

State of California
State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

April 24 - 25, 2008



Medical Errors	April 24	8:30 a.m. - 9:30 a.m.
Education	April 24	9:30 a.m. - 10:30 a.m.
Board Member Training	April 24	11:00 a.m. - 1:30 p.m.
Panel A & B Meetings	April 24	2:00 p.m. - 5:00 p.m.
Full Board	April 25	9:00 a.m. - 1:00 p.m.

**MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE**

**SACRAMENTO CONVENTION CENTER
1400 J STREET, ROOM 203 & 204
SACRAMENTO, CA**

APRIL 2008

Thursday, April 24

- **8:30 a.m. to 9:30 a.m.** Medical Errors – Room 203
(Members: Aristeiguieta, Alexander, Low, Moran, Schipske)
- **9:30 a.m. to 10:30 a.m.** Education – Room 204
(Members: Yaroslavsky, Chang, Moran, Schipske, Salomonson)
- **11:00 a.m. to 1:30 p.m.** Lunch & Board Member Training
Hearing Room at New MBC Headquarters Location
- **2:00 p.m. to 5:00 p.m.** Panel A – Room 203
(Members: Aristeiguieta, Alexander, Chang, Duruisseau, Low, Moran)
- **2:00 p.m. to 5:00 p.m.** Panel B – Room 204
(Members: Yaroslavsky, Gitnick, Salomonson, Schipske, Wender, Zerunyan)

Friday, April 25

- **9:00 a.m. to 1:00 p.m.** Full Board Meeting – Room 204
All Members

AGENDA ITEM # 3



MEDICAL BOARD OF CALIFORNIA
Executive Office



Agenda Item 3

**The Westin Los Angeles Airport
Concourse A Room
5400 West Century Blvd.
Los Angeles, CA 90045**

January 31 – February 1, 2008

MINUTES

Agenda Item 1 Call to Order/Roll Call

Dr. Fantozzi called the meeting of the Medical Board of California (Board) to order on January 31, 2008 at 3:05 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, Manager, Licensing Program
Fayne Boyd, Manager, Licensing Program
Kathi Burns, Manager, Licensing Program
Candis Cohen, Public Information Officer
Janie Cordray, Research Specialist
Nancy Edwards, Supervising Investigator, San Diego Office

Randall Freitas, Business Services Office
Kurt Heppler, Staff Counsel, DCA Legal Office
Armando Melendez, Business Services Office
Valerie Moore, Associate Analyst
Kelly Nelson, Legislative Analyst
Erich Pollak, M.D., Medical Consultant
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:

Michelle Butler, Center for Public Interest Law
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
Frank Lucido, M.D., General Public
Tim Madden, California Society of Plastic Surgery
Brett Michelin, California Medical Association
Tina Minasian, General Public
Janet Mitchell, General Public
Ty & Carole Moss, Niles Project MRSA
Carlos Ramirez, Senior Assistant Attorney General
M. Ramos, General Public
Gabriella Rodriguez, General Public
Carolyn Sam, Center for Public Interest Law
Antonette Sorrick, Deputy Director, DCA
Carrie Sparrevohn, L.M., California Association of Midwives
John Valencia, AM Society for Dermatologic Surgery
Anthony Williams, California Medical Association

Agenda Item 2 Approval of Minutes from November 1 - 2, 2007 Meeting

A. Approval of Full Board Minutes from November 1 – 2, 2007 Meeting

Anita Scuri, Senior Staff Counsel, asked for one correction; the word “moral” is used instead of the word “morale” on page 12. It was M/S/C to approve the minutes from the November 1 - 2, 2007 meeting.

B. Approval of Division of Medical Quality Minutes from November 2, 2007 Meeting
It was M/S/C (Wender/Aristeiguieta) to approve the minutes from the November 2, 2007 meeting.

C. Approval of Division of Licensing Minutes from November 2, 2007 Meeting
It was M/S/C (Chang/Wender) to approve the minutes from the November 2, 2007 meeting.

Agenda Item 3 President's Report

A. Executive Committee Update

Dr. Fantozzi reported the Executive Committee met on January 10, 2008 in Los Angeles. He stated Ms. Whitney presented several bills that will be discussed under agenda item 4. The Committee also discussed AB 329 which established a pilot program to expand the practice of telemedicine. No funding was provided for staff to assist with this program.

It was M/S/C (Wender/Chang) to accept the recommendation of the Executive Committee to use the Medical Director position to establish a program manager to oversee the development and management of the telemedicine program.

Dr. Fantozzi stated the Executive Committee approved the re-organization of the Board Committees and directed the members' attention to page 32 of the board packet for the list of revised committees.

