to the program.

Agenda Item 5 Elections

A. Timing of Elections

Dr. Fantozzi brought forward the issue of changing the officers' terms to a calendar year to stay in concert with the legislative process, as discussed during Ms. Whitney's report on legislation.

Following a discussion by the members it was M/S (Yaroslavsky/Wender) to change the terms of the officers of the board to a calendar year.

Mr. Alexander requested an amendment to the motion to hold elections today (November 2007) and the terms to take effect immediately. This amendment was accepted and the motion carried.

B. Fill Board Officer Positions

Dr. Fantozzi asked for nominations for the office of President. Ms. Yaroslavsky nominated Dr. Fantozzi as President. Dr. Fantozzi was elected President of the Medical Board by acclamation.

Dr. Fantozzi asked for nominations for the office of Vice President. Dr. Gitnick nominated Dr. Aristeiguieta as Vice President. Dr. Aristeiguieta was elected Vice President of the Medical Board by acclamation.

Dr. Fantozzi asked for nominations for the office of Secretary. Dr. Salomonson nominated Ms. Chang as Secretary. Ms. Chang was elected Secretary of the Medical Board by acclamation.

Agenda Item 6 President's Report

Dr. Fantozzi stated the board is in a time of change and transition. A summit will be held January 24, 2008 as a public forum to discuss alternatives following sunset of the Diversion Program. The Strategic Plan will be reviewed and approved. He also discussed plans to move forward to re-establish Operation Safe Medicine.

Dr. Fantozzi directed staff, upon approval of the Strategic Plan, to review the list of existing committees and task forces of the board to determine their necessity and report back with a plan at the February meeting.

Dr. Fantozzi made the following appointments and changes to the committees:

- The members of the Executive Committee will include: President, Vice President, Secretary, Past President, and one member.
- Mr. Zerunyan was appointed to the Strategic Planning Committee.
- Ms. Yaroslavsky was appointed to the Cultural and Linguistic Workgroup.
- Ms. Schipske was appointed to the Medical Errors Task Force.
- Dr. Moskowitz and Dr. Giang were appointed to the Wellness Committee.
- Mr. Alexander, Dr. Aristeiguieta, Ms. Chang, Dr. Duruisseau, Dr. Low, and Dr. Moran were appointed to Panel A.
- Dr. Gitnick, Ms. Schipske, Dr. Salomonson, Dr. Wender, Ms. Yaroslavsky, and Mr. Zerunyan were appointed to Panel B.
- Ms. Chang, Dr. Duruisseau, and Dr. Chin were appointed to the Special Programs Committee.
- Dr. Gitnick, Dr. Low, and Ms. Schipske were appointed to the Application Review Committee.

Agenda Item 7 Executive Director's Report

A. Budget Overview and Staffing Update

Ms. Johnston provided an update on staffing and reported on her tour of the district offices to meet and visit with staff. She noted staff moral was low and disappointment was high due in part to anticipated pay raises that did not occur.

Ms. Threadgill was asked to provide an update on the Enforcement Program. She reported the board continues to struggle to retain seasoned investigators and explained investigators are leaving for other agencies and/or retiring. In addition, she provided an update on the transition of the probation

monitoring functions from investigators to inspectors and discussed plans to re-establish the Operation Safe Medicine program. She also reported additional medical consultants have been hired and plans are underway to hold a training program on December 11, and 12, 2007 in Cerritos.

B. Proposed Meeting Dates for April or May 2008.

Dr. Fantozzi directed the members' attention to page 64 of their board packet for information regarding a conflict with May 1, 2, 2008 meeting date which is scheduled to be held on the same time as the annual FSMB meeting. The members were asked to check their calendar and provide their availability on April 24-25 and May 8-9, 2007 to staff.

C. Board Meeting Survey

Ms. Johnston stated staff reviewed members' suggestions from the board meeting surveys and have implemented necessary changes as indicated.

Agenda Item 8 Approval of Vertical Enforcement Report

Ms. Threadgill referred the members to page 66 of their board packet for a copy of the Vertical Enforcement Report to Legislature and requested the members' approval of the report as required by SB 231.

Dr. Wender moved to approve the Vertical Enforcement Report. The motion was seconded by Ms. Yaroslavsky. Discussion by the members followed. Dr. Aristeiguieta requested staff continue to monitor this program and collect data to determine if the trends are due to VE or other factors. Ms. Johnston stated staff will continue to collect data for review.

Mr. Alexander requested an amendment to the motion to change the language of the recommendation on page 90 to replace the word significant with trends indicate and are likely to continue. In addition, he requested a statement be added to the report indicating the board shall monitor, at the minimum of an annual basis, the measurable outcomes from this program to ensure that consumer benefits continue to be demonstrated in the future. The amendment was accepted and the motion carried unanimously.

Agenda Item 9 California Physician Corp Program Update

Ms. Yaroslavsky stated there were no significant updates to report at this time.

Agenda Item 10 Cultural and Linguistic Physician Competency Workgroup Meeting Update

Ms. Chang reported the workgroup met on September 25, 2007 in Sacramento. They heard presentations from IMQ with CMA, and Sergio Aqugilla, M.D, PhD, Director of the UCD Center for Reducing Health Disparities. The workgroup established two sub-committees to work on further advancement of Cultural and Linguistic components. The next meeting will be held in January 2008.

Agenda Item 11 Access to Care Meeting Update

Dr. Gitnick stated the committee did not meet and there was no new information to report at this time.

Agenda Item 12. Public Comments on Items not on the Agenda –

- Carmen Rodriguez, Jesus Rodriguez and Gaby Rodriquez all spoke in support of Gaby Rodriguez and her complaint against her doctor and fraudulent concealment.
- Tara Kittle presented an idea that the board should host an annual conference.
- Janet Mitchell spoke regarding citizen's concerns regarding their doctors and her concerns regarding the Medical Board.

There being no further business, the meeting adjourned at 6:12 pm.

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Friday, November 2, 2007

Agenda Item 13 Call to Order/Roll Call

Dr. Fantozzi called the meeting to order on November 2, 2007 at 10:00 am. A quorum was present and notice had been sent to interested parties.

Members Present:

Richard Fantozzi, M.D., President
Steve Alexander
Cesar Aristeiguieta, M.D.
Hedy Chang
John Chin, M.D.
Shelton Duruisseau, Ph.D.
Gary Gitnick, 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:
Reginald Low, M.D.

Agenda Item 14 Physician Humanitarian Award

Dr. Fanotozzi stated it was his honor to announce Dr. Ron Bangasser was selected as the recipient of Physician Humanitarian Award. He stated it was his sad duty to inform the board that Dr. Bangasser passed away on May 2, 2007. Dr. Bangasser was a family practitioner and director of the Wound Care Center at Redlands Community Hospital. He introduced the hyperbaric chambers to the wound care ward at Redlands Community Hospital in 1982, which treats more than 4,000 patients a year. Dr. Fantozzi introduced Dr. Susan Bangasser, and her daughter, Dr. Debra Bangasser who accepted the award on behalf their late husband and father, Dr. Ron Bangasser.

Agenda Item 15 Strategic Planning

Ms. Kirchmeyer, Deputy Director, directed the members' attention to page 131 of their board packet for a copy of the newly revised draft Strategic Plan and requested the members' approval.

It was M/S/C (Yaroslavsky/Wender) to approve the Strategic Plan as presented.

Dr. Aristeiguieta called for a point of personal privilege and commended the board and staff on the new strategic plan.

Agenda Item 16 Information Technology Application Demonstration

Diane Ingram, Manager, Information Systems Branch introduced Angelo Whitfield, principal with Sophus Consulting. Mr. Whitfield provided a powerpoint presentation and demonstration of the application system used by DOJ which could replace the outdated non-interoperable CAS system. This system would allow the board to become fully interoperable with the DOJ's information systems for vertical enforcement as required by SB 231.

It was M/S/C (Wender/Yaroslavsky) to approve MBC Information Technology (IT) replacement to improve interoperability with DOJ's information system for vertical enforcement. Staff was directed to proceed with a Request For Proposal (RFP) and contract to perform the work to consolidate the systems.

Ms. Johnston stated the estimated cost of the project would be between 2.5 – 3 million dollars. She advised she would bring the RFP and cost back to the board at a later meeting.

Agenda Item 17 Wellness Committee Update

Dr. Duruisseau reported the Committee held its first official meeting on September 26, 2007 in Sacramento. The Committee discussed how to provide outreach and publications to promote wellness. Dr. Gregg agreed to assist with publications and Dr. Norcross agreed to assist with outreach efforts and development of partnerships. The Committee is currently creating a central listing of Wellness programs throughout the state. Dr. Duruisseau also reported the Committee is exploring the possibility of malpractice carriers providing incentives for physicians to participate in wellness programs. The committee will be hearing presentations at a future meeting.

Dr. Peter Moskowitz, Executive Director of the Center for Professional and Personal Renewal, was introduced and provided a presentation of physician wellness and renewal.

Agenda Item 18 Reports from the Divisions/Committees

A. Division of Licensing (DOL)

Ms. Chang reported the following:

- The DOL directed staff to pursue the legislative proposals and regulatory changes as presented and make recommendations back to the full board including clarifying medical education and post graduate training issues, public letters of reprimand, and clarifying re-application procedures.
- The DOL approved proposed language to revise CME regulations and the board set a hearing.
- The DOL approved the Physician Assistant Committee's language to amend title 16 section 1399.540 and requested a regulatory hearing be scheduled for the February 2008 board meeting.
- The DOL approved the issuance of a special faculty permit to Peter James Goadsby, M.D.
- The DOL disapproved Kigezi International School of Medicine.
- The DOL directed staff to develop a process for use when considering the suspension of special program suspensions.

Midwifery Committee

- The Midwifery Advisory Council (MAC) and staff is working with the Office of Statewide Health Planning and Development regarding the annual midwife coding system and annual reporting documents.
- The MAC was directed to continue working on the topic of remedial training and re-education of licensed midwives.

Dr. Fantozzi asked for a motion to approve the proposals for licensing legislation as presented. A motion was made and carried.

B. Division of Medical Quality (DMQ)

Dr. Aristeiguieta reported the following:

- The DMQ directed staff to re-examine its proposal for an award recognition program for expert reviewers. Dr. Wender will be working with staff on this project.
- The DMQ held a regulatory hearing to amend section 1364.30 and 1364.32 in Article 8 of chapter 2 – oral and written arguments.
- The DMQ voted to adopt the proposed regulations with minor changes to reflect the new structure of the board.
- Mr. Ramirez and Ms. Threadgill will work together to develop an integrated operations manual for DOJ and present it at the next board meeting.

Diversion Committee

Dr. Janet Salomonson thanked Dr. Wender, Frank Valine, Dr. David Pating, and Kim Kirchmeyer for all their hard work during this transition. Ms. Kirchmeyer was asked to present the plan and directed the members' attention to page 142 of their board packet to the staff report regarding the transition plan for Diversion Program. Ms. Kirchmeyer provided a brief overview of the plan and asked the members' for approval to proceed with of the proposed policies and implementation plan as outlined.

It was M/S to approve the transition plan and policy statements for the Diversion Program.

Public comment was heard from the following:

Julie D'Angelo Fellmeth, CPIL, voiced her objection to the plan's language regarding biological fluid testing. She believes the language proposed allows too long a period to obtain a collector for urine testing.

Sandra Bressler, CMA, voiced her objection to the language requiring a minimum of 4 urine tests per month throughout probation. The CMA would like to see some language allowing for a reduction in testing for physicians with clear urine screens. They would like more flexible language such as "as needed," or reference to being able to petition for less testing.

Ms. Kirchmeyer responded and stated probationers are allowed to petition for modification of probation under Business and Professions Code section 2307.

Dr. James Hay, representing the CMA reported a work-group has been meeting and has created a framework of preliminary recommendations on the goals and parameters of a new Public Protection and Physical Health Program to protect California patients. A copy of the proposal was handed-out.

Dr. Pating spoke in support of the transition plan and recommended the board approve it.

Following discussion by the members, the motion was amended to include adopting the change to the language as suggested by Ms. Fellmeth.

Ms. Kirchmeyer addressed the issue of hospital reporting pursuant to Business and Profession Code section 821.5 and stated the current law requires the hospital to notify the diversion program administrator. She advised after June 30 2008 and until new legislation is introduced, the reporting will be directed to the Deputy and Executive Director.
Ms. Bressler, CMA stated they will be working with the Hospital Association and the board to revise a better reporting system than to the Executive Director of the Medical Board.

It was moved to approve the transition plan with the amendment. The motion carried by unanimous vote.

As a reminder, Dr. Salomonson announced there will be a Diversion Summit on January 24, 2008 in Sacramento and stated further meeting information would be made available on the board's Web site.

Agenda Item 19 Forums on Use of Lasers Update

Dr. Mary Lynn Moran provided a brief overview of SB 1423 passed in September 2006 which added Business and Professions Code section 2023.5 requiring the Medical Board of California, in conjunction with the Board of Registered Nursing, to review issues and problems with the use of lasers and other devices for elective cosmetic procedures. Dr. Moran reported three public forums have been held and provided an update of these forums. She requested this item be placed on the agenda for discussion at the full board meeting in February 2008.

Agenda Item 20 Agenda Items for February 2008 Meeting

Mr. Alexander requested staff develop a statement to explain the constraints and limitations of the board during discussion of public comment on items not on the agenda. The statement should be placed next to the public comment forms so that anyone completing the form will be placed on notice as to the limitations placed on the members.

Agenda Item 21 Public Comment on Items not on the Agenda

Public Comment was heard from the following:

- Tara Kittle spoke in support of the wellness program for addressing solutions to physician stress and burnout.
- Judy Michel spoke regarding her concern about the reinstatement of Andrew Rutland's license and his ability to practice medicine.
- Beth Pimentel spoke regarding her concerns about the reinstatement of Andrew Rutland's license and his ability to practice medicine.

- Faith Gibson, spoke in support of physician wellness and suggested the board may want to reconsider their position on widening the nurse practitioner's scope of practice to take some of the burden off physicians.

Agenda Item 22 Adjournment

There being no further business, it was M/S/C to adjourn the meeting at 11:28 am.

_____
Richard Fantozzi, M.D, President

_____
Cesar Aristeiguieta, Vice President

_____
Barb Johnston, Executive Director

MEDICAL BOARD OF CALIFORNIA

Executive Office

AGENDA ITEM 2B

DIVISION OF MEDICAL QUALITY

Hilton San Diego Mission Valley
San Diego, CA

November 2, 2007

MINUTES

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Agenda Item 1

A quorum was present and due notice having been mailed to all interested parties, the meeting was called to order at 8:04 a.m. Members present included:

Members Present:
Cesar A. Aristeiguieta, M.D., President
Barbara Yaroslavsky, Vice President
Steve Alexander
John Chin, M.D.
Shelton Duruisseau, Ph.D.
Mary L. Moran, M.D.
Janet Salomonson, M.D.
Ronald H. Wender, M.D.
Frank V. Zerunyan

Members Absent:
Reginald Low, M.D.

Staff and Guests Present:
Barb Johnston, Executive Director
Kimberly Kirchmeyer, Deputy Director
Renee Threadgill, Chief of Enforcement
Laura Sweet, Deputy Chief
Kurt Heppler, DCA Legal Counsel
Carlos Ramirez, Senior Assistant Attorney General
Michael Cochrane, Deputy Attorney General
Martin Hagan, Deputy Attorney General
Candis Cohen, Public Information Officer
Linda Whitney, Chief of Legislation
Kevin Schunke, Regulation Coordinator
Kelly Nelson, Legislative Analyst

Paulette Romero, Associate Analyst
Janie Cordray, Research Program Manager
Frank Valine, Diversion Program Manager
Rhonda Baldo, Associate Analyst
Teresa Schaeffer, Associate Analyst
Lori Taul, Administrative Assistant
Valerie Moore, Associate Analyst
Nancy Edwards, Supervising Investigator
Patricia Stillwell, Senior Investigator
Angela Chang-Mills, Investigator
Diane Ingram, Information Systems Branch Manager
Angelo Whitfield, Project Consultant
David Pating, M.D.
Julie D'Angelo Fellmeth, Center for Public Interest Law
Carolyn Sam, Center for Public Interest Law
Sandra Bressler, California Medical Association
Brett Michelin, California Medical Association
James Hay, M.D., California Medical Association
Zennie Coughlin, Kaiser Permanente Medical Group
Antonette Sorrick, Deputy Director, Department of Consumer Affairs, Board Relations
Tara Kittle
Janet Mitchell

Agenda Item 2 Approval of Orders

Approval of Orders Restoring License Following Completion of Probation
The Division reviewed and approved 14 Orders. Vote: 9-0

Approval of Orders Issuing Public Letters of Reprimand
The Division reviewed and approved 12 Orders. Vote 9-0

Approval of Orders for License Surrender During Probation/Administrative Action
The Division reviewed and approved 4 Orders. Vote 9-0

Agenda Item 3 Approval of Minutes

Kurt Heppler, DCA Legal Counsel, pointed out that a correction was needed in the first paragraph of page 9 of the agenda packet, which is page 5 of the DMQ minutes, as "bona fide" was misspelled.

It was M/S (Zerunyan/Wender) to approve the Open Session minutes of the July 27, 2007 Division Meeting with the amendment. Motion carried (9-0).

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Agenda Item 4 Legislation and Regulation Updates

No report was given.

Agenda Item 5 Diversion Program Report

Frank Valine, Diversion Program Administrator, reported at its meeting on November 1, 2007, the Diversion Committee approved the transition plan for the Diversion Program. The summit will be held on January 24, 2008.

Agenda Item 6 Division Chief's Report

Renee Threadgill, Chief of Enforcement, provided an update on staffing changes within the Board. She stated the four Area Supervising Investigator positions have been filled.

Agenda Item 6A Medical Expert Program – Survey

Ms. Threadgill reported the comments from the expert reviewers continue to be positive, as 83% of the expert reviewers expressed a high level of satisfaction with the overall experience in performing case reviews. The DMQ members requested the survey be expanded to include more questions pertaining to the expert reviewers' interaction with the DAGs.

Agenda Item 6B Expert Utilization Report

Ms. Threadgill stated the number of active expert reviewers has increased since her last report to the DMQ. The Board efforts to obtain expert reviewers in the various specialties have been successful. Staff continues to be mindful not to over utilize any single expert.

Agenda Item 6C Expert Review Program Reports

Ms. Threadgill reported in January 2007, a workgroup was convened to explore ways to improve the expert reviewer program. She presented the workgroup's recommendation to issue plaques to expert reviewers in acknowledgment of their service to the DMQ for consideration. After a thorough discussion on ways to acknowledge the expert reviewers, the DMQ determined more information is needed before instituting such a program. Dr. Wender agreed to work with staff on this issue. It was M/S to direct staff to reexamine the proposal for the award program for expert reviewers and bring the matter back to the Board at a future meeting. Motion carried unanimously.

Agenda Item 7 Vertical Enforcement Update/Progress Report

Carlos Ramirez, Senior Assistant Attorney General, introduced two newly hired Deputy

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Attorneys General in the San Diego AG's office, Michael Cochrane and Martin Hagan. Mr. Ramirez asked that his written report to the DMQ be amended to reflect Vertical Enforcement instead of Vertical Prosecution. He further stated he will work with Ms. Threadgill and present a completely integrated operations manual to the DMQ at its April 2008 meeting.

Diane Ingram, Information Systems Branch Manager, stated a feasibility study is under way to analyze alternatives for a replacement system which will allow the MBC and DOJ systems to communicate. Discussion ensued on the process of feasibility study reports and the length of time it takes to complete them.

Angelo Whitfield, Department of Justice Project Consultant, reported on the progress of an interim program which allows the DAG's to access their cases in ProLaw and to work through investigations using ProLaw.

Ms. Kirchmeyer stated staff will provide documentation of the milestones for this temporary system to the Board at its next meeting. She added Mr. Whitfield and Ms. Ingram will give a presentation showing the direction this system is headed to the full board later today.

Agenda Item 8 REGULATIONS - PUBLIC HEARING

Dr. Cesar Aristeiguieta, President of the DMQ, called the hearing to order and announced the DMQ would conduct a public hearing on the proposed regulation to amend Section 1364.30 and to add Section 1364.32 of Title 16 of the California Code of Regulations as described in the notice published in the California Regulatory Notice Register and sent by mail to those on the board's mailing list. For the record, Dr. Aristeiguieta established the date and time of the hearing as November 2, 2007, at 9:05 a.m. He briefly described the regulatory proposals and gave instructions to potential speakers. He described the six legal review standards with which regulations must comply as well as the procedures that would be followed during the hearing.

A. **Oral and Written Arguments** – Amend Section 1364.30 in Article 8 of Chapter 2, Division 13; Adopt Section 1364.32 in Article 8 of Chapter 2, Division 13. This proposal will: 1) allow an administrative law judge or panel member to ask the parties to cite the record (Sec. 1364(c)); 2) require written arguments to cite the record, and authority, if applicable, for each point addressed (Sec. 1364.32); and 3) require respondents to be placed under oath, if the respondent elects to address the panel (Sec. 1364.30(e)).

Julie D'Angelo Fellmeth, Center for Public Interest Law testified that since the DMQ will not exist after December 2007 a technical change was needed in Section 1364.30(a), i.e., the word "division" should be changed to "board."

In the absence of any other written or oral testimony, Dr. Aristeiguieta closed the regulatory hearing to further testimony.

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Discussion ensued regarding Ms. Fellmeth's comment. Mr. Heppler clarified the proposed amendments to the existing regulatory language.
It was M/S (Yaroslavsky/Wender) to proceed with the change indicated below, and delegate to the Executive Director the authority to amend Section 1364.30 and add Section 1364.32 of Title 16 of the California Code of Regulations, as proposed at the expiration of the 15 day comment period if there are no adverse comments, with the following modification to Section 1364.32, subdivision (a): "A party who wishes to present oral argument to the panel of the board that issued an order of nonadoption or reconsideration shall make a written request for oral argument not later than twenty (20) calendar days after the date of the notice of nonadoption or the order granting reconsideration." Motion carried unanimously.

The regulatory hearing was adjourned.

Agenda Item 9 Public Comment

Janet Mitchell expressed her concerns and discontentment with the Board for reinstating Dr. Rutland's license to practice medicine in California. She stated Dr. Rutland is a danger to the people in this state and needs to be monitored very carefully.

Tara Kittle encouraged the Board to continue analyzing and responding to cases involving potential medical errors in a way to ensure constructive outcomes.

Agenda Item 10 Adjournment

There being no further business, the meeting was adjourned at 9:23 a.m.

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Cesar A. Aristeiguieta, M.D., F.A.C.E.P.
President

MEDICAL BOARD OF CALIFORNIA

Licensing Program

AGENDA ITEM 2C

Division of Licensing
Quarterly Meeting

Hilton San Diego Mission Valley
Newport Ballroom
901 Camino del Rio South
San Diego, CA 92108

November 2, 2007

MINUTES

Agenda Item 1 Call to Order/Roll Call

Ms. Chang called the meeting to order on November 2, 2007, at 8:05 a.m. A quorum was present and due notice had been sent to all interested parties.

Members Present:

Hedy Chang, Vice President
Richard Fantozzi, M.D.
Gary Gitnick, M.D., Secretary
Gerrie Schipske, R.N.P., J.D.

Staff Present:

Anita Scuri, Supervising Senior Counsel, Department of Consumer Affairs
Armando Melendez, Business Services Assistant, Business Services Office
Billie Baldo, MST, Administrative Assistant, Licensing Program
Cindi Oseto, Associate Governmental Program Analyst (AGPA), Licensing Program
Elberta Portman, Executive Officer, Physician Assistant Committee
Gary Qualset, Chief, Licensing Program
Kathi Burns, Staff Services Manager I, Licensing Program
Kelly Nelson, Legislative Analyst, Legislative/Regulatory Unit
Kevin Schunke, Regulation Coordinator, Legislative/Regulatory Unit
Kimberly Kirchmeyer, Deputy Director
Kurt Heppler, Senior Counsel, Department of Consumer Affairs
Linda Whitney, Chief, Legislative/Regulatory Unit
Pat Park, AGPA, Licensing Program
Stacie Berumen, Staff Services Manager I, Licensing Program

Members of the Audience:

Carrie Sparrevohn, L.M., Midwifery Advisory Council (MAC)
Claudia Breglia, L.M., California Association of Midwives (CAM)
Faith Gibson, L.M., Chair, Midwifery Advisory Council (MAC)

Gaye Breyman, California Academy of Physician Assistants
Michelle Butler, Center for Public Interest Law, University of San Diego School of Law
Leighton Reynolds, Ph.D.

Agenda Item 5 Report on Actions Taken in Closed Session

No closed session was conducted.

Agenda Item 6 Approval of Minutes from the July 27, 2007 Meeting

It was M/S/C (Schipske/Gitnick) to approve the minutes of the July 27, 2007 meeting as amended.

Agenda Item 7 President's Report

Ms. Chang noted the Midwifery Advisory Council meeting, Cultural and Linguistic Physician Competency Program Workgroup meeting and Special Faculty Permit Review Committee meeting updates would be reported later in the day.

Agenda Item 8 Legislation and Regulation Update

A. 2007 Legislation

Ms. Whitney stated the 2007 legislative packet had been reviewed and reported upon at the full board meeting on November 1, 2007.

B. Status of Regulatory Actions

Ms. Whitney referred the members to the Status of Pending Regulations Matrix located in their packets.

C. Proposals for 2008 Legislation

Mr. Qualset referred to the 2008 proposed legislative packet and reported that a total of fourteen legislative concepts were being proposed. Nine of the fourteen addressed general clarification and clean-up items to be included in the Department of Consumer Affair's next Omnibus bill. The remaining five proposals are intended to maintain consistency between the various licensing pathways to licensure, clarify that all coursework must be completed in an approved or recognized medical school, allow the board the option of issuing a public letter of reprimand to applicants (where circumstances did not warrant denial of an application or issuance of a probationary license), and make consistent the reapplication process for applicants who were denied licensure, regardless of appeal.

It was M/S/C (Gitnick/Schipske) to direct staff to pursue the legislative proposals as presented.

D. Proposals for 2008 Regulations

1. General Clean-Up

Mr. Qualset referred the members to the Proposed Regulation Changes Matrix and recommended the Legislative/Regulatory Unit move forward administratively with the non-substantive Section 100 changes. Additionally, a recommendation was made to amend sections 1318(a), 1319.1(a), 1319.2(a), and 1319.3(a) to adjust the number of days allowed for initial review of various applications from ten days to thirty days.

It was M/S/C (Gitnick/Fantozzi) to direct staff to pursue the regulatory changes as presented.

2. Continuing Medical Education Audit

Ms. Burns requested the members amend regulations relating to continuing medical education (CME). Ms. Burns reported current regulations require licensees to complete 100 hours of CME during a four period and require licensees to complete an average of 25 hours of CME during each calendar year. However, since the four year time period is not defined in regulation it is difficult to determine the four year period in question when a CME audit is performed. Additionally, the 25 hours per calendar year requirement causes further confusion since most licensees calculate CME hours based upon their renewal cycle and expiration date; a date established not by calendar year, but by the licensee's birth month.

Ms. Burns reported the proposed amendments: 1) direct licensees to complete at least 50 hours of approved CME during a renewal cycle, the two-year period immediately preceding the expiration of the license, (which is equivalent to the current requirement of 25 hours per year for a total of 100 every four years) in order to renew the license, 2) establish that the four year period consists of the two renewal cycles immediately preceding the license expiration date, and 3) eliminate the calculation of CME hours by calendar year.

Additionally, it was recommended the regulations be further amended to clearly identify that a licensee in a CME exempt status must complete 50 hours of CME prior to restoring the license to an active status; a requirement currently not clear in regulation.

It was M/S/C (Gitnick/Fantozzi) to approve the recommendations and set the matter for a regulatory hearing at the February 2008 meeting.

3. Equivalent Psychoanalytic Institutes

Ms. Burns reported on a request from a psychoanalytic institution and applicant for registration as a student research psychoanalyst that the board amend its regulations relating to equivalency of psychoanalytic institutes. The request was to include institutes accredited by the psychoanalytic accrediting body known as the American Board for Accreditation in Psychoanalysis, Inc. (ABAP).

The members requested more information be gathered regarding the ABAP and its

accreditation prior to making a decision.

Agenda Item 9 Physician Assistant Committee

A. Update

Ms. Portman, Executive Officer of the Physician Assistant Committee (PAC), reported the following:

Currently, there are 6439 California licensed physician assistants. In fiscal year 2006/2007, 649 applications for licensure were received and 577 licenses were issued. From July 1, 2007 through October 31, 2007, 237 applications were received and 212 licenses were issued.

A workgroup established at the request of the PAC, consisting of members from the California Medical Association, the California Academy of Physician Assistants, board staff and PAC staff, met to consider a continuing education (CE) requirement as a condition for license renewal for physician assistants. The workgroup developed a recommendation and proposed language and presented it to the PAC who approved the language and a fifty (50) hour CE requirement for renewal of a physician assistant's license. A concept paper has been submitted to the Department of Consumer Affairs Legislative Unit and is currently under review.

The next meeting of the PAC will be held November 8, 2007, and will include discussion of the implementation of AB 3 (Bass). This bill allows a physician assistant to administer, provide, or issue a drug order for certain classes of controlled substances without advance approval by a supervising physician and surgeon if the physician assistant completes specified educational requirements. Also, the bill increases the number of physician assistants a physician and surgeon may supervise and makes related changes.

B. Request to Set Regulatory Hearing for Proposed Amendment to Title 16 Section 1399.540 of the California Code of Regulations Regarding Delegation of Services Agreement

Ms. Portman reported on February 15, 2007, the PAC took action to amend Title 16, California Code of Regulations, section 1399.540 to require a written, signed, and dated Delegation of Services Agreement between physician assistants and supervising physicians. Based upon a request by the board, a workgroup was formed that included board and PAC staff and other interested parties. From that, proposed language was prepared and then approved by the PAC. There has been no opposition to the regulation language now presented to the DOL for consideration.

Dr. Gitnick asked about the regulatory history and what benefit the proposed changes would bring about. Ms. Portman reported the changes will formally name the Agreement and require both the supervising physician and the physician assistant to sign and date the Agreement, a change implemented to protect both parties. It will also identify that a physician assistant may have an agreement with more than one physician.

It was M/S/C (Gitnick/Fantozzi) to approve the recommendation and set the matter for a regulatory hearing at the February 2008 meeting.

Agenda Item 10 Action on Recommendation of Special Faculty Permit Review Committee

Dr. Gitnick reported at the October 17, 2007, Special Faculty Permit Review Committee (SFPRC) meeting the members reviewed one application for a Special Faculty Permit under Business and Professions Code section 2168.1. The SFPRC recommended approval of the application of Peter James Goadsby, M.D.

It was M/S/C (Fantozzi/Gitnick) to approve the application and issue a Special Faculty Permit to Peter James Goadsby, M.D.

Agenda Item 11 Cultural and Linguistic Physician Competency Program Workgroup Meeting Update

Ms. Chang reported on the Cultural and Linguistic Physician Competency Program Workgroup update given at the full board meeting on November 1, 2007.

Agenda Item 12 Midwifery Committee Report

Ms. Chang reported the following:

The Midwifery Advisory Council (MAC) and staff are working diligently with the Office of Statewide Health Planning and Development regarding the annual midwife coding system and annual reporting documents.

The MAC was directed to continue working on the topic of remedial training and re-education of licensed midwives.

The Midwifery Committee was advised of the difficulty some licensed midwives are experiencing obtaining lab service contracts.

A. Midwifery Advisory Council Report

Ms. Burns reported the MAC completed their work on the licensed midwife coding system, and 2007 reporting forms and instructions.

B. Midwifery Advisory Council Position Appointment Process

Mr. Qualset reported on the length of member terms and the appointment process for the MAC. Two member terms will expire in February 2008, so interest letters and applications for appointment will be mailed to all interested parties and licensees on or about November 15, 2007. The deadline for submitting an application will be December 31, 2007. A list of

recommendations will be presented to the board members at their meeting in February 2008.

Agenda Item 13 Recognition of International Medical School Programs

A. Kigezi International School of Medicine – Cambridge, England

Mr. Qualset reported a review of Kigezi International School of Medicine revealed its program does not meet the requirements established in Title 16, California Code of Regulations (CCR), section 1314.1 and therefore, recommended the international medical school be disapproved pursuant CCR 1314(c). Kigezi International School of Medicine-England is closed, not recognized by the government of the United Kingdom, and was not properly chartered in England thereby not qualifying the school for recognition by the board.

Dr. Gitnick asked if disapproving one and not other international medical schools in similar circumstances (not qualifying for and having not sought recognition), would somehow send an unintended message or consequence. Ms. Scuri advised the members they are authorized to issue such disapprovals and it is clearly within their discretion. She also commented that this school may be distinguished from others because it was not properly chartered in the country of its domicile.

It was M/S/C (Gitnick/Fantozzi) to disapprove Kigezi International School of Medicine.

Agenda Item 14 Division Chief's Report

Mr. Qualset reported the following:

During the first quarter of the fiscal year the board received 1,465 new physician and surgeon applications and issued 1,271 new licenses. Initial application review times for US and Canadian graduate applications are currently at 30 days and international graduate applications are at 65 days. Initial review times for international graduate applications increased due it being a high volume time of year and the recent turnover of experienced licensing staff.

The Consumer Information Unit received a total of 17,269 calls last quarter.

During the first quarter of the fiscal year the board's licensed midwife program received four applications, issued five licenses, and denied no applications. Three applications are currently pending. As of August 31, 2007, there were 172 current and renewed licensed midwives.

The next Midwifery Advisory Committee meeting is scheduled for December 6, 2007, and the Cultural and Linguistic Competency of Physicians Program Workgroup and Special Faculty Permit Review Committee meetings are expected to occur in January 2008.

Due to recent concerns with three of the eight medical schools in California who participate in the board's special programs pursuant to Business and Professions Code sections 2111, 2113, and 2168 suspensions were issued by the executive staff. One institution was ordered to cease

operation of all current and future participants. This school worked quickly with the board to resolve the concerns and within a few weeks current participants were allowed to resume activities. Once this school submits written procedures related to the internal operations of their special programs, the suspension of new applications will be lifted. One particular department within a school received a three-year suspension for new appointments under sections 2111 and 2113; however, the school can petition for early termination. Another school received a suspension of new appointments under sections 2111 and 2113. A site visit is scheduled at this school for December 5th and 6th to review the schools programs.

Dr. Gitnick expressed concern that the suspensions of these institutions were not fully and completely addressed by the division or an appropriate committee. The division supports and trusts staff but a process must be developed to include committee or division members in decisions relating to special program suspensions.

It was M/S/C (Gitnick/Fantozzi) to direct staff to develop a process for use when considering the suspension of special programs within a school or department.

Agenda Item 15 Public Comment on Items Not on the Agenda

None.

Agenda Item 17 Adjournment

Ms. Chang adjourned the meeting at 9:44 a.m.

Hedy Chang, Vice President

Gary Gitnick, M.D., Secretary

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. Hedy Chang	Gary Gitnick, M.D.	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	
Cultural & Linguistic Competency Work Group	Hedy Chang, Chair Shelton Duruisseau, Ph.D. Barbara Yaroslavsky		Gary Qualset Kathi Burns	
Physician Recognition Committee	**Mary Lynn Moran, M.D., Chair** Frank V. Zerunyan, JD		Candis Cohen	
Education Committee	**Barbara Yaroslavsky, Chair** Hedy Chang Mary Lynn Moran, M.D. Gerrie Schipske, RN, JD	Janet Salomonson, M.D.	Candis Cohen	Candis Cohen
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	
Medical Errors Task Force	**Cesar Aristeiguieta, M.D., Chair** Steve Alexander Reginald Low, M.D. Mary Lynn Moran, M.D. Gerrie Schipske, RN, JD		Janie Cordray	
Wellness Committee	**Shelton Duruisseau, Ph.D., Chair** John Chin, M.D. Daniel Giang, M.D. Laurie C. Gregg, M.D.	Peter Moskowitz, M.D William Norcross, M.D.	Kevin Schunke	
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	

Members of Executive Committee include: President, Vice President, Secretary, Immediate Past President, and 1 other member. (*note: there should be one member within group of five members)

Revised: 1/08

	Closed Session Committees		
Application Review Committee	Gary Gitnick, M.D. Reginald Lowe, M.D. Gerrie Schipske, RN, JD	Gary Qualset	Billie Baldo
Special Programs Committee	Ronald H. Wender, M.D. John Chin, M.D. Hedy Chang Shelton Duruisseau, Ph.D.	Gary Qualset	Billie Baldo
Panel A	Steve Alexander Cesar Aristeiguieta, M.D. Hedy Chang Shelton Duruisseau, Ph.D. Reginald Low, M.D. Mary Lynn Moran, M.D.	Renee Threadgill	
Panel B	Gary Gitnick, M.D. Janet Salomonson, M.D. Gerrie Schipske, RN, JD Ronald Wender, M.D. Barbara Yaroslavsky Frank Zerunyan, JD	Renee Threadgill	

Revised: 1/08

Medical Board of California
2007 Tracker II - Legislative Bills
1/23/2008

BILL	AUTHOR	TITLE	STATUS	AMENDED	POSITION
AB 54	Dymally	Health Care Coverage: acupuncture	Approps.	01/16/08	
AB 64	Berg	Uniform Emergency Volunteer Health Practitioners Act	Sen. Rules	07/11/07	
AB 158	Ma	Medi-Cal: nondisabled persons infected with chronic hep. B	Approps.	01/18/08	
AB 272	Garcia	HIV Tests	Health		
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 636	Levine	Acupuncture	B&P	03/27/07	
AB 638	Bass	Physician Assistants: educational loan program	Approps.	01/18/08	
AB 865	Davis	State Agencies: live customer service agents	Approps.	01/22/08	
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	
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 1276	Karnette	Pharmacies: prescription containers: labels	B&P	04/17/07	
AB 1390	Huffman	Health Care Service Plans: unfair payment patterns	Sen. Health		
AB 1399	Richardson	Pharmacies: prescription labels	Health		
AB 1436	Hernandez	Nurse Practitioners	Approps.	01/07/08	
AB 1444	Emmerson	Physical therapists: scope of practice	B&P	04/09/07	
AB 1468	Garrick	Hospitals: patient data	Health	04/10/07	
AB 1486	Calderon	Licensed Professional Counselors	Sen. B&P	06/26/07	

Medical Board of California
2007 Tracker II - Legislative Bills
1/23/2008

BILL	AUTHOR	TITLE	STATUS	AMENDED	POSITION
AB 1555	Lieber	Health Care Services: chronic care model task force	Approps.	04/26/07	
AB 1643	Niello	Nurse Practitioners	B&P		
ABX1 2	Nunez	Health Care Reform	Health	11/08/07	
ABX1 6	Nakanishi	Physician Assistants: educational loan program	Introduced		
ACR 87	Hayashi	Legislative Task Force on Peripheral Neuroopathy	Introduced		
SB 136	Cedillo	Acupuncture: Tui Na	B&P	04/16/07	
SB 356	Negrete McLeod	List of Reportable Diseases and Conditions	Inactive File	08/20/07	
SB 618	Alquist	State Agencies: electronic records	Appr.-Susp		
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 809	Ashburn	Nurse Practitioners: scope of practice	Floor	03/26/07	
SB 825	Padilla	Public Health: shaken baby syndrome	Approps.	01/17/08	
SB 840	Kuehl	Single-Payer Health Care Coverage	Asm. Approps.	07/10/07	
SB 843	Calderon	Medical Information	Judiciary	01/07/08	
SB 907	Calderon	Physcians and Surgeons: referrals	Floor		
SB 963	Ridley-Thomas	Regulatory Boards: Operations	Asm. B&P	06/25/07	
SB 971	McClintock	Government Reorganization: realignment of closure	G.O.	01/09/08	
SB 1014	Kuehl	Taxation: single-payer health care coverage tax	Rev.&Tax	04/23/07	
SB 1098	Migden	Medical Marijuana	Introduced		
SBX1 6	Runner	Hospitals: preventative medical services	Rules		
SBX1 9	Runner	Primary Care Clinics	Health	01/10/08	
SBX1 12	Runner	Health Care Cost and Quality Transparency	Health	01/04/08	

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SBX1 24
Author: Ashburn
Bill Date: October 11, 2007, introduced
Subject: Nurse Practitioners: scope of practice.
Sponsor: Author

STATUS OF BILL:

This bill is currently assigned to the Senate Rules Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would revise the scope of practice and educational requirements for nurse practitioners. Current law requires nurse practitioners to be supervised by a physician. This bill removes a majority of the physician supervision requirements.

ANALYSIS:

This bill expands the scope of practice for nurse practitioners and removes physician supervision. This bill would allow nurse practitioners to prescribe drugs once he or she is certified by the Board of Registered Nursing to have completed at least six months supervised experience in prescribing. This bill would delete the prohibition against a physician supervising more than four nurse practitioners at one time. This bill would make nurse practitioners eligible to receive direct payment for patient care services.

FISCAL: None

POSITION: Oppose

January 22, 2008

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.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SBX1 19
Author: Cogdill (Coauthor: Harman)
Bill Date: October 11, 2007, introduced
Subject: Medical corporations.
Sponsor: Author

STATUS OF BILL:

This bill is currently assigned to the Senate Health Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would delete the Corporate Practice prohibition in the Medical Practice Act that prohibits corporations and other artificial entities from having professional rights, privileges, and powers.