Dr. Fantozzi advised the Board will continue to take public comment on every agenda item but noted comments on non-agenda items are listed only on today's agenda. However, as this is a change, he will continue to take non-agenda item public comments today, as well as at the beginning of tomorrow's portion of the meeting.

B. Diversion Summit Update

Dr. Fantozzi reported the Board held a Diversion Summit on January 24, 2008 to allow interested parties the opportunity to provide options for the future, due to the impending sunset of the Board's Diversion Program. A summary of this summit will be made available on the Board's Web site within the next couple of weeks.

Agenda Item 4 Legislation Update

Linda Whitney, Chief of Legislation, provided an update on 2007 - 2008 Legislation and Proposals. She directed the Board's attention to their Legislative Packet.

The Board took the following positions:

AB 547 (Ma)	Cap on Fees	Support if Amended
AB 1154 (Leno)	Diabetes	Refer to Access to Care

SB 761 (Ridley-Thomas)	Diversion & Vertical Enforcement	Sponsor/Support
SB 797 (Ridley-Thomas)	Professions & Vocations	Support
SJR 19 (Ridley-Thomas)	Health Professionals: torture	Watch
ABX1 1 (Nunez)	Health Care Reform	Failed
SBX1 19 (Cogdill)	Medical Corporations	Oppose
SB1 24 (Ashburn)	Nurse Practitioners: scope of practice	Oppose

Ms. Whitney advised the Board that since most bills will not be introduced until the end of February, the Board may need an Executive Committee meeting to take positions on the newly introduced legislation.

Ms. Whitney directed the Board’s attention to a copy of the legislative proposals approved by the Board as follows:

- 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 and allow the Board to have a two-to- six month reserve. AB 547 was introduced and Board staff is working with the author on this bill.
- Legislation for the extension of the Vertical Enforcement/Prosecution pilot. SB 797 is still on the Assembly floor.
- Legislation has been introduced on peer reporting under Business and Professions (B&P) Code sections 821.5 and 821.6 which requires the reporting of investigations conducted by hospitals when physicians have physical or psychiatric conditions. This legislation provides for reporting to the Executive Director and includes language for confidentiality of the reports.
- Legislation to amend section 2233 of the B&P Code to allow the Board to require an education course be included with a public letter of reprimand. The language has been developed, reviewed by Mr. Zerunyan, and Dr. Nakanishi has agreed to move it forward.
- Legislation to clarify language in B&P Code sections 801.1 and 801.01 related to multiple physicians reporting in settlements, judgments and arbitration awards. Staff proposes to develop this in regulatory language.
- Authorize staff to re-open discussions on the proposal for initial license for disabled individuals. Ms. Whitney will work with Dr. Gitnick and various legislative offices regarding the proposal.
- Public letter of reprimand for initial license for minor violations; the language has been approved, and put forward by Dr. Nakanishi.
- Division of Licensing approved various technical amendments. Many of these will be carried in the omnibus bill sponsored by Senate Business and Professions Committee. It will be introduced in March.
- \$500,000 one time for the Health Professions Education Foundation is being developed by legislation (bill) or carried by the budget act. Ms. Whitney has been meeting with the appropriate budget chairs to see if they would consider carrying this or if we should continue with legislation.

Dr. Gitnick reported since the Board's last meeting, the Health Professions Education Foundation has not come up with matching funds, but they are trying to develop private funding for the Steven M. Thompson Fund.

Jim Hay, M.D., California Medical Association (CMA), stated because there are surplus funds in the Board's budget this year and because there are no other alternatives at the moment, CMA did not oppose licensing fees being applied to the Steven M. Thompson Fund. He also wanted to clarify that the Orange County Register said that the CMA lobbied the Board to make this happen and that statement is incorrect.

Ms. Whitney stated she has been working with the Chief Consultant for the Senate Business and Professions Committee and Senator Ridley-Thomas, to entertain the idea of legislation related to the laser issue as it integrates with outpatient surgery settings for elective procedures. It was M/S/C to support in concept, the proposal to raise the priority level of unlicensed activity and corporate practice violations.

Steve Alexander stated the Board adopted a motion and would look at recommendations to the legislature about how to deal with the results of the Diversion Summit. Mr. Alexander stated this is a serious issue and the Board should not ignore the problem of impaired physicians.

After much deliberation by the Board, it was M/S/C to seek direction from its Education Committee to provide education and information within the current medical training system regarding physician impairment, wellness prevention and treatment, licensure and practice implications, and other issues relevant to informing physicians and applicants of the significant issue of impairment.

Ms. Whitney directed the Board's attention to the regulatory matrix in their board packet.