ANALYSIS:

Corporations and other artificial entities would have professional rights, privileges, and powers. This takes the health care decisions making away from physicians and puts it in the hands of the profit motive corporations.

FISCAL: None

POSITION: Oppose

January 22, 2008

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.~~

~~(c) 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.~~

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: ABX1 1
Author: Nunez (Coauthor: Perata)
Bill Date: January 16, 2008, amended
Subject: Health Care Reform.
Sponsor: Author

STATUS OF BILL:

This bill is currently assigned to the Senate Health Committee and is set for hearing on January 23, 2008.

DESCRIPTION OF CURRENT LEGISLATION:

This bill enacts the California Health Care Security and Cost Reduction Act (Act). The Act includes an expansion of the Medi-Cal Program and the Healthy Families Program (HFP), creation of a statewide purchasing pool (the California Cooperative Health Insurance Purchasing Pool or Cal-CHIPP), creation of an individual mandate to purchase health insurance, modification of the individual and group insurance markets, expansion of preventive health programs and imposition of a medical loss ratio (MLR), which requires insurers to spend a specified proportion of premiums collected on medical care.

ANALYSIS:

As is relates to the Medical Board, this bill creates The Task Force on Nurse Practitioner Scope of Practice. The Task Force would consist of the Director of Consumer Affairs, three members of the Medical Board of California (Board), three members of the Board of Registered Nursing, and two representatives of an institution of higher education. Two of the Medical Board member representatives will be appointed by the Governor and the third will be appointed by the Senate Committee on Rules.

The Board's Executive Committee voted to issue a policy statement, rather than take an official position on this bill.

FISCAL: None

POSITION: Issue Policy Statement

January 22, 2008

AMENDED IN SENATE JANUARY 16, 2008

AMENDED IN ASSEMBLY DECEMBER 17, 2007

AMENDED IN ASSEMBLY DECEMBER 13, 2007

AMENDED IN ASSEMBLY NOVEMBER 8, 2007

CALIFORNIA LEGISLATURE—2007–08 FIRST EXTRAORDINARY SESSION

ASSEMBLY BILL No. 1

Introduced by Assembly Member Nunez
(Principal coauthor: Senator Perata)

September 11, 2007

An act to amend Section 2069 of, to add Sections 4040.1, 4071.2, 4071.3, and 4071.4 to, and to add and repeal Section 2838 of, the Business and Professions Code, to add Section 49452.9 to the Education Code, to add Sections 12803.2, 12803.25, 22830.5, and 22830.6 to, and to add Chapter 15 (commencing with Section 8899.50) to Division 1 of Title 2 of, the Government Code, to amend Sections 1357.54, 1365, 124900, 124905, 124910, 124920, 128745, and 128748 of, to amend, repeal, and add Section 1399.56 of, to add Sections 1262.9, 1342.9, 1347, 1356.2, 1367.16, 1367.205, 1367.38, 1368.025, 1378.1, 1395.2, 1399.58, 104376, 124905.1, 124946, and 130545 to, to add Chapter 1.6 (commencing with Section 155) to Part 1 of Division 1 of, to add Article 11.6 (commencing with Section 1399.820) to Chapter 2.2 of Division 2 of, to add Article 1 (commencing with Section 104250) to Chapter 4 of Part 1 of Division 103 of, to add Article 3 (commencing with Section 104705) to Chapter 2 of Part 3 of Division 103 of, and to add Chapter 4 (commencing with Section 128850) to Part 5 of Division 107 of, the Health and Safety Code, to amend Sections 12693.43, 12693.70, 12693.73, and 12693.76 of, to amend, repeal, and add Section 796.02 of, to add Sections 796.05, 10113.10, 10113.11, 10123.56, 10176.15,

10273.6, 12693.56, 12693.57, 12693.58, 12693.59, 12693.766, 12886, and 12887 to, to add Chapter 9.6 (commencing with Section 10919) to Part 2 of Division 2 of, and to add Part 6.45 (commencing with Section 12699.201) and Part 6.7 (commencing with Section 12739.50) to Division 2 of, the Insurance Code, to add Section 96.8 to the Labor Code, to amend Sections 19167 and 19611 of, to add Sections 17052.31, 17052.32, 19528.5, and 19553.5 to, and to add and repeal Section 17052.30 of, the Revenue and Taxation Code, to add Sections 301.1 and 1120 to, and to add Division 1.2 (commencing with Section 4800) to, the Unemployment Insurance Code, and to amend Sections 12306.1, 14005.30, and 14011.16 of, to add Sections 14005.301, 14005.305, 14005.306, 14005.310, 14005.311, 14005.331, 14005.333, 14011.16.1, 14074.5, 14081.6, 14092.5, 14132.105, and 14137.10 to, and to add Article 5.215 (commencing with Section 14167.22) to, and to add and repeal Article 5.21 (commencing with Section 14167.1) of, Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1, as amended, Nunez. Health care reform.

(1) Existing law creates the California Health and Human Services Agency.

This bill would require the agency, in consultation with the Board of Administration of the Public Employees' Retirement System (PERS), to assume lead agency responsibility for professional review and development of best practice standards for high-cost chronic diseases that state health care programs would be required to implement upon their adoption. The bill would additionally require the agency, in consultation with PERS and health care provider groups, to develop health care provider performance measurement benchmarks, as specified.

The bill, effective July 1, 2008, would create the California Health Care Cost and Quality Transparency Committee in the California Health and Human Services Agency, with various powers and duties, including the development and periodic review of a health care cost and quality transparency plan. The bill would require the Office of Statewide Health Planning and Development to assist the committee in that regard. The bill would require the Secretary of California Health and Human Services to track and assess the effects of health care reform and to

report to the Legislature by March 1, 2012, and biennially thereafter. The bill would also create the California Health Benefits Service within the State Department of Health Care Services, with various powers and duties relative to creation of joint ventures between certain county-organized health plans and various other entities. The bill would require these joint ventures to be licensed as health care service plans and would create a stakeholder committee.

(2) Existing law does not provide a system of health care coverage for all California residents. Existing law does not require employers to provide health care coverage for employees and dependents, other than coverage provided as part of the workers' compensation system for work-related employee injuries, and does not require individuals to maintain health care coverage. Existing law provides for the creation of various programs to provide health care coverage to persons who have limited incomes and meet various eligibility requirements. These programs include the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, and the Medi-Cal program, administered by the State Department of Health Care Services and county welfare departments.

This bill would require California residents, subject to certain exceptions, to enroll in and maintain at least minimum creditable health care coverage, as determined by the Managed Risk Medical Insurance Board, for themselves and their dependents, as defined. The bill would require the board to establish, by regulation, the definition and standards for minimum creditable coverage, including an affordability standard and hardship exemptions, by March 1, 2009, and would require the board to facilitate enrollment in public or private coverage and to establish an education and awareness program, by January 1, 2010, relating to the requirement to obtain minimum creditable coverage. The bill would enact related provisions, including authorizing a school district, on and after January 1, 2010, to provide parents and guardians information explaining these health care coverage requirements.

The bill would, as of January 1, 2009, create the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), which would function as a statewide purchasing pool for health care coverage and be administered by the Managed Risk Medical Insurance Board. The bill would specify eligibility for Cal-CHIPP and would require the board to develop and offer a variety of benefit plan designs, including the Cal-CHIPP Healthy Families plan in which enrollment would be restricted to specified low-income persons. The bill would authorize

an employer to pay all or a part of the premium payment required of its employees enrolled in Cal-CHIPP. The bill would make it an unfair labor practice for an employer to refer an employee, or his or her dependent, to Cal-CHIPP or to arrange for their application to that program to separate them from group coverage provided through the employment relationship, and for an employer to change the share-of-cost ratio or modify coverage in order for an employee or his or her dependents to enroll in that program. Because an unfair labor practice may be punishable as a crime, the bill would impose a state-mandated local program. The bill would create the California Health Trust Fund in the State Treasury for the purposes of this act. The bill would require the State Department of Health Care Services to seek any necessary federal approval to enable the state to receive federal Medicaid funds for specified persons who could otherwise be made eligible for Medi-Cal benefits, with the state share of funds to be provided from the California Health Trust Fund. The bill, on and after July 1, 2010, would also extend Medi-Cal benefits to parents and caretaker relatives and various other persons meeting certain eligibility requirements. The bill would require certain of these individuals to receive their benefits in the form of a benchmark package, which would be the Cal-CHIPP Healthy Families benefit package. The bill would provide for the benchmark benefits to be administered by the Managed Risk Medical Insurance Board, pursuant to an interagency agreement with the department. The bill would make these provisions subject to federal financial participation and approval, as specified.

The bill would require the State Department of Health Care Services to establish a Healthy Action Incentives and Rewards Program to be provided as a covered benefit under the Medi-Cal program, subject to federal financial participation and approval. The bill would also require the Director of Health Care Services to establish a local coverage option program for low-income adults that would be the exclusive Medi-Cal coverage for a 4-year period beginning with the program's commencement, for county residents who, among other requirements, have a family income at or below 100% of the federal poverty level and are not otherwise eligible for the Medi-Cal program. The bill would specify that the program would become operational for services rendered on or after July 1, 2010. The bill would specify that coverage under the program would be provided at a county's option and only by a county that operates a designated public hospital, subject to approval by the State Department of Health Care Services and contingent on

establishment of a county share of cost. The bill would require the State Department of Health Care Services, by January 1, 2010, to contract with an independent 3rd party to develop an assessment tool to measure the care provided under the program. The bill would require the department, after 3 years of the program's operation, to evaluate the program using the assessment tool and would extend the program for an additional 2 years if the program substantially met certain criteria and would terminate the program if it did not. The bill would enact other related provisions.

The bill, subject to future appropriation of funds, would expand the number of children eligible for coverage under the Healthy Families Program on and after July 1, 2009. The bill would, on and after July 1, 2009, delete as an eligibility requirement for a child under the Healthy Families Program and the Medi-Cal program that the child satisfy citizen and immigration status requirements applicable to the programs under federal law, thereby creating a state-only element of the programs. The bill would additionally, on and after July 1, 2009, disregard all income over 250% but less than or equal to 300% of the federal poverty level and would apply Medi-Cal program income deductions to a family income greater than 300% of the federal poverty level in determining eligibility for the Healthy Families Program. The bill would authorize the board to provide, or arrange for the provision of, an electronic personal health record under the Healthy Families Program, to the extent funds are appropriated for that purpose, and would provide for the confidentiality of information obtained pursuant to the program.

The bill would require the department to exercise its federal option as necessary to simplify Medi-Cal eligibility by exempting all resources for certain applicants and recipients, commencing July 1, 2010.

The bill would enact the Medi-Cal Physician Services Rate Increase Act, which would establish, with respect to services rendered to Medi-Cal beneficiaries on and after July 1, 2010, to the extent funds are appropriated in the annual Budget Act, increased reimbursements of up to 100% of the Medicare rate for physicians, physician groups, as defined, and others that are enrolled Medi-Cal providers eligible to receive payments for Medi-Cal services. The bill would permit some of these rate increases to be linked to specified performance measures and would provide that these rate increases would be implemented only to the extent that state funds are appropriated for the nonfederal share of these increases. The bill would require the Director of Health Care Services to seek federal approval of the rate methodology set forth in

the act and would prohibit the methodology from being implemented if federal approval is not obtained.

Because each county is required to determine eligibility for the Medi-Cal program, expansion of program eligibility would impose a state-mandated local program.

This bill would also enact the Medi-Cal Hospital Rate Stabilization Act, which would revise the methodology by which safety net care pool funds are paid to designated public hospitals for providing uncompensated care to the uninsured. The bill would require the State Department of Health Care Services to determine an outpatient base rate and an inpatient base rate, as defined, for various types of hospitals. The bill would also, commencing July 1, 2010, establish specified reimbursement rate methodologies under the Medi-Cal program for hospital services, as defined, that are rendered by designated public hospitals and for managed health care plans, as specified, and would require managed health care plans to expend 100% of moneys received under the increased rates for payments to hospitals for providing services to Medi-Cal patients. The bill would make implementation of certain of these provisions contingent on the establishment of certain requirements under which counties pay a share of cost for persons enrolled in the Medi-Cal program, and would make implementation of all of these provisions contingent on the imposition of a 4% fee on the net patient revenue of general acute care hospitals.

This bill would also require a portion of the nonfederal share of the reimbursement for designated public hospitals be transferred to the Workforce Development Program Fund, which the bill would create in the State Treasury. Moneys in the fund would, upon appropriation, be used exclusively for retraining county hospital and clinic systems' health care workers and be allocated by the Office of Statewide Health Planning and Development.

(3) Existing law provides for the county administered In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons are provided with services in order to permit them to remain in their own homes and avoid institutionalization.

Existing law permits services to be provided under the IHSS program either through the employment of individual providers, a contract between the county and an entity for the provision of services, the creation by the county of a public authority, or a contract between the county and a nonprofit consortium.

Existing law provides that when any increase in provider wages or benefits is negotiated or agreed to by a public authority or nonprofit consortium, the county shall use county only funds for the state and county share of any increase in the program, unless otherwise provided in the Budget Act or appropriated by statute.

Existing law establishes a formula with regard to provider wages or benefits increases negotiated or agreed to by a public authority or nonprofit consortium, and specifies the percentages required to be paid by the state and counties, beginning with the 2000–01 fiscal year, with regard to the nonfederal share of any increases.

This bill would revise the formula for state participation in provider health benefit increases. The bill would also authorize a county employee representative to elect to provide health benefits through a trust fund, as specified.

(4) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

This bill would enact various health insurance market reforms, to be operative on specified dates, including requirements for guarantee issue of individual health care service plan contracts and health insurance policies and other requirements relating to individual coverage, modified disclosures, and other related changes. The bill, on and after July 1, 2010, would require at least 85% of full-service health care service plan dues, fees, and other periodic payments and health insurance premiums to be spent on health care benefits and not on administrative costs. The bill would allow a health care service plan and a health insurer to provide notices by electronic transmission using specified procedures.

The bill would require a health care service plan providing prescription drug benefits and maintaining a drug formulary to, commencing on or before January 1, 2010, make the most current formularies available electronically to prescribers and pharmacies and would require health care service plans that provide services to certain beneficiaries under a Medi-Cal managed care program to be subject solely to the filing, reporting, monitoring, and survey requirements established by the State Department of Health Care Services for the Medi-Cal managed care program for designated subjects. The bill would require the department and the State Department of Health Care Services to develop a joint filing and review process for medical quality surveys.

The bill would also require group health care service plan contracts and group health insurance policies offered, amended, or renewed on or after January 1, 2009, to offer to include a Healthy Action Incentives and Rewards Program, as specified. The bill would also authorize an employer to provide health coverage that includes a Healthy Action Incentives and Rewards Program to his or her employees.

Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

(5) The Personal Income Tax Law authorizes various credits against the taxes imposed by that law.

This bill would, for taxable years beginning on or after January 1, 2010, and before January 1, 2015, allow to a qualified taxpayer, as defined, a refundable credit against those taxes in an amount equal to those qualified health care plan premium costs, as defined, that are in excess of 5.5% of a qualified taxpayer's adjusted gross income for the taxable year, except as provided. This bill would, upon appropriation by the Legislature, require that all amounts deposited into the California Health Trust Fund be transferred to the Managed Risk Medical Insurance Board for purposes of advancing the refundable credit and to the Franchise Tax Board for purposes of recovering amounts expended for the refunds, as provided.

(6) Existing law creates the Employment Development Department in the Labor and Workforce Development Agency and vests that department with the duties, purposes, responsibilities, and jurisdiction previously exercised by the State Department of Benefit Payments or the California Health and Human Services Agency with respect to job creation activities.

This bill would require the department to establish data collection and reporting methods and requirements, as specified, to collect and report information related to employer health expenditures on behalf of their employees. The bill would require the department to report on that data to the Managed Risk Medical Insurance Board and the Legislature on an annual basis commencing April 1, 2011, and would authorize the department to adopt regulations to implement these provisions.

(7) Under existing federal law, a cafeteria plan is a written plan through which employees choose among 2 or more benefits consisting of cash and qualified benefits. Existing federal law provides that, except as specified, no amount is included in the gross income of a participant

in a cafeteria plan solely because the participant may choose among the benefits of the plan.

This bill would, beginning January 1, 2010, require an employer to adopt and maintain a cafeteria plan to allow employees to pay premiums for health care coverage to the extent amounts for that coverage are excludable from the gross income of the employee, as specified. The bill would require an employer who fails to establish or maintain a cafeteria plan to pay a penalty of $100 or $500 per employee, as specified.

(8) Existing law authorizes the Board of Administration of the Public Employees' Retirement System to contract with carriers offering health benefit plans for coverage for eligible employees and annuitants.

This bill would require the board, on or before January 1, 2010, to provide or arrange for the provision of an electronic personal health record for enrollees receiving health care benefits.

(9) Existing law establishes the State Department of Public Health, which licenses and regulates health facilities and also administers funds for programs relating to smoking cessation. Under existing law, a noncontracting hospital is required to contact an enrollee's health care service plan to obtain the enrollee's medical record information prior to admitting the enrollee for inpatient poststabilization care, as defined, or prior to transferring the enrollee, if certain conditions apply. Existing law prohibits the hospital from billing the enrollee for poststabilization care if it is required to, and fails to, contact the enrollee's health care service plan. Under existing law, a violation of any of these provisions is punishable as a misdemeanor.

This bill would prohibit a noncontracting hospital, as defined, from billing a covered patient for emergency health care services and poststabilizing care except for applicable copayments and cost shares. By changing the definition of an existing crime, this bill would impose a state-mandated local program.

The bill would also require the department to maintain the California Diabetes Program to provide information and assistance pertaining to the prevention and treatment of diabetes. The bill would also establish the Comprehensive Diabetes Services Program in the State Department of Health Care Services to provide diabetes prevention and management services to certain beneficiaries in the Medi-Cal program, to the extent funding is available for this purpose. The bill would also require the department, in consultation with the Department of Managed Health Care, the State Department of Health Care Services, the Managed Risk

Medical Insurance Board, and the Department of Insurance, to annually identify the 10 largest providers of health care coverage in the state, to ascertain and summarize the smoking cessation benefits provided by those coverage providers, to publish the benefit summary on the department's Internet Web site, to include the benefit summary as part of its preventive health education against tobacco use campaign, and to evaluate any changes in connection with the smoking cessation benefits provided by the coverage providers, as provided. The bill would also require the department, to the extent that funds are available and appropriated for this purpose, to increase the capacity of effective smoking cessation services available from, and expand the awareness of, services available through, the California Smokers' Helpline, as prescribed.

The bill would also create the Community Makeover Grant program that would be administered by the department and would require it to award grants to local health departments in cities and counties, which would serve as the local lead agencies in administering the program, for the purpose of developing new programs or improving existing programs that promote active living and healthy eating. The bill would require the department to issue guidelines and to specify data reporting requirements for local lead agencies to comply with various requirements relating to the administration of the program. The bill would also require the department to develop a sustained media campaign to educate the public about the importance of obesity prevention.

(10) Existing law requires the State Department of Health Care Services to select certain primary care clinics to be reimbursed for delivering medical services, including preventive health care and smoking prevention and cessation health education, to program beneficiaries, based upon specified criteria. Existing law requires that a clinic meet specified requirements in order to receive a reimbursement. Under existing law, a program beneficiary is a person whose income is at or below 200% of the federal poverty level. Existing law requires the department to utilize existing contractual claims processing services to promote efficiency and maximize the use of funds.

This bill would additionally require that, in order receive a reimbursement, a clinic serve as a designated primary care medical home for program beneficiaries, as specified. The bill would also revise the definition of program beneficiary to mean a person whose income is at or below 250% of the poverty level and who either does not have

private or employer-based health care coverage or is not enrolled in or is ineligible for public health care coverage programs. This bill would delete the provision requiring the department to utilize existing contractual claims processing services and instead authorize the department to contract with public and private entities or utilize existing health care service provider enrollment and payment mechanisms in order to perform its duties, as specified. The bill would additionally require that the department maximize the availability of federal funding for services provided pursuant to these provisions. The bill would make related changes.

(11) Existing law provides for the Office of Statewide Health Planning and Development, which has specified powers and duties. Existing law requires the office to publish specified reports.

This bill would require the office to publish risk-adjusted outcome reports for percutaneous coronary interventions, commencing January 1, 2010, and would require the office to establish a clinical data collection program to collect data on percutaneous coronary interventions and establish by regulation the data to be reported by each hospital.

(12) Existing law provides for the certification and regulation of nurses, including nurse practitioners and nurse-midwives, by the Board of Registered Nursing and for the licensure and regulation of physician assistants by the Physician Assistant Committee of the Medical Board of California. Existing law provides that a medical assistant may administer medication upon the specific authorization and supervision of a licensed physician and surgeon or licensed podiatrist or, in specified clinic settings, upon the specific authorization and supervision of a nurse practitioner, nurse-midwife, or physician assistant.

This bill would remove the requirement that a medical assistant's administration of medication upon the specific authorization and supervision of a nurse practitioner, nurse-midwife, or physician assistant occur in specified clinic settings, and would make related changes.

(13) Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing which is within the Department of Consumer Affairs.

This bill would, until July 1, 2011, create the Task Force on Nurse Practitioner Scope of Practice that would consist of specified members appointed by the Governor, the Speaker of the Assembly, and the Senate Committee on Rules. The bill would make the task force responsible for developing a recommended scope of practice for nurse practitioners

and would require the task force to report the recommended scope of practice to the Governor and the Legislature on or before June 30, 2009. The bill would require the Director of Consumer Affairs, on or before July 1, 2010, to promulgate regulations that adopt the recommended scope of practice. The bill would require the aforementioned boards to pay the state administrative costs of implementing these provisions.

(14) Existing law, the Pharmacy Law, defines an electronic transmission prescription and sets forth the requirements for those types of prescriptions.

This bill would require electronic prescribing systems to meet specified standards and requirements and would require a prescriber or prescriber's authorized agent to offer patients a written receipt of information transmitted electronically, including the patient's name and the drug prescribed, and would require the State Department of Health Care Services to develop a pilot program to foster the adoption and use of electronic prescribing by health care providers that contract with the Medi-Cal program, as specified. The bill would require every licensed prescriber, or prescriber's authorized agent, or pharmacy operating in California, on or before January 1, 2010, to have the ability to transmit and receive prescriptions by electronic data transmission.

(15) This bill would give the State Department of Health Care Services, in consultation with the Department of Finance, authority to take various actions as necessary to implement the bill, including promoting flexibility of implementation and maximizing federal financial participation. The bill would require the Director of Health Care Services to notify the Chair of the Joint Legislative Budget Committee prior to exercising this flexibility. The bill would declare the intent of the Legislature to implement the bill to harmonize and best effectuate the purposes and intent of the bill.

(16) This bill would declare the Legislature's intent that the act's provisions be financed by contributions from various sources, including payments by acute care hospitals and employers, and by increasing the taxes on cigarettes and other tobacco products.

(17) The bill would make its provisions operative upon the date that the Director of Finance files a finding with the Secretary of State that, among other circumstances, sufficient state resources will exist in the Health Care Trust Fund to implement those provisions. The bill would also require the director to transmit that finding to the Chief Clerk of the Assembly, the Secretary of the Senate, and the chairs of the

appropriate committees of the Legislature at least 90 days prior to implementation of its provisions.

(18) The bill would require that all of its provisions become inoperative, as specified, if any portion of the bill is held to be invalid, as determined by a final judgment of a court of competent jurisdiction.

(19) 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 with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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. This act shall be known and may be cited as the
2 Health Care Security and Cost Reduction Act.
3 SEC. 2. It is the intent of the Legislature to accomplish the
4 goal of universal health care for all California residents. To
5 accomplish this goal, the Legislature proposes to take all of the
6 following steps:
7 (a) Ensure that all Californians have access to affordable,
8 comprehensive health care.
9 (b) Leverage available federal funds to the greatest extent
10 possible through existing federal programs.
11 (c) Maintain and strengthen the health insurance system and
12 improve availability and affordability of private health care
13 coverage for all purchasers through (1) insurance market reforms;
14 (2) enhanced access to effective primary and preventive services,
15 including management of chronic illnesses; (3) promotion of
16 cost-effective health technologies; and (4) implementation of
17 meaningful, systemwide cost containment strategies.
18 (d) Engage in early and systematic evaluation at each step of
19 the implementation process to identify the impacts on state costs,
20 the costs of coverage, employment and insurance markets, health

delivery systems, quality of care, and overall progress in moving toward universal coverage.

SEC. 3. Section 2069 of the Business and Professions Code is amended to read:

2069. (a) (1) Notwithstanding any other provision of law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon, nurse practitioner, nurse-midwife, physician assistant, or licensed podiatrist.

(2) The licensed physician and surgeon may, at his or her discretion, in consultation with the nurse practitioner, nurse-midwife, or physician assistant, provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, nurse-midwife, or physician assistant within the standardized procedures or protocol, and that tasks may be performed when the licensed physician and surgeon is not onsite, so long as the following apply:

(A) The nurse practitioner or nurse-midwife is functioning pursuant to standardized procedures, as defined by Section 2725, or protocol. The standardized procedures or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner or nurse-midwife, and the facility administrator or his or her designee.

(B) The physician assistant is functioning pursuant to regulated services defined in Section 3502 and is approved to do so by the supervising physician or surgeon.

(b) As used in this section and Sections 2070 and 2071, the following definitions shall apply:

(1) "Medical assistant" means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist, or group thereof, for a medical, nursing, or podiatry corporation, for a physician assistant, a nurse practitioner, or a nurse-midwife as provided in subdivision (a), or for a health care service plan,

who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the Division of Licensing. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.

(2) "Specific authorization" means a specific written order prepared by the licensed physician and surgeon, nurse practitioner, nurse-midwife, physician assistant, or licensed podiatrist authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the licensed physician and surgeon, nurse practitioner, nurse-midwife, physician assistant, or licensed podiatrist, authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.

(3) "Supervision" means the supervision of procedures authorized by this section by the following practitioners, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures:

(A) A licensed physician and surgeon.

(B) A licensed podiatrist.

(C) A physician assistant, nurse practitioner, or nurse-midwife.

(4) "Technical supportive services" means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a nurse-midwife.

(c) Nothing in this section shall be construed as authorizing the licensure of medical assistants. Nothing in this section shall be construed as authorizing the administration of local anesthetic agents by a medical assistant. Nothing in this section shall be construed as authorizing the division to adopt any regulations that violate the prohibitions on diagnosis or treatment in Section 2052.

(d) Notwithstanding any other provision of law, a medical assistant may not be employed for inpatient care in a licensed

general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

(e) Nothing in this section shall be construed as authorizing a medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1200). Nothing in this section shall be construed as authorizing a nurse practitioner, nurse-midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (7) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.

SEC. 5. Section 2838 is added to the Business and Professions Code, to read:

2838. (a) The Task Force on Nurse Practitioner Scope of Practice is hereby created and shall consist of the following members:

(1) The Director of Consumer Affairs, who shall serve as an ex officio member of the task force and shall cast the deciding vote in any matter voted upon by the task force that results in a tie vote.

(2) Three members of the Medical Board of California, two of whom shall be appointed to the task force by the Governor, and one of whom shall be appointed to the task force by the Speaker of the Assembly.

(3) Three members of the Board of Registered Nursing, two of whom shall be appointed to the task force by the Governor, and one of whom shall be appointed to the task force by the Senate Committee on Rules.

(4) Two representatives of an institution of higher education, who shall be appointed to the task force by the Governor as nonvoting members.

(b) The duty of the task force shall be to develop a recommended scope of practice for nurse practitioners.

(c) The task force shall report its recommended scope of practice for nurse practitioners to the Governor and the Legislature on or before June 30, 2009.

(d) On or before July 1, 2010, the Director of Consumer Affairs shall promulgate regulations *consistent with existing law* that adopt the task force's recommended scope of practice.

(e) The Medical Board of California and the Board of Registered Nursing shall pay the state administrative costs of implementing this section.

(f) This section shall become inoperative on July 1, 2011, and, as of January 1, 2012, is repealed, unless a later enacted statute, that is enacted before January 1, 2012, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 7. Section 4040.1 is added to the Business and Professions Code, to read:

4040.1. (a) Electronic prescribing shall not interfere with a patient's existing freedom to choose a pharmacy, and shall not interfere with the prescribing decision at the point of care.

(b) Notwithstanding subdivision (c) of Section 4040, "electronic prescribing" or "e-prescribing" means a prescription or prescription-related information transmitted between the point of care and the pharmacy using electronic media.

SEC. 8. Section 4071.2 is added to the Business and Professions Code, to read:

4071.2. (a) On or before January 1, 2012, every licensed prescriber, prescriber's authorized agent, or pharmacy operating in California shall have the ability to transmit and receive prescriptions by electronic data transmission.

(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, 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 section with respect to their respective licensees.

(c) Nothing in this section shall be construed to diminish or modify any requirements or protections provided for in the prescription of controlled substances as otherwise established by this chapter or by the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code).

SEC. 9. Section 4071.3 is added to the Business and Professions Code, to read:

4071.3. Every electronic prescription system shall meet all of the following requirements:

(a) Comply with nationally recognized or certified standards for data exchange or be accredited by a recognized accreditation organization.

(b) Allow real-time verification of an individual's eligibility for benefits and whether the prescribed medication is a covered benefit.

(c) Comply with applicable state and federal confidentiality and data security requirements.

(d) Comply with applicable state record retention and reporting requirements.

SEC. 10. Section 4071.4 is added to the Business and Professions Code, to read:

4071.4. A prescriber or prescriber's authorized agent using an electronic prescription system shall offer patients a written receipt of the information that has been transmitted electronically to the pharmacy. The receipt shall include the patient's name, the dosage and drug prescribed, the name of the pharmacy where the electronic prescription was sent, and shall indicate that the receipt cannot be used as a duplicate order for the same medicine.

SEC. 11. Section 49452.9 is added to the Education Code, to read:

49452.9. (a) On and after January 1, 2010, the school district may provide an information sheet regarding health insurance requirements to the parent or guardian of all of the following:

(1) A pupil enrolled in kindergarten.

(2) A pupil enrolled in first grade if the pupil was not previously enrolled in kindergarten.

(3) A pupil enrolled during the course of the year in the case of children who have recently arrived, and intend to remain, in California.

(b) The information sheet described in subdivision (a) shall include all of the following:

(1) An explanation of the health insurance requirements under Section 8899.50 of the Government Code.

(2) Information on the important relationship between health and learning.

(3) A toll-free telephone number to request an application for Healthy Families, Medi-Cal, or other government-subsidized health insurance programs.

(4) Contact information for county public health departments.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SJR 19
Author: Ridley-Thomas
Bill Date: January 7, 2008, introduced
Subject: Health professionals: torture
Sponsor: American Friends Services Committee

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This resolution states that the United States Department of Defense (DOD) authorizes participation of military health personnel in the interrogation of detainees in Guantanamo Bay and other foreign military prisons operated by the United States in violation of profession ethics. This resolution requests the DOD and the Central Intelligence Agency to remove all the California-licensed health professionals from participating in prisoner and detainee interrogations.

ANALYSIS:

This resolution comes as a result of reports that many physicians, including some licensed in California, are part of the U.S. system of torture. The State of California has an obligation to notify its licensees of laws concerning torture that may result in their prosecution. The American Friends Service Committee (AFSC) reports that there are California licensed physicians, psychologists and other medical professionals involved in activities that constitute torture under U.S. and internationally-recognized laws. The AFSC states that California should be the first state in the nation to withdraw its consent to torture, should require that the state medical and health boards notify all licensees regarding their professional obligations under current state, federal, and international laws and to inform licensees that they may be subject to prosecution if they do in fact violate their legal obligations, and should call upon the U.S. Department of Defense and the CIA to remove all California-licensed health professionals from participating in any way in prisoner of detainee interrogations.

FISCAL: Minor and absorbable.

POSITION: Recommendation: Watch

January 22, 2008

Senate Joint Resolution No. 19

Introduced by Senator Ridley-Thomas

January 7, 2008

Senate Joint Resolution No. 19—Relative to health professionals.

LEGISLATIVE COUNSEL'S DIGEST

SJR 19, as introduced, Ridley-Thomas. Health professionals: torture.

This measure would request all relevant California agencies to notify California-licensed health professionals about their professional obligations under international law relating to torture and the treatment of detainees, as specified, and to also notify those professionals that those who participate in torture, among other forms of treatment, may be subject to prosecution. In addition, the measure would request the United States Department of Defense and the Central Intelligence Agency to remove all California-licensed health professionals from participating in prisoner and detainee interrogations.

Fiscal committee: yes.

WHEREAS, The citizens of the United States and the residents of the State of California acknowledge January 15th as the birthday of Dr. Martin Luther King, Jr., and mark the third Monday in January as a federal and state holiday to commemorate his lifework as a civil rights leader, an activist, and an internationally acclaimed proponent of human rights who warned, "He who passively accepts evil is as much involved in it as he who helps to perpetrate it"; and

WHEREAS, Dr. King challenged Americans to remain true to their most basic values, stating, "The ultimate measure of a man is not where he stands in moments of comfort and convenience, but where he stands at times of challenge and controversy"; and

WHEREAS, In 2002, for the first time in American history, the Bush administration initiated a radical new policy allowing the torture of prisoners of war and other captives with confirmed reports from the International Red Cross, The New England Journal of Medicine, The Lancet (a British medical journal), military records, and first-person accounts stating that California-licensed physicians, psychologists, and nurses have participated in torture or its cover up against detainees in United States custody; and

WHEREAS, In honor of the birthday of Dr. Martin Luther King, Jr., a broad coalition of medical, human rights, and legal organizations are petitioning the State of California to warn its medical licensees of the legal prohibitions against torture and the risks of prosecution, and are demanding that the United States government remove California doctors and psychologists from interrogation and torture of detainees; and

WHEREAS, Representatives of Californians to Stop Medical Torture are carrying petition signatures to the California State Senate, asking that the Senate warn California-licensed physicians, psychologists, nurses, and other health care workers of possible future prosecution for participation in torture — cruel and degrading practices that have become a national shame; and

WHEREAS, Health professionals licensed in California, including, but not limited to, physicians, osteopaths, naturopaths, psychologists, psychiatric workers, and nurses, have and continue to serve nobly and honorably in the armed services of the United States; and

WHEREAS, United States Army regulations and the War Crimes Act and, relative to the treatment of prisoners of war, Common Article III of the Geneva Conventions and the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (CAT) require that all military personnel report and not engage in acts of abuse or torture; and

WHEREAS, CAT defines the term "torture" as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of

or with the consent or acquiescence of a public official or other person acting in an official capacity"; and

WHEREAS, In 2002, the United States Department of Justice reinterpreted national and international law related to the treatment of prisoners of war in a manner that purported to justify long-prohibited interrogation methods and treatment of detainees; and

WHEREAS, Physicians and other medical personnel and psychologists serving in noncombat roles are bound by international law and professional ethics to care for enemy prisoners and to report any evidence of coercion or abuse of detainees; and

WHEREAS, The World Medical Association (WMA) issued guidelines stating that physicians shall not use nor allow to be used their medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal; and

WHEREAS, The guidelines issued by the WMA also state that physicians shall not participate in or facilitate torture or other forms of cruel, inhuman, or degrading procedures of prisoners or detainees in any situations; and

WHEREAS, The American Medical Association's (AMA) ethical policy prohibits physicians from conducting or directly participating in an interrogation and from monitoring interrogations with the intention of intervening; and

WHEREAS, AMA policy also states that "[t]orture refers to the deliberate, systematic or wanton administration of cruel, inhumane and degrading treatments or punishments during imprisonment or detainment. Physicians must oppose and must not participate in torture for any reason .... Physicians should help provide support for victims of torture and, whenever possible, strive to change the situation in which torture is practiced or the potential for torture is great"; and

WHEREAS, Section 2340 of Title 18 of the United States Code defines the term "torture" as an act committed by a person acting under the color of law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody or physical control. That section further defines the term "severe mental pain or suffering" as the prolonged mental harm

1 caused by or resulting from: (A) the intentional infliction or
2 threatened infliction of severe physical pain or suffering; (B) the
3 administration or application, or threatened administration or
4 application, of mind-altering substances or other procedures
5 calculated to disrupt profoundly the senses or the personality; (C)
6 the threat of imminent death; or (D) the threat that another person
7 will imminently be subjected to death, severe physical pain or
8 suffering, or the administration or application of mind-altering
9 substances or other procedures calculated to disrupt profoundly
10 the senses or personality; and
11 WHEREAS, In May 2006, the American Psychiatric Association
12 stated that psychiatrists should not "participate directly in the
13 interrogation of persons held in custody by military or civilian
14 investigative or law enforcement authorities, whether in the United
15 States or elsewhere," and that "psychiatrists should not participate
16 in, or otherwise assist or facilitate, the commission of torture of
17 any person. Psychiatrists who become aware that torture has
18 occurred, is occurring, or has been planned must report it promptly
19 to a person or persons in a position to take corrective action"; and
20 WHEREAS, In August 2006, the American Psychological
21 Association stated that "psychologists shall not knowingly
22 participate in any procedure in which torture or other forms of
23 cruel, inhuman, or degrading treatment or cruel, inhuman, or
24 degrading punishment is used or threatened" and that "should
25 torture or other cruel, inhuman, or degrading treatment or cruel,
26 inhuman, or degrading punishment evolve during a procedure
27 where a psychologist is present, the psychologist shall attempt to
28 intervene to stop such behavior, and failing that exit the procedure";
29 and
30 WHEREAS, In June 2005, the House of Delegates of the
31 American Nurses Association issued a resolution stating all of the
32 following: "prisoners and detainees have the right to health care
33 and humane treatment"; "registered nurses shall not voluntarily
34 participate in any deliberate infliction of physical or mental
35 suffering"; "registered nurses who have knowledge of ill-treatment
36 of any individuals including detainees and prisoners must take
37 appropriate action to safeguard the rights of that individual"; "the
38 American Nurses Association shall condemn interrogation
39 procedures that are harmful to mental and physical health"; "the
40 American Nurses Association shall advocate for nondiscriminatory

access to health care for wounded military and paramilitary personnel and prisoners of war"; and "the American Nurses Association shall counsel and support nurses who speak out about acts of torture and abuse"; and

WHEREAS, In March 2005, the California Medical Association stated that it "condemns any participation in, cooperation with, or failure to report by physicians and other health professionals the mental or physical abuse, sexual degradation, or torture of prisoners or detainees"; and

WHEREAS, In November 2004, the American Public Health Association stated that it "condemns any participation in, cooperation with, or failure to report by health professionals the mental or physical abuse, sexual degradation, or torture of prisoners or detainees," that it "urges health professionals to report abuse or torture of prisoners and detainees," and that it "supports the rights of health workers to be protected from retribution for refusing to participate or cooperate in abuse or torture in military settings"; and

WHEREAS, The United States military medical system in Guantanamo Bay, Afghanistan, Iraq, and other foreign military prisons operated by the United States failed to protect detainees' rights to medical treatment, failed to prevent disclosure of confidential medical information to interrogators and others, failed to promptly report injuries or deaths caused by beatings, failed to report acts of psychological and sexual degradation, and sometimes collaborated with abusive interrogators and guards; and

WHEREAS, Current United States Department of Defense guidelines authorize the participation of certain military health personnel, especially psychologists, in the interrogation of detainees as members of "Behavioral Science Consulting Teams" in violation of professional ethics. These guidelines also permit the use of confidential clinical information from medical records to aid in interrogations; and

WHEREAS, Evidence in the public record indicates that military psychologists participated in the design and implementation of psychologically abusive interrogation methods used at Guantanamo Bay, in Iraq, and elsewhere, including sleep deprivation, long-term isolation, sexual and cultural humiliation, forced nudity, induced hypothermia and other temperature extremes, stress positions,

sensory bombardment, manipulation of phobias, force-feeding hunger strikers, and more; and

WHEREAS, Published reports indicate that the so-called "enhanced interrogation methods" of the Central Intelligence Agency reportedly include similar abusive methods and that agency psychologists may have assisted in their development; and

WHEREAS, Medical and psychological studies and clinical experience show that these abuses can cause severe or serious mental pain and suffering in their victims, and therefore may violate the "torture" and "cruel and inhuman treatment" provisions of CAT and the United States War Crimes Act, as amended by the Military Commissions Act of 2006; and

WHEREAS, The United States Department of Defense has failed to oversee the ethical conduct of California-licensed health professionals related to torture; and

WHEREAS, Nobel Peace Prize Laureate Dr. Martin Luther King, Jr., said, "Commit yourself to the noble struggle for human rights. You will make a greater person of yourself, a greater nation of your country and a finer world to live in"; now, therefore, be it

Resolved by the Senate and the Assembly of the State of California, jointly, That the Legislature hereby requests all relevant California agencies, including, but not limited to, the Board of Behavioral Sciences, the Dental Board of California, the Medical Board of California, the Osteopathic Medical Board of California, the Bureau of Naturopathic Medicine, the California State Board of Pharmacy, the Physician Assistant Committee of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Vocational Nursing and Psychiatric Technicians, the Board of Psychology, and the Board of Registered Nursing, to notify California-licensed health professionals via newsletter, email, and Web site about their professional obligations under international law, specifically Common Article III of the Geneva Conventions, the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, and the amended War Crimes Act, which prohibit the torture of, and the cruel, inhuman, and degrading treatment or punishment of, detainees in United States custody; and be it further

Resolved, That the Legislature hereby requests all relevant California agencies to notify health professionals licensed in California that those who participate in torture and other forms of

1 cruel, inhuman, or degrading treatment or punishment may one
2 day be subject to prosecution; and be it further
3 *Resolved,* That the Legislature hereby requests the United States
4 Department of Defense and the Central Intelligence Agency to
5 remove all California-licensed health professionals, including, but
6 not limited to, physicians and psychologists, from participating in
7 any way in prisoner and detainee interrogations, in view of their
8 respective ethical obligations, the record of abusive interrogation
9 practices, and the Legislature's interest in protecting California
10 health professionals from the risk of criminal liability; and be it
11 further
12 *Resolved,* That the Secretary of the Senate transmit copies of
13 this resolution to the United States Department of Defense, the
14 Central Intelligence Agency, and all relevant California agencies,
15 including, but not limited to, the Board of Behavioral Sciences,
16 the Dental Board of California, the Medical Board of California,
17 the Osteopathic Medical Board of California, the Bureau of
18 Naturopathic Medicine, the California State Board of Pharmacy,
19 the Physician Assistant Committee of the Medical Board of
20 California, the California Board of Podiatric Medicine, the Board
21 of Vocational Nursing and Psychiatric Technicians, the Board of
22 Psychology, and the Board of Registered Nursing.

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: Support

STATUS OF BILL:

This bill is currently the Assembly Floor.

DESCRIPTION OF LEGISLATION:

This bill would extend 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 specify that an investigator is not under the supervision of the deputy attorney general who is simultaneously assigned to a complaint. The bill would require 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 require 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.

FISCAL: Within existing resources.

POSITION: Support MBC provisions.

January 22, 2008

AMENDED IN ASSEMBLY SEPTEMBER 7, 2007

SENATE BILL No. 797

Introduced by Senator Ridley-Thomas

February 23, 2007

An act to amend Sections ~~7026.1 and 7028~~ *490, 2006, 2531, 2531.75, 2841, 2847, 3041.3, 4501, 4503, 4982, 4989.54, 4990.32, 4992.3, 5552.5, 7026.1, 7028, 7303, 8005, 22258, and 22259* of the Business and Professions Code, *and to amend Sections 12529, 12529.5, 12529.6, and 12529.7 of the Government Code,* relating to ~~contractors~~ *professions and vocations*, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 797, as amended, Ridley-Thomas. ~~Contractors.~~ *Professions and vocations.*

~~Existing~~

(1) 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 suspend or revoke a license on certain bases, including the licensee's conviction of a crime that is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued.

This bill would specify that this authorization to suspend or revoke a license is in addition to any other action that a board is permitted to take against the licensee.

(2) Existing law, the Speech-Language Pathologists and Audiologists Licensure Act, establishes the Speech-Language Pathology and Audiology Board and provides for its issuance of a speech-language pathology license and an audiology license to qualified applicants and for its regulation of those licensees. Under existing law, the provisions

establishing the board and authorizing its appointment of an executive officer will become inoperative on July 1, 2008, and will be repealed on January 1, 2009.

This bill would extend those dates, making the provisions inoperative on July 1, 2009, and repealing them on January 1, 2010.

(3) Existing law, the Vocational Nursing Practice Act, establishes the Board of Vocational Nursing and Psychiatric Technicians and provides for its issuance of a vocational nurse license and a psychiatric technician's license to qualified applicants and for its regulation of those licensees. Under existing law, the provisions establishing the board and authorizing its selection of an executive officer will become inoperative on July 1, 2008, and will be repealed on January 1, 2009.

This bill would extend those dates, making the provisions inoperative on July 1, 2009, and repealing them on January 1, 2010.

(4) Existing law, the Architects Practice Act, establishes the California Architects Board and provides for its licensure and regulation of architects. Under existing law, the board is authorized to implement an intern development program until July 1, 2009.

This bill would extend the authority of the board to implement this program to July 1, 2011.

(5) Existing law provides for the certification of optometrists to diagnose and treat certain conditions of the human eye or its appendages, and to use therapeutic pharmaceutical agents. It requires the board to decide all issues relating to the equivalency of an optometrists' education or training for certification, as specified.

This bill would delete an obsolete reference to the Therapeutic Pharmaceutical Agent Advisory Committee.

(6) Existing law, the Contractors' State License Law, creates the Contractors' State License Board within the Department of Consumer Affairs and provides for the licensure and regulation of contractors. Existing law defines "contractor" and includes certain persons who perform tree removal, tree pruning, stump removal, and tree or limb cabling or guying, except as specified, within that definition. Existing law requires contractors to pay specified fees, which are deposited into the continuously appropriated Contractors' License Fund, and requires the deposit of fines collected under the Contractors' State License Law into the fund. Existing law, makes it a misdemeanor for any person to engage in the business or act in the capacity of a contractor without having a license, and subjects a person who violates this prohibition to specified fines and imprisonment.

This bill would also define "contractor" to include a person who offers to perform, purport to have the capacity to perform, or submits a bid to perform tree removal, tree pruning, stump removal, or tree or limb cabling or guying, except as specified. The bill would revise the penalties provisions accordingly and would apply specified penalty provisions to a person named on a revoked license and held responsible for the act or omission resulting ~~the~~ in the revocation. Because the bill would increase moneys deposited into the continuously appropriated Contractors' License Fund, the bill would make an appropriation. Because the bill would expand the definition of a contractor and thereby create new crimes, it would impose a state-mandated local program.

~~The~~

(7) Existing law, the Barbering and Cosmetology Act, establishes the State Board of Barbering and Cosmetology and provides for its issuance of a cosmetology license, a barbering license, an esthetician license, a manicurist license, and an electrologist license and for its regulation of those licensees. Under existing law, the provisions establishing the board will become inoperative on July 1, 2008, and will be repealed on January 1, 2009.

This bill would extend those dates, making the provisions inoperative on July 1, 2009, and repealing them on January 1, 2010.

(8) Existing law provides for the licensure or registration, and regulation of marriage and family therapists, licensed educational psychologists, and clinical social workers by the Board of Behavioral Sciences. Under existing law, the board may refuse to issue a registration or license, or may suspend or revoke a license or registration, if the applicant, registrant, or licensee has been guilty of unprofessional conduct, as specified. Under existing law, the board may refuse to issue a registration or license, or may suspend or revoke a license or registration, if the applicant, registrant, or licensee has been guilty of unprofessional conduct, as specified. Existing law authorizes the board to file a specified accusation against these licensees or registrants within certain limitations periods for, among other things, an alleged act or omission involving a minor that is the basis for disciplinary action.

This bill would specify that unprofessional conduct includes engaging in specified acts with a minor regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. The bill would also specify that, if after the limitations periods have expired, the board discovers a specified alleged act with a minor,

and there is independent evidence corroborating the allegation, an accusation shall be filed within 3 years from the date the board discovers that alleged act.

(9) Existing law imposes specified requirements and prohibitions on tax preparers, as defined, and exempts specified persons from these requirements and prohibitions. A violation of those provisions is a misdemeanor. Under existing law, those provisions will become inoperative on July 1, 2008, and will be repealed on January 1, 2009.

This bill would extend the inoperative and repeal dates, making the provisions inoperative on July 1, 2009, and repealing them on January 1, 2010. The bill would also expand the category of persons exempted from these provisions and revise the requirements for exemption, including imposing a requirement that specified tax returns are signed by a licensed accountant, attorney, or by a person who is enrolled to practice before the Internal Revenue Service. The bill would also specify that preparation of a tax return includes the inputting of tax data into a computer. Because this bill would impose additional qualifications on the exemption from tax preparer provisions, the violation of which would be a crime, it would impose a state-mandated local program.

(10) Existing law authorizes the Court Reporters Board to, among other things, appoint an executive officer and employ other employees as may be necessary. These provisions will become inoperative on July 1, 2008, and be repealed on January 1, 2009.

This bill would extend those dates, making the provisions inoperative on July 1, 2009, and repealing them on January 1, 2010.

(11) 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. Existing law also requires the medical board, in consultation with specified agencies, to report and

make recommendations to the Governor and the Legislature on this prosecution model by July 1, 2007.

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 specify that an investigator is not under the supervision of the deputy attorney general simultaneously assigned to a complaint. The bill would require 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 also require 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.

(12) This bill would incorporate additional changes in Section 490 of the Business and Professions Code, proposed by AB 1025, to be operative only if AB 1025 and this bill are both chaptered and become effective on or before January 1, 2008, and this bill is chaptered last.

(13) This bill would incorporate additional changes in Sections 12529 and 12529.5 of the Government Code, proposed by SB 1048, to be operative only if SB 1048 and this bill are both chaptered and become effective on or before January 1, 2008, and this bill is chaptered last.

(14) 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: yes. Fiscal committee: yes. State-mandated local program: yes.

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

1 *SECTION 1. Section 490 of the Business and Professions Code*
2 *is amended to read:*
3 490. ~~A~~ *(a) In addition to any other action that a board is*
4 *permitted to take against a licensee, a* board may suspend or revoke
5 a license on the ground that the licensee has been convicted of a
6 crime, if the crime is substantially related to the qualifications,
7 functions, or duties of the business or profession for which the
8 license was issued.~~A~~

(b) Notwithstanding any other provision of law, a board may exercise any authority to discipline a licensee for conviction of a crime that is independent of the authority granted under subdivision (a) only if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the licensee's license was issued.

(c) 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~~ *that* 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, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code.

(d) The Legislature hereby finds and declares that the application of this section has been made unclear by the holding in Petropoulos v. Department of Real Estate (2006) 142 Cal.App.4th 554, and that the holding in that case has placed a significant number of statutes and regulations in question, resulting in potential harm to the consumers of California from licensees who have been convicted of crimes. Therefore, the Legislature finds and declares that this section establishes an independent basis for a board to impose discipline upon a licensee, and that the amendments to this section made by Senate Bill 797 of the 2007–08 Regular Session do not constitute a change to, but rather are declaratory of, existing law.

SEC. 1.5 Section 490 of the Business and Professions Code is amended to read:

490. ~~A~~*(a) In addition to any other action that a board is permitted to take against a licensee, 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~~

(b) Notwithstanding any other provision of law, a board may exercise any authority to discipline a licensee for conviction of a crime that is independent of the authority granted under subdivision (a) only if the crime is substantially related to the qualifications,

functions, or duties of the business or profession for which the licensee's license was issued.

(c) 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~~ *that* 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~~, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code~~.

(d) 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.

(e) 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 (d).

(f) The Legislature hereby finds and declares that the application of this section has been made unclear by the holding in Petropoulos v. Department of Real Estate (2006) 142 Cal.App.4th 554, and that the holding in that case has placed a significant number of statutes and regulations in question, resulting in potential harm to the consumers of California from licensees who have been convicted of crimes. Therefore, the Legislature finds and declares that this section establishes an independent basis for a board to impose discipline upon a licensee, and that the amendments to this section made by Senate Bill 797 of the 2007–08 Regular Session do not constitute a change to, but rather are declaratory of, existing law.

SEC. 2. Section 2006 of the Business and Professions 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~~ *directed* by employees of the Department of Justice.

(b) 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. 3. Section 2531 of the Business and Professions Code is amended to read:

2531. There is in the Department of Consumer Affairs a Speech-Language Pathology and Audiology Board in which the enforcement and administration of this chapter is vested. The Speech-Language Pathology and Audiology Board shall consist of nine members, three of whom shall be public members.

This section shall become inoperative on July 1, ~~2008~~ *2009*, and, as of January 1, ~~2009~~ *2010*, is repealed, unless a later enacted statute, that becomes effective on or before January 1, ~~2009~~ *2010*, deletes or extends the inoperative and repeal dates. The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473).

SEC. 4. Section 2531.75 of the Business and Professions Code is amended to read:

2531.75. (a) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.

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

SEC. 5. Section 2841 of the Business and Professions Code is amended to read:

2841. There is in the Department of Consumer Affairs a Board of Vocational Nursing and Psychiatric Technicians of the State of California, consisting of 11 members.

Within the meaning of this chapter, board, or the board, refers to the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

This section 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 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. 6. Section 2847 of the Business and Professions Code is amended to read:

2847. (a) The board shall select an executive officer who shall perform duties as are delegated by the board and who shall be responsible to it for the accomplishment of those duties.

(b) The person selected to be the executive officer of the board shall be a duly licensed vocational nurse under this chapter, a duly licensed professional nurse as defined in Section 2725, or a duly licensed psychiatric technician. The executive officer shall not be a member of the board.

(c) With the approval of the Director of Finance, the board shall fix the salary of the executive officer.

(d) The executive officer shall be entitled to traveling and other necessary expenses in the performance of his or her duties. He or she shall make a statement, certified before some duly authorized person, that the expenses have been actually incurred.

(e) This section 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 the dates on which it becomes inoperative and is repealed.

SEC. 7. Section 3041.3 of the Business and Professions Code is amended to read:

3041.3. (a) In order to be certified to use therapeutic pharmaceutical agents and authorized to diagnose and treat the conditions listed in subdivisions (b), (d), and (e) of Section 3041, an optometrist shall apply for a certificate from the board and meet all requirements imposed by the board.

(b) The board shall grant a certificate to use therapeutic pharmaceutical agents to any applicant who graduated from a California accredited school of optometry prior to January 1, 1996, is licensed as an optometrist in California, and meets all of the following requirements:

(1) Satisfactorily completes a didactic course of no less than 80 classroom hours in the diagnosis, pharmacological, and other treatment and management of ocular disease provided by either an accredited school of optometry in California or a recognized residency review committee in ophthalmology in California.

(2) Completes a preceptorship of no less than 65 hours, during a period of not less than two months nor more than one year, in either an ophthalmologist's office or an optometric clinic. The training received during the preceptorship shall be on the diagnosis, treatment, and management of ocular, systemic disease. The preceptor shall certify completion of the preceptorship. Authorization for the ophthalmologist to serve as a preceptor shall be provided by an accredited school of optometry in California, or by a recognized residency review committee in ophthalmology, and the preceptor shall be licensed as an ophthalmologist in California, board-certified in ophthalmology, and in good standing with the Medical Board of California. The individual serving as the preceptor shall schedule no more than three optometrist applicants for each of the required 65 hours of the preceptorship program. This paragraph shall not be construed to limit the total number of optometrist applicants for whom an individual may serve as a preceptor, and is intended only to ensure the quality of the preceptorship by requiring that the ophthalmologist preceptor schedule the training so that each applicant optometrist completes each of the 65 hours of the preceptorship while scheduled with no more than two other optometrist applicants.

(3) Successfully completes a minimum of 20 hours of self-directed education.

(4) Passes the National Board of Examiners in Optometry's "Treatment and Management of Ocular Disease" examination or, in the event this examination is no longer offered, its equivalent, as determined by the State Board of Optometry.

(5) Passes the examination issued upon completion of the 80-hour didactic course required under paragraph (1) and provided by the accredited school of optometry or residency program in ophthalmology.

(6) When any or all of the requirements contained in paragraph (1), (4), or (5) have been satisfied on or after July 1, 1992, and before January 1, 1996, an optometrist shall not be required to fulfill the satisfied requirements in order to obtain certification to

use therapeutic pharmaceutical agents. In order for this paragraph to apply to the requirement contained in paragraph (5), the didactic examination that the applicant successfully completed shall meet equivalency standards, as determined by the board.

(7) Any optometrist who graduated from an accredited school of optometry on or after January 1, 1992, and before January 1, 1996, shall not be required to fulfill the requirements contained in paragraphs (1), (4), and (5).

(c) The board shall grant a certificate to use therapeutic pharmaceutical agents to any applicant who graduated from a California accredited school of optometry on or after January 1, 1996, who is licensed as an optometrist in California, and who meets all of the following requirements:

(1) Passes the National Board of Examiners in Optometry's national board examination, or its equivalent, as determined by the State Board of Optometry.

(2) Of the total clinical training required by a school of optometry's curriculum, successfully completed at least 65 of those hours on the diagnosis, treatment, and management of ocular, systemic disease.

(3) Is certified by an accredited school of optometry as competent in the diagnosis, treatment, and management of ocular, systemic disease to the extent authorized by this section.

(4) Is certified by an accredited school of optometry as having completed at least 10 hours of experience with a board-certified ophthalmologist.

(d) The board shall grant a certificate to use therapeutic pharmaceutical agents to any applicant who is an optometrist who obtained his or her license outside of California if he or she meets all of the requirements for an optometrist licensed in California to be certified to use therapeutic pharmaceutical agents.

(1) In order to obtain a certificate to use therapeutic pharmaceutical agents, any optometrist who obtained his or her license outside of California and graduated from an accredited school of optometry prior to January 1, 1996, shall be required to fulfill the requirements set forth in subdivision (b). In order for the applicant to be eligible for the certificate to use therapeutic pharmaceutical agents, the education he or she received at the accredited out-of-state school of optometry shall be equivalent to the education provided by any accredited school of optometry in

California for persons who graduate before January 1, 1996. For those out-of-state applicants who request that any of the requirements contained in subdivision (b) be waived based on fulfillment of the requirement in another state, if the board determines that the completed requirement was equivalent to that required in California, the requirement shall be waived.

(2) In order to obtain a certificate to use therapeutic pharmaceutical agents, any optometrist who obtained his or her license outside of California and who graduated from an accredited school of optometry on or after January 1, 1996, shall be required to fulfill the requirements set forth in subdivision (c). In order for the applicant to be eligible for the certificate to use therapeutic pharmaceutical agents, the education he or she received by the accredited out-of-state school of optometry shall be equivalent to the education provided by any accredited school of optometry for persons who graduate on or after January 1, 1996. For those out-of-state applicants who request that any of the requirements contained in subdivision (c) be waived based on fulfillment of the requirement in another state, if the board determines that the completed requirement was equivalent to that required in California, the requirement shall be waived.

(3) The State Board of Optometry shall decide all issues relating to the equivalency of an optometrist's education or training under this subdivision~~, and the committee established pursuant to Section 3041.1 shall recommend protocols for the board to use in this regard, as described in Section 3041.1~~.

SEC. 8. Section 4501 of the Business and Professions Code is amended to read:

4501. (a) "Board," as used in this chapter, means the Board of Vocational Nursing and Psychiatric Technicians.

(b) This section 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 the dates on which it becomes inoperative and is repealed.

SEC. 9. Section 4503 of the Business and Professions Code is amended to read:

4503. (a) The board shall administer and enforce this chapter.

(b) This section 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 the dates on which it becomes inoperative and is repealed.

SEC. 10. Section 4982 of the Business and Professions Code is amended to read:

4982. The board may refuse to issue any registration or license, or may suspend or revoke the license or registration of any registrant or licensee if the applicant, licensee, or registrant has been guilty of unprofessional conduct. Unprofessional conduct shall include, but not be limited to:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter shall be deemed to be a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration 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, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using of any of the dangerous drugs specified in Section 4022, or of any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or

license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license, or the conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this subdivision, or any combination thereof. The board shall deny an application for a registration or license or revoke the license or registration of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing marriage and family therapy services.

(d) Gross negligence or incompetence in the performance of marriage and family therapy.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(f) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity.

(g) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee, allowing any other person to use his or her license or registration.

(h) Aiding or abetting, or employing, directly or indirectly, any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(i) Intentionally or recklessly causing physical or emotional harm to any client.

(j) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(k) Engaging in sexual relations with a client, or a former client within two years following termination of therapy, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a marriage and family therapist.

(*l*) Performing, or holding oneself out as being able to perform, or offering to perform, or permitting any trainee or registered intern under supervision to perform, any professional services beyond the scope of the license authorized by this chapter.

(m) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client which is obtained from tests or other means.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. Nothing in this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (n).

(p) Advertising in a manner that is false, misleading, or deceptive.

(q) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device.

(r) Any conduct in the supervision of any registered intern or trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.

(s) Performing or holding oneself out as being able to perform professional services beyond the scope of one's competence, as established by one's education, training, or experience. This subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(t) Permitting a trainee or registered intern under one's supervision or control to perform, or permitting the trainee or registered intern to hold himself or herself out as competent to

perform, professional services beyond the trainee's or registered intern's level of education, training, or experience.

(u) The violation of any statute or regulation governing the gaining and supervision of experience required by this chapter.

(v) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(w) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board.

SEC. 11. Section 4989.54 of the Business and Professions Code is amended to read:

4989.54. The board may deny a license or may suspend or revoke the license of a licensee if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) Conviction of a crime substantially related to the qualifications, functions and duties of an educational psychologist.

(1) The record of conviction shall be conclusive evidence only of the fact that the conviction occurred.

(2) The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee under this chapter.

(3) A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee under this chapter shall be deemed to be a conviction within the meaning of this section.

(4) The board may order a license suspended or revoked, or may decline to issue a license 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, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty or setting aside the verdict of guilty or dismissing the accusation, information, or indictment.

(b) Securing a license by fraud, deceit, or misrepresentation on an application for licensure submitted to the board, whether engaged in by an applicant for a license or by a licensee in support of an application for licensure.

(c) Administering to himself or herself a controlled substance or using any of the dangerous drugs specified in Section 4022 or an alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to himself or herself or to any other person or to the public or to the extent that the use impairs his or her ability to safely perform the functions authorized by the license.

(d) Conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in subdivision (c) or any combination thereof.

(e) Advertising in a manner that is false, misleading, or deceptive.

(f) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(g) Commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee.

(h) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action imposed by another state or territory or possession of the United States or by any other governmental agency, on a license, certificate, or registration to practice educational psychology or any other healing art. A certified copy of the disciplinary action, decision, or judgment shall be conclusive evidence of that action.

(i) Revocation, suspension, or restriction by the board of a license, certificate, or registration to practice as a clinical social worker or marriage and family therapist.

(j) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(k) Gross negligence or incompetence in the practice of educational psychology.

(*l*) Misrepresentation as to the type or status of a license held by the licensee or otherwise misrepresenting or permitting

1 misrepresentation of his or her education, professional
2 qualifications, or professional affiliations to any person or entity.
3 (m) Intentionally or recklessly causing physical or emotional
4 harm to any client.
5 (n) Engaging in sexual relations with a client or a former client
6 within two years following termination of professional services,
7 soliciting sexual relations with a client, or committing an act of
8 sexual abuse or sexual misconduct with a client or committing an
9 act punishable as a sexually related crime, if that act or solicitation
10 is substantially related to the qualifications, functions, or duties of
11 a licensed educational psychologist.
12 (o) Prior to the commencement of treatment, failing to disclose
13 to the client or prospective client the fee to be charged for the
14 professional services or the basis upon which that fee will be
15 computed.
16 (p) Paying, accepting, or soliciting any consideration,
17 compensation, or remuneration, whether monetary or otherwise,
18 for the referral of professional clients.
19 (q) Failing to maintain confidentiality, except as otherwise
20 required or permitted by law, of all information that has been
21 received from a client in confidence during the course of treatment
22 and all information about the client that is obtained from tests or
23 other means.
24 (r) Performing, holding himself or herself out as being able to
25 perform, or offering to perform any professional services beyond
26 the scope of the license authorized by this chapter or beyond his
27 or her field or fields of competence as established by his or her
28 education, training, or experience.
29 (s) Reproducing or describing in public, or in any publication
30 subject to general public distribution, any psychological test or
31 other assessment device the value of which depends in whole or
32 in part on the naivete of the subject in ways that might invalidate
33 the test or device. An educational psychologist shall limit access
34 to the test or device to persons with professional interests who can
35 be expected to safeguard its use.
36 (t) Aiding or abetting an unlicensed person to engage in conduct
37 requiring a license under this chapter.
38 (u) When employed by another person or agency, encouraging,
39 either orally or in writing, the employer's or agency's clientele to

utilize his or her private practice for further counseling without the approval of the employing agency or administration.

(v) Failing to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(w) Failing to comply with the elder and adult dependent abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(x) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board.

SEC. 12. Section 4990.32 of the Business and Professions Code is amended to read:

4990.32. (a) Except as otherwise provided in this section, an accusation filed pursuant to Section 11503 of the Government Code against a licensee or registrant under the chapters the board administers and enforces shall be filed within three years from the date the board discovers the alleged act or omission that is the basis for disciplinary action or within seven years from the date the alleged act or omission that is the basis for disciplinary action occurred, whichever occurs first.

(b) An accusation filed against a licensee alleging the procurement of a license by fraud or misrepresentation is not subject to the limitations set forth in subdivision (a).

(c) The limitations period provided by subdivision (a) shall be tolled for the length of time required to obtain compliance when a report required to be filed by the licensee or registrant with the board pursuant to Article 11 (commencing with Section 800) of Chapter 1 is not filed in a timely fashion.

(d) An accusation alleging sexual misconduct shall be filed within three years after the board discovers the act or omission alleged as the grounds for disciplinary action or within 10 years after the act or omission alleged as the grounds for disciplinary action occurred, whichever occurs first. This subdivision shall apply to a complaint alleging sexual misconduct received by the board on and after January 1, 2002.

(e) If an alleged act or omission involves a minor, the seven-year limitations period provided for by subdivision (a) and the 10-year limitations period provided for by subdivision (d) shall be tolled

until the minor reaches the age of majority. *However, if the board discovers an alleged act of sexual contact with a minor under Section 261, 286, 288, 288.5, 288a, or 289 of the Penal Code after the limitations periods described in this subdivision have otherwise expired, and there is independent evidence that corroborates the allegation, an accusation shall be filed within three years from the date the board discovers that alleged act.*

(f) The limitations period provided by subdivision (a) shall be tolled during any period if material evidence necessary for prosecuting or determining whether a disciplinary action would be appropriate is unavailable to the board due to an ongoing criminal investigation.

(g) For purposes of this section, "discovers" means the latest of the occurrence of any of the following with respect to each act or omission alleged as the basis for disciplinary action:

(1) The date the board received a complaint or report describing the act or omission.

(2) The date, subsequent to the original complaint or report, on which the board became aware of any additional acts or omissions alleged as the basis for disciplinary action against the same individual.

(3) The date the board receives from the complainant a written release of information pertaining to the complainant's diagnosis and treatment.

SEC. 13. Section 4992.3 of the Business and Professions Code is amended to read:

4992.3. The board may refuse to issue a registration or a license, or may suspend or revoke the license or registration of any registrant or licensee if the applicant, licensee, or registrant has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere

made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter is a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration 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, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022 or any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license, or the conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this subdivision, or any combination thereof. The board shall deny an application for a registration or license or revoke the license or registration of any person who uses or offers to use drugs in the course of performing clinical social work. This provision does not apply to any person also licensed as a physician and surgeon under Chapter 5 (commencing with Section 2000) or the Osteopathic Act who lawfully prescribes drugs to a patient under his or her care.

(d) Gross negligence or incompetence in the performance of clinical social work.

(e) Violating, attempting to violate, or conspiring to violate this chapter or any regulation adopted by the board.

(f) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity. For purposes of this subdivision, this misrepresentation includes, but is not limited to, misrepresentation of the person's qualifications as an adoption service provider pursuant to Section 8502 of the Family Code.

(g) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee, allowing any other person to use his or her license or registration.

(h) Aiding or abetting any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(i) Intentionally or recklessly causing physical or emotional harm to any client.

(j) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(k) Engaging in sexual relations with a client or with a former client within two years from the termination date of therapy with the client, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a clinical social worker.

(*l*) Performing, or holding one's self out as being able to perform, or offering to perform or permitting, any registered associate clinical social worker or intern under supervision to perform any professional services beyond the scope of the license authorized by this chapter.

(m) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client which is obtained from tests or other means.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. Nothing in this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (n).

(p) Advertising in a manner which is false, misleading, or deceptive.

(q) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device.

(r) Any conduct in the supervision of any registered associate clinical social worker or intern by any licensee that violates this chapter or any rules or regulations adopted by the board.

(s) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(t) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board.

SEC. 14. Section 5552.5 of the Business and Professions Code is amended to read:

5552.5. The board may, by regulation, implement an intern development program until July 1, ~~2009~~ *2011*.

~~SECTION 1.~~

SEC. 15. Section 7026.1 of the Business and Professions Code is amended to read:

7026.1. The term "contractor" includes all of the following:

(a) Any person not exempt under Section 7053 who maintains or services air-conditioning, heating, or refrigeration equipment that is a fixed part of the structure to which it is attached.

(b) Any person, consultant to an owner-builder, firm, association, organization, partnership, business trust, corporation,

or company, who or which undertakes, offers to undertake, purports to have the capacity to undertake, or submits a bid, to construct any building or home improvement project, or part thereof.

(c) A temporary labor service agency that, as the employer, provides employees for the performance of work covered by this chapter. The provisions of this subdivision shall not apply if there is a properly licensed contractor who exercises supervision in accordance with Section 7068.1 and who is directly responsible for the final results of the work. Nothing in this subdivision shall require a qualifying individual, as provided in Section 7068, to be present during the supervision of work covered by this chapter. A contractor requesting the services of a temporary labor service agency shall provide his or her license number to that temporary labor service agency.

(d) Any person not otherwise exempt by this chapter, who performs, offers to perform, purports to have the capacity to perform, or submits a bid to perform tree removal, tree pruning, stump removal, or tree or limb cabling or guying. The term contractor does not include a person performing the activities of a nurseryperson who in the normal course of routine work performs incidental pruning of trees, or guying of planted trees and their limbs. The term contractor does not include a gardener who in the normal course of routine work performs incidental pruning of trees measuring less than 15 feet in height after planting.

(e) Any person engaged in the business of drilling, digging, boring, or otherwise constructing, deepening, repairing, reperforating, or abandoning any water well, cathodic protection well, or monitoring well.

~~SEC. 2.~~

SEC. 16. Section 7028 of the Business and Professions Code is amended to read:

7028. (a) It is a misdemeanor for any person to engage in the business or act in the capacity of a contractor within this state without having a license therefor, unless the person is particularly exempted from the provisions of this chapter.

(b) If a person has been previously convicted of the offense described in this section, unless the provisions of subdivision (c) are applicable, the court shall impose a fine of 20 percent of the price of the contract under which the unlicensed person performed, or offered to perform, contracting work, or four thousand five

hundred dollars ($4,500), whichever is greater, and, unless the sentence prescribed in subdivision (c) is imposed, the person shall be confined in a county jail for not less than 90 days, except in an unusual case where the interests of justice would be served by imposition of a lesser sentence or a fine. If the court imposes only a fine or a jail sentence of less than 90 days for second or subsequent convictions under this section, the court shall state the reasons for its sentencing choice on the record.

(c) A third or subsequent conviction for the offense described in this section is punishable by a fine of not less than four thousand five hundred dollars ($4,500) nor more than the greater amount of either ten thousand dollars ($10,000) or 20 percent of the contract price under which the unlicensed person performed, or offered to perform, contracting work or by imprisonment in a county jail for not more than one year or less than 90 days, or by both that fine and imprisonment. The penalty provided by this subdivision is cumulative to the penalties available under all other laws of this state.

(d) A person who violates this section is subject to the penalties prescribed in subdivision (c) if the person was named on a license that was previously revoked and, either in fact or under law, was held responsible for any act or omission resulting in the revocation.

(e) In the event the person performing the contracting work has agreed to furnish materials and labor on an hourly basis, "the price of the contract" for the purposes of this section means the aggregate sum of the cost of materials and labor furnished and the cost of completing the work to be performed.

(f) Notwithstanding any other provision of law to the contrary, an indictment for any violation of this section by the unlicensed contractor shall be found or an information or complaint filed within four years from the date of the contract proposal, contract, completion, or abandonment of the work, whichever occurs last.

SEC. 17. Section 7303 of the Business and Professions Code is amended to read:

7303. (a) Notwithstanding Article 8 (commencing with Section 9148) of Chapter 1.5 of Part 1 of Division 2 of Title 2 of the Government Code, there is in the Department of Consumer Affairs the State Board of Barbering and Cosmetology in which the administration of this chapter is vested.

(b) The board shall consist of nine members. Five members shall be public members, and four members shall represent the professions. The Governor shall appoint three of the public members and the four professions members. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint one public member. Members of the board shall be appointed for a term of four years, except that of the members appointed by the Governor, two of the public members and two of the professions members shall be appointed for an initial term of two years. No board member may serve longer than two consecutive terms.

(c) The board shall appoint an executive officer who is exempt from civil service. The executive officer shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter. The appointment of the executive officer is subject to the approval of the director. ~~In the event that~~ *If* a newly authorized board replaces an existing or previous bureau, the director may appoint an interim executive officer for the board who shall serve temporarily until the new board appoints a permanent executive officer.

(d) The executive officer shall provide examiners, inspectors, and other personnel necessary to carry out the provisions of this chapter.

(e) This section 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 the dates on which it becomes inoperative and is repealed.

SEC. 18. Section 8005 of the Business and Professions Code is amended to read:

8005. The Court Reporters Board of California is charged with the executive functions necessary for effectuating the purposes of this chapter. It may appoint committees as it deems necessary or proper. The board may appoint, prescribe the duties, and fix the salary of an executive officer. Except as provided by Section 159.5, the board may also employ other employees as may be necessary, subject to civil service and other provisions of law.

This section 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 the dates on which it becomes inoperative and is repealed.

SEC. 19. Section 22258 of the Business and Professions Code is amended to read:

22258. *(a)* The following persons are exempt from the requirements of this title, *subject to the requirements of subdivision (b)*:

~~(a)~~

(1) A person with a current and valid license issued by the California Board of Accountancy~~ and his or her employees while functioning within the scope of their employment~~.

~~(b)~~

(2) A person who is an active member of the State Bar of California~~ and his or her employees while functioning within the scope of their employment~~.

~~(c) An employee of any~~

(3) Any trust company or trust business as defined in Chapter 1 (commencing with Section 99) of Division 1 of the Financial Code~~ while functioning within the scope of his or her employment~~.

~~(d)~~

(4) A financial institution regulated by the state or federal government,~~ and employees thereof,~~ insofar as the activities~~ of the employees are related to their employment and the activities~~ of the financial institution with respect to tax preparation are subject to federal or state examination or oversight.

~~(e)~~

(5) A person who is enrolled to practice before the Internal Revenue Service pursuant to Subpart A (commencing with Section 10.1) of Part 10 of Title 31 of the Code of Federal Regulations~~;~~ ~~and his or her employees while functioning within the scope of his or her employment~~.

(6) Any employee of any person described in paragraph (1), (2), (3), (4), or (5).

(7) Any employee of any corporation, partnership, association, or any entity described in subparagraph (B) of paragraph (1) of subdivision (a) of Section 2225.

(b) (1) Paragraph (6) of subdivision (a) shall apply only if all tax returns prepared by that employee are signed by an employer described in paragraph (1), (2), or (5) of subdivision (a).

(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 th~~e 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.

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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 is currently in the Assembly Appropriations Committee and has not been set for hearing.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would extend 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 authorize the board to employ special agents and to transition investigators who are peace officers to a special agents classification. It would delete 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.

FISCAL: None

POSITION: Sponsor/Support

January 22, 2008

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: AB 1154
Author: Leno
Bill Date: January 17, 2008, amended
Subject: Diabetes Pilot Program
Sponsor: Author

STATUS OF BILL:

This bill has been referred to the Assembly Appropriations Committee and is set for hearing on January 24, 2008.

DESCRIPTION OF CURRENT LEGISLATION:

The bill as introduced contained intent language by which the State would create a program which gives free diabetes medicine/supplies to government employees who have diabetes if they volunteer counseling with their pharmacists.

As amended, this bill would require the Department of Health Services, 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.

This bill was amended to require the Department of Public Health to consult with the Task Force on Obesity and Diabetes Causes, which is created by the bill, on the diabetes risk reduction program within the minimum number of counties necessary to represent the demographic populations in the state to review, analyze, and report on the outcomes from integrative care of diabetes through proactive prevention.

ANALYSIS:

This bill as introduced declares the intent of the legislature to create a statewide pilot program which gives free diabetes medicine and supplies to state, county, and municipal employees who have diabetes. Free medicine and supplies are provided only if the program participants volunteer to undergo monthly counseling with specially trained pharmacists. The author's office has indicated that this program will be modeled after a similar program in North Carolina which has proven to be successful. However, staff has indicated that they are working on extensive amendments which will fully delineate the parameters of the program. The bill will not move until amendments are made.

The amendments to this bill would require the Department of Health Services (DHS) in consultation with the California Health Alliance Commission to develop a diabetes risk reduction pilot program. This bill fully describes the pilot program.

This program would use information technology and media to facilitate and reinforce messages of the benefits of more nutritious whole foods, along with good hydration and physical activity. The communities selected to enroll in the pilot program shall be provided with dedicated health professionals and support personnel by the DHS to implement the pilot program, as recommended by the commission's Diabetes Risk Reduction Update. This pilot program is to analyze and report the outcomes of integrated care through proactive prevention.

At the same time, the DHS and the Department of Public Health are involved in a Diabetes Prevention and Management Initiative pursuant to the Governor's health care reform proposal. Many departments and professional groups are involved in this initiative, including the Medical Board. This initiative is to develop a diabetes care model for targeted medi-cal populations for short and long term savings to the state.

In addition the Board is involved with the Department of Managed Health Care (DMHC) and UC Davis in examining use of the telemedicine education model as a part of diabetes prevention and care. The Board has taken a support position on AB 329, a telemedicine bill giving the Board clear authority to pursue its efforts with DMHC and UC Davis.

Amendments to the bill create the Task Force on Obesity and Diabetes Causes and require the Department of Public Health to consult with the task force on a diabetes risk reduction pilot program within the minimum number of counties necessary to represent the demographic populations in the state to review, analyze, and report on the outcomes from integrative care of diabetes through proactive prevention.

FISCAL: None

POSITION: Refer to Access to Care Committee should this bill pass out of the Assembly.

January 22, 2008

AMENDED IN ASSEMBLY JANUARY 17, 2008

AMENDED IN ASSEMBLY JANUARY 7, 2008

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 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 Public Health to perform studies, demonstrate innovative methods, and disseminate information relating to the protection, preservation, and advancement of public health.

This bill would require the department, in consultation with the ~~California Health Alliance Commission~~ *Task Force on Obesity and Diabetes Causes, which is created by the bill,* to develop and administer a diabetes risk reduction pilot program within ~~24~~ *the minimum number of* counties *necessary to represent the demographic populations in the state* to review, analyze, and report on the outcomes from integrative care of diabetes through proactive prevention. The bill would establish the Diabetes Prevention and Treatment Pilot Program Fund in the State Treasury, and would require the department to deposit any moneys received from the federal government or from private donations into the fund to be used, upon appropriation by the Legislature, for the pilot program. The bill would provide that it shall only become operative if

adequate funds, as determined by the department, are appropriated *from the fund* in the annual Budget Act for the pilot program. The bill would provide that its provisions shall become inoperative on July 1 following the 4th fiscal year after the first appropriation is made for purposes of the bill and are repealed on the January 1 following that date.

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. The Legislature finds and declares all of the
2 following:
3 (a) Clear and substantial evidence indicates that a combination
4 of better food and hydration, with prudent activity and a healthy
5 attitude, promotes health and reduces the risk of chronic diseases,
6 particularly diabetes. The benefits of this combination range from
7 restorative sleep to enhanced hormone and neurochemical balance.
8 All of these contribute to, and are synergistic in achieving, a
9 healthy balance of sugar and energy in the body. As a result,
10 effective habit modification is able to reduce the risk of diabetes,
11 particularly in at-risk participants.
12 (b) Recent research confirms a rapid and accelerating increase
13 in diabetes, particularly in California's children. The human and
14 financial costs are staggering and avoidable. Access to healthier
15 choices and resources facilitates the practice of healthy habits.
16 (c) Diabetes and its antecedents and consequences drain precious
17 resources from the state.
18 (d) Diabetes negatively impacts productivity and quality of life,
19 while increasing substantially the risk of complications ranging
20 from heart attacks to kidney failure, stroke to blindness, and fragile
21 blood vessels to amputation. The promotion of healthy habits that
22 is reinforced with information and documentation of perceived
23 and tangible benefits is more effective than communicating a
24 general message of prevention while largely focusing on early
25 disease detection and communicating the principles of prevention
26 in the abstract rather than actionable terms.
27 (e) Proactive prevention in diabetes risk mitigation is a public
28 health concept that supports community health promotion habits
29 and practices that show evidence-based efficacy in at-risk
30 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)~~

(1) "Department" means the State Department of Public Health.

~~(3)~~

(2) "Director" means the state public health officer.

(3) "Task force" means the Task Force on Obesity and Diabetes Causes.

(b) There hereby established in the department the Task Force on Obesity and Diabetes Causes, which shall be comprised of the following members:

(1) A representative of the Californians Health Alliance.

(2) A representative of the American Society of Integrative Medical Practice.

(3) A representative of Health Studies Collegium.

(4) A representative of a community foundation.

(5) Three ex officio members, one of which shall be appointed by the Governor, one of which shall be appointed by the President pro Tempore of the Senate, and one of which shall be appointed by the Speaker of the Assembly.

~~(b)~~

(c) The department shall, in consultation with the ~~California Health Alliance Commission~~ *task force*, develop and administer a diabetes risk reduction pilot program within ~~24 counties~~ *the minimum number of counties necessary to represent the demographic populations of California* to review, analyze, and report on the outcomes from integrative care of diabetes through proactive prevention.

~~(c)~~

(d) The department, in consultation with the ~~commission~~ *task force*, shall design the pilot program to include all of the following components:

(1) Strategies aimed at diabetes risk reduction that are directed at low-income, at-risk communities and populations. In communities invited to participate in the pilot program, the pilot program shall provide dedicated health professionals and support personnel to implement this pilot program as recommended by the ~~California Health Alliance Commission's~~ *task force's* Diabetes Risk Reduction Update.

(2) The department shall provide technical and logistical support as needed and predicated upon funding of the public-private partnership responsible for this pilot program. Nothing in the pilot program shall be in conflict with the federal Diabetes Prevention Guidelines of the Centers for Disease Control and Prevention (CDC). This proactive prevention pilot program shall document

the risk and harm reduction as well as the outcomes of this community-based public health initiative.

(3) Strategies aimed at providing incentives for food stamp recipients to promote their health and reduce health risk behaviors shall be a priority of this program. Increasing access, reinforcing the benefits, and documenting the results of those strategies as implemented under the pilot program shall also be included, the department shall report quarterly to the ~~California Health Alliance Commission~~ *task force* no later than 30 days after the close of each quarter on the effectiveness of the pilot program.

(4) The department shall seek any necessary federal government approval to allow the use of food stamp electronic benefits cards, as provided in Chapter 3 (commencing with Section 10065) of Part 1 of Division 9 of the Welfare and Institutions Code, to provide those incentives, and to implement this pilot program as an essential priority for the 2009–10 fiscal year.

~~(d)~~

(e) In developing the pilot program, the department shall ~~include~~ *consider* all of the following:

(1) ~~At least two counties~~ *Counties* that have above the food stamp average county participation.

(2) ~~At least two counties~~ *Counties* that have below the food stamp average county participation.

(3) ~~At least two counties~~ *Counties* with above-average rates of diabetes.

(4) ~~At least two counties~~ *Counties* with above-average rates of obesity.

(5) ~~At least two counties~~ *Counties* with above-average rates of cardiovascular diseases.

(6) ~~At least two counties~~ *Counties* with ~~a predominantly~~ *the highest percentage of* Native American population.

(7) ~~At least two counties~~ *Counties* with ~~a predominantly~~ *the highest percentage of* African-American population.

(8) ~~At least two counties~~ *Counties* with ~~a predominantly~~ *the highest percentage of* Hispanic population.

~~(9) At least two urban counties.~~

~~(10) At least two rural counties.~~

(9) Counties with the highest percentage of Asian Pacific Islander population.

(10) Urban counties.

(11) Rural counties.

~~(e) 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.~~

(f) The department shall consider the availability of appropriate technology in targeted counties and communities to implement the program and collect the data necessary to evaluate the pilot program.

~~(f)~~

(g) The department shall develop 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 regarding the use of healthier choices, particularly those aimed at diabetes risk reduction. The evaluation shall also consider options that are appropriate to each community and implement those options with the highest likely benefit for that community. The department shall also conduct and perform real time data collection and prompt data analysis of outcomes. The department shall, at the earliest feasible time, make recommendations to the Legislature regarding the continuation of the pilot program, and shall include a statement of any federal policy changes needed to support the goals of the pilot program.

~~(g)~~

(h) The Diabetes Prevention and Treatment Pilot Program Fund is hereby created in the State Treasury. The department shall deposit any moneys received from the federal government or from private donations, and, notwithstanding Section 16305.7 of the Government Code, any interest earned on moneys in the fund, into the fund to be used, upon appropriation by the Legislature, for the pilot program.

~~(h)~~

(i) This section shall only be implemented if adequate implementation funds, as determined by the department, are appropriated *from the Diabetes Prevention and Treatment Pilot Program Fund* in the annual Budget Act or other statute. *No other*

state funds shall be used to fund the pilot program created pursuant to this section.

~~(i)~~

(j) This section shall become inoperative on July 1, following the fourth fiscal year after the first appropriation is made for purposes of this section 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 the date on which this section is repealed, deletes or extends the dates on which it becomes inoperative and is repealed.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 547
Author: Ma
Bill Date: January 7, 2008, amended
Subject: "Cap" on Fees
Sponsor: Medical Board of California

STATUS OF BILL:

This bill is currently in the Assembly Appropriations Committee and has been set for hearing on January 24, 2008.

DESCRIPTION OF CURRENT LEGISLATION:

This bill is set to be amended to included language that will establish a "cap" or "ceiling" on the physician licensing fees instead of a fixed amount as in current law. The initial licensing fee will be fixed by the Board at no greater than seven hundred ninety dollars ($790). The biennial renewal fee will also be fixed at no greater than seven hundred ninety dollars ($790).

ANALYSIS:

This bill is a result of a fiscal audit by the Bureau of State Audits where it concluded that the Board had excess in its reserve fund and should reduce the fee. In order to reduce the fee the Board would need legislation to allow for a fee set by regulation. The Board, in November 2007, authorized staff to seek legislation allowing for a "cap" on the current ($790) physician initial and renewal fees. Inserting the "fixed by the board" language into the law will allow the Board to set and revise the fee by regulatory action up to the "cap."

In addition, the Board authorized staff to seek authority to have a fund reserve between two and six months instead of at approximately two months. This amendment has not been accepted by the author to date. Staff continues to work with the author's office on this amendment.

FISCAL: None

POSITION: Executive Committee: Support if amended to provide flexibility in the fund's reserve.

January 22, 2008

AMENDED IN ASSEMBLY JANUARY 7, 2008

AMENDED IN ASSEMBLY APRIL 19, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL No. 547

Introduced by Assembly Member Ma

February 21, 2007

~~An act to add and repeal Section 12699.64 of the Insurance Code, relating to health care coverage.~~ *An act to amend Section 2435 of the Business and Professions Code, relating to medicine, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

AB 547, as amended, Ma. ~~County Health Initiative Matching Fund: application assistance.~~ *Medical Board of California: licensure fees.*

Existing law~~, the County Health Initiative Matching Fund, establishes a fund that is managed by the Managed Risk Medical Insurance Board. Under existing law, a county, county agency, a local initiative, or a county organized health system, defined as applicants, may apply to the board for funding to provide comprehensive health insurance coverage to a person who meets specified income criteria~~ *creates the Medical Board of California to license and regulate physicians and surgeons. Licensees of the board are required to pay licensure fees, including an initial licensing fee of $790 and a biennial renewal fee of $790. Existing law authorizes the board to increase those fees in certain circumstances.*

This bill would~~ establish a pilot program to authorize, until December 31, 2008, the applicants, defined as the City and County of San Francisco and the local initiative with which it contracts to provide~~

~~comprehensive health care coverage, to pay a fee to a person or entity who assists another to apply for coverage or to renew his or her coverage with the applicant, as specified. The bill would prohibit the applicants from using federal financial participation revenue from the County Health Initiative Matching Fund to pay the fee and would authorize the applicants to adopt procedures regarding implementation of the fee award process~~ *require those fees to be fixed by the board at a maximum of $790, while retaining the authority of the board to raise those fees in certain circumstances.*

This bill, by January 1, 2012, would require the Bureau of State Audits to conduct a review of the board's financial status, including, but not limited to, a review of the board's revenue projections, and, on the basis of that review, to report to the Joint Legislative Audit Committee on any adjustment to fees required to maintain a 2-month reserve in the Contingent Fund of the Medical Board of California, a continuously appropriated fund, and also taking into account the projected number of new licensees of the board. The review would be funded from licensure fees in the fund, thereby making an appropriation.

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

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

1 *SECTION 1. Section 2435 of the Business and Professions*
2 *Code is amended to read:*
3 2435. The following fees apply to the licensure of physicians
4 and surgeons:
5 (a) Each applicant for a certificate based upon a national board
6 diplomate certificate, each applicant for a certificate based on
7 reciprocity, and each applicant for a certificate based upon written
8 examination, shall pay a nonrefundable application and processing
9 fee, as set forth in subdivision (b), at the time the application is
10 filed.
11 (b) The application and processing fee shall be fixed by the
12 ~~Division of Licensing~~ *board* by May 1 of each year, to become
13 effective on July 1 of that year. The fee shall be fixed at an amount
14 necessary to recover the actual costs of the licensing program as
15 projected for the fiscal year commencing on the date the fees
16 become effective.

(c) Each applicant who qualifies for a certificate, as a condition precedent to its issuance, in addition to other fees required herein, shall pay an initial license fee, if any, *which fee shall be fixed by the board consistent with this section.* The initial license fee shall be *up to* seven hundred ninety dollars ($790). An applicant enrolled in an approved postgraduate training program shall be required to pay only 50 percent of the initial license fee.

(d) The biennial renewal fee shall be *fixed by the board consistent with this section. The biennial renewal fee shall be up to* seven hundred ninety dollars ($790).

(e) Notwithstanding subdivisions (c) and (d) and to ensure that subdivision (k) of Section 125.3 is revenue neutral with regard to the board, the board may, by regulation, increase the amount of the initial license fee and the biennial renewal fee by an amount required to recover both of the following:

(1) The average amount received by the board during the three fiscal years immediately preceding July 1, 2006, as reimbursement for the reasonable costs of investigation and enforcement proceedings pursuant to Section 125.3.

(2) Any increase in the amount of investigation and enforcement costs incurred by the board after January 1, 2006, that exceeds the average costs expended for investigation and enforcement costs during the three fiscal years immediately preceding July 1, 2006. When calculating the amount of costs for services for which the board paid an hourly rate, the board shall use the average number of hours for which the board paid for those costs over these prior three fiscal years, multiplied by the hourly rate paid by the board for those costs as of July 1, 2005. Beginning January 1, 2009, the board shall instead use the average number of hours for which it paid for those costs over the three-year period of fiscal years 2005–06, 2006–07, and 2007–08, multiplied by the hourly rate paid by the board for those costs as of July 1, 2005. In calculating the increase in the amount of investigation and enforcement costs, the board shall include only those costs for which it was eligible to obtain reimbursement under Section 125.3 and shall not include probation monitoring costs and disciplinary costs, including those associated with the citation and fine process and those required to implement subdivision (b) of Section 12529 of the Government Code.

(f) Notwithstanding Section 163.5, the delinquency fee shall be 10 percent of the biennial renewal fee.

(g) The duplicate certificate and endorsement fees shall each be fifty dollars ($50), and the certification and letter of good standing fees shall each be ten dollars ($10).

(h) It is the intent of the Legislature that, in setting fees pursuant to this section, the board shall seek to maintain a reserve in the Contingent Fund of the Medical Board of California equal to approximately two months' operating expenditures.

(i) ~~Not later than July 1, 2007, the Bureau of State Audits (BSA) shall conduct a review of the board's financial status, its financial projections and historical projections, including, but not limited to, its projections related to expenses, revenues, and reserves. The BSA shall, on the basis of the review, report to the Joint Legislative Audit Committee before January 1, 2008, on any adjustment to the amount of the licensure fee that is required to maintain the reserve amount in the Contingent Fund of the Medical Board of California pursuant to subdivision (h) of Section 2435, and whether a refund of any excess revenue should be made to licentiates~~ *Not later than January 1, 2012, the Bureau of State Audits (BSA) shall conduct a review of the board's financial status, including, but not limited to, a review of the board's revenue projections. The BSA shall, on the basis of the review, report to the Joint Legislative Audit Committee on any adjustment to the fees imposed by this section required to maintain the reserve in the Contingent Fund of the Medical Board of California as provided by subdivision (h), and also taking into account the projected number of new licensees of the board. The review shall be funded from licensure fees in the fund.*

~~SECTION 1. Section 12699.64 is added to the Insurance Code, to read:~~

~~12699.64. (a) An applicant may, but is not required to, pay an application assistance fee to a person or entity if the following conditions are met:~~

~~(1) The person or entity assists an individual to complete an application to enroll in the comprehensive health insurance coverage provided by the applicant or to renew that coverage with the applicant.~~

~~(2) The individual enrolls or renews his or her coverage with the applicant as a result of the application assistance. Placement~~

~~of an individual on a waiting list shall not constitute enrollment or renewal for purposes of payment of an application assistance fee.~~

~~(b) The applicant shall not use any federal financial participation revenue from the fund to pay an application assistance fee.~~

~~(c) The applicant may establish procedures for the implementation of the fee award described in subdivision (a), including establishing a list of persons or entities or categories of persons or entities who are eligible for the fee, the amount of the fee, and other rules to ensure the integrity of the fee award process.~~

~~(d) "Applicant," for purposes of this section, means the City and County of San Francisco and the local initiative that contracts with the City and County of San Francisco to provide comprehensive health care coverage, as described in Section 12699.53.~~

~~(e) This section constitutes a pilot program that shall remain in effect only until January 1, 2009, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2009, deletes or extends that date.~~

O

Medical Board of California
Tracker - Legislative Bill File
1/22/2008

BILL	AUTHOR	TITLE	STATUS	POSITION	VERSION OF BILL POS. BASED	LAST AMEND
AB 547	Ma	"Cap" on Fees	Approps. (1/24)	Support if Amended	Amended	1/7/2008
AB 1154	Leno	Diabetes	Approps. (1/24)	Refer to Access to Care	Amended	1/17/2008
SB 761	Ridley-Thomas	Diversion and Vertical Prosecution	Asm. Approps.	Sponsor/Support	Amended	7/18/2007
SB 797	Ridley-Thomas	Professions and Vocations	Floor	Contained VE/P - Support	Amended	9/7/2007
SJR 19	Ridley-Thomas	Health professionals: torture	Approps.	Rec: Watch	Introduced	
ABX1 1	Nunez	Health Care Reform	Sen. Health (1/23)	Issue Policy Statement	Amended	1/16/2008
SBX1 19	Cogdill	Medical Corporations	Health	Oppose	Introduced	
SBX1 24	Ashburn	Nurse Practitioners: scope of practice	Health	Oppose	Introduced	

The following are legislative proposals staff is developing for 2008 Legislation.

Legislation to allow for a "cap" on the current ($790) physician initial and renewal fees. This will allow the board to set and revise the fee by regulatory action. Additionally, allow the board to have two to six months in reserves.

The "cap" has been introduced in AB 547. Staff is working with the author to include a range for the amount in the reserve.

Legislation for the extension of the vertical enforcement/prosecution pilot.

SB 797 is on the Assembly floor. It needs to be amended to include an urgency clause to take effect immediately upon signature (before July 1, 2008). Staff is working with Senate Business & Professions staff.

Legislation on the peer reporting under B&P 821.5 and 821.6 that will be consistent with existing law to continue reporting this information to the board and to ensure the confidentiality of these reports as currently ensured by the diversion program.

Staff has sent the language to Dr. Salomonson, per the direction of the board, for review. Staff has secured a member to carry this language, to be introduced soon.

Legislation to amend section 2233 of the Business & Professions Code to allow the Executive Director to ask for an education course to be included with the public letter of reprimand.

Staff has reviewed the proposed language with Mr. Zerunyan, per the direction of the board. Staff has secured a member to carry this language, to be introduced soon.

Authorized staff to develop language to clarify 801.1 and 801.01 reporting related to multiple physician reporting in settlements, judgments and arbitration awards. Also, to develop language to clarify what is meant by a canceled license.

Staff has met with legal staff and will attempt to draft the clarifications in regulations. If this is not successful, then staff will seek legislation.

Authorize staff to reopen discussions regarding the proposal for an initial limited license (disabled) to determine if it is feasible for introduction into legislation.

Staff has met with legislative members regarding this concept, but has not met with the various interested parties and Dr. Gitnick, who was designated by the board as the point person on this issue. Staff expects to begin those discussions during February and March.

Legislation to allow for a Public Letter of Reprimand at the time of initial license for minor issues that would not lead to a denial or probation.

Staff has developed this language and it will go in the bill that carries the training addition to the Public Letter of Reprimand used in enforcement.

Develop proposed "fixes" to the Licensing laws and place as many as possible in an omnibus bill.

Staff has developed this language and shared it with CMA for input. This language will be submitted to the Senate Business & Professions staff for inclusion in the health professions omnibus bill.

Other proposals developed by the board.

MEDICAL BOARD OF CALIFORNIA
Status of Pending Regulations

Subject	Current Status	Date Approved by Division	Date Notice Published by OAL	Date of Public Hearing	Date of Final Adoption	Date to DCA for Review *	Date to OAL for Review **	Date to Sec. of State
Oral and Written Arguments	At 11/2/07 hearing, text was modified and then mailed out; no public comments were received; file is being completed by staff.	7/28/07	9/7/07	11/2/07	11/2/07			
Continuing Education Requirements	Public Hearing to be held 2/1/08	11/2/07	12/07/07	2/1/08				
Physician Assistant Comm: Delegation of Services	Public Hearing to be held 2/1/08	11/2/07	12/07/07	2/1/08				
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations pending Spring 2008							

* - DCA is allowed 30 calendar days for review
** - OAL is allowed 30 working days for review

Prepared by Kevin A. Schunke
Updated January 9, 2008
For questions, call (916) 263-2368

AGENDA ITEM 4B

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	1,908,000	35,777,000	4,334,000	2,810,000	1,387,000	3,063,000	2,727,000	52,006,000
$ Spent thru 11/30*	668,000	15,190,000	2,115,000	1,025,000	579,000	1,330,000	869,000	21,776,000 *
Positions Authorized	8.8	147.6	44.5	15.0	14.0	16.0	19.0	264.9

* net expenditures (includes unscheduled reimbursements)

1/10/2008
Budget Overview by Program.xls

AGENDA ITEM 5A

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	$ 16,655	$ 15,487	$ 10,075
Prior Year Adjustment		$ 576	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 12,775	$ 18,467	$ 16,655	$ 15,487	$ 10,075
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			$ (1,213)	$ (1,213)	$ (1,213)
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	$ 327	$ 313	$ 198	$ 85
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	$ 50,231	$ 49,437	$ 49,728	$ 50,014
Transfers:						
Trans to Steven M. Thompson Phys Corp Loan Repayment Prgm				$ (500)		
Totals, Revenues and Transfers		$ 49,688	$ 50,231	$ 48,937	$ 49,728	$ 50,014
Total Resources		$ 62,463	$ 68,698	$ 65,592	$ 65,215	$ 60,089
EXPENDITURES						
0840 State Controller (State Operations)		$ 25	$ 37	$ 36	$ -	$ -
1110 Program Expenditures (State Operations)		$ 43,971	$ 51,606	$ 51,282	$ 52,308	$ 53,354
	Peer Review Study		$ 400			
	Elimination of Diversion Program			$ (1,213)	$ (1,213)	$ (1,213)
	Proposed BCP: Operation Safe Medicine				$ 1,924	$ 1,620
	Proposed BCP: Probation Program Expansion				$ 621	$ 514
	Proposed BCP: Replace IT Infrastructure				$ 1,500	$ 1,500
Total Expenditures and Expenditure Adjustments		$ 43,996	$ 52,043	$ 50,105	$ 55,140	$ 55,775
FUND BALANCE						
Reserve for economic uncertainties		$ 18,467	$ 16,655	$ 15,487	$ 10,075	$ 4,314
Months in Reserve		4.3	4.0	3.4	2.2	0.9

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED.

B. EXPENDITURE GROWTH PROJECTED AT 2% BEGINNING FY 2009-10.

1/11/2008

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	$ 16,655	$ 15,487	$ 14,201
Prior Year Adjustment		$ 576	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 12,775	$ 18,467	$ 16,655	$ 15,487	$ 14,201
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			$ (1,213)	$ (1,213)	$ (1,213)
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	$ 327	$ 313	$ 278	$ 240
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	$ 50,231	$ 49,437	$ 49,808	$ 50,169
Transfers:						
Trans to Steven M. Thompson Phys Corp Loan Repayment Prgm				$ (500)		
Totals, Revenues and Transfers		$ 49,688	$ 50,231	$ 48,937	$ 49,808	$ 50,169
Total Resources		$ 62,463	$ 68,698	$ 65,592	$ 65,295	$ 64,370
EXPENDITURES						
0840 State Controller (State Operations)		$ 25	$ 37	$ 36	$ -	$ -
1110 Program Expenditures (State Operations)		$ 43,971	$ 51,606	$ 51,282	$ 52,308	$ 53,354
	Peer Review Study		$ 400			
	Elimination of Diversion Program			$ (1,213)	$ (1,213)	$ (1,213)
	NO CHANGE IN AUTHORITY FOR PLANNED PROGRAMS					
Total Expenditures and Expenditure Adjustments		$ 43,996	$ 52,043	$ 50,105	$ 51,095	$ 52,141
FUND BALANCE						
Reserve for economic uncertainties		$ 18,467	$ 16,655	$ 15,487	$ 14,201	$ 12,229
Months in Reserve		4.3	4.0	3.6	3.3	2.8

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED.

B. EXPENDITURE GROWTH PROJECTED AT 2% BEGINNING FY 2009-10.

1/11/2008

Medical Board of California
FY 07/08
Budget Expenditure Report
(As of November 30, 2007)
(41.7% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	15,306,508	5,713,029	37.3	9,593,479
DEC	24,000	6,000	25.0	18,000
Board Members	31,500	7,600	24.1	23,900
Phy Fitness Incentive Pay	29,623	8,710	29.4	20,913
Temp Help	1,144,410	476,426	41.6	667,984
Allocated Proctor	0	129		(129)
Overtime	12,143	21,971	180.9	(9,828)
Staff Benefits	6,485,271	2,658,129	41.0	3,827,142
Salary Savings	(803,979)			(803,979)
TOTALS, PERS SERVICES	22,229,476	8,891,994	40.0	13,337,482
OPERATING EXP & EQUIP				
General Expense	891,585	118,505	13.3	773,080
Fingerprint Reports	373,448	140,667	37.7	232,781
Printing	835,648	384,438	46.0	451,210
Communications	567,855	98,920	17.4	468,935
Postage	444,459	132,303	29.8	312,156
Insurance	37,956	9,804	25.8	28,152
Travel In-State	421,039	129,793	30.8	291,246
Travel Out-of-State	2,800	0	0.0	2,800
Training	62,910	40,239	64.0	22,671
Facilities Operation (Rent)	2,784,152	1,967,677	70.7	816,475
Consult/Prof Services	1,369,919	1,248,803	91.2	121,116
Departmental Prorata	4,028,381	1,671,835	41.5	2,356,546
Consolidated Data Ctr (Teale)	572,639	102,762	17.9	469,877
Data Processing	106,263	99,757	93.9	6,506
Central Admin Svcs (Statewide Prorata)	1,793,449	897,291	50.0	896,158
Attorney General Services	12,419,270	5,123,151	41.3	7,296,119
Office of Administrative Hearings	1,643,939	593,316	36.1	1,050,623
Court Reporter Services	160,000	32,159	20.1	127,841
Evidence/Witness	1,676,318	433,075	25.8	1,243,243
DOI-Investigative	2,434	980	40.3	1,454
Major Equipment	232,300	98,095	42.2	134,205
Minor Equipment	182,300	255,795	140.3	(73,495)
Vehicle Operation/Other Items	242,370	120,526	49.7	121,844
TOTALS, OE&E	30,851,434	13,699,891	44.4	17,151,543
TOTALS, EXPENDITURES	53,080,910	22,591,885	42.6	30,489,025
Scheduled Reimbursements	(384,000)	(148,588)	38.7	(235,412)
Distributed Costs	(691,000)	(281,604)	40.8	(409,396)
NET TOTAL, EXPENDITURES	52,005,910	22,161,693	42.6	29,844,217
Unscheduled Reimbursements		(385,332)		
		21,776,361		

Budget Expenditure Report.xls
Date: January 4, 2008

ENFORCEMENT/PROBATION RECEIPTS
MONTHLY PROFILE: JULY 2005 - NOVEMBER 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	13,851	10,837	7,104								59,591
Criminal Cost Recovery	0	0	0	0	0								0
Probation Monitoring	31,949	49,534	24,134	32,231	119,692								257,540
Exam	3,545	4,227	1,248	1,820	1,209								12,049
Cite/Fine	1,200	9,100	6,250	4,800	13,440								34,790
MONTHLY TOTAL	51,768	75,586	45,483	49,688	141,445	0	0	0	0	0	0	0	363,970
FYTD TOTAL	51,768	127,354	172,837	222,525	363,970	363,970	363,970	363,970	363,970	363,970	363,970	363,970	

**not included in monthly and FYTD totals*

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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 - November 30, 2007

	Per Diem*				Travel Expenses*	Total Sept-Nov	Total FYTD
	SEPT	OCT	NOV	TOTAL			
DMQ							
Mr. Alexander	100	300	300	700	49.70	749.70	2,036.17
Dr. Aristeiguieta	0	0	0	0	0.00	0.00	0.00
Dr. Chin	0	0	200	200	0.00	200.00	711.25
Dr. Corday	0	0	0	0	0.00	0.00	728.50
Dr. Duruisseau	300	300	400	1,000	498.66	1,498.66	2,579.16
Dr. Low	0	0	200	200	0.00	200.00	200.00
Dr. Moran	0	0	0	0	0.00	0.00	0.00
Dr. Salomonson	500	500	400	1,400	976.04	2,376.04	3,657.58
Dr. Wender	0	0	200	200	404.55	604.55	1,210.90
Ms. Yaroslavsky	0	0	0	0	0.00	0.00	0.00
Mr. Zerunyan	300	700	400	1,400	610.76	2,010.76	3,310.76
SUB TOTAL	1,200	1,800	2,100	5,100	2,539.71	7,639.71	14,434.32
LICENSING							
Ms. Chang	0	0	0	0	158.50	158.50	158.50
Dr. Fantozzi	500	700	1,200	2,400	136.00	2,536.00	6,170.80
Dr. Gitnick	0	0	0	0	0.00	0.00	0.00
Dr. Gregg	0	0	0	0	0.00	0.00	1,577.50
Ms. Schipske	0	0	500	500	350.67	850.67	1,554.45
SUB TOTAL	500	700	1,700	2,900	645.17	3,545.17	9,461.25
BOARD TOTAL	1,700	2,500	3,800	8,000	3,184.88	11,184.88	**23,895.57**

*includes claims paid/submitted through December 31, 2007

Board Members Expense Report.xls
Date: January 10, 2008

MEDICAL BOARD OF CALIFORNIA
EXECUTIVE PROGRAM
BUDGET REPORT
JULY 1, 2007 - NOVEMBER 30, 2007

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	642,738	252,905	current
Staff Benefits	270,921	93,377	current
TOTAL PERSONAL SERVICES	913,659	346,282	
OPERATING EXPENSE & EQUIPMENT			
General Expense 1/	70,500	18,124	1-2
Printing	300,000	56,141	1-2
Communications	26,292	2,749	1-2
Postage	181,375	60,605	1-2
Travel In-State	105,455	29,012	1-2
Travel Out-of-State	800	0	current
Training	5,000	692	1-2
Facilities Operations 2/	72,000	53,623	current
Consultant & Professional Services	24,000	8,150	1-2
Departmental Services 3/	143,813	60,185	current
Other Items of Expense	0	207	1-2
Data Processing	1,000	0	1-2
Central Administrative Services 4/	64,026	32,033	current
DOI-Investigation	0	35	current
Minor Equipment	0	516	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	994,261	322,072	
TOTAL BUDGET/EXPENDITURES	**1,907,920**	**668,354**	

See footnotes on next page

1/4/08
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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.

1/4/08
g/admin/execbud.xls

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2007 - NOVEMBER 30, 2007

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	9,181,962	3,472,815	current
Staff Benefits	3,636,751	1,496,249	current
TOTAL PERSONAL SERVICES	12,818,713	4,969,064	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	256,104	27,694	1-2
Printing	373,148	297,292	1-2
Communications	310,994	58,613	1-2
Postage	101,806	28,630	1-2
Insurance	29,930	7,138	current
Travel In-State	122,358	36,237	1-2
Travel Out-of-State	900	0	current
Training	21,806	23,381	1-2
Facilities Operations	1,622,789	1,452,365	current
Consultant/Professional Services	750,000	634,128	1-2
Departmental Services	2,758,232	1,138,520	current
Data Processing	12,000	3,592	1-2
Central Administrative Services	1,227,975	614,379	current
Attorney General 1/	12,229,270	5,062,801	current
OAH	1,643,939	593,316	current
Evidence/Witness Fees	1,606,750	424,335	1-2
DOI-Investigative	2,434	670	current
Court Reporter Services	160,000	32,159	1-2
Major Equipment	112,800	0	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	72	14,503	1-2
Vehicle Operations	184,098	75,187	1-2
Minor Equipment	65,500	10,890	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	23,592,905	10,535,830	
DISTRIBUTED COSTS	(634,562)	(267,495)	
TOTAL BUDGET/EXPENDITURES	**35,777,056**	**15,237,399**	
Unscheduled Reimbursements		(47,707)	
		15,189,692	

1/See next page for monthly billing detail

1/4/08
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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	6,933.50	158.00	1,095,493.00
	Paralegal Services	65.25	101.00	6,590.25
	Auditor/Analyst Services	6.00	63.00	378.00
	Cost of Suit			828.50
				1,103,289.75
September	Attorney Services	6,143.50	158.00	970,673.00
	Paralegal Services	240.00	101.00	24,240.00
	Auditor/Analyst Services	69.50	63.00	4,378.50
	Cost of Suit			2,997.12
				1,002,288.62
October	Attorney Services	6,653.25	158.00	1,051,213.50
	Paralegal Services	241.50	101.00	24,391.50
	Auditor/Analyst Services	107.00	63.00	6,741.00
	Special Agent Services	2.00	110.00	220.00
	Cost of Suit			320.76
				1,082,886.76
November	Attorney Services	5,400.75	158.00	853,318.50
	Paralegal Services	253.50	101.00	25,603.50
	Auditor/Analyst	63.00	63.00	3,969.00
	Special Agent Services	10.00	110.00	1,100.00
	Cost of Suit			
				883,991.00
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 - November =	**5,062,800.63**
FY 07/08 Enforcement AG Budget =	**12,229,270.00**

Revised 12/14/07

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2007 - NOVEMBER 30, 2007

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,858,777	752,845	current
Staff Benefits	822,264	346,382	current
TOTAL PERSONAL SERVICES	2,681,041	1,099,227	
OPERATING EXPENSES & EQUIPMENT			
General Expense	44,460	10,399	1-2
Fingerprint Reports*	369,948	139,288	current
Printing	100,000	16,453	1-2
Communications	73,816	15,542	1-2
Postage	137,446	42,223	1-2
Travel In-State	25,000	14,998	1-2
Training	4,000	764	1-2
Facilities Operation	185,000	155,682	current
Consult/Professional Services	448,919	587,597	1-2
Departmental Services	331,536	140,435	current
Data Processing	500	141	1-2
Central Administrative Services	147,601	73,846	current
Vehicle Operations	0	71	1-2
Attorney General	190,000	60,350	current
Evidence/Witness Fees	5,000	0	1-2
DOI-Investigation	0	80	current
Minor Equipment	0	968	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	2,063,226	1,258,837	
SCHEDULED REIMBURSEMENTS	(384,000)	(148,588)	
DISTRIBUTED COSTS	(26,089)	(6,522)	
TOTAL BUDGET/EXPENDITURES	**4,334,178**	**2,202,954**	
Unscheduled Reimbursements		(87,564)	
		2,115,390	

*Department of Justice invoices for fingerprint reports, name checks, and subsequent arrest reports

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MEDICAL BOARD OF CALIFORNIA
ADMINISTRATIVE SERVICES PROGRAM
BUDGET REPORT
JULY 1, 2007 - NOVEMBER 30, 2007

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	830,002	375,298	current
Staff Benefits	364,020	162,305	current
TOTAL PERSONAL SERVICES	1,194,022	537,603	
OPERATING EXPENSE & EQUIPMENT			
General Expense	433,121	44,975	1-2
Printing	30,000	7,021	1-2
Communications	80,435	6,053	1-2
Postage	10,131	190	1-2
Travel In-State	20,000	7,758	1-2
Training	3,000	0	1-2
Facilities Operations	695,363	123,117	current
Consultant & Professional Services	37,000	14,921	1-2
Departmental Services	229,215	96,970	current
Data Processing	1,000	14,902	1-2
Central Administrative Services	102,047	51,055	current
Vehicle Operations/Insurance/Other	2,445	2,427	1-2
DOI-Investigations	0	55	current
Major Equipment	0	42,728	1-2
Minor Equipment	0	82,097	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	1,643,757	494,269	
DISTRIBUTED COSTS	(28,357)	(7,089)	
TOTAL BUDGET/EXPENDITURES	**2,809,422**	**1,024,783**	

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MEDICAL BOARD OF CALIFORNIA
DIVERSION PROGRAM
BUDGET REPORT
JULY 1, 2007 - NOVEMBER 30, 2007

	FY 07/08 BUDGET	EXPEND/ ENCUMB YR-TO-DATE	PERCENT OF BUDGET EXP/ENCUMB	LAG TIME (MONTHS)
PERSONAL SERVICES				
Salaries & Wages	720,179	307,401	42.7	current
Staff Benefits	308,814	119,626	38.7	current
TOTAL PERSONAL SERVICES	1,028,993	427,027	41.5	
OPERATING EXPENSES & EQUIPMENT				
General Expense	22,000	11,073	50.3	1-2
Printing	10,000	5,174	51.7	1-2
Communications	22,822	3,379	14.8	1-2
Postage	5,255	538	10.2	1-2
Insurance	1,702	516	30.3	current
Travel In-State	75,000	24,481	32.6	1-2
Travel Out-of-State	1,100	0	0.0	current
Training	4,418	0	0.0	1-2
Facilities Operation	30,000	28,290	94.3	current
Departmental Services	109,572	45,140	41.2	current
DP Maint/Supplies	500	0	0.0	1-2
Central Administrative Services	48,782	24,406	50.0	current
Major Equipment	16,000	0	0.0	current
Vehicle Operations	11,000	8,967	81.5	1-2
DOI-Investigations	0	25		
TOTAL OPERATING EXPENSES & EQUIPMENT	358,151	151,989	42.4	
TOTAL BUDGET/EXPENDITURES	**1,387,144**	**579,016**	41.7	

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MEDICAL BOARD OF CALIFORNIA
INFORMATION SYSTEMS PROGRAM
BUDGET REPORT
JULY 1, 2007 - NOVEMBER 30, 2007

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,036,606	450,728	current
Staff Benefits	458,865	174,361	current
TOTAL PERSONAL SERVICES	1,495,471	625,089	
OPERATING EXPENSE & EQUIPMENT			
General Expense	38,400	5,490	1-2
Printing	15,000	1,808	1-2
Communications	21,503	5,044	1-2
Postage	5,255	102	1-2
Travel In-State	21,441	1,272	1-2
Training	20,186	15,401	1-2
Facililties Operations	138,000	118,083	current
Consultant/Professional Services	110,000	4,008	1-2
Departmental Services	240,897	100,310	current
Consolidated Data Centers (Teale)	572,639	102,762	current
Data Processing	90,763	81,051	1-2
Central Administrative Services	107,248	53,657	current
Major Equipment	71,500	55,367	1-2
Minor Equipment	116,800	161,324	1-2
DOI-Investigations	0	60	current
TOTAL OPERATING EXPENSES & EQUIPMENT	1,569,632	705,739	
DISTRIBUTED COSTS	(1,992)	(498)	
TOTAL BUDGET/EXPENDITURES	**3,063,111**	**1,330,330**	

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MEDICAL BOARD OF CALIFORNIA
PROBATION MONITORING
BUDGET REPORT
JULY 1, 2007 - NOVEMBER 30, 2007

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,473,940	621,874	current
Staff Benefits	623,637	265,829	current
TOTAL PERSONAL SERVICES	2,097,577	887,703	
OPERATING EXPENSES & EQUIPMENT			
General Expense	30,500	2,130	1-2
Printing	7,500	548	1-2
Communications	31,993	7,541	1-2
Postage	3,191	15	1-2
Insurance	6,079	0	current
Travel In-State	51,785	16,035	1-2
Training	4,500	0	1-2
Facilities Operation	41,000	36,516	current
Departmental Services	215,116	90,275	current
Data Processing	500	70	1-2
Central/Administrative Services	95,770	47,915	current
Evidence/Witness Fees	64,568	8,796	1-2
Major Equipment	32,000	0	1-2
Vehicle Operations/Other Items	45,000	21,314	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	629,502	231,155	
TOTAL BUDGET/EXPENDITURES	**2,727,079**	**1,118,858**	
Unscheduled Reimbursements*		(250,061)	
		868,797	

*no authority to spend

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1/7/2008

MEDICAL BOARD OF CALIFORNIA

Executive Office

Agenda Item #10

DATE REPORT ISSUED:	January 11, 2008
ATTENTION:	Members, Medical Board of California
DEPARTMENT:	Medical Board of California (MBC)
SUBJECT:	Update on public affairs activities of MBC staff
STAFF CONTACT:	Candis Cohen, Public Information Officer
REQUESTED ACTION:	None-Information update.
STAFF RECOMMEDATION:	Continue to follow Board approved Communications Plan.

SUMMARY:

The Medical Board of California (MBC) adopted a Communications Plan in 2003 that details the overall goals and objectives and specific strategies of our outreach program. The summary that is emailed to board members provides a monthly update of both media interaction and public and professional outreach efforts by board members and staff that are aligned with current goals and objectives. This memo highlights the presentation to be made to the newly named Education Committee (formerly the Public Education Committee [PEC]) on January 31. The purpose of this memo is to inform members of the scope of work performed by staff of the public affairs unit of the board in efforts to reach out and educate the public about the Medical Board.

Since the last meeting of the PEC on November 2, 2006, staff has issued 29 news releases and also has represented the board at scores of outreach activities statewide, ranging from consumer to licensing fairs to health care professional meetings. See Attachment "A". These activities are listed in the updates sent to all board members at the end of each month. It is routine for staff to take advantage of opportunities to reach the public when appropriate. Staff accepts requests for radio and TV interviews when the subject matter is appropriate and the topic is something we can discuss publicly. Interviews in Spanish are available if requested. Staff often is able to generate a board-related news article when given timely notice of a public-record action dealing with a specific physician and by contacting reporter(s) who inquired about him or her.

Board staff consistently responds to many phone calls from a wide variety of media entities. The calls are time-consuming, since the vast majority are based on news sources, and most have no idea about how our enforcement process works and what is public and what is not. Staff provides education about the Board during these conversations and the reporters frequently call back for more information. When Anna Nicole Smith died, staff received literally scores of calls, and is still receiving calls for updates, from news entities ranging from CNN to "Entertainment Tonight." Board staff Googled the name "Candis Cohen" and "Anna Nicole Smith" and received 54,000 hits as of January 15, 2008. When Donda West (mother of a well known musician) died this past November, staff received calls from 38 reporters, and some of them are still calling. Staff returns every call and provides consistent information to each caller.

Staff has been receiving unprecedented positive feedback regarding MBC's newsletter. We received an extraordinary number of emails and phone calls from physicians, including some from out of state, about the "House" article by Dr. Aristeiguieta and the wellness article by Dr. Duruisseau in our November 2007 newsletter. Historically the newsletter has generated questions from physicians, but rarely compliments.

Public affairs staff also handles Public Record Act requests. These are formal requests for public records that must be handled in a legally prescribed manner. The board receives between two and five requests per week. Most are from attorneys, some from incarcerated individuals, some from consumer advocates, and some from the general public. Staff tracks and ensures that the board responds to these requests within the mandated 10 days.

The MBC Webmaster receives and responds on the same day to about 20-40 emails. Most are inquiries about licensing matters; the rest include a variety of issues such as consumers inquiring about our enforcement process, and physicians and others with technical, legal questions. Our Web site is constantly updated both as necessary day-to-day, and also through a formal meeting of managers and support staff once a month. The board's Information Systems Branch manager will give a tour of our newly updated Web site at the full-board meeting on January 31.

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

December 3, 2007 *ATTACHMENT A*

TO: MEMBERS OF THE BOARD

FROM: CANDIS COHEN
Information Officer

RE: Strategic Communications Plan – Monthly Report

This monthly report illustrates how our media and outreach activities fulfill the goals and strategies of the board's Strategic Communications Plan. Our communications activities are designed to support the strategies and activities the board adopted in that plan (with the understanding that we are limited by both our current budget and staff). We want to be sure that our activities are strategic and focused on the elements of that plan so that we achieve the maximum results from our work on behalf of the board and the public. The format below first identifies the section of the plan (goal, objective, strategy, etc.) and is followed by the activities with which we are engaged that implement that plan's section.

Goal: To improve the confidence and engagement of the public, physicians and stakeholders in the board by increasing the number of Californians who know what the Medical Board of California is and how they can use the board's services.

Objective: Broaden the board's outreach on key issues with major metropolitan news organizations

Objective: Identify guidelines and develop a proactive plan for working with key media outlets to communicate with their audiences about the board and its role with consumers and licensees.

Strategy: Assess news angles and pitch stories as appropriate for print and electronic media.

⇒ Activity:

I was interviewed on camera on Nov. 1 by Gina Silva of Fox 11 re the board's information disclosure policy (this was in conjunction with their story on Sandy Witzling, M.D.).

Supervising Investigator Carmen Aguilera-Marquez, Glendale District Office, was interviewed on camera in Spanish by Nazeli Nazar of Univision on Nov. 9 about how to choose a physician, the unlicensed practice of medicine, and basic enforcement procedures of MBC.

I gave a taped statement on Nov. 14 to Christina of KPAY radio regarding the surrender of the medical license of Chae Moon.

I was interviewed by KCRA-TV producer Chyresse Lowther on Nov. 20 about what consumers should know when considering cosmetic surgery and how to check on physicians via our Web site.

Objective: Broaden the board's outreach on key issues with major metropolitan news organizations.

Strategy: Identify key professional groups with opportunities for prioritized, leveraged communication through existing channels.

⇒ Activity:

Supervising Investigator Andrew Hegelein and Complaint Unit Manager Curt Worden spoke at California State University, Sacramento on Nov. 16 to a group of about 20 elderly members of the Renaissance Society, which sponsored a "Learning in Retirement" day. They discussed how to file a complaint and also how physicians are licensed.

Kevin Schunke represented the board at the following licensing fairs:

- UCSF on Nov. 11; about 100 residents attended
- Kaiser Oakland on Nov. 28; about 40 residents attended

Erlinda Suarez and Armando Melendez represented the board on Nov. 17 at the 8th Annual Community Pride Day in Sacramento. Approximately 1,000 people attended the event, which included many other community-based organizations.

Strategy: Review, update and monitor the board's Web site to ensure accurate, timely and useful information for Web site users.

⇒ Activity:

Staff from our Information Systems Branch and MBC managers (the Users Group, meets monthly) met on Nov. 14. Staff reviews the progress of all pending projects to stay on top of each; troubleshoots, and discusses ideas for improving our Web site. In Oct. 2007, the board's Web site profiles received 680,141 hits.

Objective: Measurably increase the board's outreach and dialogue with physicians and allied health professionals regulated by the board.

Strategy: Utilize existing venues for communications with physicians and allied health professionals through an alliance with physician and healthcare associations as highly leveraged mechanisms to create dialogue…regarding the board.

⇒ Activities:

Former Medical Board Chief of Enforcement Joan Jerzak spoke to the Indian Medical Association of So. CA on Nov. 18 about how to avoid medical malpractice. About 200

physicians attended.

Gary Qualset met on Nov. 16 with Neil Simon and Harvey Englander, president of the American University of Antigua, and consultant, respectively, to discuss the board's international medical school approval process.

Calls from reporters

- Inquiries about individual licensees:

  David Kipper, M.D. – of Beverly Hills; Public Reprimand issued 9/5/07. (Jacob Edelman, AP–L.A; Aiden Pickering, "Inside Edition"; Alice Standish, *Canyon News*)

  William Ayres, M.D. – of San Mateo; full PC 23 issued 4/11/07. (Victoria Balfour, *Ladies Home Journal*)

  Hamid Safari, M.D. – of Fresno; Accusation filed 9/28/07. (Tracy Correa, *Fresno Bee)*

  Borko Djordjevic, M.D. – of Palm Desert; 7 years' probation effective 10/8/07. (Kay Kaufman, *Desert Sun*)

  Jan Adams, M.D. – of Los Angeles; Accusation filed 4/10/07. (This is the physician implicated in the death of Donda West, mother of Kanye West.) (Marissa Yaremich and Cheryl, "Inside Edition"; T.J. Matthews, David Mattingly, Corrine Winter, and Doug Ganley, CNN; Fred Mamoun, KNBC; Dennis Broad and Mike Walters, TMZ.com; Maureen, "E Entertainment"; Claudia Peschiutta and Jon Baird, KNX; Andrew Blankstein, Scott Glover, and Ron Lin, *L.A. Times*; Pat Lalama, Fox; Monique Mitchell, *People Magazine*; Jeremiah Marquez, AP; Andy Murr, *Newsweek*; Alissa Panitz, *Star Magazine*; Brenda Duran and Paula Carvajal, *Us Weekly Magazine*; Robin Singer, CBS Network News; Alicia Chang, AP; Miriam Hernandez, ABC 7; Celine Darkaostanian, "Access Hollywood"; David Goldstein, KCAL; Audrey Wood, "CBS News Early Show"; Daniel Clements and Jennifer Henderson, "Entertainment Tonight"; Nancy Dillon, *New York Daily News*; Greg Overzat, Court TV; Christopher Liss, "Extra"; GiGi Graciett, Fox 10 News; Maureen Harrington and Wendy Grossman, *People Magazine*; Simon Ray, TV Guide Network; Ryan Jimenez, "Larry King Live")

  Chae Moon – of Redding; license revoked 6/8/07. (Ryan Sabalow, *Redding Record Searchlight;* Samantha Young, AP)

  Thomas Ross Evans, M.D. – of Tulare; Public Reprimand issued 3/26/01; 5 years' probation effective 9/17/07. (Julie Fernandez, *Tulare Voice*)

  Hootan Roozrokh, M.D. – of San Francisco; under investigation by MBC and AG. (Jesse McKinley, *N.Y. Times*)

David Matlock, M.D. – of Huntington Park; probation completed 6/19/04. (Dennis Broad, TMZ.com)

Edwin Krick, M.D. – of Loma Linda; public record clear. (Susan Sward, *S.F. Chronicle*)

Lisa Nagy, M.D. – of MA; license in delinquent status. (Julia Hoppock, ABC News)

Patrick Golden, M.D. – of Fresno; Accusation filed 5/16/07. (Tracey Correa, *Fresno Bee*)

Brian West, M.D. – of Huntington Beach; 5 years' probation effective 11/16/05; Accusation filed 2/26/07. (Marcus Wolfson, AP, S.F.)

- Other reporters' calls:

Melissa Knievel of KGET had questions about cosmetic surgery, and who may perform what types of procedures.

David McFadden of AP had questions about some medical schools in the Caribbean, and I directed him to our list of approved and unapproved schools on our Web site.

John Hill of the *Sacramento Bee* asked if MBC had a unit dedicated to proactively looking for misleading advertising, and I told him we do not, but that when staff comes upon something suspicious looking, it will be reviewed.

David Goldstein of KCAL asked if a physician must be certified by the American Board of Radiology to read mammograms. Answer: No

Lyndsay Paulo of KCRA asked for information about a med spa in Sacramento and what consumers should be aware of when dealing with them.

Tom Kisken of the *Ventura County Star* asked questions about the "House" article of Dr. Aristeiguieta's which I answered since Dr. A. was out of the country and not reachable.

Christopher Liss of "Extra" asked about the incident of the overdosing of the newborn twins of Dennis Quaid, and I told him the board's policy about not disclosing complaint or investigative information. We also discussed our enforcement process.

John Hill of the *Sacramento Bee* asked if the law (B&P Code section 801.01) requires insurers to report sexual misconduct or fraud in malpractice settlements to the board. After consulting with DCA legal counsel, I told him the law is broad and vague and does not specify those two issues, and that their reporting in settlements would be up to the insurers' interpretation of the code section.

Tom Kisken of the *Ventura County Star* asked for the number of complaints the board received in '06-07 re sexual misconduct. Answer: 130

MEDICAL BOARD OF CALIFORNIA

INITIAL STATEMENT OF REASONS

Hearing Date: February 1, 2008

Subject Matter of Proposed Regulations:

1) Continuing Education Required

Section Affected: 1) Amend Section 1336 in Article 11 of Chapt. 1, Div.13

Specific Purpose of each adoption, amendment, or repeal:

This rulemaking 1) directs licensees to complete at least 50 hours of approved CME during the renewal cycle, the two-year period immediately preceding the expiration of the license, (which is equivalent to the current requirement of 25 hours per year for a total of 100 every four years) in order to renew the license, and 2) changes the calculation of CME hours from calendar year to renewal cycle.

Factual Basis/Rationale:

1) The Division of Licensing (Division) of the Medical Board of California has performed three audits of continuing medical education (CME) over the past few years. These audits have uncovered two issues causing confusion related to CME. One is regarding Title 16, California Code of Regulation (CCR) section 1336(d) that requires the licensee to complete 100 hours of CME during a four year period and the other is regarding Title 16, CCR section 1336(a) that requires the licensee complete an average of 25 hours of CME during each calendar year. The four year time period is not defined in the regulation, which allows for a random and varied calculation of the cumulative 100 hours that is further complicated by the requirement that the licensee complete an average of 25 hours of CME per calendar year. Additionally, licensees often calculate CME hours based upon their renewal cycle and expiration date, which is established not by calendar year, but by the licensee's birth month.

Underlying Data

None.

Business Impact

This regulation will not have a significant adverse economic impact on businesses.

This initial determination is based on the following facts or evidence/documents/testimony:

The proposed regulation amendments only clarify time periods for calculating CME hours for license renewal. There are no additional costs associated with these amendments.

Specific Technologies or Equipment

This regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives

No reasonable alternative to the regulation would be either more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed regulation.

California Code of Regulations, Title 16
Medical Board of California
Specific Language of Proposed Changes
Continuing Education Requirements

Section 1336 is amended to read:

§ 1336. Continuing Education Required.

(a) Each physician is required to complete not less than 50 ~~an average of at least 25~~ hours of approved continuing education during each two year period immediately preceding the expiration date of the license ~~calendar year~~. If an initial license was issued for less than 13 months, only 25 hours of continuing education must be completed.

(b) Each physician renewing his or her license under the provisions of Article 19 (commencing with Section 2420) of the Medical Practice Act may be required to submit proof satisfactory to the division of compliance with the provisions of this article a minimum of every four (4) years.

(c) Each physician in order to renew his or her license at each renewal thereof shall report progress towards compliance with the continuing education requirement.

(d) Any physician who does not ~~cannot~~ complete a minimum of 50~~100~~ hours of approved continuing education during the two-year period immediately preceding the expiration date of the license ~~a four (4) year period~~ shall be ineligible for renewal of his or her license under Section 1338 unless such physician applies for and obtains a waiver pursuant to Section 1339 below.

Note: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2005, 2190 and 2420, Business and Professions Code.

TITLE 16. Medical Board of California

NOTICE IS HEREBY GIVEN that the Medical Board of California is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments orally or in writing relevant to the action proposed at a hearing to be held at the Westin Hotel - Los Angeles Airport, 5400 W Century Blvd., Los Angeles, CA 90045, at **9:00 a.m.**, on **February 1, 2008**. Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office not later than 5:00 p.m. on **January 21, 2008**, or must be received by the Board at the hearing. The Medical Board of California, upon its own motion or at the instance of any interested party, may thereafter adopt the proposals substantially as described below or may modify such proposals if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the proposal.

Authority and Reference: Pursuant to the authority vested by Sections 2018 of the Business and Professions Code, and to implement, interpret or make specific Sections 2005, 2190 and 2420 of said Code, the Medical Board of California is considering changes to Division 13 of Title 16 of the California Code of Regulations as follows:

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Amend section 1336 in Article 11 of Chapter 1, Division 13, relating to continuing medical education requirements. This rulemaking 1) directs licensees to complete at least 50 hours of approved CME during the renewal cycle, the two-year period immediately preceding the expiration of the license, (which is equivalent to the current requirement of 25 hours per year for a total of 100 every four years) in order to renew the license, and 2) changes the calculation of CME hours from calendar year to renewal cycle.

FISCAL IMPACT ESTIMATES

Fiscal Impact on Public Agencies Including Costs or Savings to State Agencies or Costs/Savings in Federal Funding to the State: None.

Nondiscretionary Costs/Savings to Local Agencies: None.

Local Mandate: None.

Cost to Any Local Agency or School District for Which Government Code Section 17561 Requires Reimbursement: None.

Business Impact:

The Medical Board of California has made an initial determination that the proposed regulatory action would have no significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.

The proposed regulation amendments only clarify time periods for calculating CME hours for license renewal. There are no additional costs associated with these amendments.

Impact on Jobs/New Businesses:

The Medical Board of California has determined that this regulatory proposal will not have any impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California.

Cost Impact on Representative Private Person or Business:

The Medical Board of California is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

Effect on Housing Costs: None.

EFFECT ON SMALL BUSINESS

The Medical Board of California has determined that the proposed regulations would not affect small businesses.

The proposed regulation amendments clarify time periods for calculating CME hours for license renewal.

CONSIDERATION OF ALTERNATIVES

The Board must determine that no reasonable alternative it considered or that has otherwise been identified and brought to its attention would be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons that the proposed action.

Any interested person may present statements or arguments orally or in writing relevant to the above determinations at the above-mentioned hearing.

INITIAL STATEMENT OF REASONS AND INFORMATION

The Medical Board of California has prepared an initial statement of the reasons for the proposed action and has available all the information upon which the proposal is based.

TEXT OF PROPOSAL

Copies of the exact language of the proposed regulations and of the initial statement of reasons, and all of the information upon which the proposal is based, may be obtained at the hearing or prior to the hearing upon request from the Medical Board of California at 1426 Howe Avenue, Suite 92, Sacramento, California 95825.

AVAILABILITY AND LOCATION OF THE FINAL STATEMENT OF REASONS AND RULEMAKING FILE

All the information upon which the proposed regulations are based is contained in the rulemaking file which is available for public inspection by contacting the person named below.

You may obtain a copy of the final statement of reasons once it has been prepared, by making a written request to the contact person named below or by accessing the website listed below.

CONTACT PERSON

Inquiries or comments concerning the proposed rulemaking action may be addressed to:

Name:	Kathi Burns
Address:	Medical Board of California 1426 Howe Avenue, Suite 92 Sacramento, CA 95825
Telephone No.:	(916) 263-2417
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

The backup contact person is:

Name:	Kevin Schunke
Address:	Medical Board of California 1426 Howe Avenue, Suite 92
Telephone No.:	(916) 263-2368
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

Website Access: Materials regarding this proposal can be found at www.mbc.ca.gov.

MEDICAL BOARD OF CALIFORNIA

INITIAL STATEMENT OF REASONS

Hearing Date: 1 February 2008

Subject Matter of Proposed Regulations: Delegation of Services – Physician Assistants

(1) Section Affected: 1399.540

Specific Purpose of each adoption, amendment, or repeal:

The existing regulation requires that a physician assistant may only provide medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience and which are delegated in writing by a supervising physician.

This proposal would formally recognize that the writing which delegates the medical services to the physician assistant be known as a "Delegation of Services Agreement" and require that it now be signed and dated by both the supervising physician and physician assistant.

This proposal would also allow the delegation of services agreement to be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. Also, a physician assistant may provide medical services pursuant to more than one delegation of services agreement.

Factual Basis/Rationale

Section 1399.540 of the Physician Assistant regulations states, in part, "A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant."

These writings which delegate the medical services performed by the physician assistant are the foundation of the physician assistant's practice. The document specifies the names of the supervising physicians who will supervise the physician assistant. It also specifies what type of medical services the physician assistant will perform, how they are performed, how the patient charts will be reviewed and countersigned, and what type of medications the physician assistant will transmit on behalf of the supervising physician. Additionally, the

document describes emergency transport procedures for medical situations beyond the physician assistant's scope of practice.

These documents which are used by physician assistants and their supervising physicians to meet the requirements of Section 1399.540 are universally known in the medical community as a "Delegation of Services Agreement."

The current regulation, although it requires a delegation to be in writing, does not mandate that the physician assistant and his or her supervising physician sign it.

Requiring both parties to sign the document makes it more likely they understand and agree to the contents of the document and the nature of their relationship. Consumer protection would be enhanced by ensuring complete and full understanding of the contents of the delegation of services agreement. Also, with the signature of both parties, the document takes on the flavor of a true document.

Additionally, a document signed by the physician assistant and supervising physician would assist the committee with enforcement duties. Neither party could claim that they didn't agree to the delegated medical tasks or the existence of the document.

The Physician Assistant Committee lacks legal authority to adopt, amend, or repeal regulations affecting the scope of practice of physician assistants and supervising physicians. This authority has been statutorily granted to the Medical Board of California.

On April 26, 2007 Elberta Portman, Executive Officer of the Physician Assistant Committee, made a presentation to the members of the Division of Licensing of the Medical Board of California to request that they consider regulatory action on this matter.

After discussion, members of the Board requested that staff of the Division of Licensing schedule a work group meeting to discuss the proposed regulatory change.

A work group meeting was held on July 18, 2007. Key members from the Medical Board Division of Licensing and Legislative/Regulatory Unit, Physician Assistant Committee, Department of Consumer Affairs Legal Office, California Medical Association, and the California Academy of Physician Assistants participated in this meeting. Participants developed the proposed language.

At the November 1, 2007 Medical Board of California meeting, members requested that staff set this regulatory proposal for a hearing at their February 1, 2008 board meeting.

Underlying Data

Technical, theoretical or empirical studies or reports relied upon:

None.

Business Impact

This regulation will not have a significant adverse economic impact on businesses. Because the document is already required by the regulations, the only effort is in signing the document.

Specific Technologies or Equipment

This regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives

No reasonable alternative to the regulation would be either more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed regulation.

Set forth below are the alternatives which were considered and the reasons each alternative was rejected:

1) Not amend regulation. This alternative was rejected because the writings defined by section 1399.540 are known to the physician assistant community as a Delegation of Services Agreement.

2) Amend the regulation to require that the writings defined by section 1399.540 as a Delegation of Services Agreement and require that the document be signed and dated by both the physician assistant and supervising physician.

The committee determined that the second alternative was the most feasible because the title, "Delegation of Services Agreement" is now universally understood by the medical community as the title for this document. Having the document signed by both the physician assistant and supervising physician would ensure that both parties understand and agree with the contents of the document.

Additionally, the signed document would assist the committee with enforcement duties. Neither party could claim that they didn't agree to the delegated medical tasks or the existence of the document.

California Code Of Regulations, Title 16
Medical Board Of California
Specific Language Of Proposed Changes
Delegation Of Services Agreement

Amend Section 1399.540 to read as follows:

1399.540. Limitation on Medical Services.

(a) A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant.

(b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

(c) The committee or division or their representative may require proof or demonstration of competence from any physician assistant for any tasks, procedures or management he or she is performing.

(d) A physician assistant shall consult with a physician regarding any task, procedure or diagnostic problem which the physician assistant determines exceeds his or her level of competence or shall refer such cases to a physician.

NOTE: Authority: Sections 2018, 3502 and 3510, Business and Professions Code. Reference: Section 3502, Business and Professions Code.

California Code of Regulations, Title 16
Medical Board of California
Specific Language of Proposed Changes
Continuing Education Requirements

Section 1336 is amended to read:

§ 1336. Continuing Education Required.

(a) Each physician is required to complete not less than 50 ~~an average of at least 25~~ hours of approved continuing education during each two year period immediately preceding the expiration date of the license ~~calendar year~~. If an initial license was issued for less than 13 months, only 25 hours of continuing education must be completed.

(b) Each physician renewing his or her license under the provisions of Article 19 (commencing with Section 2420) of the Medical Practice Act may be required to submit proof satisfactory to the division of compliance with the provisions of this article a minimum of every four (4) years.

(c) Each physician in order to renew his or her license at each renewal thereof shall report progress towards compliance with the continuing education requirement.

(d) Any physician who does not ~~cannot~~ complete a minimum of 50~~100~~ hours of approved continuing education during the two-year period immediately preceding the expiration date of the license ~~a four (4) year period~~ shall be ineligible for renewal of his or her license under Section 1338 unless such physician applies for and obtains a waiver pursuant to Section 1339 below.

Note: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2005, 2190 and 2420, Business and Professions Code.

TITLE 16. PHYSICIAN ASSISTANT COMMITEE

NOTICE IS HEREBY GIVEN that the Medical Board of California (Board) is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments orally or in writing relevant to the action proposed at a hearing to be held at Westin Hotel-Los Angeles Airport, 5400 West Century Boulevard, Los Angeles, California 90045, at 9:05 a.m, on February 1, 2008. Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office not later than 5:00 p.m. on January 21, 2008 or must be received by the Board at the hearing. The Board, upon its own motion or at the instance of any interested party, may thereafter adopt the proposals substantially as described below or may modify such proposals if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the proposal.

Authority and Reference: Pursuant to the authority vested by Sections 2018, 3502, and 3510 of the Business and Professions Code, and to implement, interpret or make specific Sections 3502 of said Code, the Board is considering changes to Division 13.8 of Title 16 of the California Code of Regulations as follows:

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Amend Section 1399.540.

The existing regulation requires that a physician assistant may only provide medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience and which are delegated in writing by a supervising physician.

Section 3502(a) of the Business and Professions Code states, in pertinent part, that a physician assistant may only 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.

This proposal would formally recognize that the writing which delegates the medical services to the physician assistant be known as a "Delegation of Services Agreement" and require that it now be signed and dated by both the supervising physician and the physician assistant.

This proposal would also allow the delegation of services agreement to be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

FISCAL IMPACT ESTIMATES

Fiscal Impact on Public Agencies Including Costs or Savings to State Agencies or Costs/Savings in Federal Funding to the State: None

Nondiscretionary Costs/Savings to Local Agencies: None

Local Mandate: None

Cost to Any Local Agency or School District for Which Government Code Section 17561 Requires Reimbursement: None

Business Impact:

The Board has made an initial determination that the proposed regulatory action would have no significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states because it only affects individual licensees. Licensees should already be reading and preparing the document. The only impact is that they would be required to sign the document.

The following studies/relevant data were relied upon in making the above determination: none.

Impact on Jobs/New Businesses:

The Board has determined that this regulatory proposal will not have any impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California.

Cost Impact on Representative Private Person or Business:

The Board is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

Effect on Housing Costs: None

EFFECT ON SMALL BUSINESS

The Board has determined that the proposed regulations would not affect small businesses. Because the document is already required by the regulations, the only effort is in signing the document.

CONSIDERATION OF ALTERNATIVES

The Board must determine that no reasonable alternative it considered to the regulation or that has otherwise been identified and brought to its attention would either be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposal described in this Notice.

Any interested person may present statements or arguments orally or in writing relevant to the above determinations at the above-mentioned hearing.

INITIAL STATEMENT OF REASONS AND INFORMATION

The Board has prepared an initial statement of the reasons for the proposed action and has available all the information upon which the proposal is based.

TEXT OF PROPOSAL

Copies of the exact language of the proposed regulations and of the initial statement of reasons, and all of the information upon which the proposal is based, may be obtained at the hearing or prior to the hearing upon request from the Medical Board of California at 1434 Howe Avenue, Suite 92, Sacramento, California 95825.

AVAILABILITY AND LOCATION OF THE FINAL STATEMENT OF REASONS AND RULEMAKING FILE

All the information upon which the proposed regulations are based is contained in the rulemaking file which is available for public inspection by contacting the person named below.

You may obtain a copy of the final statement of reasons once it has been prepared, by making a written request to the contact person named below or by accessing the website listed below.

CONTACT PERSON

Any inquiries or comments concerning the proposed rulemaking action may be addressed to:

Name:	Kelly Nelson
Address:	1434 Howe Avenue, Suite 92 Sacramento, CA 95825
Telephone No.:	(916) 263-2389
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

The backup contact person is:

Name:	Kevin A. Schunke
Address:	1434 Howe Avenue, Suite 92 Sacramento, CA 95825
Telephone No.:	(916) 263-2368
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

Website Access : Materials regarding this proposal can be found at: www.mbc.ca.gov.

Meeting Month/Year	Physician's & Surgeon's Applications	Number of Calendar Days to Initial Review (Low)	Number of Calendar Days to Initial Review (High)	Number of Calendar Days to Initial Review (Average)
February-08	US/CAN	54	96	76
February-08	IMG	35	110	71
November-07	US/CAN	18	50	30
November-07	IMG	37	87	65
July-07	US/CAN	25	43	38
July-07	IMG	21	61	46
April-07	US/CAN	34	55	43
April-07	IMG	15	56	33
February-07	US/CAN	26	39	32
February-07	IMG	26	58	40
Historical Information				
February-06	US/CAN	Not Available	Not Available	127
February-06	IMG	Not Available	Not Available	117

FY 07/08	Number of Physician's & Surgeon's Applications Received	Number of Physician's & Surgeon's Licenses Issued
1st Quarter	1,465	1,271
2nd Quarter	1,540	904
3rd Quarter		
4th Quarter		
TOTAL	3,005	2,175

FY 06/07	Number of Physician's & Surgeon's Applications Received	Number of Physician's & Surgeon's Licenses Issued
TOTAL	6,034	5,285

Special Program FY 07/08	2111 Applications Processed	2112 Applications Processed	2113 Applications Processed	2168 Applications Processed
1st Quarter	24	1	17	1
2nd Quarter	4	0	3	4
3rd Quarter				
4th Quarter				
TOTAL	28	1	20	5

Special Program FY 07/08	2072 Applications (Correctional Facility) Processed	Hospital 1327 Renewals/Site Visits	Medical School 2111/2113 Site Visits
1st Quarter	0	1	0
2nd Quarter	0	0	0
3rd Quarter			
4th Quarter			
TOTAL	0	1	0

Agenda Item # 17

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 4, 2008
ATTENTION:	Medical Board of California (board)
DEPARTMENT:	Licensing Operations
SUBJECT:	Midwifery Advisory Council (MAC) Appointments
STAFF CONTACT:	Kathi Burns

REQUESTED ACTION:	Appoint two members to the MAC
STAFF RECOMMENDATION:	Reappoint Carrie Sparrevohn, L.M., and Board Member Barbara Yaroslavsky to the MAC for three-year terms

EXECUTIVE SUMMARY:

The MAC was established in 2007 to make recommendations to the board on issues related to the practice of midwifery in California. The MAC consists of six members and is currently comprised of three California licensed midwives and three members of the public that include one board member and two California licensed medical doctors. At least half of the members must be licensed midwives.

The term of each position will be three years; however, to establish staggered term expirations, initially two positions were set to expire after one year and two were set to expire after two years.

These two positions, set to expire in February 2008, include one licensed midwife position, held by Carrie Sparrevohn, and one public member position, held by board member Barbara Yaroslavsky.

Seven applications for appointment to the MAC were received. Six applicants are licensed midwives and one is a member of the public with interest in the practice of midwifery.

Midwifery Advisory Council Interest Form Response

No.	Name	CA Licensed Midwife	Affiliation (If any)	Position/ Occupation
1.	ADLER, Meile		None/personal interest	None given
2.	BACHNER, Elizabeth	X	None/personal interest	Licensed Midwife, Doula, Acupuncturist
3.	DeKRUYF, Genie	X	None/personal interest	Licensed Midwife
4.	FARRELL, Rachel	X	Rachel Farrell, A Physician Assistant Corp.	Licensed Midwife/Physician Assistant
5.	FRITZ, Donna	X	None/personal interest	Licensed Midwife
6.	SPARREVOHN, Carrie	X	CA Association of Midwives (CAM)	Licensed Midwife, CAM Liaison to MBC & Legislative Chair
7.	WILSON, Renee	X	CA Association of Midwives (CAM)	Licensed Midwife

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 11, 2008
ATTENTION:	Medical Board of California
DEPARTMENT:	Licensing Program
SUBJECT:	Special Faculty Permit Review Committee Recommendations
STAFF CONTACT:	Kathi Burns

REQUESTED ACTION: Board approve the recommendations of the Special Faculty Permit Review Committee (committee) with respect to, 1) the appointments pursuant to Section 2168.1 of the California Business and Professions Code, and 2) the waivers of the Business and Professions Code section 2113 appointment limits for the below listed candidates.

STAFF RECOMMENDATION:
Staff recommends that the Board accept the recommendations of the Special Faculty Permit Review Committee.

EXECUTIVE SUMMARY:
Under Article 8.5 of the Medical Practice Act commencing with Section 2168, the Board is authorized to issue a Special Faculty Permit (permit) to a person who is deemed to be academically eminent under the provisions of the statute and meets the other eligibility requirements for issuance of a permit. This permit authorizes a holder to practice medicine only within the facilities of the appointing medical school and any affiliated institutions in which the permit holder is providing instruction.

A review committee was created to review applications and make recommendations to the Board on the approval of such permits and other items - including waivers and position appointments within the medical school. The review committee consists of one representative from each of the eight medical schools in California and two board members for a total of ten members.

At the January 10, 2008 meeting of the Special Faculty Permit Review Committee, the members reviewed the qualifications and credentials of candidates; Graeme Bydder, M.D.; Ian Everall, M.D.; Santiago Horgan, M.D and Felipe Medeiros, M.D. After discussion, the committee voted unanimously to recommend approval of each of these candidates to appointments pursuant to Section 2168.1 of the Business and Professions Code. The recommendations include granting a waiver of section 2168.1(a)(5) for Bydder, Everall, and Medeiros, as these applicants held Special Programs certificates pursuant to Business and Professions Code section 2113 for a period of two years or more preceding the date of application for a Special Faculty Permit.

FISCAL CONSIDERATIONS:
None.

PREVIOUS MBC AND/OR COMMITTEE ACTION:
Not applicable.

State of California | Department of Consumer Affairs

Memorandum

To: Renée Threadgill, Chief of Enforcement
Medical Board of California

Date: January 2, 2008

AGENDA ITEM 19B

From: Susan Goetzinger
Expert Reviewer Program

Subject: Results of the Expert Survey Questionnaires

Questionnaires Sent this quarter (October-December 2007)	27
Feedback Received from the questionnaires sent this quarter	27 (100%)
Total Feedback Received for this quarter's report	39

Questions 1-8, *positive response*: Yes
Question 9, *positive response*: No
Questions 10-13, *positive response*: Yes

1	Were you provided sufficient information/evidence to allow you to render a medical opinion?	100 percent YES
2	Were you encouraged to render an unbiased opinion?	90 percent YES 2 percent NO 8 percent responded N/A
3	Was the case directly related to your field of expertise?	100 percent YES
4	Were you given sufficient time to review the case?	98 percent YES 2 percent NO
5	Did the training material provided to you (the Expert Reviewer Guidelines and videotape/DVD) give you adequate information to perform your case review?	96 percent YES 2 percent NO 2 percent responded N/A
6	Were you given clear, concise, and easy to follow instructions throughout the process?	92 percent YES 2 percent NO 6 percent responded N/A
7	Was the investigator and/or MBC staff readily available to answer questions or concerns about the case?	96 percent YES 4 percent responded N/A
8	Is the required written report adequate to cover all aspects of your opinion?	100 percent YES
9	Do you feel the MBC has requested your services more frequently than you would prefer?	2 percent YES 98 percent NO
10	Would you be willing to accept more MBC cases for review?	100 percent YES

11	If you were required to testify, was the Deputy Attorney General readily available to answer questions and provide direction?	15 percent YES 85 percent N/A
12	**Do you feel the reimbursement amount for case review is appropriate for the work you are required to perform?**	52 percent YES 46 percent NO 2 percent N/A
13	**Do you think that more physicians would be willing to become experts if the Board offered CME in addition to monetary compensation?**	54 percent YES 39 percent NO 7 percent responded N/A
Level of satisfaction with overall experience performing case reviews for MBC		85 percent HIGH 10 percent AVERAGE 5 percent LOW

COMMENTS:

Last chart was huge, disorganized & had many duplications!
The "going rate" for medical record review for medical-legal cases is significantly higher than the MBC's rate of $100/hr. The reimbursement could be raised and still be a good value for MBC. I often get to follow-up on the cases I've reviewed and written opinions on. I'd like to find out what the end result is.
Please feel free to utilize my services again.
Perhaps a direct and specific feedback would be useful.
Physicians have other opportunities for CME credits.
The prior reimbursement rate was low, current rate is better. Examples of reports with packet (expert package) are very helpful.
Investigator has guided me very well; my experience in this case review is excellent.
The rates for reviewing civil cases for experienced reviewers is $350-400/hr. Raising to $150 was long overdue. Additional rate increases should be considered in the future. I have found the investigators, DAGs & medical consultants very conscientious, professional and easy to work with.

For several years I did not get any requests to review cases. This year however, I was asked to review 2 cases. Most physicians easily meet CME requirements so it would not be necessary to offer CME as part of case review. Medical consultant, Dr. Klessig was very helpful. Investigator Hollis was always available by phone to answer any questions.
It will be very helpful if the records are sorted better and in a more organized fashion. Also a digital format (CD) of interviews?
Deputy Attorney General Cindy Lopez was superb and thorough in her communications.
I am delighted to review cases for MBC and welcome the opportunity to do so whenever the need arises.
I suggest increasing base hours from 10 to 15 although it was stated that additional review time possible if physician discusses with investigator. Investigator Baker very competent and helpful!

MEDICAL BOARD OF CALIFORNIA
EXPERT REVIEWER PROGRAM
Expert Evaluation of MBC Case Review Process

AGENDA ITEM 19C

Expert Reviewer:	Investigator:
Case Number:	Medical Consultant:

Please answer "Yes" or "No" to the following questions by filling in the appropriate circle. If the question does not apply to your experience, please indicate so by filling in the circle for N/A. Please explain any "No" answer(s) on the reverse.

	RATING		
1) Were you provided sufficient information/evidence to allow you to render a medical opinion?	Yes ○	No ○	N/A ○
2) Were you encouraged to render an unbiased opinion?	Yes ○	No ○	N/A ○
3) Was the case directly related to your field of expertise?	Yes ○	No ○	N/A ○
4) Were you given sufficient time to review the case? If not, how much time would have been appropriate for this review?	Yes ○	No ○	N/A ○
5) Did the MBC staff meet your expectations to provide you with what you needed to complete your review? If no, what should have been provided to facilitate your review?	Yes ○	No ○	N/A ○
6) Did the training material provided to you (Expert Reviewer Guidelines and DVD) give you adequate information to perform your case review?	Yes ○	No ○	N/A ○
7) Were you given clear, concise, and easy to follow instructions throughout the process?	Yes ○	No ○	N/A ○
8) Was the investigator and/or MBC staff readily available to answer questions or concerns about the case?	Yes ○	No ○	N/A ○
9) Is the required written report format adequate to cover all aspects of your opinion?	Yes ○	No ○	N/A ○
10) Do you feel the MBC has requested your services more frequently than you would prefer?	Yes ○	No ○	N/A ○
11) Would you be willing to accept more MBC cases for review?	Yes ○	No ○	N/A ○
12) If you were required to testify, was the Deputy Attorney General readily available to answer questions and provide direction?	Yes ○	No ○	N/A ○
13) Did the Deputy Attorney General or his/her representative meet your expectations to provide you with what you needed prior to testifying? If no, what would have made testifying for the Board easier?	Yes ○	No ○	N/A ○
14) Do you feel the reimbursement rate of $150/hr for case review appropriate for the work you are required to perform?	Yes ○	No ○	N/A ○

Please rate your level of satisfaction with your overall experience performing case reviews for the MBC.

Satisfaction Level: ○ High ○ Average ○ Low

Do you have any suggestions for improvement to the program?

_____

_____

_____

Please explain any "No" answer(s):

_____

_____

_____

_____

Is there anyone you would like to recommend to become an Expert Reviewer? Please provide names and addresses.

_____

_____

_____

Comments (Please use this section for any other issues you would like to address):

_____

_____

_____

_____

_____

Information provided on this form is for the sole purpose of maintaining the integrity of the Expert Reviewer Program. This form will be reviewed by the Executive Director of the Medical Board of California (MBC) and will be kept confidential.

Please mail completed form to:

Susan Goetzinger
Medical Board of California
320 Arden Avenue, Suite 250
Glendale, CA 91203

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
CALENDAR YEAR 2007

AGENDA ITEM 19D

SPECIALTY	Number of cases reviewed/sent to Experts	Number of Experts used and how often utilized	Active List Experts (TOTAL=1,126 ↑)
ADDICTION	1	1	11
AEROSPACE MEDICINE	0	0	1
ALLERGY & IMMUNOLOGY	2	1	10
ANESTHESIOLOGY	21	19	87 ↑
BIOETHICS	1	1	1
COLON & RECTAL SURGERY	1	1	6
COMPLEMENTARY/ALTERNATIVE MEDICINE	7	4 3 experts reviewed 2 cases 1 expert reviewed 1 case	13
CORRECTIONAL MEDICINE	2	1	6 ↑
DERMATOLOGY	11	5 2 experts reviewed 3 cases 2 experts reviewed 2 cases 1 expert reviewed 1 case	10 ↓
EMERGENCY	20	13 3experts reviewed 3 cases 1 expert reviewed 2 cases 9 experts reviewed 1 case each	64 ↑
FAMILY	58	36 1 expert reviewed 5 cases including physical evaluation 5 experts reviewed 3 cases 8 experts reviewed 2 cases 22 experts reviewed 1 case each	97 ↑
HOSPICE & PALLIATIVE CARE	0		7
INTERNAL General Internal Med & sub-specialties not listed below	58	45 1 expert reviewed 4 cases 2 experts reviewed 3 cases 6 experts reviewed 2 cases 36 experts reviewed 1 case each	231 ↑
INTERNAL - CARDIOLOGY Interventional Cardiology	22	10 1 expert reviewed 5 cases 2 experts reviewed 4 cases 2 experts reviewed 2 cases 5 experts reviewed 1 case each	30 ↑ (13↑)
INTERNAL-ENDOCRINOLOGY & METABOLISM			9
INTERNAL - GASTROENTEROLOGY	10	4 List experts 1 outside expert	15↑

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
CALENDAR YEAR 2007
Page 2

INTERNAL -INFECTIOUS DISEASES	1	1	9 ↑
INTERNAL - NEPHROLOGY			7
INTERNAL - ONCOLOGY	5	4	9
MEDICAL GENETICS	0	0	1
MIDWIFE	1	1	12
NEUROLOGICAL SURGERY	9	6 List experts 1 Outside expert	13
NEUROLOGY	10	7 3 experts reviewed 2 cases 4 experts reviewed 1 case each	20
NEUROLOGY (CHILD)	2	1	2
OBSTETRICS & GYNECOLOGY	69	42 1 expert reviewed 9 cases 2 experts reviewed 4 cases 4 experts reviewed 3 cases 5 experts reviewed 2 cases 30 experts reviewed 1 case each	83↑
REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY	2	1 List expert 1 Outside expert	4 ↑
OCCUPATIONAL MEDICINE	0	0	8
OPHTHALMOLOGY	9	8	49 ↑
ORAL & MAXILLOFACIAL SURGERY	0	0	1
ORTHOPAEDIC SURGERY	20	18	44 ↓
OTOLARYNGOLOGY	8	6	35
PAIN MEDICINE ((13ABMS↑; 12 ABPM = 25)	10	8	25↑
PATHOLOGY (Anatomic/Clinical-12; Anatomic-1)	1	1	13 ↓
PEDIATRICS	9	7	61 ↑
PEDIATRIC CARDIOLOGY	1	1	4
PEDIATRIC HEMATOLOGY/ONCOLOGY			4 ↑
PEDIATRIC INFECTIOUS DISEASES (BOARD CERTIFIED)	1	1	2 ↑
PEDIATRIC SURGERY			4 ↑
PHYSICAL MEDICINE & REHABILITATION	1	1	9 ↑

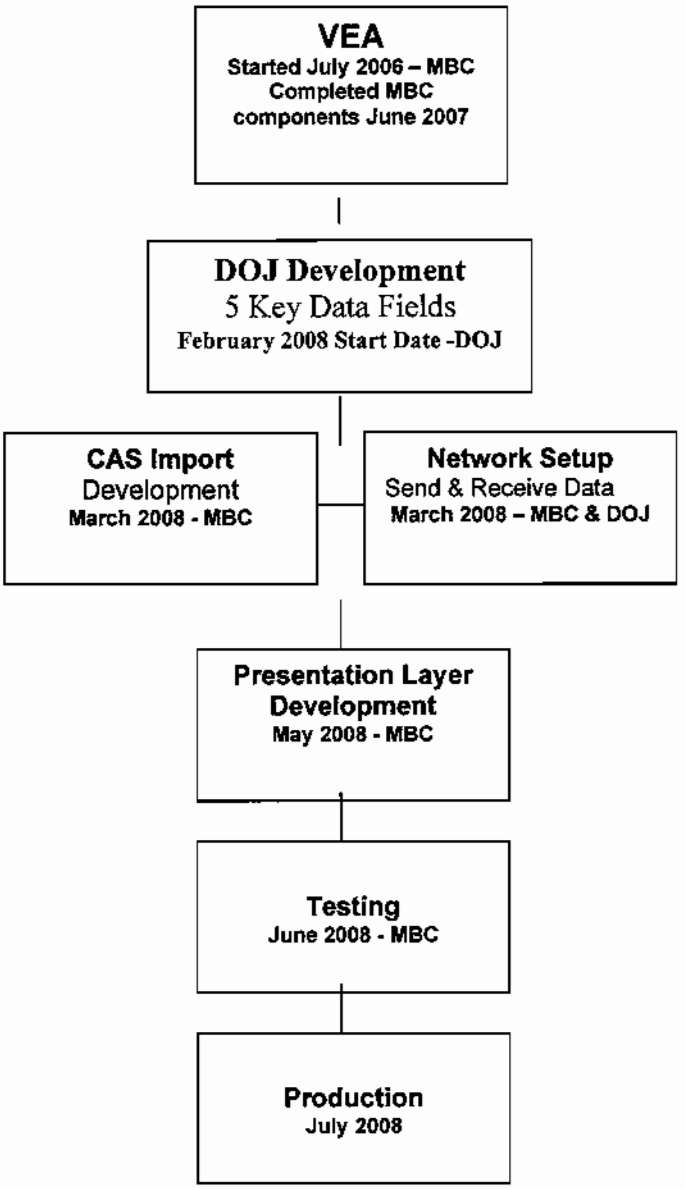
CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
CALENDAR YEAR 2007
Page 3

PLASTIC SURGERY (ABMS-391; ABFPRS-8=47)	35	16 List experts 2 Outside experts 1 expert reviewed 5 cases 2 experts reviewed 4 cases 2 experts reviewed 3 cases 3 experts reviewed 2 cases 10 experts reviewed 1 case each	47 ↑
PSYCHIATRY	65	32 List experts 2 Outside experts	113 ↑
PUBLIC HEALTH & GENERAL PREVENTIVE MEDICINE	1	1	6
DIAGNOSTIC RADIOLOGY-31/ RADIOLOGY-5/ NUCLEAR MEDICINE-7	8	5 1 expert reviewed 3 cases 1 expert reviewed 2 cases 3 experts reviewed 1 case each	43 ↑
VASCULAR/INTERVENTIONAL RADIOLOGY			1
RADIATION ONCOLOGY -4 / THERAPEUTIC RADIOLOGY -2	1	1	6
SLEEP MEDICINE			8 ↑
SPINE SURGERY (ABSS-MBC APPROVED)			1
SURGERY	22	16	59 ↑
THORACIC SURGERY	10	7	18 ↑
VASCULAR SURGERY	1	1	5
UROLOGY	13	4 List xperts 1 Outside expert 1 expert reviewed 5 cases 1 expert reviewed 3 cases 2 experts reviewed 2 cases 1 expert reviewed 1 case	16
WORKERS' COMP/QME/IME	1	1	5

/susan (12/27/07)

Timeline for Vertical Enforcement Application (VEA)
MBC DOJ Data Sharing Project

AGENDA ITEM 20A



Terminology

VEA: Vertical Enforcement Application is a real-time web application designed to pull key data elements from mainframe application and display them in "real time".

CAS: Consumer Affairs System. The mainframe application that holds all of the licensing and enforcement data elements used in VEA.

5 Key Data Fields From DOJ: Date Accepted by AG for Prosecution, Date Accusation Sent to Client, Date of Request to Set Hearing, Date Stipulation Signed by Respondent, Date Stipulation Sent to Client

Timeline for Case Management Project

Dec 2007	Jan 2008	Feb 2008	March 2008	April 2008	May 2008	June 2008	July 2008	Aug 2008	Sept 2008	Oct 2008	Nov 2008	Dec 2008
Case Mgmt. FSR in progress	FSR to DCA 1/18/08 for approval		BCP Concept Paper for staff & costs for project due to DCA	Develop BCP	Finalize BCP	Submit BCP to DCA	Case Mgmt. FSR and BCP to DOF				FSR must be approved so BCP can be approved	Approval for funding in proposed 09/10 budget RFP begin Jan 2009 released July 2009

Terminology

BCP: Budget Change Proposal. *A BCP is required for additional staffing levels and spending authority for project. The BCP must be approved by DCA and DOF. Prior to writing a BCP a concept paper must be submitted to DCA.*

DCA: Department of Consumer Affairs.

DOF: Department of Finance. *Responsible for California State Budget and oversight for Information Technology projects depending upon cost and risk associated.*

Timeline for Case Management Project

FSR: Feasibility Study Report. *An FSR must be approved by Department of Consumer Affairs at minimum, and by Department of Finance based upon spending delegation and project risk.*

RFP: Request for Proposal. *We cannot begin RFP until FSR & BCP are approved by DCA and Finance.*

Vertical Enforcement 2007 Statistics

	2007
Average Number of Days to Close Cases That Did Not Result in Prosecution	267
Average Time to Obtain an ISO	39
Average Number of Days to Obtain Medical Records	61
Average Number of Days to Obtain a Physician Interview	50
Average Number of Days to Obtain Expert Opinions	43
Average Number of Days to Complete Investigation and File Accusation	340

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 11, 2008
DEPARTMENT:	Enforcement Program
SUBJECT:	Proposed Regulations – *Manual of Model Disciplinary Orders and Disciplinary Guidelines*
STAFF CONTACT:	Kimberly Kirchmeyer

REQUESTED ACTION:
1) Adopt changes in the *Manual of Model Disciplinary Orders and Disciplinary Guidelines* to reflect the elimination of the Diversion Program and the elimination of the Division of Medical Quality.
2) Approve a request to set a regulatory hearing in April 2008 to incorporate by reference the revised *Manual of Model Disciplinary Orders and Disciplinary Guidelines* into regulation.
3) Establish a task force of two board members (one physician and one public member) to meet with staff to review the disciplinary guidelines for further edits/changes.

STAFF RECOMMENDATION:
The Board authorize staff to move forward with the rulemaking process in order to make regulations consistent with the elimination of the Diversion Program and the Division of Medical Quality. The Board establish a task force to review the guidelines for modifications.

EXECUTIVE SUMMARY:
The *Manual of Model Disciplinary Orders and Disciplinary Guidelines* is the tool adopted by the Medical Board for use by those involved in the physician disciplinary process. Administrative Law Judges, defense attorneys, physician-respondents, trial attorneys from the office of the Attorney General, Board panel members, and staff who review proposed decisions and stipulations use these guidelines for guidance.

As there was no legislation approved to extend the Diversion Program, on June 30, 2008 the legislation authorizing the Diversion Program will become inoperative. Absent the Diversion Program, the model orders/guidelines referencing the program become obsolete. For that reason, staff and legal counsel are proposing the optional condition for the Diversion Program [condition number 12] be eliminated, the language for biological fluid testing [condition number 11] be changed as approved by the Board at the November 2, 2007 Board meeting, and all references to the Diversion Program be eliminated.

In addition, all references to the Division of Medical Quality will be amended to read "Board" to reflect the restructuring of the Board and the elimination of the Division on January 1, 2008.

Traditionally, the Board adopts the content of the *Manual of Model Disciplinary Orders and Disciplinary Guidelines*, and promulgates regulations reflecting their adoption by reference. Therefore, it is proposed the Board adopt the amendments to the guidelines, and move forward with the rulemaking process to codify the changes in regulations.

The *Manual of Model Disciplinary Orders and Disciplinary Guidelines* has not been amended since 2003 and there are several edits/clarifications that need to be made. Additionally, several Board members have raised concerns over some of the guidelines and have requested a complete review to determine if further enhancements are needed to make the guidelines more consistent with the decisions of the Board.

FISCAL CONSIDERATIONS:
No fiscal impact is anticipated.

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. At the November 2007 meeting, members adopted a transitional plan in light of the program's elimination. The proposed regulatory change is consistent with prior Board actions.

State of California
State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA
~~DIVISION OF MEDICAL QUALITY~~
MANUAL OF MODEL DISCIPLINARY ORDERS AND DISCIPLINARY GUIDELINES

~~9th~~ *10th* Edition
~~2003~~*2008*

STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
~~DIVISION OF MEDICAL QUALITY~~

~~Ronald Wender, M.D.~~ ***Richard Fantozzi, M. D.***
President
~~Lori Rice~~ ***Cesar Aristeiguita, M.D.***
Vice President
~~Ronald Morton, M.D.~~ ***Hedy Chang***
Secretary

~~The 21 member Medical Board of California (MBC) is made up of two autonomous divisions. Each division has exclusive jurisdiction over its own specialized area of responsibility: the Division of Licensing (DOL), licensing of physicians, 7 Board members; and the Division of Medical Quality (DMQ), physician discipline, 14 Board members. The DMQ is divided into two panels of seven members for the purpose of deciding disciplinary cases.~~

The ~~DMQ~~ *Board* produced this Manual of Model Disciplinary Orders and Disciplinary Guidelines, ~~9th~~ *10th* Edition for the intended use of those involved in the physician disciplinary process: Administrative Law Judges, defense attorneys, physicians-respondents, trial attorneys from the Office of the Attorney General, and ~~DMQ~~ *the Board's disciplinary* panel members who review proposed decisions and stipulations and make final decisions. These guidelines are not binding standards.

The Federation of State Medical Boards and other state medical boards have requested and received this manual. All are welcome to use and copy any part of this material for their own work.

For additional copies of this manual, please write to:

Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
Phone (916) 263-2466

Revisions to the Manual of Model Disciplinary Orders and Disciplinary Guidelines, are made periodically. Listed below are the most recent changes included in the ~~9th~~ *10th* edition approved by the ~~DMQ~~ *Board* following open discussion at a public meeting.

Summary of Changes
Model Condition Number:

6. Controlled Substances - Surrender of DEA Permit
References to the "Division" (Division of Medical Quality) changed to "Board."

8. Controlled Substances - Maintain Records and Access To Records and Inventories
References to the "Division" (Division of Medical Quality) changed to "Board."

9. Controlled Substances - Abstain From Use
References to the "Division" (Division of Medical Quality) changed to "Board."

11. Biological Fluid Testing
The following language was deleted:

Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon the request of the Division or its designee. A certified copy of any laboratory test results may be received in evidence in any proceedings between the Board and the respondent. Failure to submit to, or failure to complete the required biological fluid testing, is a violation of probation.

The following language replaces the above:

Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon request of the Board or its designee. Prior to practicing medicine, 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."

Former # 12 "Diversion Program" was eliminated:
12 was formerly entitled "Diversion Program." As the Diversion Program is eliminated on June 30, 2008, the following language was deleted:

Within 30 calendar days from the effective date of this Decision, respondent shall enroll and participate in the Board's Diversion Program until the Diversion Program determines that further treatment and rehabilitation are no longer necessary. Upon enrollment, respondent shall execute a release authorizing the Diversion Program to notify the Division of the following: 1) respondent requires further treatment and rehabilitation; 2) respondent no longer requires treatment and rehabilitation; and 3) respondent may resume the practice of medicine. Respondent shall execute a release authorizing the Diversion Program to provide confirmation to the Division whenever the Diversion Program has determined that respondent shall cease the practice of medicine.

Within 5 calendar days after being notified by the Diversion Program of a determination that further treatment and rehabilitation are necessary, respondent shall notify the Division in writing. The Division shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Diversion Program determines that further treatment and rehabilitation are no longer necessary. Within 24 hours after being notified by the Diversion Program of a determination that respondent shall cease the practice of medicine, respondent shall notify the Division and respondent shall not engage in the practice of medicine until notified in writing by the Division or its designee of the Diversion Program's determination that respondent may resume the practice of medicine. Failure to cooperate or comply with the Diversion Program requirements and recommendations, quitting the program without permission, or being expelled for cause is a violation of probation.

12. Community Service - Free Services
Formerly number 13, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

13. Education Course
Formerly # 14, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

14. Prescribing Practices Course
Formerly # 15, it is re-numbered to reflect the deletion of former #12.." Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

15. Medical Record Keeping Course
Formerly # 16, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

16. Ethics Course
Formerly # 17, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

17. Professional Boundaries Program
Formerly # 18, it is re-numbered to reflect the deletion of former #12.." Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

18. Clinical Training Program
Formerly # 19, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

19. Oral or Written Examination
Formerly # 20, it is re-numbered to reflect the deletion of former #12.." Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

20. Psychiatric Evaluation
Formerly # 21, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

21. Psychotherapy
Formerly # 22, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

22. Medical Evaluation and Treatment
Formerly # 23, it is re-numbered to reflect the deletion of former #12.." Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

23. Monitoring - Practice/Billing
Formerly # 24, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

24. Solo Practice
Formerly # 25, it is re-numbered to reflect the deletion of former #12.

25. Third Party Chaperone
Formerly # 26, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

26. Prohibited Practice
Formerly # 27, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

27. Notification
Formerly # 28, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

28. Supervision of Physician Assistants
Formerly # 29, it is re-numbered to reflect the deletion of former #12.

29. Obey All Laws
Formerly # 30, it is re-numbered to reflect the deletion of former #12.

30. Quarterly Declarations
Formerly # 31, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

31. Probation Unit Compliance
Formerly # 32, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

32. Interview with the Board or its designee
Formerly # 33, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

33. Residing or Practicing Out-of-State
Formerly # 34, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

34. Failure to Practice Medicine- California Resident
Formerly # 35, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

35. Completion of Probation
Formerly # 36, it is re-numbered to reflect the deletion of former # 12.

36. Violation of Probation
Formerly # 37, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

37. Cost Recovery
Formerly # 38, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

38. License Surrender
Formerly # 39, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

39. Probation Monitoring Costs
Formerly # 40, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."

STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
~~DIVISION OF MEDICAL QUALITY~~
MODEL DISCIPLINARY ORDERS AND DISCIPLINARY GUIDELINES

Business and Professions Code section 2229 mandates protection of the public shall be the highest priority for the ~~Division of Medical Quality (DMQ)~~ *Medical Board* and for the Administrative Law Judges of the Medical Quality Hearing Panel. Section 2229 further specifies that, to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees. To implement the mandates of section 2229, the *Board* has adopted the Manual of Model Disciplinary Orders and Disciplinary Guidelines (guidelines), ~~9th~~ *10th* Edition. Consistent with the mandates of section 2229, these guidelines set forth the discipline the ~~DMQ~~ *Board* finds appropriate and necessary for the identified violations. In addition to protecting the public and, where not inconsistent, rehabilitating the licensee, the ~~DMQ~~ *Board* finds that imposition of the discipline set forth in the guidelines will promote uniformity, certainty and fairness, and deterrence, and, in turn, further public protection.

The ~~DMQ~~ *Board* expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility and demonstrated willingness to undertake ~~DMQ~~ *Board* ordered rehabilitation, Administrative Law Judges hearing cases on behalf of the ~~DMQ~~ *Board* and proposed settlements submitted to the ~~DMQ~~ *Board* will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

The Model Disciplinary Orders contain three sections: three (3) Disciplinary Orders; ~~twenty-four (24)~~ *twenty-three (23)* Optional Conditions whose use depends on the nature and circumstances of the particular case; and thirteen (13) Standard Conditions that generally appear in all probation cases. All orders should place the Order(s) first, optional condition(s) second, and standard conditions third.

The Model Disciplinary Guidelines list proposed terms and conditions for more than twenty-four (24) sections of the Business and Professions Code.

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MODEL DISCIPLINARY ORDERS

1. Revocation - Single Cause

Certificate No._____ issued to respondent _____ is revoked.

2. Revocation - Multiple Causes

Certificate No. _____ issued to respondent _____ is revoked pursuant to Determination of Issues (e.g. I, II, and III), separately and for all of them.

3. Standard Stay Order

However, revocation stayed and respondent is placed on probation for (e.g., ten) years upon the following terms and conditions.

OPTIONAL CONDITIONS

4. Actual Suspension

As part of probation, respondent is suspended from the practice of medicine for (e.g., 90 days) beginning the sixteenth (16th) day after the effective date of this decision.

5. Controlled Substances - Total Restriction

Respondent shall not order, prescribe, dispense, administer, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section11362.5.

If respondent forms the medical opinion, after a good faith prior examination, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following a good faith examination, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver

was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

6. Controlled Substances - Surrender of DEA Permit

Respondent is prohibited from practicing medicine until respondent provides documentary proof to the ~~Division~~ *Board* or its designee that respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms. Thereafter, respondent shall not reapply for a new DEA permit without the prior written consent of the ~~Division~~ *Board* or its designee.

7. Controlled Substances - Partial Restriction

Respondent shall not order, prescribe, dispense, administer, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule(s)_____(e.g., IV and V) of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section11362.5. If respondent forms the medical opinion, after a good faith prior examination, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following a good faith examination, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Note: Also use Condition 8, which requires that separate records be maintained for all controlled substances prescribed.

(Option)
Respondent shall immediately surrender respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, respondent shall submit proof that respondent has surrendered

respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, the respondent shall submit a true copy of the permit to the ~~Division~~ *Board* or its designee.

8. Controlled Substances- Maintain Records and Access to Records and Inventories

Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the ~~Division~~ *Board* or its designee at all times during business hours and shall be retained for the entire term of probation.

Failure to maintain all records, to provide immediate access to the inventory, or to make all records available for immediate inspection and copying on the premises, is a violation of probation.

9. Controlled Substances - Abstain From Use

Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawful prescription medications, respondent shall notify the ~~Division~~ *Board* or its designee of the: issuing practitioner's name, address, and telephone number; medication name and strength; and issuing pharmacy name, address, and telephone number.

10. Alcohol - Abstain From Use

Respondent shall abstain completely from the use of products or beverages containing alcohol.

11. Biological Fluid Testing

~~Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon the request of the Division or its designee. A certified copy of any laboratory test results may be received in evidence in any proceedings between the Board and the respondent. Failure to submit to, or failure to complete the required biological fluid testing, is a violation of probation.~~

Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon request of the Board or its designee. Prior to practicing medicine, 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."

~~**12. Diversion Program**~~

~~Within 30 calendar days from the effective date of this Decision, respondent shall enroll and participate in the Board's Diversion Program until the Diversion Program determines that further treatment and rehabilitation are no longer necessary. Upon enrollment, respondent shall execute a release authorizing the Diversion Program to notify the Division of the following: 1) respondent requires further treatment and rehabilitation; 2) respondent no longer requires treatment and rehabilitation; and 3) respondent may resume the practice of medicine. Respondent shall execute a release authorizing the Diversion Program to provide confirmation to the Division whenever the Diversion Program has determined that respondent shall cease the practice of medicine.~~

~~Within 5 calendar days after being notified by the Diversion Program of a determination that further treatment and rehabilitation are necessary, respondent shall notify the Division in writing. The Division shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Diversion Program determines that further treatment and rehabilitation are no longer necessary. Within 24 hours after being notified by the Diversion Program of a determination that respondent shall cease the practice of medicine, respondent shall notify the Division and respondent shall not engage in the practice of medicine until notified in writing by the Division or its designee of the Diversion Program's determination that respondent may resume the practice of medicine. Failure to cooperate or comply with the Diversion Program requirements and recommendations, quitting the program without permission, or being expelled for cause is a violation of probation.~~

~~13.~~ *12.* Community Service - Free Services

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the ~~Division~~ *Board* or its designee for prior approval a community service plan in which respondent shall within the first 2 years of probation, provide_____ hours of free services (e.g., medical or nonmedical) to a community or non-profit organization. If the term of probation is designated for 2 years or less, the community service hours must be completed not later than 6 months prior to the completion of probation.

Prior to engaging in any community service respondent shall provide a true copy of the Decision(s) to the chief of staff, director, office manager, program manager, officer, or the chief executive officer at every community or non-profit organization where respondent provides community service and shall submit proof of compliance to the ~~Division~~ *Board* or its designee within 15 calendar days. This condition shall also apply to any change(s) in community service.

Community service performed prior to the effective date of the Decision shall not be accepted in fulfillment of this condition. Note: In quality of care cases, only non-medical community service is allowed unless respondent passes a competency exam or otherwise demonstrates competency prior to providing community service.

~~14.~~ *13.* Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the ~~Division~~ *Board* or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the ~~Division~~ *Board* or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

~~15.~~ *14.* Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices, at respondent's expense, approved in advance by the ~~Division~~ *Board* or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the ~~Division~~ *Board* or its designee, be accepted towards the fulfillment of this condition if

the course would have been approved by the ~~Division~~ *Board* or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the ~~Division~~ *Board* or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

~~16.~~ *15.* Medical Record Keeping Course

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the ~~Division~~ *Board* or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the ~~Division~~ *Board* or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the ~~Division~~ *Board* or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the ~~Division~~ *Board* or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

~~17.~~ *16.* Ethics Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in ethics, at respondent's expense, approved in advance by the ~~Division~~ *Board* or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

An ethics course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the ~~Division~~ *Board* or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the ~~Division~~ *Board* or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the ~~Division~~ *Board* or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

~~18.~~ *17.* Professional Boundaries Program

Within 60 calendar days from the effective date of this Decision, respondent shall enroll in a professional boundaries program, at respondent's expense, equivalent to the Professional Boundaries Program, Physician Assessment and Clinical Education Program

at the University of California, San Diego School of Medicine ("Program"). Respondent, at the Program's discretion, shall undergo and complete the Program's assessment of respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the ~~Division~~ *Board* or its designee deems relevant. The Program shall evaluate respondent at the end of the training and the Program shall provide any data from the assessment and training as well as the results of the evaluation to the ~~Division~~ *Board* or its designee.

Failure to complete the entire Program not later than six months after respondent's initial enrollment shall constitute a violation of probation unless the ~~Division~~ *Board* or its designee agrees in writing to a later time for completion. Based on respondent's performance in and evaluations from the assessment, education, and training, the Program shall advise the ~~Division~~ *Board* or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that respondent can practice medicine safely. Respondent shall comply with Program recommendations. At the completion of the Program, respondent shall submit to a final evaluation. The Program shall provide the results of the evaluation to the ~~Division~~ *Board* or its designee.

The Program's determination whether or not respondent successfully completed the Program shall be binding.

Failure to participate in and complete successfully all phases of the Program, as outlined above, is a violation of probation.

(Option # 1: Condition Precedent)
Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the ~~Division~~ *Board* or its designee in writing.

(Option # 2: Condition Subsequent)
If respondent fails to complete the Program within the designated time period, respondent shall cease the practice of medicine within 72 hours after being notified by the ~~Division~~ *Board* or its designee that respondent failed to complete the Program.

~~19.~~ *18.* Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and

judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the ~~Division~~ *Board* or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the ~~Division~~ *Board* or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the ~~Division~~ *Board* or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

(Option #1: Condition Precedent)
Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the ~~Division~~ *Board* or its designee in writing, except that respondent may practice in a clinical training program approved by the ~~Division~~ *Board* or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

(Option#2: Condition Subsequent)
If respondent fails to complete the clinical training program within the designated time period, respondent shall cease the practice of medicine within 72 hours after being notified by the ~~Division~~ *Board* or its designee that respondent failed to complete the clinical training program.

(Option#3)
After respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's

expense during the term of probation, or until the ~~Division~~ *Board* or its designee determines that further participation is no longer necessary.

Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation.

~~20.~~ *19.* Oral and/or Written Examination

Within 60 calendar days of the effective date of this Decision, respondent shall take and pass an oral and/or written examination, administered by the Probation Unit. The ~~Division~~ *Board* or its designee shall administer the oral and/or written examination in a subject to be designated by the ~~Division~~ *Board* or its designee and the oral examination shall be audio tape recorded.

If respondent fails the first examination, respondent shall be allowed to take and pass a second examination, which may consist of an oral and/or written examination. The waiting period between the first and second examinations shall be at least 90 calendar days.

Failure to pass the required oral and/or written examination within 180 calendar days after the effective date of this Decision is a violation of probation. Respondent shall pay the costs of all examinations. For purposes of this condition, if respondent is required to take and pass a written exam, it shall be either the Special Purpose Examination (SPEX) or an equivalent examination as determined by the ~~Division~~ *Board* or its designee.

(Continue with either one of these two options:)

(Option 1: Condition Precedent)
Respondent shall not practice medicine until respondent has passed the required examination and has been so notified by the ~~Division~~ *Board* or its designee in writing. This prohibition shall not bar respondent from practicing in a clinical training program approved by the ~~Division~~ *Board* or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

Note: The condition precedent option is particularly recommended in cases where respondent has been found to be incompetent, repeatedly negligent, or grossly negligent.

(Option 2: Condition Subsequent)
If respondent fails to pass the first examination, respondent shall be suspended from the practice of medicine. Respondent shall cease the practice of medicine within 72 hours after being notified by the ~~Division~~ *Board* or its designee that respondent has failed the examination.

Respondent shall remain suspended from the practice of medicine until respondent successfully passes a repeat examination, as evidenced by written notice to respondent from the ~~Division~~ *Board* or its designee.

~~21.~~ *20.* Psychiatric Evaluation

Within 30 calendar days of the effective date of this Decision, and on a whatever periodic basis thereafter may be required by the ~~Division~~ *Board* or its designee, respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a ~~Division~~ *Board* -appointed board certified psychiatrist, who shall consider any information provided by the ~~Division~~ *Board* or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the ~~Division~~ *Board* or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the ~~Division~~ *Board* or its designee.

Failure to undergo and complete a psychiatric evaluation and psychological testing, or comply with the required additional conditions or restrictions, is a violation of probation.

(Option: Condition Precedent)
Respondent shall not engage in the practice of medicine until notified by the ~~Division~~ *Board* or its designee that respondent is mentally fit to practice medicine safely. The period of time that respondent is not practicing medicine shall not be counted toward completion of the term of probation.

~~22.~~ *21.* Psychotherapy

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the ~~Division~~ *Board* or its designee for prior approval the name and qualifications of a board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the ~~Division~~ *Board* or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the ~~Division~~ *Board* or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the ~~Division~~ *Board* or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent.

Respondent shall have the treating psychotherapist submit quarterly status reports to the

~~Division~~ *Board* or its designee. The ~~Division~~ *Board* or its designee may require respondent to undergo psychiatric evaluations by a ~~Division~~ *Board*-appointed board certified psychiatrist. If, prior to the completion of probation, respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the ~~Division~~ *Board* shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the ~~Division~~ *Board* determines that respondent is mentally fit to resume the practice of medicine without restrictions.

Respondent shall pay the cost of all psychotherapy and psychiatric evaluations. Failure to undergo and continue psychotherapy treatment, or comply with any required modification in the frequency of psychotherapy, is a violation of probation.

Note: This condition is for those cases where the evidence demonstrates that the respondent has had impairment (impairment by mental illness, alcohol abuse and/or drug self-abuse) related to the violations but is not at present a danger to respondent's patients.

~~23.~~ *22.* Medical Evaluation and Treatment

Within 30 calendar days of the effective date of this Decision, and on a periodic basis thereafter as may be required by the ~~Division~~ *Board* or its designee, respondent shall undergo a
medical evaluation by a ~~Division~~ *Board* -appointed physician who shall consider any information provided by the ~~Division~~ *Board* or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the ~~Division~~ *Board* or its designee.

Following the evaluation, respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after being notified by the ~~Division~~ *Board* or its designee. If respondent is required by the ~~Division~~ *Board* or its designee to undergo medical treatment, respondent shall within 30 calendar days of the requirement notice, submit to the ~~Division~~ *Board* or its designee for prior approval the name and qualifications of a treating physician of respondent's choice. Upon approval of the treating physician, respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the ~~Division~~ *Board* or its designee.

The treating physician shall consider any information provided by the ~~Division~~ *Board* or its designee or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports to the ~~Division~~ *Board* or its designee indicating whether or not the respondent is capable of practicing medicine safely. Respondent shall provide the ~~Division~~ *Board* or its designee with any and all medical records pertaining to treatment, that the ~~Division~~ *Board* or its designee deems necessary.

If, prior to the completion of probation, respondent is found to be physically incapable of

resuming the practice of medicine without restrictions, the ~~Division~~ *Board* shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the ~~Division~~ *Board* determines that respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

Failure to undergo and continue medical treatment or comply with the required additional conditions or restrictions is a violation of probation.

(Option- Condition Precedent)
Respondent shall not engage in the practice of medicine until notified in writing by the ~~Division~~ *Board* or its designee of its determination that respondent is medically fit to practice safely.

Note: This condition is for those cases where the evidence demonstrates that medical illness or disability was a contributing cause of the violations.

~~24.~~ *23.* Monitoring - Practice/Billing

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the ~~Division~~ *Board* or its designee for prior approval as a _____(i.e., practice, billing, or practice and billing) monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the ~~Division~~ *Board*, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The ~~Division~~ *Board* or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's _____ (i.e., practice, billing, or practice and billing) shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor(s) shall submit a quarterly written report to the ~~Division~~ *Board* or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the ~~Division~~ *Board* or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the ~~Division~~ *Board* or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the ~~Division~~ *Board* or designee.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

~~25.~~ *24.* Solo Practice

Respondent is prohibited from engaging in the solo practice of medicine.

~~26.~~ *25.* Third Party Chaperone

During probation, respondent shall have a third party chaperone present while consulting, examining or treating _____(e.g., male, female, or minor) patients. Respondent shall, within 30 calendar days of the effective date of the Decision, submit to the ~~Division~~ *Board* or its designee for prior approval name(s) of persons who will act as the third party chaperone.

Each third party chaperone shall initial and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision(s) and the Accusation(s), and fully understand the role of the third party chaperone.

Respondent shall maintain a log of all patients seen for whom a third party chaperone is required. The log shall contain the: 1) patient name, address and telephone number; 2) medical record number; and 3) date of service. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the ~~Division~~ *Board* or its designee, and shall retain the log for the entire term of probation. Failure to maintain a log of all patients requiring a third party chaperone, or to make the log available for immediate inspection and copying on the premises, is a violation of probation.

(Option)

Respondent shall provide written notification to respondent's patients that a third party chaperone shall be present during all consultations, examination, or treatment with (e.g., male, female or minor) patients. Respondent shall maintain in the patient's file a copy of the written notification, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the ~~Division~~ *Board* or its designee, and shall retain the notification for the entire term of probation.

Note: Sexual offenders should normally be placed in a monitored environment.

~~27.~~ *26.* Prohibited Practice

During probation, respondent is prohibited from _____(e.g., practicing, performing, or treating) _____ (e.g., a specific medical procedure; surgery; on a specific patient population). After the effective date of this Decision, the first time that a patient seeking the prohibited services makes an appointment, orally notify the patient that respondent does not _____(e.g., practice, perform or treat) _____(e.g., a specific medical procedure; surgery; on a specific patient population). Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the ~~Division~~ *Board* or its designee, and shall retain the log for the entire term of probation. Failure to maintain a log as defined in the section, or to make the log available for immediate inspection and copying on the premises during business hours is a violation of probation.

In addition to the required oral notification, after the effective date of this Decision, the first time that a patient who seeks the prohibited services presents to respondent, respondent shall provide a written notification to the patient stating that respondent does not _____(e.g., practice, perform or treat)_____(e.g., a specific medical procedure; surgery; on a specific patient population). Respondent shall maintain a copy of the written notification in the patient's file, shall make the notification available

for immediate inspection and copying on the premises at all times during business hours by the ~~Division~~ *Board* or its designee, and shall retain the notification for the entire term of probation. Failure to maintain the written notification as defined in the section, or to make the notification available for immediate inspection and copying on the premises during business hours is a violation of probation.

STANDARD CONDITIONS

~~28.~~ *27.* Notification

Prior to engaging in the practice of medicine the respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the ~~Division~~ *Board* or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

~~29.~~ 28. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

~~30.~~ *29.* Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

~~31.~~ *30.* Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the ~~Division~~ *Board*, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

~~32.~~ *31.* Probation Unit Compliance

Respondent shall comply with the ~~Division's~~ *Board's* probation unit. Respondent shall, at all times, keep the ~~Division~~ *Board* informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the ~~Division~~ *Board* or its designee.

Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the ~~Division~~ *Board* or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

~~33.~~ *32.* Interview with the ~~Division~~ *Board* or its Designee

Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the ~~Division~~ *Board* or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

~~34.~~ *33.* Residing or Practicing Out-of-State

In the event respondent should leave the State of California to reside or to practice respondent shall notify the ~~Division~~ *Board* or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the ~~Division~~ *Board* or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing

and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

(Optional)

Any respondent disciplined under B&P Code sections 141(a) or 2305 (another state discipline) may petition for modification or termination of penalty: 1) if the other state's discipline terms are modified, terminated or reduced; and 2) if at least one year has elapsed from the effective date of the California discipline.

~~35.~~ *34.* Failure to Practice Medicine - California Resident

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the ~~Division~~ *Board* or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the ~~Division~~ *Board* or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

~~36.~~ *35.* Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

~~37.~~ *36.* Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the ~~Division~~ *Board*, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation,

the ~~Division~~ *Board* shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

~~38.~~ *37.* Cost Recovery

Within 90 calendar days from the effective date of the Decision or other period agreed to by the ~~Division~~ *Board* or its designee, respondent shall reimburse the ~~Division~~ *Board* the amount of $_____ for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve the respondent his/her obligation to reimburse the ~~Division~~ *Board* for its costs.

~~39.~~ *38.* License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The ~~Division~~ *Board* reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the ~~Division~~ *Board* or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

~~40.~~ *39.* Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the ~~Division~~ *Board*, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the ~~Division~~ *Board* or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

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DISCIPLINE BY ANOTHER STATE [B&P 141(a) & 2305]
Minimum penalty: Same for similar offense in California
Maximum penalty: Revocation
1. Oral or Written Examination as a condition precedent to practice in California [~~20~~]

MISLEADING ADVERTISING (B&P 651 & 2271)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [~~14~~] *[13]*
3. Ethics Course [~~17~~] *[13]*
4. Monitoring-Practice/Billing [~~24~~] *[13]*
5. Prohibited Practice [~~27~~] *[13]*

EXCESSIVE PRESCRIBING (B&P 725), or
PRESCRIBING WITHOUT A PRIOR EXAMINATION (B&P 2242)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances - Total DEA restriction [5],
Surrender DEA permit [6] or,
Partial DEA restriction [7]
3. Maintain Records and Access to Records and Inventories [8]
4. Education Course [~~14~~] *[13]*
5. Prescribing Practices Course [~~15~~] *[14]*
6. Medical Record Keeping Course [~~16~~] *[15]*
7. Ethics Course [~~17~~] *[16]*
8. Clinical Training Program [~~19~~] *[18]* or Oral or Written Examination [~~20~~] *[19]*
9. Monitoring - Practice/Billing [~~24~~] *[23]*

EXCESSIVE TREATMENTS (B&P 725)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [~~14~~] *[13]*
3. Medical Record Keeping Course [~~16~~] *[15]*
4. Ethics Course [~~17~~] *[16]*
5. Clinical Training Program [~~19~~] *[18]* or Oral or Written Examination [~~20~~] *[19]*
6. Monitoring - Practice/Billing [~~24~~] *[23]*
7. Prohibited Practice [~~27~~] *[26]*

SEXUAL MISCONDUCT (B&P 726)
Minimum penalty: Stayed revocation, 7 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [~~14~~] *[13]*
3. Ethics Course [~~17~~] *[16]*
4. Professional Boundaries Program [~~18~~] *[17]*
5. Psychiatric Evaluation [~~21~~] *[20]*
6. Psychotherapy [~~22~~] *[21]*
7. Monitoring-Practice/Billing [~~24~~] *[23]*
8. Third Party Chaperone [~~26~~] *[24]*
9. Prohibited Practice [~~27~~] *[26]*

SEXUAL EXPLOITATION (B&P 729)
Effective January 1, 2003, Business and Professions Code 2246 was added to read, "Any proposed decision or decision issued under this article that contains any finding of fact that the licensee engaged in any act of sexual exploitation, as described in paragraphs (3) to (5), inclusive, of subdivision (b) of Section 729, with a patient shall contain an order of revocation. The revocation shall not be stayed by the administrative law judge."

MENTAL OR PHYSICAL ILLNESS (B&P 820)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
~~1. Diversion Program~~ [12]
~~2.~~ *1.* Oral or Written Examination [~~20~~] *[19]*
~~3.~~ *2.* Psychiatric Evaluation [~~21~~] *[20]*
~~4.~~ *3.* Psychotherapy [~~22~~] *[21]*
~~5.~~ *4.* Medical Evaluation and Treatment [~~23~~] *[22]*
~~6.~~ *5.* Monitoring-Practice/Billing [~~24~~] *[23]*
~~7.~~ *6.* Solo Practice [~~25~~] *[24]*
~~8.~~ *7.* Prohibited Practice [~~27~~] *[26]*

GENERAL UNPROFESSIONAL CONDUCT (B&P 2234), or
GROSS NEGLIGENCE [B&P 2234 (b)], or
REPEATED NEGLIGENT ACTS [B&P 2234(c)], or
INCOMPETENCE [B&P 2234(d)], or
FAILURE TO MAINTAIN ADEQUATE RECORDS (B&P 2266)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Education course [~~14~~] *[13]*
2. Prescribing Practices Course [~~15~~] *[14]*
3. Medical Record Keeping Course [~~16~~] *[15]*
4. Ethics Course [~~17~~] *[16]*
5. Clinical Training Program [~~19~~] *[18]*
6. Oral or Written Examination [~~20~~] *[19]* (preferably Condition Precedent)
7. Monitoring - Practice Billing [~~24~~] *[23]*

8. Solo Practice [~~25~~] *[24]*
9. Prohibited Practice [~~27~~] *[26]*

DISHONESTY - Substantially related to the qualifications, functions or duties of a physician and surgeon and arising from or occurring during patient care, treatment, management or billing [B&P 2234(e)]
Minimum penalty: Stayed revocation, one year suspension at least 7 years probation
Maximum penalty: Revocation
1. Ethics Course [~~17~~] *[16]*
2. Oral or Written Examination [~~20~~] *[19]*
3. Psychiatric Evaluation [~~21~~] *[20]*
4. Medical Evaluation [~~23~~] *[22]*
5. Monitoring-Practice/Billing [~~24~~] *[23]*
6. Solo Practice [~~25~~] *[24]*
7. Prohibited Practice [~~27~~] *[26]*

DISHONESTY - Substantially related to the qualifications, function or duties of a physician and surgeon but not arising from or occurring during patient care, treatment, management or billing [BP 2234 (e)]
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Ethics Course [~~17~~] *[16]*
3. Psychiatric Evaluation [~~21~~] *[20]*
4. Medical Evaluation [~~23~~] *[22]*
5. Monitoring-Practice/Billing (if financial dishonesty or conviction of financial crime) [~~24~~] *[23]*
6. Restitution to Victim

PROCURING LICENSE BY FRAUD (B&P 2235)
1. Revocation [1] [2]

CONVICTION OF CRIME - Substantially related to the qualifications, functions or duties of a physician and surgeon and arising from or occurring during patient care, treatment, management or billing (B&P 2236)
Minimum penalty: Stayed revocation, one year suspension, at least 7 years probation
Maximum penalty: Revocation
1. Ethics Course [~~17~~] *[16]*
2. Oral or Written Examination [~~20~~] *[19]*
3. Psychiatric Evaluation [~~21~~] *[20]*
4. Medical Evaluation and Treatment [~~23~~] *[22]*
5. Monitoring-Practice/Billing [~~24~~] *[23]*
6. Solo Practice [~~25~~] *[24]*
7. Prohibited Practice [~~27~~] *[26]*

CONVICTION OF CRIME - Felony conviction substantially related to the qualifications, functions or duties of a physician and surgeon but not arising from or occurring during patient care, treatment, management or billing (B&P 2236)
Minimum penalty: Stayed revocation, 7 years probation
Maximum penalty: Revocation
1. Suspension of 30 days or more [4]
2. Ethics Course [~~17~~] *[16]*
3. Psychiatric Evaluation [~~21~~] *[20]*
4. Medical Evaluation and Treatment [~~23~~] *[22]*
5. Monitoring-Practice/Billing (if dishonesty or conviction of a financial crime) [~~24~~] *[23]*
6. Victim Restitution

CONVICTION OF CRIME - Misdemeanor conviction substantially related to the qualifications, functions or duties of a physician and surgeon but not arising from or occurring during patient care, treatment, management or billing (B&P 2236)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Ethics Course [~~17~~] *[16]*
2. Psychiatric Evaluation [~~21~~] *[20]*
3. Medical Evaluation and Treatment [~~23~~] *[22]*
4. Victim Restitution

CONVICTION OF DRUG VIOLATIONS (B&P 2237), or
VIOLATION OF DRUG STATUTES (B&P 2238), or
EXCESSIVE USE OF CONTROLLED SUBSTANCES (B&P 2239), or
PRACTICE UNDER THE INFLUENCE OF NARCOTIC (B&P 2280)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances - Total DEA restriction [5],
Surrender DEA permit [6], or
Partial DEA restriction [7]
3. Maintain Drug Records and Access to Records and Inventories [8]
4. Controlled Substances - Abstain From Use [9]
5. Alcohol-Abstain from Use [10]
6. Biological Fluid Testing [11]
~~7. Diversion Program [12]~~
~~8.~~ *7.* Education Course [~~14~~] *[13]*
~~9.~~ *8.* Prescribing Practices Course [~~15~~] *[14]*
~~10.~~ *9.* Medical Record Keeping Course [~~16~~] *[15]*
~~11.~~ *10.* Ethics Course [~~17~~] *[16]*
~~12.~~ *11.* Oral or Written Examination [~~20~~] *[19]*
~~13.~~ *12.* Psychiatric Evaluation [~~21~~] *[20]*

~~14~~. *13*. Psychotherapy [~~22~~] *[21]*
~~15~~. *14*. Medical Evaluation and Treatment [~~23~~] *[22]*
~~16~~. *15*. Monitoring-Practice/Billing [~~24~~] *[23]*
~~17~~. *16*. Prohibited Practice [~~27~~] *[26]*

ILLEGAL SALES OF CONTROLLED SUBSTANCES (B&P 2238)
Revocation [1] [2]

EXCESSIVE USE OF ALCOHOL (B&P 2239) or
PRACTICE UNDER THE INFLUENCE OF ALCOHOL (B&P 2280)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances-Abstain From Use [9]
3. Alcohol-Abstain from Use [10]
4. Biological Fluid Testing [11]
~~5. Diversion Program [12]~~
~~6~~. *5*. Ethics Course [~~17~~] *[16]*
~~7~~. *6*. Oral or Written Examination [~~20~~] *[19]*
~~8~~. *7*. Psychiatric Evaluation [~~21~~] *[20]*
~~9~~. *8*. Psychotherapy [~~22~~] *[21]*
~~10~~. *9*. Medical Evaluation and Treatment [~~23~~] *[22]*
~~11~~. *10*. Monitoring-Practice/Billing [~~24~~] *[23]*

PRESCRIBING TO ADDICTS (B&P 2241)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances- Total DEA restriction [5],
Surrender DEA permit [6], or
Partial restriction [7]
3. Maintain Drug Records and Access to Records and Inventories [8]
4. Education Course [~~14~~] *[13]*
5. Prescribing Practices Course [~~15~~] *[14]*
6. Medical Record Keeping Course [~~16~~] *[15]*
7. Ethics Course [~~17~~] *[16]*
8. Clinical Training Program [~~19~~] *[18]*
9. Oral or Written Examination [~~20~~] *[21]*
10. Monitoring-Practice/Billing [~~24~~] *[23]*
11. Prohibited Practice [~~27~~] *[26]*

ILLEGAL CANCER TREATMENT (B&P 2252)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education course [~~14~~] *[13]*

3. Ethics Course [~~17~~] *[16]*
4. Clinical Training Program [~~19~~] *[18]*
5. Oral or Written Examination [~~20~~] *[19]*
6. Monitoring-Practice/Billing [~~24~~] *[23]*
7. Prohibited Practice [~~27~~] *[26]*

MAKING FALSE STATEMENTS (B&P 2261), or
ALTERATION OF MEDICAL RECORDS (B&P 2262)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Ethics Course [~~17~~] *[16]*
3. Medical Record Keeping Course [~~16~~] *[15]*
4. If fraud involved, see "Dishonesty" guidelines

AIDING AND ABETTING UNLICENSED PRACTICE (B&P 2264)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [~~14~~] *[13]*
3. Ethics Course [~~17~~] *[16]*
4. Oral or Written Examination [~~20~~] *[19]*
5. Monitoring-Practice/Billing [~~24~~] *[23]*
6. Prohibited Practice [~~27~~] *[26]*

FICTITIOUS NAME VIOLATION (B&P 2285)
Minimum penalty: Stayed revocation, one year probation
Maximum penalty: Revocation

IMPERSONATION OF APPLICANT IN EXAM (B&P 2288)
1. Revocation [1] [2]

PRACTICE DURING SUSPENSION (B&P 2306)
1. Revocation [1] [2]

BUSINESS ORGANIZATION IN VIOLATION OF CHAPTER (B&P 2417)
Effective January 1, 2002, Business and Professions Code section 2417 was added to read, in part, "(b) A physician and surgeon who practices medicine with a business organization knowing that it is owned or operated in violation of Section 1871.4 of the Insurance Code, Section 14107 or 14107.2 of the Welfare and Institutions Code, or Section 549 or 550 of the Penal Code shall have his or her license to practice permanently revoked."

VIOLATION OF PROBATION

Minimum penalty: 30 day suspension

Maximum penalty: Revocation

The maximum penalty should be given for repeated similar offenses or for probation violations revealing a cavalier or recalcitrant attitude.

A violation of any of the following conditions of probation should result in, at minimum, a 60 day suspension:

1. Controlled Substances -Maintain Records and Access to Records and Inventories [8]
2. Biological Fluid Testing [11]

~~3. Diversion Program [12]~~

~~4.~~ *3.* Professional Boundaries Program [~~18~~] *[17]*

~~5.~~ *4.* Clinical Training Program [~~19~~] *[18]*

~~6.~~ *5.* Psychiatric Evaluation [~~21~~] *[20]*

~~7.~~ *6.* Psychotherapy [~~22~~] *[21]*

~~8.~~ *7.* Medical Evaluation and Treatment [~~23~~] *[22]*

~~9.~~ *8.* Third Party Chaperone [~~26~~] *[25]*

MEDICAL BOARD STAFF REPORT

AGENDA ITEM 22

DATE REPORT ISSUED:	January 14, 2008
DEPARTMENT:	Licensing Program
SUBJECT:	Proposed Regulations – Fee Reduction
STAFF CONTACT:	Kevin A Schunke

REQUESTED ACTION:

Approve a request to set a regulatory hearing to reduce the initial and renewal licensing fees to offset the decrease in its spending authority as a result of the elimination of the Diversion Program. This hearing would be set for April, 2008.

STAFF RECOMMENDATION:

To reduce the initial and renewal licensing fees through the regulatory process in an amount commensurate with the decrease in spending authority due to the discontinuation of the Board's Diversion Program.

EXECUTIVE SUMMARY:

Section 2435.2 of the Business and Professions Code states that the Board shall reduce license and renewal fees if the Diversion Program is eliminated.

In FY 2008-09, the expenditures of the Diversion Program were forecast to be $1,213,000.

Annually, there are about 53,500 license renewals and 2000 new licenses issued. (Actually, the number of new licenses issued each year is about double that number. However, the vast majority of those new licenses are issued to residents in training and subject to a reduced fee; thus, the figure of 2000 is used.) This totals 55,500 annual licenses.

The Board has voted to discontinue the Diversion Program. Therefore, pursuant to the requirements of Section 2435.2 of the Business and Professions Code:

$1,213,000 / 55,500 = $21.86 reduction in the fee for each initial license and renewal

Section 1351.5 of the Board's governing regulations set the initial license fee at $805, and Section 1352 sets the biennial renewal fee at $805.

Both of those fees should be reduced to $783.00.

FISCAL CONSIDERATIONS:

None. This is a cost-neutral proposal.

PREVIOUS MBC AND/OR COMMITTEE ACTION:

The Board last adjusted the licensing fees in 2006 to offset the loss of investigative cost recovery income.

Consumer Information Unit Activity FY 07/08	Number of Calls Answered	Number of Callers Connected to an Operator Immediately	Percent of Callers Who Experienced a Two Minute or Less Wait Time
1st Quarter	17,269	9,686	56%
2nd Quarter	17,662	9,144	52%
3rd Quarter			
4th Quarter			
TOTAL	34,931	18,830	NA

LICENSED MIDWIFE ACTIVITY 2007/2008			
Licenses Issued	Applications Received	Applications Pending	Applications Denied
7	9	3	0

Licenses Current/Renewed (as of November 30, 2007)	Licenses Delinquent (as of November 30, 2007)	Licenses Canceled (as of November 30, 2007)
172	23	15

State of California

Department of Consumer Affairs
Medical Board of California

MEMORANDUM

To: Medical Board of California
Diversion Committee

Date: January 14, 2008

Frank L Valine

From: Frank L. Valine
Diversion Program Administrator

Subject: Quality Review Report –2nd Quarter of FY 2007/2008

Attached are the quarterly reports of Quality Review issues requested by the Diversion Committee. They include a review of Intakes, Relapses and Releases during the period of October 1, 2007 through December 31, 2007.

INTAKES

A total of **5** physicians contacted the Program during the 2nd Quarter. The following charts reflect the outcomes of contact with these physicians as of December 31, 2007, as well as, other categories of information.

Status at Intake	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Totals
Active: Approved by DEC & Signed Agreement	0	0			0
Accepted; Waiting for Signature:	1	0			1
Intake Complete; Awaiting DEC:	5	3			8
Contacted Program/Telephone Intake:	6	2			8
Ineligible:	0	0			0
Not interested in Program:	2	0			2
Terminated	0	0			0
Out-of-State:	0	0			0
Total Contacts	14	5			19

Other Information		1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Totals
In Treatment;	At intake:	4	5			9
	Currently:	7	3			10
Referral Type;	Board Action:	6	0			6
	Self-Referral:	8	5			13
Impairment[1];	Chemical:	9	1			10
	Dual Disorder:	5	4			9
	Mental Only:	0	0			0
Practicing;	Yes:	3	0			3
	No:	11	5			16

[1] The determination of a participant's status as Chemically Dependent, Dual Disorder, or Mentally Ill frequently changes as additional information is gathered. Initially, the Program receives self-reported information during the intake process. Additional information, resulting in a change of status, may be received during either the evaluative or formal participation periods from evaluation reports and treatment records.

Physician Diversion Program –
Releases (54 participants for the time period of October 2007 – December 2007, 2nd Quarter, FY07/08)

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time in Program at Release	Treatment prior to Diversion	Relapses(s)	Treatment during Diversion	Practice Status at Release
2164	Completed	Board	SOU	Alcohol, Meth.	No	4 yrs 4 mo	No	No	No	Practicing
2081	Completed	Self	None	Alcohol, Hydroc.	Yes	5 yrs	Yes	No	No	Practicing
2195	Completed	Self	None	Alcohol, Fent.	No	3 yrs 3 mo	No	No	No	Practicing
2212	Completed	Self	None	Ambien, Ultram	No	3 yrs 8 mo	No	No	No	Practicing
2204	Completed	Self	None	Alcohol	No	3 yrs 9 mo	No	No	No	Practicing
2095	Completed	Self	None	Opiates	No	5 yrs	No	No	No	Practicing
2264	Completed	Self	None	Alcohol	No	3 yrs	No	No	No	Practicing
2116	Completed	Board	SOU	Demerol	Yes	5 yrs	No	No	No	Practicing
2106	Completed	Self	None	Alcohol	No	5 yrs	No	No	No	Practicing
2100	Completed	Self	None	Alcohol	No	5 yrs	No	No	No	Practicing
2162	Completed	Board	SOU	Cocaine	No	4 yrs 4 mo	No	No	No	Practicing

Physician Diversion Program –
Releases (54 participants for the time period of October 2007 – December 2007, 2nd Quarter, FY07/08)

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time in Program at Release	Treatment prior to Diversion	Relapses(s)	Treatment during Diversion	Practice Status at Release
2189	Completed	Board	SOU	Alcohol, Benzos	No	4 yrs	No	No	No	Practicing
2127	Completed	Board	SOU	Vicodin, Klonopin	Yes	4 yrs 8 mo	No	No	No	Practicing
2154	Completed	Self	None	Opiates	Yes	4 yrs 6 mo	No	No	No	Practicing
2122	Completed	Self	None	Vicodin, Soma	No	4 yrs 6 mo	No	No	No	Practicing
2111	Completed	Board	SOU	Meth.	No	5 yrs	No	No	No	Practicing
2086	Completed	Board	SOU	Benzos	No	5 yrs	Yes	No	No	Practicing
2179	Completed	Board	SOU	Vicodin, Hydroc.	No	4 yrs	Yes	No	No	Practicing
2120	Completed	Self	None	Marijuana	No	4 yrs 9 mo	No	No	No	Practicing
2039	Completed	Board	SOU	Alcohol, Ativan	No	5 yrs	No	No	No	Practicing
2160	Completed	Board	SOU	Alcohol, Opiates	No	4 yrs 1 mo	Yes	No	No	Practicing
2145	Completed	Self	None	Alcohol, Xanax, Opiates	No	4 yrs 5 mo	Yes	No	No	Practicing

Physician Diversion Program –

Releases (54 participants for the time period of October 2007 – December 2007, 2nd Quarter, FY07/08)

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time in Program at Release	Treatment prior to Diversion	Relapses(s)	Treatment during Diversion	Practice Status at Release
2132	Completed	Board	SOU	Alcohol	Yes	4 yrs 9 mo	No	No	No	Practicing
1991	Completed	Self	None	Vicodin	Yes	6 yrs	Yes	No	No	Practicing
2153	Completed	Board	SOU	Opiates	No	4 yrs 4 mo	No	No	No	Practicing
2094	Completed	Board	SOU	Marijuana, Cocaine	No	4 yrs 4 mo	No	No	No	Practicing
2228	Completed	Self	None	Alcohol, Marijuana	Yes	3 yrs 5 mo	No	No	No	Practicing
2080	Completed	Self	None	Alcohol, Cocaine	No	5 yrs	Yes	No	No	Practicing
2161	Completed	Board	SOU	Alcohol	No	4 yrs 1 mo	No	No	No	Practicing
2238	Completed	Board	SOU	Opiates	No	3 yrs 3 mo	No	No	No	Practicing
2173	Completed	Self	None	Fentanyl	No	3 yrs 11 mo	No	No	No	Practicing
2069	Completed	Board	SOU	Alcohol, Marijuana	No	5 yrs	No	No	No	Practicing
2172	Completed	Self	None	Alcohol, Cocaine	No	4 yrs 3 mo	No	No	No	Practicing

Physician Diversion Program –
Releases (54 participants for the time period of October 2007 – December 2007, 2nd Quarter, FY07/08)

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time in Program at Release	Treatment prior to Diversion	Relapses(s)	Treatment during Diversion	Practice Status at Release
2112	Completed	Board	SOU	Cocaine, Ambien	Yes	4 yrs 11 mo	No	No	No	Practicing
2110	Completed	Self	None	Alcohol	No	4 yrs 8 mo	No	No	No	Practicing
2221	Completed	Board	SOU	Alcohol	No	3 yrs 9 mo	No	No	No	Practicing
2229	Completed	Self	None	Alcohol	Yes	3 yrs 5 mo	No	No	No	Practicing
2090	Completed	Board	SOU	Alcohol, Xanax	Yes	5 yrs	No	No	No	Practicing
2109	Completed	Self	None	Alcohol, Valium	No	4 yrs 10 mo	No	No	No	Practicing
2234	Completed	Self	None	Opiates	Yes	3 yrs 5 mo	No	No	No	Practicing
1858	Completed	Self	None	Alcohol	Yes	Over 7 yrs	No	No	No	Practicing
1746	Completed	Self	None	Alcohol, Morphine, Vicodin	Yes	Over 7 yrs	No	Yes		Practicing
2170	Completed	Self	None	Alcohol	No	3 yrs 9 mo	No	No	No	Practicing
2187	Completed	Board	SOU	Alcohol	Yes	3 yrs 9 mo	Yes	No	No	Not Practicing

Physician Diversion Program –
Releases (54 participants for the time period of October 2007 – December 2007, 2nd Quarter, FY07/08)

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time In Program at Release	Treatment prior to Diversion	Relapses(s)	Treatment during Diversion	Practice Status at Release
2198	Completed	Board	SOU	Alcohol, Opiates	Yes	4 yrs	No	No	No	Practicing
2472	Terminated	Board	SOU	Alcohol, Cocaine	Yes	4 mo	Yes	Yes	No	Not Practicing
2333	Terminated	Self	None	Vicodin	No	2 yrs	Yes	No	No	Practicing
2433	Terminated	Self	None	Alcohol	No	9 mo	No	No	No	Not Practicing
2396	Terminated	Board	SOU	Alcohol	No	1 yr 2 mo	No	No	No	Leaving State
2436	Terminated	Board	SOU	Alcohol, Cocaine	No	9 mo	No	Yes	No	Returned to Enforcement
2211	Terminated	Board	SOU	Alcohol	Yes	3 yrs 5 mo	No	Yes	No	Terminally ill; Not Practicing
2200	Terminated	Self	Referred to Enforcement	Cocaine, Heroin	No	3 yrs 6 mo	No	No	No	Practicing
2448	Terminated	Board	SOU	Alcohol, Darvocet	No	8 mo	No	No	No	Not Practicing
2445	Terminated	Board	SOU	Alcohol	No	7 mo	No	No	No	In Jail

RELEASES

The table below shows the case details for the 54 participants (**for the time period of October 2007 – December 2007, the 2nd quarter**) who were released from the program; 45 successfully and 9 unsuccessfully.

		1st Qtr	2nd Qtr
Type of Referral:	Board Action: Self-Referral:	7 6	27 27
Participant Impairment:	Chemical Dependency: Dual Disorder: Mental Only:	7 6 0	33 21 0
Successful/Unsuccessful:	Successful: Unsuccessful	10 3	45 9
Release Time for Successful Participants in Program:	3-5 years in program: 5-6 years in program: 6+ years in program:	0 10 0	31 12 2
Treatment prior to program:		7	19
Treatment while in program:		6	11
Relapses while in program:		1	3

		3rd Qtr	4th Qtr
Type of Referral:	Board Action: Self-Referral:		
Participant Impairment:	Chemical Dependency: Dual Disorder: Mental Only:		
Successful/Unsuccessful:	Successful: Unsuccessful		
Successful Release Time in Program:	5-6 years in program: 6+ years in program:		
Treatment prior to program:			
Treatment while in program:			
Relapses while in program:			

		Totals Qtrs 1-4
Type of Referral:	Board Action: Self-Referral:	34 33
Participant Impairment:	Chemical Dependency: Dual Disorder: Mental Only:	40 27 0
Successful/Unsuccessful:	Successful: Unsuccessful	55 12
Release Time for Successful Participants in Program:	3-5 years in program: 5-6 years in program: 6+ years in program:	31 22 2
Treatment prior to program:		26
Treatment while in program:		17
Relapses while in program:		4

RELAPSES (7)

The table below shows the case details for total participant relapses during the time period reported. There were **7** relapses during the time frame from October 2007 – December 2007, 2nd Quarter.

Quarters		1st	2nd	3rd	4th	Totals
Type of Referral:	Board Action:	4	5			9
	Self- Referral:	4	2			6
Participant Impairment:	Chemical Dependency:	5	6			11
	Dual Disorder:	3	1			4
Length of Time in Program at Relapse:	0-1 year	4	2			6
	1-2 years	1	2			3
	2-3 years	1	2			1
	3-4 years	2	0			2
	4-5 years	0	1			1
	7-8 years	0	0			0
Total with Prior Relapses:		6	2			8
Method of Detection:	Random UDS:	7	5			12
	Collector Detection:	0	0			0
	DUI:	0	0			0
	Self Report:	0	0			0
	Treatment Center:	1	0			1
Practice Restrictions in Response to Relapse:	Stop Practice Initiated:	5	5			10
	Stop Practice Continued:	1	1			2
Clinical Response to Relapse:	Inpatient treatment:	5	1			6
	Increase group/urine tests:	0	0			0
	Retesting:	8	5			13
	Outpatient Treatment:	0	0			0
	DEC further review:	2	0			2
	Termination:	0	2			2
	Death:	0	0			0
Withdrew from Program:		0	2			2

KEY TO CASE REVIEW TERMS	
DEC	Diversion Evaluation Committee
GF	Group Facilitator
CM	Diversion Program Case Manager
CC	DEC Case Consultant
PM	Diversion Program Manager
UDS	Urine Drug Screen
PCP	Primary Care Physician
EtG Test	Ethyl Glucuronide Lab Screen (Special lab testing screen for Alcohol. Detects Alcohol in the urine for up to 80 hours prior to the date a specimen is collected.)

Case	Current Status	Prior Relapses	Referral	Enforcement Activity	Primary Drug(s)	Mental Health Disorder	Date of Relapse	How Detected
2438	Not Practicing	No	Self	Investigation	Alcohol	Yes	10.4.07	Random UDS Test

Drugs) of Relapse	Time in Program at Relapse	Program Response to Relapse:
Alcohol	7 months	Already not practicing; Terminated from Program.

Case	Current Status	Prior Relapses	Referral	Enforcement Activity	Primary Drug(s)	Mental Health Disorder	Date of Relapse	How Detected
2249	Treatment	Yes	Board	Investigation	Fentanyl	No	10.30.07	Random UDS Test

Drugs) of Relapse	Time in Program at Relapse	Program Response to Relapse:
Fentanyl	3 Years	Already not practicing; New sobriety date; Sent to treatment.

Case	Current Status	Prior Relapses	Referral	Enforcement Activity	Primary Drug(s)	Mental Health Disorder	Date of Relapse	How Detected
2436	Treatment	Yes	Self	Investigation	Cocaine	No	11.5.07	Random UDS Test

Drugs) of Relapse	Time in Program at Relapse	Program Response to Relapse:
Cocaine	8 months	Already not practicing; Terminated from Program.

Case	Current Status	Prior Relapses	Referral	Enforcement Activity	Primary Drug(s)	Mental Health Disorder	Date of Relapse	How Detected
2469	Treatment	No	Board	Investigation	Demerol	No	11.8.07	Random UDS Test

Drugs) of Relapse	Time in Program at Relapse	Program Response to Relapse:
Clonazepam	3 months	Pulled from work; quit program; referred to Enforcement.

Case	Current Status	Prior Relapses	Referral	Enforcement Activity	Primary Drug(s)	Mental Health Disorder	Date of Relapse	How Detected
2278	Treatment	Yes	Board	None	Alcohol	No	11.26.07	Random UDS Test
Drugs) of Relapse		**Time in Program at Relapse**		**Program Response to Relapse:**				
Alcohol		2 Years 8 months		Sent to treatment.				

Case	Current Status	Prior Relapses	Referral	Enforcement Activity	Primary Drug(s)	Mental Health Disorder	Date of Relapse	How Detected
2103	Not Practicing	Yes	Board	Investigation	Opiates	No	12.19.07	Random UDS Test
Drugs) of Relapse		**Time in Program at Relapse**		**Program Response to Relapse:**				
Fentanyl		4 Years		Terminated from program.				

Case	Current Status	Prior Relapses	Referral	Enforcement Activity	Primary Drug(s)	Mental Health Disorder	Date of Relapse	How Detected
2289	Treatment	Yes	Self	None	Vercet	No	12.29.07	Random UDS Test
Drugs) of Relapse		**Time in Program at Relapse**		**Program Response to Relapse:**				
Alcohol		2 Years		Pulled from work; 2nd Etg test is pending.				

State of California

Department of Consumer Affairs
Medical Board of California

Memorandum

To: Frank Valine
Diversion Program Administrator

Date: January 15, 2008

From: Letitia Robinson
Collection System Manager

Subject: Collection System Status Report for October - December 2007

Attached are the charts reporting the collective test results for Urine Drug Screen (UDS) samples taken during the 2nd Quarter, October - December of FY 2007/2008.

The majority of positive results continue to be a result of approved prescriptions for Naltrexone taken by some participants, or medications prescribed for surgery/medical condition. One participant still shows positive results on occasion as a result of sugar imbalances from his diabetes.

Six participants with positive UDS samples were determined to have relapsed. Two participants were ordered into inpatient treatment, as indicated on the quarterly report.

During this reporting period the "Turn Around Time" as reported by Quest lab:

	Collection to lab receipt	*Lab receipt to results reported*	*Total Time*
Averages:	3.4 days	1.4 days	4.8 days

Attachments

UDS Test Results – 2nd Quarter October – December 2007

POSITIVE TEST RESULTS				
Month 2007	***Total # of Tests***	***Total Positive Results***	***Number of Positives***	***Comments***
October	784	45	1 1 3 38 2	Participants relapsed; terminated from Program (Alcohol # 2438) Participants relapsed. (Fentanyl # 2249) Approved prescriptions other than Naltrexone. Approved prescriptions by case manager for Naltreoxne. Positives resulting from alcohol-producing microorganisms associated with participant's diabetes.
November	757	43	1 1 1 4 35 1	Participant relapsed; sent to treatment. (Alcohol # 2278) Participant relapsed; terminated from Program. (Cocaine # 2436) Participant relapsed; quit Program. (Clonazepam # 2469) Approved prescriptions other than Naltrexone. Approved prescriptions by case manager for Naltreoxne. Positives resulting from alcohol-producing microorganisms associated with participant's diabetes.
December	671	37	1 4 31 1	Participant relapsed; quit Program. (Fentanyl # 2103) Approved prescriptions other than Naltrexone. Approved prescriptions by case manager for Naltreoxne. Positive for alcohol; EtG negative.
TOTAL	**2212**	**125**	**125**	

NEGATIVE-DILUTE TEST RESULTS				
Month 2007	***Total # of Tests***	***Total Negative- Dilute Results***	***Number of Negative-Dilute Results***	***Comments***
October	784	2	2	Case Managers notified and retested.
November	757	6	6	Case Managers notified and retested.
December	671	3	3	Case Managers notified and retested.
TOTAL	**2212**	**11**	**11**	

UDS Test Results – 2nd Quarter October – December 2007

INVALID/REJECTED TEST RESULTS				
Month 2007	***Total # of Tests***	***Total Invalid or Rejected Results***	***Number of Invalid or Rejected Results***	***Comments***
October	784	5	1	Possible Oxidant Activity; retested.
			1	The sample leaked in transport; retested.
			1	No donor ID on specimen container; retested.
			2	Insufficient volume: lab used entire vial prior to completing the test; retested.
November	757	5	1	Collector name/Signature not on Chain of Custody form; retested.
			1	The sample leaked in transport; retested.
			1	Insufficient volume: lab used entire vial prior to completing the test; retested.
			2	Specimen ID# mismatch/missing
December	671	3	1	Collector name/Signature not on Chain of Custody form; retested.
			1	Insufficient volume: lab used entire vial prior to completing the test; retested.
			1	Immunoassay Interference; oxidixing adulterants were negative.
TOTAL	**2212**	**13**	**13**	

Action taken on Positive (UDS Test) Results – October 2007

2nd Qtr: Oct. – Dec. 2007

OCTOBER POSITIVE TEST RESULTS (other than Naltrexone)					
	Collection Date	***Lab Received Date***	***Lab Reported Date***	***Substance***	***Action Taken/Comments***
1	10/04/07	10/08/07	10/12/07	Alcohol – 2438	Relapse; just released from treatment; terminated from Program.
2	10/13/07	10/16/07	10/22/07	Buprenorphine	@ RX; not working.
3	10/17/07	10/23/07	10/25/07	Alcohol	EtG negative; glucose 3+; due to participant's diabetes.
4	10/25/07	10/29/07	11/01/07	Buprenorphine	@ RX; not working.
5	10/26/07	10/30/07	11/01/07	Alcohol	EtG negative; glucose 3+; due to participant's diabetes.
6	10/30/07	11/01/07	11/02/07	Fentanyl – 2249	Relapse; stopped practice.
7	10/31/07	11/5/07	11/9/07	Buprenorphine	@ RX; not working.

OCTOBER NEGATIVE-DILUE TEST RESULTS					
	Collection Date	***Lab Received Date***	***Lab Reported Date***	***Result***	***Action Taken/Comments***
1	10/07/07	10/10/07	10/11/07	Negative-Dilute	No history of prior dilutes; retest scheduled.
2	10/12/07	10/15/07	10/16/07	Negative-Dilute	No history of dilutes; not working; retest scheduled.

Action taken on Positive (UDS Test) Results – November 2007 2nd Qtr: Oct. – Dec. 2007

NOVEMBER POSITIVE TEST RESULTS (other than Naltrexone)					
	Collection Date	***Lab Received Date***	***Lab Reported Date***	***Substance***	***Action Taken/Comments***
1	11/5/07	11/6/07	11/9/07	Buprenorphine	@ RX; not working.
2	11/5/07	11/7/07	11/8/07	Cocaine – 2436	Relapse; stopped practice; terminated from Program.
3	11/8/07	11/12/07	11/15/07	Clonazepam – 2469	Relapse; quit Program.
4	11/11/07	11/14/07	11/16/07	Buprenorphine	@ RX; not working.
5	11/18/07	11/20/07	11/24/07	Temazepam	@ Rx for surgical procedure.
6	11/23/07	11/28/07	12/3/07	Buprenorphine	@ RX; not working.
7	11/26/07	11/29/07	12/1/07	Alcohol, EtG – 2278	Relapse; stopped practice; sent to treatment.
8	11/26/07	11/29/07	12/2/07	Alcohol	EtG negative; glucose 3+; due to participant's diabetes.

NOVEMBER NEGATIVE-DILUE TEST RESULTS					
	Collection Date	***Lab Received Date***	***Lab Reported Date***	***Result***	***Action Taken/Comments***
1	11/5/07	11/6/07	11/7/07	Negative-Dilute	No history of prior dilutes; retest scheduled.
2	11/5/07	117/07	11/8/07	Negative-Dilute	2nd dilute this year; retest scheduled.
3	11/6/07	11/8/07	11/9/07	Negative-Dilute	2nd dilute this year plus a positive dilute; terminated from Program.
4	11/13/07	11/15/07	11/16/07	Negative-Dilute	No history of prior dilutes; retest scheduled.
5	11/24/07	11/27/07	11/28/07	Negative-Dilute	No history of prior dilutes; retest scheduled.
6	1125/07	11/29/07	11/30/07	Negative-Dilute	No history of prior dilutes; retest scheduled.

Action taken on Positive (UDS Test) Results – December 2007

2nd Qtr: Oct. – Dec. 2007

DECEMBER POSITIVE TEST RESULTS (other than Naltrexone)					
	Collection Date	***Lab Received Date***	***Lab Reported Date***	***Substance***	***Action Taken/Comments***
1	12/1/07	12/3/07	12/7/07	Fentanyl	@ RX; not working.
2	12/4/07	12/5/07	12/8/07	Fentanyl	@ RX; not working; same participant as above.
3	12/9/07	12/12/07	12/18/07	Buprenorphine	@ RX; not working.
4	12/19/07	12/21/07	12/29/07	Fentanyl	Relapse; quit Program.
5	12/20/07	12/24/07	12/29/07	Buprenorphine	@ RX; not working.
6	12/29/07	1/2/08	1/4/08	Alcohol	EtG negative.

DECEMBER NEGATIVE-DILUE TEST RESULTS					
	Collection Date	***Lab Received Date***	***Lab Reported Date***	***Result***	***Action Taken/Comments***
1	12/2/07	12/6/07	12/11/07	Negative-Dilute	Five prior dilutes since 5/07; retest scheduled.
2	12/2/07	12/4/07	12/5/07	Negative-Dilute	No history of dilutes; retest scheduled.
3	12/12/07	12/18/07	12/19/07	Negative-Dilute	One other dilute 11/07; retest scheduled

MEDICAL BOARD OF CALIFORNIA
Executive Office

AGENDA ITEM 23B

Date: January 15, 2008

To: Members

From: Frank L. Valine
Diversion Program Manager

Subject: Diversion Program Budget Report

Senate Bill 231 (Figueroa 2005) added Section 2343(b) to the Business and Professions Code. This section requires the Diversion Program Manager to... "account for all expenses and revenues of the Diversion Program and separately report this information to the board on a quarterly basis."

Attached is the Program's budget for FY 2007/2008. The Program's budget for FY 2007/2008 is $1,389,269. Expenditures from July 1, 2007 through November 30, 2007 are $579,016, this is 41.7% of the FY 2007/2008 budget.

The Program's budget includes travel for Program staff to over 35 Diversion Evaluation Committee (DEC) meetings and four Board meetings each year. The budget also includes travel and per diem expenses for DEC members.

Travel for staff and DEC members July 1, 2007 through December 31, 2007 totaled $11,251.49.

Per diem for DEC members from October 2007 through December 2007 totaled $6,600.00.

Please let me know if you have any questions.

Attachments

MEDICAL BOARD OF CALIFORNIA
DIVERSION PROGRAM
BUDGET REPORT
JULY 1, 2007 - NOVEMBER 30, 2007

	FY 07/08 BUDGET	EXPEND/ ENCUMB YR-TO-DATE	PERCENT OF BUDGET EXP/ENCUMB	LAG TIME (MONTHS)
PERSONAL SERVICES				
Salaries & Wages	720,179	307,401	42.7	current
Staff Benefits	308,814	119,626	38.7	current
TOTAL PERSONAL SERVICES	1,028,993	427,027	41.5	
OPERATING EXPENSES & EQUIPMENT				
General Expense	22,000	11,073	50.3	1-2
Printing	10,000	5,174	51.7	1-2
Communications	22,822	3,379	14.8	1-2
Postage	5,255	538	10.2	1-2
Insurance	1,702	516	30.3	current
Travel In-State	75,000	24,481	32.6	1-2
Travel Out-of-State	1,100	0	0.0	current
Training	4,418	0	0.0	1-2
Facilities Operation	30,000	28,290	94.3	current
Departmental Services	109,572	45,140	41.2	current
DP Maint/Supplies	500	0	0.0	1-2
Central Administrative Services	48,782	24,406	50.0	current
Major Equipment	16,000	0	0.0	current
Vehicle Operations	11,000	8,967	81.5	1-2
DOI-Investigations	0	25		
TOTAL OPERATING EXPENSES & EQUIPMENT	358,151	151,989	42.4	
TOTAL BUDGET/EXPENDITURES	**1,387,144**	**579,016**	41.7	

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1/4/2008

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: February 1, 2008
SUBJECT: Review of Laser Use per Section 2023.5 of the Business and Professions Code
STAFF CONTACT: Janie Cordray

REQUESTED ACTION:
1) Approve the two attached statements for publication and distribution (Attachments C and D).
2) Continue to support the reestablishment of Operation Safe Medicine to assist with the investigation of these cases and encourage staff to increase the use of the citation and fine process to act as a deterrent for these violations.

STAFF RECOMMENDATION:
Staff recommends that the Board approve the two prepared statements. The first is a statement outlining the responsibilities of physicians in cosmetic procedures, including the supervision of allied health staff performing laser procedures. The second is a statement to better inform consumers on cosmetic procedures. In addition, staff is recommending the Operation Safe Medicine Unit, once reestablished, investigate these matters and increase the use of citations.

EXECUTIVE SUMMARY:
SB 1423 (Figueroa; Chap. 873, Stats. of 2006) added section 2023.5 to the Business & Professions Code, which requires the Medical Board and the Board of Registered Nursing, in consultation with the Physician Assistant Committee, to examine the issues surrounding the use of lasers in cosmetic procedures and patient safety.

Medical Board and Nursing Board staff held three public forums to solicit comments from physician, nursing, and physician assistant organizations, the laser industry, and patients, among others. The meetings were chaired by members of both boards, including Drs. Mary Moran and Janet Salomonson of the Medical Board.

Following consideration from testimony at the three forums and analysis of the laws and regulations that relate to cosmetic procedures and the delegation of procedures to allied health professionals, staff is not recommending regulatory action at this time. Staff believes that after reestablishment of the Operation Safe Medicine Unit and reviewing the impact of the citation and fine process, the board will be in a stronger position to make recommendations regarding any future legislative/regulatory action, e.g. increased fine amount, supervision definition, etc.

FISCAL CONSIDERATIONS:
No additional fiscal considerations at this time.

PREVIOUS MBC AND/OR COMMITTEE ACTION:
At the November 2007 Board Meeting, the Members approved the reestablishment of the Operation Safe Medicine Unit.
Attachments
A – Memo summarizing the laser forums
B – Memo analyzing current laws and regulations on the use of lasers and background information
C – Article regarding physician responsibility
D – Article for consumers

State of California Department of Consumer Affairs

Medical Board of California

January 7, 2008

TO: Members,
Medical Board of California

FROM: Janie Cordray,
Research Director

SUBJECT: **SB 1423 (Figueroa; Chap. 873, Stats. of 2006) – Medical Board's Responsibility to Review Laser Safety in Elective Cosmetic Procedures; Report on Laser Forums**

SB 1423, which (Figueroa; Chap 873, Stats. of 2006) added section 2023.5 to the Business & Professions Code, directs the Medical Board of California and the Board of Registered Nursing to review the issues of the safety of lasers in elective cosmetic procedures.

Section 2023.5 provides:

(a) The board, in conjunction with Board of Registered Nursing, and in consultation with the Physician Assistant Committee and professionals in the field, shall review issues and problems surrounding the use of laser or intense light pulse devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants. The review shall include, but need not be limited to, all of the following:

(1) The appropriate level of physician supervision needed.

(2) The appropriate level of training to ensure competency.

(3) Guidelines for standardized procedures and protocols that address, at minimum, all of the following:

(A) Patient selection.

(B) Patient education, instruction, and informed consent.

(C) Use of topical agents.

(D) Procedures to be followed in the event of complications or side effects from the treatment.

(E) Procedures governing emergency and urgent care situations.

(b) On or before January 1, 2009, the board and the Board of Registered Nursing shall promulgate regulations to implement changes determined to be necessary with regard to the use of laser or intense pulse light devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants.

Review of Issues – Information Gathered at Public Forums:

To begin to conduct the mandated review of issues, the Medical and Nursing Boards decided to hold three public forums to solicit comment on the safety of the use of lasers in cosmetic procedures.

In preparation of the Forums, Medical Board and Nursing Board staff met to discuss the issues relating to the current environment of cosmetic laser practice. Staff noted that the environment of laser practice was often not safe or legal, and, specifically, had observed the following problems:

- Ownership violations of "Medical Spas" or combined cosmetic & medical practices;
- Corporate practice violations: the employment of a "Medical Director, ""Collaborative Physician" or "Supervising Physician";

- Fee-splitting, paying for referrals, and a number of business schemes designed to circumvent the prohibition of hiring physicians;
- Remote or absent supervision;
- Use of non-licensed, or inappropriately licensed personnel;
- Consumer confusion as to the medical nature of laser procedures and issues of liability;
- Potential for patient harm.

As a result of the forums, held in Santa Ana, Sacramento, and San Diego on August 31, September 13, and October 31, board members and staff have heard from a number of interested parties. Those who made formal presentations were:

- American Academy of Cosmetic Surgeons
- American Laser Centers
- American Association of Medical Esthetic Nurses
- American Society of Cosmetic Dermatology & Aesthetic Surgery
- California Academy of Cosmetic Surgeons
- California Academy of Facial Plastic and Reconstructive Surgeons
- California Academy of Physician Assistants
- California Association of Nurse Practitioners
- California Nursing Association
- American Society of Dermatological Surgery
- California Society for Dermatological Surgery
- California Society of Dermatologists
- California Society of Plastic Surgeons
- Norm Davis, J.D., Healthcare attorney
- Christine Lee, M.D., Dermatologist
- Lumier Medical, Inc.
- Stephen Moore, Patient Advocate
- Alan Voss, A. L. Voss, Associates, Medical Device Consultant

(Minutes of all three forums are available on the Board's website.)

In addition to the formal presentations made by these individuals and organizations, a number of persons offered comment, including individual nurses, physicians, physician assistants, and consumers.

The presentations made by the various professional associations echoed the problems discussed by staff. Testimony demonstrated that there is frequent disregard of the law in the use of these devices in the treatment of patients. In addition to highlighting the problems of the industry, there were a number of recommendations voiced by those offering testimony, including:

- Increase the definition of medical practice and medical offices or settings.
- Better define the span of control over sites, and possibly limit the number of persons supervised.

- Accredit or certify locations or sites of the procedures.
- Increase supervision of RNs, requiring the same for RN's standardized procedures as for physician assistants.
- Set minimum standards for training, and perhaps require some kind of certification and examination requirement for the use of the devices.
- Establish certification or accreditation requirements for the training courses.
- Close any loopholes in the standardized procedure guidelines of nurses.
- Promulgate regulations to define lay-involvement and corporate practice.
- Require that the supervising physician be on-site, or available via telecommunications at all times during the procedures.
- Allow delegation of tasks or procedures only consistent with the supervising physicians' specialty or "usual or customary practice."
- Require physician supervisors to review and examine the nurse's performance.
- Established back-up procedures and emergency plans.
- Require physicians do a skin exam before any laser treatments.
- Only allow laser treatments in medical settings.
- Enforce the current laws and regulations.

Medical Board Jurisdiction:

While the law requires the Medical and Nursing Boards to jointly study the issues and consult with the Physician Assistant Committee, any proposed regulations would be heard separately by each board or committee. The Nursing Board, Physician Assistant Committee and the Medical Board only have jurisdiction over and can only impose regulations on their licensees. For that reason, the Board must focus on the issues relating to physicians and their responsibilities, including their responsibilities as supervisors of allied health professionals.

Discussion of Future Actions of the Boards:

The public forums held jointly by the Medical and Nursing Boards have accomplished their purpose of gathering information. The Boards now have a greater understanding of the issues, how practices are violating current law, the risks of injury, the lack of knowledge of licensees and patients, and how the lack of enforcement may have contributed to the risks and violations.

It appears there may be no need for further laws or regulations; however, there is a need for more resources for enforcement to proactively address the issues. The development of a strategy or method to enforce current laws should precede any efforts to seek any additions or amendments without obtaining further resources and commitment to their enforcement. (See following memorandum, "Current Laws Relating to the Use of Lasers and Their Enforcement.")

By law, the members are directed to review the issues relating to laser safety and take actions they deem necessary by January 1, 2009. This matter is scheduled for discussion at the Board meeting on February 1, 2008.

Medical Board of California

January 7, 2008

TO: Members,
Medical Board of California

FROM: Janie Cordray,
Research Director

SUBJECT: Current Laws and Regulations Relating to the Use of Lasers and The Enforcement Thereof

Background

SB 1423 (Figueroa; Chap 873, Stats. of 2006) added section 2023.5 to the Business & Professions Code, which directs the Medical Board and Board of Registered Nursing to review the issues of the safety of lasers in elective cosmetic procedures. To gather information on this subject, the Boards held three joint forums to solicit testimony from providers and users of this technology.

As more fully explained in the previous memo, entitled "SB 1423; Medical Board's Responsibility to Review Laser Safety in Elective Cosmetic Procedures; Report on Laser Forums," there is often disregard for the current law and regulations. The forums yielded testimony from patients and the profession on how some current practice environments often violate the law and endanger patients.

In summary, there has been a tremendous increase in cosmetic procedures, and the treatments are often performed in non-traditional, non-medical settings. The current environment can give rise to violations of the laws governing the business models and ownership of medical practices, including violations of the corporate practice bar, as well as fee-splitting and payment for referrals. The illegal business models may give rise to the use of non-licensed or inappropriately licensed personnel, paper-only supervision (rent-a-license) of allied health professionals, consumer confusion over the medical nature of the procedures, and confusion over who is responsible for the patient. Patients may not be fully informed of the risks and often do not know the medical nature of the treatments or who is responsible for their care.

The profession may not be well informed either. In some cases, physicians are approached by companies that solicit their involvement in business schemes that are not consistent with existing law. A specific example is a corporation soliciting physicians to essentially rent their license to medical spas for $400 per month, per site, with no real involvement or real supervision of nursing personnel, by acting as a "medical director."

In addition, physicians are being asked to participate in a business management that may be legal on paper, but in reality are in violation of the responsibility of physicians operating medical practices. Ironically, some of those making presentations or testifying at the forums essentially admitted to being part of a practice that violated one or several California laws.

Discussion of Current Statutes and Regulations and Current Enforcement as they Relate to Physicians

As more fully explained in the previous memorandum (SB 1423; Medical Board's Responsibility to Review Laser Safety in Elective Cosmetic Procedures; Report on Laser Forum") those testifying at the forums voiced a number of concerns and recommended changes or additions in law, as well as enforcement actions. The majority of recommendations made by those in attendance at the Forums relate to legal requirements already addressed by existing statute and regulations.

Current Law & Regulations

It is important to note that while the law requires the Medical and Nursing Boards to jointly study the issues and consult with the Physician Assistant Committee, the Medical Board only has jurisdiction over its licensees, and can only impose regulations on physicians. For that reason, the Board must focus on the issues relating to physicians and their responsibilities, including their responsibilities as supervisors of allied health professionals. For that reason, the following discussion is confined to the issues as they relate to physicians.

Use of unlicensed or inappropriately licensed personnel by physicians:

Current law prohibits the use of lasers by non-licensed or inappropriately licensed persons. Only physicians may legally use these devices, or they may delegate the laser's use on **their** patients to physician assistants, registered nurses, and nurse practitioners under their supervision. Regardless of supervision, physicians may not delegate laser use to non-licensed medical assistants, licensed estheticians or other inappropriately licensed persons.

Lack of supervision, inappropriate delegation, and lack of review of nurses' performance:

While current law allows the delegation of laser treatments to the above mentioned licensees, the law requires supervision by the physician. Standardized procedures for nurses, and delegation of services agreements for physician assistants, allow the procedures to be performed while the physician is not on-site, however, they do not absolve physicians from their supervision responsibilities.

Many of the comments made at the forums address the current, illegal practice of "rent-a-license," that is to say, becoming a paper-only supervisor while providing little, or, in many cases, absolutely no supervision to the nurses or physician assistants. Current law prohibits this practice.

Under the standardized procedure guidelines, physicians may only delegate to nurses they know to be capable of performing the delegated task. (This is true for lasers, and any other procedure in any specialty.) The guidelines require that the experience, training, and education requirements for performance of the delegated function be documented, and that a method of initial and continuing evaluation of the nurses' competence be established.

Standardized procedure guidelines require that functions performed be in an "Organized Health Care System." When the regulations were promulgated jointly by the Nursing and Medical Boards in the 1970s, both Boards envisioned nurses practicing in healthcare settings, not beauty salons. Legally, nothing has changed since the promulgation of the regulations. Nurses must perform procedures in a health-care setting, under all of the standardized procedure guidelines. (Attached) The law does not allow a nurse to set-up a practice in a salon, hire a physician supervisor, and perform medical procedures independently.

The guidelines further require that circumstances be articulated "which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition." This implies two things: 1) that the patient is the physician's responsibility, and; 2) that there be a means in which to immediately contact the supervising physician. Delegation of the procedure to the nurse does not absolve physicians from their responsibility to their patients. While there is no actual mileage limit in the law relating to supervision, this requirement certainly means that the physician must be immediately reachable. According to the materials on the BRN's website, relating to Nurse Practitioners, who have much greater autonomy than registered nurses, it states:

> "*The mileage between the nurse practitioner and the supervising physician is not specifically addressed in the NPA. However, the physician should be within a geographical distance, which enables her/him to effectively supervise the nurse practitioner in the performance of the standardized procedure functions.* "

There has been much said over the years about the lack of legal definition of supervision. A legal definition might be helpful, but a simple dictionary may do the job:

> According to *Webster's Encyclopedic Dictionary of the English Language,*
> "**supervise**, to oversee for direction; to superintend; to inspect.
> **supervision**, the act of supervising; superintendence; direction
> **supervisor**, one who supervises; and overseer, an inspector, a superintendent."
>
> According to *Funk & Wagnalls Standard College Dictionary,*
> **Supervise:** to have charge of directing
> **Supervision:** the act of supervising
> **Supervisor:** one who supervises or oversees; superintendent; inspector
>
> *Random House* defines "**supervise**" as "to oversee (a process, work, workers, etc.) during execution or performance; superintend; have the oversight and direction of."

A physician who is, on paper, a supervisor, who does not give direction, oversee or inspect, is not, in plain English, performing the task of supervising.

Physician assistant (PA) supervision guidelines are articulated more specifically. (Regulations attached) To supervise a PA, the regulatory requirements are:

- All care provided to the patient by a PA is the ultimate responsibility of the physician.
- Physicians are limited to supervising no more than four PAs at any moment in time.
- Physicians must be in the same facility as the PA or be immediately available by electronic communication.
- Before authorizing PAs to perform any procedure, the physician is responsible for evaluating the PA's education, experience, knowledge, and ability to perform it safely and competently.
- PAs may not own a medical practice (although they may own up to 49% of the stock in a professional medical corporation.)
- PAs may not hire their supervisors.

There are four methods in which physicians may provide supervision:

1) Physician sees the patient the same day as they are treated by PA, or;

2) The physician reviews, signs and dates the medical record of every patient treated by the PA within 30 days of treatment, or;

3) The physician adopts written protocols to guide the specific actions of the PA. The physician must select, review, sign, and date at least 5% of the medical records of patients treated under the protocols within 30 days of the treatment, or;

4) Under special circumstances, the physician provides supervision through additional methods which must be approved in advance by the Physician Assistant Committee.

While the PA regulations are written more specifically, they are not unlike the nursing regulations. The nursing law and regulations, while written more broadly, require that physicians be responsible for their patients, supervise the nurse, including the evaluation of their training and competence. They also do not allow nurses to hire their supervisor or solely own the practice. While the nursing regulations do not require a specific percentage of cases that must be reviewed, the regulations do require evaluations, which cannot be done without <u>any</u> review of cases.

<u>Lack of Qualifications of Supervisors:</u>

Physicians may only delegate to those that they know to be capable of performing the delegated task. If they are to supervise the task, it can be implied that the physician too should be capable of performing it. One cannot provide guidance, direction, evaluation and oversight unless one is knowledgeable and competent in the procedure being delegated.

The term "core physician" was used in the forum discussions, meaning that a supervising physician specialized in an area that is appropriate to supervise the use of laser treatments, such as plastic surgery, cosmetic surgery, or dermatology. In PA regulations, PAs cannot be delegated tasks outside of the physician's customary practice.

While nursing regulations are less specific, again, the regulations still require supervision. Current law allows for nurses to be supervised by physicians in any specialty, however, the physicians must fulfill their supervision obligations. The regulations imply that this would include, regardless of the primary specialty or certification of the physician, being proficient in the procedure being delegated so that they are capable of providing direction, guidance and evaluation.

<u>Lack of training or certification:</u>

Medicine is in constant change. Physicians who have been practicing for 20 years will not be practicing in the same manner as they were when they graduated from medical school. As knowledge and technology improves, the practice of medicine evolves.

Physicians are licensed after obtaining their medical degree, completing their postgraduate training, and passing the licensing examinations. While not legally required, most physicians continue their education through specialty postgraduate training and will become board-certified in a specialty. They are not retested or required to go back to medical school every time there is a scientific discovery, a new medicine is approved, or a new surgical technique developed. Physicians over 50-years-old practicing plastic surgery or dermatology, for example, may not have learned how to perform liposuction in their formal post-graduate medical training. No "liposuction license" is granted, and no examination or certification for the procedure is given. Physicians learn new techniques from training courses, colleague mentoring, and preceptorships, and they are legally able to practice these procedures without any kind of specialty or procedural certification.

Similarly, registered nurses do not have specialized licenses, and become specialized in specific procedures through experience and training in their practice environment. Specialty courses also exist, and some provide certification. Most certificates granted, however, have no legal standing. Many of the nurses testifying at the forums stated they had taken courses in laser use and had been certified. While it is laudable that they completed training, there are no national certification standards in the procedure, and no nationally or state approved certification standards, making the certification, legally speaking, without meaning. It is the supervising physicians that are responsible for evaluating the qualifications of the nurses to whom they are delegating regardless of whether they have been "certified" or not.

Lack of back-up systems and emergency plans:

As established by existing laws and regulations, physicians performing or delegating treatments are responsible for their patients' care. As supervisors, they are responsible to ensure back-up systems and emergency plans. Under current law, the patients are the physicians' responsibility, and they are responsible for treating mishaps, complications or any other emergency that might arise from the treatments they delegated. While nurses are responsible for their patients within their scope-of-practice, under the Medical Practice Act, physicians have the ultimate responsibility for the care of their patient.

Lack of appropriate prior examination:

The delegation of the patients' prior appropriate examination may only be delegated to nurse practitioners, not to registered nurses. For furnishing or ordering drugs or prescriptive devices, the examination may be delegated to a nurse practitioner functioning under standardized procedures. As B&P Code Section 2836.1 was added in 2004 by AB 2560 (Montanez; Chap. 205, Statutes of 2004) to grant this authority to nurse practitioners, it is clear that no such authority is granted to registered nurses.

Physician Assistants may be delegated the "prior appropriate examination" as long as their regulations are followed, which are much more stringent and specific than RN standardized procedure guidelines. The PA must be working for a physician specialist in cosmetic medicine, and the requirements of the supervisor are much more specific, as explained above.

Lay-owned businesses – violation of corporate practice bar:

California law prohibits the corporate practice of medicine. Laypersons or lay entities may not own any part of a medical practice. (Business & Professions Code Section 2400)

In an attempt to circumvent this legal prohibition, some have created some business and management schemes that violate the law. Businesses that provide management services, franchises or other models that result in any unlicensed person or entity influencing or making medical decisions is in violation of the law.

As an example, businesses that control medical records, the hiring and firing of healthcare staff, decisions over coding and billing, the approving of or selecting medical equipment or drugs, violate the law. Management Service Organizations (MSO) arranging for advertising, or providing medical services rather than only providing administrative staff and services for a physician's medical practice (non-physician exercising controls over a physician's medical practice, even where physicians own and operate the business) would be illegal. Also, many current business arrangements violate the prohibition against fee-splitting or giving any consideration for patient referrals (B&P 650). The current practice of lay-owned businesses hiring a medical director is also prohibited.

Physicians who become employees of lay-owned spas and violate other business provisions of laws may be disciplined for unprofessional conduct.

Procedures performed in inappropriate settings:

Current law allows physicians to perform laser treatments in any setting, including salons. They may not, however, be paid by or hired by the salon, nor may they pay for referrals or split fees with the salon or any other entity. Nurses providing laser treatments delegated under standardized procedures must perform them in an "organized healthcare system." The same is true for PAs.

Lack of patient informed consent and education:

Consumers generally view procedures as they are marketed. If laser treatments are advertised in the same manner as facials or hair services, it is not surprising that customers are not fully aware of their medical nature, or conscious of their risks. All medical procedures must be preceded by informed consent, which would include the possible risks associated with the treatment. While there is no specific code that enumerates what must be told to patients, the well-established doctrine of informed consent in case law requires that patients must be, at a minimum, informed of:

1) the nature of the treatment,
2) the risks, complications, and expected benefits, including its likelihood of success, and
3) Any alternative to the recommended treatment, including the alternative of no treatment, and their risks and benefits.

Providing sufficient information to constitute informed consent is the responsibility of the physician.

There are often violations of advertising law as well. Business & Professions Code Section 2272 requires advertising to include the physician's name, or the name for which they have a fictitious name permit. While the nurses may be performing the treatment, the name of the supervising physician, or his or her registered fictitious name, must be in the advertisement.

There is also a need for the Boards to do more in educating patients, which is discussed below.

Enforcement and Public Education

The following is confined to the enforcement procedures and actions of the Medical Board.

Current Enforcement:

The Medical Board's enforcement actions and their priorities are dictated by law. Section 2220.05 of the Business and Professions Code establishes the priority in which cases are to be handled, which are:

1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients;
2) Drug or alcohol abuse by the physician involving death or injury to a patient;
3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of doing so without a good-faith prior examination;
4) Sexual misconduct with one or more patients during the course of treatment or examination;
5) Practicing medicine while under the influence of drugs or alcohol.

Cases involving laser procedures generally do not fall into the above categories. The most common issues relating to these types of treatments are:

- Corporate Practice:
  As a result of the legally set priorities and limited investigative staff, in 2002 the enforcement program reviewed corporate practice of medicine cases. At that time, the staff's handling of the cases was to inform the physician and unlicensed person or firm that they appeared to be in violation of the law and obtain compliance, and, in some instances, issue a citation. These cases were complex and necessitated substantial legal resources, resulting in long timeframes to complete these cases. According to the consulting Deputy Attorney General, in order for citations to be issued, more information was required from investigation to prove violations.

  In 2004, after a meeting of staff of the Medical Board and Attorney General staff, it was decided that corporate practice cases would not be investigated unless there was patient harm. If sufficient evident was present without investigation, then action would be taken.

  Complaints relating to corporate practice rarely involve patient harm, and generally are received from competitors, not patients. Actions have been taken for unlicensed practice and violating the corporate practice bar, including a recent case that has been adopted as a precedential decision. In addition, there is an accusation pending against a physician for gross negligence in their supervision of nurses while acting as a "medical director" for a laser business. Both cases, however, involve patient harm.

- Advertising:
  Cases involving advertising violations are generally handled without being sent to the field for investigation. Physicians are issued a letter that they are in violation of the law. If they comply and cease violating the law, no further action is taken. If not, they are generally handled through the citation process. Most complaints relating to advertising are received from competitors, not patients.

- Lack of adequate supervision:
  As we have heard from the testimony, while there has certainly been instances of patient harm, there have been no deaths or life-threatening injury reported in California as a result of laser treatments. (There was one story of undiagnosed skin cancer presented in the testimony at the first forum; however, it was not noted whether it was a patient in California, and if so, whether a complaint had been filed with the Medical Board.) Under current Medical Board procedures, only those involving patient harm will be sent to the field for investigation to build a case for formal disciplinary action.

  If there is no physician involvement, or if there appears to be only nurse involvement, the Medical Board will refer the case to the Nursing Board for their action.

Future Enforcement Opportunities:

- Re-establishment of "Operation Safe Medicine" (OSM)

  In 2000, the Medical Board had a unit in its enforcement program called "Operation Safe Medicine." It was dedicated to the unlicensed practice of medicine and actively worked to discover unlicensed medical clinics and unlicensed persons soliciting patients. A number of celebrated cases came from their work, and it was very effective in addressing the problem

of unlicensed clinics that primarily preyed on certain ethnic populations, as well as other types of unlicensed practice. Unfortunately, due to the budget reduction in 2002, the unit was disbanded and remaining staff was re-directed to general enforcement.

At the November 2007 Board meeting, the members approved the re-establishment of OSM. If successful in obtaining adequate staff positions and an allocation of funds through the State's budgetary process, this unit may be able to dedicate staff to the enforcement of the laws relating to laser procedures.

- Increase the Use of the Citation and Fine Process for Violators:

  There are opportunities to utilize the citation and fine process in cases that do not involve patient harm, especially those involving advertising and business violations. The current law authorizes the Board to issue citations and fines, and while the issuing of a citation may take less time than a formal accusation, it must be proven by a preponderance of evidence. There is significant due process granted to physicians, requiring presentation of evidence and a hearing, if requested.

  At the forums, it was suggested that a significant fine be established by legislation to address these issues. However, it is too early to suggest this proposal, as the Medical Board needs to re-establish the OSM Unit to determine if a more aggressive citation program is a deterrent and addresses the advertising and corporate practice violations.

- Re-direction of Resources:

  The purpose of the law setting enforcement priorities is clearly to protect the public from serious harm. While there has been some harm done to patients, and there certainly is a potential for patient harm, laser treatments do not generally fit into the top five priorities established. The Board could certainly make it their priority and direct more aggressive enforcement of advertising and corporate practice statutes, however, that shift in resources would be at the cost of other cases. It is difficult to argue that a laser hair removal advertising case should take priority over the investigation of a grossly negligent and incompetent cardiologist or a surgeon operating while under the influence of drugs.

  Any redirection of resources to aggressively enforce cases outside of the statutorily established priorities, without any increase in allocation of funds and employees, would result in less effective and slower enforcement of more dangerous practices.

- Better communication and coordination between the Boards:

  At the forum on September 13, we heard testimony from a patient advocate about his experience with filing complaints with the Board, with unsatisfactory results. In several of the presented cases, the complaint involved nurses who he alleged were practicing without supervision. In these types of cases, where there is no supervising physician identified, they are sent to the Nursing Board for action. If their investigation results in no disciplinary action against the nurse, there may still be violations of the law by the supervising physician. In the instances presented, if physicians were involved, there may have been violations of advertising and fictitious name permit requirements.

While the Boards' enforcement staffs regularly communicate and cooperate on investigations, it is possible that a more formal procedure should be developed to ensure that cases referred are also referred back for action.

Education of Licensees and Patients:

The testimony presented at the forums demonstrated that licensees are not fully educated in the law, and patients often lack understanding of the medical nature of laser treatments. The Boards need to do a better job of educating licensees and patients.

Public education materials and outreach efforts need to be developed to inform patients of the medical nature of the treatments. They also need to be informed that, even if nurses are providing the treatment, the physician has ultimate responsibility for their care and safety. While physicians have the responsibility to provide adequate informed consent to their patients, the Board needs to do a better job of ensuring patients are better aware of the risks, as well as their rights.

Licensees may also need to be reminded that these procedures are governed by the same laws and regulations as any other medical practice. Frequently, there has been the tendency to view them as something other than medical, even by some licensees. Physicians need to be fully informed of their legal responsibilities, and the laws that govern their practice, including laws relating to the business of medicine and advertising.

Discussion of Future Actions of the Board/Recommendations

The public forums held jointly by the Medical and Nursing Boards have accomplished their purpose of gathering information. The Boards now have a greater understanding of the issues, how practices may be violating current law, the risks of injury, the lack of understanding of licensees and patients, and how the lack of enforcement may have contributed to the risks and violations.

It appears there may be no need for further laws or regulations, but there is a need for enforcement resources to enforce the laws and regulations already in effect. The development of a strategy or method to enforce current laws should precede any efforts to seek any additions or amendments.

The members must review the issues relating to laser safety and take any action they deem necessary by January 1, 2009. Members should discuss the following possible solutions:

Recommendations

Short Term:

- Publish a statement clearly outlining the current law and the responsibilities of physicians in providing laser treatments. A draft article is attached, and staff would ask the Board's approval to publish it in the Board's Newsletter and on its Web site.
- Re-write and distribute "Medical Spa – What You Need to Know," an article for consumers. The draft of the article is attached, and staff would ask that the Board approve it for publication and distribution.

Long Term:

- Affirm that it is the Board's intention to support the reestablishment of "Operation Safe Medicine" which, in addition to addressing unlicensed practice, will work to enforce the laws relating to cosmetic procedures;
- Direct staff to work with the Nursing Board to develop an enhanced communication system in cases involving physicians and nurses;
- Direct staff to use the citation and fine process to deter further violations; and
- Direct staff, after all action is taken, and before January 1, 2009, to report to the Legislature on the Board's actions and intentions.

This paper is not intended to cover all of the points raised at the forums or problems identified. It is a summary of the major concerns raised, how the current laws may apply to physicians, and the possible solutions that should be considered.

Relevant Laws and Regulations:

Business & Professions Code Section 2023.5, Medical & Nursing Boards to Study Safety of Lasers & Intense Pulse Light Devices in Elective Cosmetic Procedures

(a) The board, in conjunction with Board of Registered Nursing, and in consultation with the Physician Assistant Committee and professionals in the field, shall review issues and problems surrounding the use of laser or intense light pulse devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants. The review shall include, but need not be limited to, all of the following:

(1) The appropriate level of physician supervision needed.

(2) The appropriate level of training to ensure competency.

(3) Guidelines for standardized procedures and protocols that address, at a minimum, all of the following:

(A) Patient selection.

(B) Patient education, instruction, and informed consent.

(C) Use of topical agents.

(D) Procedures to be followed in the event of complications or side effects from the treatment.

(E) Procedures governing emergency and urgent care situations.

(b) On or before January 1, 2009, the board and the Board of Registered Nursing shall promulgate regulations to implement changes determined to be necessary with regard to the use of laser or intense pulse light devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants.

Business & Professions Code Section 2400 – Corporate Practice of Medicine

Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the Division of Licensing may in its discretion, after such investigation and review of such documentary evidence as it may 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.

Business & Professions Code Section 2264 – Aiding & Abetting Unlicensed Practice of Medicine

The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

Business & Professions Code Section 2266 – Physician's Responsibility to Maintain Medical Records

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

Business & Professions Code Section 2272 – Advertising Must Include Physician's Name or FNP Name

Any advertising of the practice of medicine in which the licensee fails to use his or her own name or approved fictitious name constitutes unprofessional conduct.

Business & Professions Code Section 2273 – Employment of Runners, Cappers, Steerers, and others to procure patients

(a) Except as otherwise allowed by law, the employment of runners, cappers, steerers, or other persons to procure patients constitutes unprofessional conduct.

(b) A licensee shall have his or her license revoked for a period of 10 years upon a second conviction for violating any of the following provisions or upon being convicted of more than one count of violating any of the following provisions in a single case:

Section 650 of this code, Section 750 or 1871.4 of the Insurance Code, or Section 549 or 550 of the Penal Code. After the expiration of this 10-year period, an application for license reinstatement may be made pursuant to Section 2307.

Business & Professions Code Section 650 – Payment for Patient Referrals/Fee Splitting

(a) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code, the offer, delivery, receipt, or acceptance by any person licensed under this division or the Chiropractic Initiative Act of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest or coownership in or with any person to whom these patients, clients, or customers are referred is unlawful.

(b) The payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payer.

(c) The offer, delivery, receipt, or acceptance of any consideration between a federally-qualified health center, as defined in Section 1396d(l)(2)(B) of Title 42 of the United States Code, and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to the health center entity pursuant to a contract, lease, grant, loan, or other agreement, if that agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center, shall be permitted only to the extent sanctioned or permitted by federal law.

(d) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2, it shall not be unlawful for any person licensed under this division to refer a person to any laboratory, pharmacy, clinic (including entities exempt from licensure pursuant to Section 1206 of the Health and Safety Code), or health care facility solely because the licensee has a proprietary interest or coownership in the laboratory, pharmacy, clinic, or health care facility; provided, however, that the licensee's return on investment for that proprietary interest or coownership shall be based upon the amount of the capital investment or proportional ownership of the licensee which ownership interest is not based on the number or value of any patients referred. Any referral excepted under this section shall be unlawful if the prosecutor proves that there was no valid medical need for the referral.

(e) (1) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2, it shall not be unlawful to provide nonmonetary remuneration, in the form of hardware, software, or information technology and training services, necessary and used solely to receive and transmit electronic prescription information in accordance with the standards set forth in Section 1860D-4(c) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (42 U.S.C. Sec. 1395w-104) in the following situations:

(A) In the case of a hospital, by the hospital to members of its medical staff.

(B) In the case of a group medical practice, by the practice to prescribing health care professionals that are members of the practice.

(C) In the case of Medicare prescription drug plan sponsors or Medicare Advantage organizations, by the sponsor or organization to pharmacists and pharmacies participating in the network of the sponsor or organization and to prescribing health care professionals.

(2) The exceptions set forth in this subdivision are adopted to conform state law with the provisions of Section 1860D-4(e)(6) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (42 U.S.C. Sec. 1395w-104) and are limited to drugs covered under Part D of the federal Medicare Program that are prescribed to Part D eligible individuals (42 U.S.C. Sec. 1395w-101).

(3) The exceptions set forth in this subdivision shall not be operative until the regulations required to be adopted by the Secretary of the United States Department of Health and Human Services, pursuant to Section 1860D-4(e) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (42 U.S.C. Sec. 1395W-104) are effective. If the California Health and Human Services Agency determines that regulations are necessary to ensure that implementation of the provisions of paragraph (1) is consistent with the regulations adopted by the Secretary of the United States Department of Health and Human Services, it shall adopt emergency regulations to that effect.

(f) "Health care facility" means a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, and any other health facility licensed by the State Department of Health Services under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(g) A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in the county jail for not more than one year, or by imprisonment in the state prison, or by a fine not exceeding fifty thousand dollars ($50,000), or by both that imprisonment and fine. A second or subsequent conviction is punishable by imprisonment in the state prison or by imprisonment in the state prison and a fine of fifty thousand dollars ($50,000).

Physician Assistant Regulation:

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS
TITLE 16. PROFESSIONAL AND VOCATIONAL REGULATIONS
DIVISION 13.8. PHYSICIAN ASSISTANT EXAMINING COMMITTEE OF THE MEDICAL BOARD
OF CALIFORNIA
ARTICLE 4. PRACTICE OF PHYSICIAN ASSISTANTS

S 1399.545. Supervision Required.

(a) A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.
(b) A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.
(c) A supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured of competency.
(d) The physician assistant and the supervising physician shall establish in writing transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the physician assistant's scope of practice for such times when a supervising physician is not on the premises.
(e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms:

(1) Examination of the patient by a supervising physician the same day as care is given by the physician assistant;
(2) Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant;
(3) The supervising physician may adopt protocols to govern the performance of a physician assistant for some or all tasks. The minimum content for a protocol governing diagnosis and management as referred to in this section 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, drugs to recommend to the patient, and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the physician, adopted from, or referenced to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the physician assistant. The supervising physician shall review, countersign, and date a minimum of 10% sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient;
(4) Other mechanisms approved in advance by the committee.

(f) In the case of a physician assistant operating under interim approval, the supervising physician shall review, sign and date the medical record of all patients cared for by that physician assistant within seven (7) days if the physician was on the premises when the physician assistant diagnosed or treated the patient. If the physician was not on the premises at that time, he or she shall review, sign

and date such medical records within 48 hours of the time the medical services were provided.
(g) The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision.

Note: Authority cited: Sections 2018, 3502 and 3510, Business and Professions Code. Reference: Sections 3502 and 3516, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 1399.522 to section 1399.545 filed 9-20-83; effective thirtieth day thereafter (Register 83, No. 39).
2. Amendment filed 7-12-85; effective thirtieth day thereafter (Register 85, No. 28).
3. Amendment of subsection (e)(3) and repealer of subsection (g) and relettering filed 1-28-92; operative 2-27-92 (Register 92, No. 12).

16 CCR s 1399.545, 16 CA ADC s 1399.545
1CAC
16 CA ADC s 1399.545
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Medical Board of California Regulation: Physicians must comply with Standardized Procedure Guidelines:

Article 4. Standardized Procedure Guidelines

1379. Standardized Procedures for Registered Nurses.

A physician and surgeon or a podiatrist who collaborates in the development of standardized procedures for registered nurses shall comply with Title 16 California Administrative Code Sections 1470 through 1474 governing development and use of standardized procedures.

NOTE: Authority cited: Sections 2018 and 2725, Business and Professions Code. Reference: Section 2725, Business and Professions Code.
HISTORY:

1. Renumbering and amendment of former Article 4 (Sections 1376-1377.1) to Article 2 (Sections 1366 and 1366.1), and new Article 4 (Section 1379) filed 8-3-83, effective thirtieth day thereafter (Register 83, No. 32). For prior history, see Registers 81, No 32; and 78, No. 17

The Bottom Line:
The Business of Medicine – Medical Spas

There has been an explosion of cosmetic medicine over the past years, and many physicians are being approached to "increase their bottom line" by entering into this lucrative field. Recently, our office received a letter from a business promoting the many programs they offered to physicians that contained the following message:

"... Lastly, we are very excited to announce our Medical Director program. This opportunity allows Doctors and Physicians to earn up to $400 per month per spa in their area. We have several DaySpas that anxiously await a Medical Director and we would anticipate a large number of client referrals to your practice.'.....'We would be happy to discuss how they can benefit your practice and grow your bottom line.'"

What this business is offering is the opportunity for a physician, for a fee, to rent their license to a business so that they may engage in the practice of medicine --- a profession for which they have no license or qualifications.

Is what they propose legal? Can physicians simply sign-on, lend their name on paper to a salon or spa, collect "up to" $400 a month, and escape any liability or responsibility for the patients treated by the business? NO!

In 2006, Senator Liz Figueroa authored legislation (SB 1423, Chap 873) that directed the Medical and Nursing Boards to work together to study the issue of safety in the use of lasers in cosmetic procedures. Over the past year, the boards have been holding public forums on the subject. What we have learned is that the current law is being violated with impunity by many in the cosmetic medical field.

The current environment gives rise to violations of the laws governing the business of medical practices, including violations of the corporate practice bar, as well as fee-splitting and payment for referrals. The illegal business models give rise to the use of non-licensed or inappropriately licensed personnel, paper-only supervision (rent-a-license) of allied health professionals, consumer confusion over the medical nature of the procedures, and confusion over who is responsible for the patient. Patients are not fully informed of the risks and often do not know the medical nature of the treatments or who is responsible for their care.

The use of prescriptive medical devices and injections for cosmetic reasons is the practice of medicine:

There is a tendency for the public, and some in the profession, to view laser treatments, Botox and cosmetic filler injections as cosmetics, rather than medical treatments. The use of prescriptive drugs and devices, however, is the practice of medicine, and the same laws and regulations apply to these types of treatments as those driven by medical necessity. There are no separate laws governing these procedures, and physicians will be held to the same standard as they are for their routine medical practices. This means that the standards for informed consent, delegation to allied health professionals, physician-patient confidentiality and boundaries, maintaining medical records, as well as responsibility and liability apply to physicians.

Physician responsibility in the delegation to allied health professionals:

In the practice of medicine in all specialties, physicians routinely delegate functions to allied health professionals. In delegating anything to others, physicians must only delegate to appropriately licensed staff that they know to be capable of performing the task. The use of lasers and other prescriptive devices and prescriptive drugs must only be performed by licensed registered nurses, nurse practitioners, or physician assistants. No unlicensed staff, such as medical assistants, may use these devices or drugs, regardless of the level of training or supervision. Likewise, delegation to improperly licensed personnel, such as estheticians, is prohibited.

Supervision of those to whom procedures are being delegated:

While current law allows the delegation of laser treatments and injections to the above mentioned licensees, the law requires supervision by the physician. In the current environment, many have operated under the misguided opinion that since the nursing regulations are broadly written, nurses may perform anything anywhere with essentially no supervision as long as there is "standardized procedures" or "delegation of services" documents on file.

Nurses:

Standardized procedures for nurses allow procedures to be performed while the physician is not on-site, however, they do not absolve physicians from their supervision responsibilities. Nor does the law allow nurses to set-up a practice in a salon, hire a physician supervisor, and perform medical procedures independently.

The law does not contain a legal definition of supervision, and therefore, absent a legal definition, the plain English definition applies. "Supervision" is defined as the act of supervising, which is to oversee, to direct, to have charge, to inspect, to provide guidance and evaluation. The law and regulations support this definition.

As an example, the regulations for "standardized procedures guidelines" require physicians be responsible for ensuring the experience, training, and education requirements for performance of the delegated function – and documented, and that a method of initial and continuing evaluation of the nurses' competence be established. Further, it is the responsibility of the physician to examine the patient before delegating the task to a registered nurse.

When functioning under "standardized procedures," physicians need not be present in the facility when the procedures are being performed. The facility, however, must be a medical setting. Regulations require that the location be an "organized healthcare system," which is not a salon, spa, or other facility not under the control of the physician.

An appropriate prior examination is required for all prescriptive drugs and devices, and the examination may not be delegated to registered nurses. After performing the examination, the supervising physician may delegate the procedure to a nurse working under standardized procedures.

The guidelines further require that circumstances be articulated "which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition." While there is no actual mileage limit in the law relating to supervision, this requirement certainly means that the physician must be immediately reachable and able to provide guidance in the event of an

emergency or the need for a higher-level of care that must be provided by the physician. Physicians must be within a geographical distance which will enable them to effectively provide supervision and support when needed.

For more specific information on registered nurse and nurse practitioner regulation, the Board of Registered Nursing website is: www.rn.ca.gov.

Nurse Practitioners:

Nurse Practitioners are granted much more autonomy than registered nurses. They are advance practice nurses who are master-level educated, and, for that reason, have a broader scope of practice than registered nurses. The major exception to the rules governing their supervision in cosmetic procedures is that they may be delegated the task of providing the "appropriate prior examination" and order the drug or prescriptive device for the patient, if acting under "standardized procedures."

Physician Assistants:

The supervision of Physician Assistants is similar to that of nurses', however, their regulations are much more specific. First, PAs may only be delegated tasks that are part of the physician's customary practice. In other words, obstetricians may supervise PAs treating obstetrical patients; pediatricians may supervise PAs providing care to pediatric patients, and so forth. Therefore, if cosmetic medicine is not a part of the physician's customary practice, the physician may not supervise a PA providing cosmetic procedures. In addition, physicians may only supervise four PAs at any moment in time, and must be in the facility with the PA or be immediately available by electronic communication if they are working under a delegation of services agreement.

PAs may be delegated the "appropriate prior examination" of the patient, but there are methods enumerated in the law and regulations on how physicians must provide their supervision and evaluation. For more specific information, all of the rules and regulations are available at the Physician Assistant Committee website: www.pac.ca.gov.

Supervision of all allied health professionals:

"Supervise" is a verb, and it requires those calling themselves supervisors to act by supervising, which is to guide, direct, oversee, and evaluate performance. Physicians must really supervise, not lend their license to allied health professionals on paper without providing any supervision. A physician who is, on paper, a supervisor, who does not give direction, oversee or inspect, is not performing the task of supervising, and is in violation of the law.

Qualifications of Physician Supervisors:

Physicians may only delegate to those that they know to be capable of performing the task. If they are to supervise the procedure, the physician too should be capable of performing it. One cannot provide guidance, direction, evaluation and oversight unless one is knowledgeable and competent in the procedure being delegated.

The law does not require board certification to perform cosmetic procedures. That said, however, one should not think that the absence of this requirement allows anyone of any specialty to

supervise cosmetic procedures, unless the physician has sufficient knowledge and training in the procedures being performed --- by the physician or delegated to others under his or her supervision.

Business arrangements; issues of ownership and control:

California law prohibits the corporate practice of medicine. Laypersons or lay entities may not own any part of a medical practice. (Business & Professions Code Section 2400) Physicians must either own the practice, or must be employed or contracted by a physician-owned practice or a medical corporation. (The majority of stock in a medical corporation must be owned by California licensed physicians, with no more than 49% owned by other licensed health care professionals, such as nurses, physician assistants, nurse practitioners, etc. No stock in a medical corporation may be owned by a lay-person. (Corporation Code Section 13401.5(a))

In an attempt to circumvent this legal prohibition, some have created business and management schemes that violate the law. Businesses that provide management services, franchises or other models that result in any unlicensed person or entity influencing or making medical decisions is in violation of the law.

As an example, businesses that control medical records, the hiring and firing of healthcare staff, decisions over coding and billing, and the approving or selection of medical equipment or drugs, violate the law. Management Service Organizations (MSO) arranging for advertising, or providing medical services rather than only providing administrative staff and services for a physician's medical practice (non-physician exercising controls over a physician's medical practice, even where physicians own and operate the business) would also be illegal. Also, many current business arrangements violate the prohibition against fee-splitting or giving any consideration for patient referrals. The current practice of lay-owned businesses hiring medical directors is also prohibited.

Physicians who become employees or contractors of lay-owned spas and violate other business provisions of the laws may be disciplined for unprofessional conduct.

Physician Responsibility for back-up systems and emergency plans:

Physicians performing or delegating treatments are responsible for their patients' care. As supervisors, they are responsible to ensure back-up systems and emergency plans. Under current law, the patients are the physicians' responsibility, and they are responsible for treating mishaps, complications or any other emergency that might arise from the treatments they delegated. While nurses are responsible for their patients within their scope-of-practice, under the Medical Practice Act, physicians have the ultimate responsibility for the care of their patients.

Physician responsibility for patient informed consent and education:

All medical procedures must be preceded by informed consent, which should include the possible risks associated with the treatment. While there is no specific code that enumerates what must be told to patients, the well-established doctrine of informed consent in case law requires that patients must be, at a minimum, informed of:

1) the nature of the treatment,
2) the risks, complications, and expected benefits, including its likelihood of success, and

3) Any alternative to the recommended treatment, including the alternative of no treatment, and their risks and benefits.

Providing sufficient information to constitute informed consent is the responsibility of the physician.

Physician responsibility for advertising and marketing:

California law requires advertising to include the physician's name, or the name for which they have a fictitious name permit. (Business & Professions Code Section 2272) While the nurses may be performing the treatment, the name of the supervising physician, or his or her registered fictitious name, must be in the advertisement.

The law governing physician advertising is specific, and requires the physician ads not be misleading. California law is very specific in prohibiting many of the advertising practices currently being used to promote cosmetic treatments. The use of models, without stating that they are models, the use of touched-up or refined photos, and claiming superiority of the facility or procedures with no objective scientific evidence is prohibited. Also, the use of discount or bait and switch promotions is also not allowed. The use of "for as low as" in advertising procedures, is strictly prohibited. The laws relating to physician advertising, Business & Professions Code Section 651 may be viewed on the Medical Board's website: www.mbc.ca.gov.

The Bottom Line:

Cosmetic procedures are the practice of medicine, and physicians are responsible for their patients, regardless of who performs the treatments. There is no legal scheme that allows physicians to collect a fee for signing their name to an agreement to lend their license to an entity to practice medicine. Legally, the "clients" of the spa or salon are patients — the ***physician's*** patients, and that arrangement comes with all of the responsibility *and liability* that goes with any other doctor-patient relationship. Becoming involved in these types of business arrangements, may, in the short term, raise a physician's economic bottom line. In the long run, however, the risks are great. In reality, the bottom line is that physicians who become embroiled in these illegal arrangements may lose their license, or their livelihoods.

It is impossible to cover all of the relevant legal issues in this short article, and the content is not a substitute for professional legal advice. Physicians may want to consult with their attorneys or malpractice carriers for additional legal advice.

Medical Spas (Article for Action Report's Consumer Corner):

Medical Spa. It sounds so soothing. It evokes images of candles, beautiful music, warmth and papering. Spahhhh! The word itself makes one relax.

Medical Spas are marketing vehicles for medical procedures. The use of the term "spa" is for advertising purposes to make the procedures seem more appealing. In reality, however, they're the practice of medicine.

There's no harm in seeking pampering or in wanting to look better. A visit to a spa may provide a needed respite from our stressful lives, and treatments that makes us look better often makes us feel better. Those of us at the Medical Board, however, become concerned when medicine is marketed like a pedicure, and consumers are led to believe that being injected, lasered, and resurfaced requires no more thought than changing hair-color.

Wrong. Medical treatments should be performed by medical professionals. There is risk to any procedure, however minor, and consumers should be aware of the dangers. While it is illegal for non-licensed personnel to provide these types of treatments, consumers should know that there are persons and firms operating illegally. Cosmetologists, while licensed professionals and highly qualified in superficial treatments such as facials and microdermabrasion, may never inject the skin, use lasers, or perform medical-level dermabrasion or skin peels. Those types of treatments must be performed by qualified medical personnel. In California, that means a licensed physician, or a licensed registered nurse or physician assistant under the supervision of a physician.

Patients must know the qualifications of those they are trusting with their health. Those seeking cosmetic procedures should know that the person performing them is medically qualified and experienced. Specifically, patients should:

1) Know who will perform the procedure and their licensing status:

If a physician is performing the treatment, you should ask about his or her qualifications. Is the doctor a specialist in these procedures? Is he or she board certified in an appropriate specialty? Licensing status may be verified at the Board's website: www.mbc.ca.gov. Board certification status may be verified at www.abms.org.

If a nurse or physician assistant will be doing the procedure, what are their qualifications? Where is the doctor supervising them? Are they really being supervised, or are they acting alone with a paper-only supervisor? Again, you should check the supervising doctor's credentials, as well as the nurse's or physician assistant's. Those websites are www.rn.ca.gov and www.physicianassistant.ca.gov.

An appropriate examination must be conducted before treatments are performed. This exam must be conducted by a physician, or the doctor may delegate the

examination to licensed nurse practitioners or physician assistants. Physicians may not delegate this examination to registered nurses.

2) Be fully informed of about the risks:

All procedures carry risks, and conscientious practitioners will fully disclose them. Medical professionals have an ethical responsibility to be realistic with their patients and tell them what they need to know. If procedures are being heavily marketed, with high-pressure sales techniques promising unrealistic results, run.

3) Observe the facility and its personnel:

Medical procedures should be done in a clean environment. While one cannot see germs, one can see if the facility looks clean and personnel wash their hands, use gloves, and use sound hygienic practices. If you observe dirty conditions, or notice that the personnel does not wash their hands before approaching you, find another facility.

4) Ask about complications, and who is available to handle them:

In the event you should have an adverse reaction, you want to know who will be there to help. Who should you call, and what hospital or facility is available where the doctor can see you? If you get an unsatisfactory answer that minimizes your concerns, or they don't have an answer, find someone else. Qualified physicians have facilities or privileges at hospitals where they can handle emergencies. If they don't, that's cause for concern.

5) Don't be swayed by advertisements and promises of low prices:

There are a host of medical professionals offering competent, safe cosmetic procedures. If they are being offered at sub-standard prices, there's a good probability that what they are advertising is not what will be delivered. Genuine Botox, Collagen, Restalyne, and other injections are pricey. If someone is offering an injection for $50, when the going rate at doctors' offices is $500, then you can be sure it's not the real McCoy. There have been tragic cases of unscrupulous practitioners injecting industrial silicone and toxic counterfeit drugs that have made patients critically ill, caused disfigurement, or killed them.

Cosmetic procedures, at best, can boost one's mood and appearance. At worst, they can kill you. Don't trust your health, your skin, or your face to the unqualified or unscrupulous. Know that there is a substantial financial cost to obtaining qualified treatments, as well as some risk. If you want the best results, do your homework and only trust those who demonstrate competence and caution.