Ms. Whitney and Ms. Kirchmeyer discussed several issues that arose with the elimination of the two divisions and requested the Board provide direction on the following issues:

It was M/S/C (Wender/Yaroslavky) for licensing decisions to require two members to hold a decision to bring the matter back to the panel to discuss.

It was M/S/C (Wender/Chang) to change the legislation to require a majority vote instead of four votes to revoke a license. (Vote: 12-2, 1 abstained)

It was M/S/C (Wender/Gitnick) for licensing application decisions to continue without oral argument hearings.

It was M/S/C (Yaroslavsky/Wender) for the petitions for modification or termination of probation on licensing cases to mirror the enforcement process and be heard by an Administrative Law Judge.

Agenda Item 5 Executive Director's Report

A. Budget Overview and Staffing Update

Executive Director Barb Johnston provided her report on the budget and staffing update. She directed the Board's attention to page 37 of their board packet for information on the fund balance and the program expenditures.

Jim Hay, M.D., CMA, stated he is concerned there is \$4,000,000 in added expenditures, which is an 8% increase over prior budget. He stated the CMA is in support of AB 547 as currently written.

Frank Zerunyan requested clarification regarding the drop in surplus money investments as shown by item 150300 Income from Surplus Money Investments, page 37. He also requested clarification on budget 2007-2008 year showing a structural deficit between revenues and expenditures.

Ms. Kirchmeyer stated the drop in surplus money investments was based on the interest due on the Board's lower fund condition. Ms. Kirchmeyer explained the deficit between revenue and expenditures.

Mr. Zerunyan pointed out that this report shows by 2010-2011 the Board will be left with less than one month in reserve.

Ms. Johnston and Ms. Kirchmeyer explained the fund condition is always being reconciled.

B. Update on Board Mandated Reports

Ms. Johnston provided an update on Board mandated reports:

- Study of peer review pursuant to B&P Code section 805.2 – the study is being conducted by Lumetra and is due to be submitted to the legislature by July 31, 2008.
- Study of public disclosure pursuant to B&P Code section 2026 – the study is being conducted by the California Research Bureau and is due to the legislature on July 1, 2008.
- Study of medical malpractice insurance for Volunteers pursuant to B&P section Code 2023 – although this study was due January 1, 2008, the Board has been unable to locate an appropriate vendor to conduct this study. The Board is endeavoring to have this study completed by June 1, 2008.

Agenda Item 6 Demonstration of MBC Web site

Diane Ingram, Manager, Information Systems Branch, provided a Power-Point presentation and demonstration of the new MBC Web site and its features.

Agenda Item 7 California Physician Corp Program Update

Ms. Yaroslavky stated the Health Professions Education Foundation (HPEF) presented 12 loan re-payment awards to physicians in 2007, but no additional funds have been raised for future awards.

In regards to the volunteer program, this is on hold pending the outcome of the malpractice study and the implementation of those recommendations.

Agenda Item 8 Cultural and Linguistic Physician Competency Workgroup Meeting Update

Ms. Chang reported the group is working on a strategic plan. She would like the California Endowment to give a presentation to the Board on what they have done. Finally, the Department of Health and Human Services has a workgroup to discuss Medi-Cal reimbursement for the interpreter services.

Agenda Item 9 Access to Care Meeting Update

Dr. Gitnick reported the group discussed the implementation of AB 329 (Telemedicine). They reviewed the current and potential role of telemedicine in benefiting the public and the underserved. The group initiated the discussion of models of healthcare delivery such as project Dolce and minute-clinics. Staff was directed to research issues related to the scope of practice of non-physician health care providers.

A motion was made and seconded (Wender/Yaroslavsky) to support AB 1154, a pilot program giving diabetes medications and supplies to public employees.

Dr. Aristeiguieta stated the Board should take a “watch” position on this as he thinks this would serve a public that already has access to insurance and that can provide these services for themselves.

Public comment was heard from Janet Mitchell. She stated she has a daughter in college who is insulin dependent and upon her graduation will not be able to stay on their insurance. College students need a bridge of insurance and would be a perfect fit for this study.

The motion carried to support AB 1154. (Vote: 14-1)

Agenda Item 10 Education Committee Update

Ms. Yaroslavsky stated the committee name has been changed from the Public Education Committee to the Education Committee because the committee is expanding their outreach. Ms. Yaroslavsky updated the Board on the committee’s work on proactive communication efforts. The committee reviewed AB 1154 and voted to support it.

Agenda Item 11 Medical Errors Task Force Update

Dr. Aristeiguieta stated their inaugural meeting was today and they had a round table discussion. They established a working objective/problem statement that states, “The Board would like to examine its

roll to determine if it could provide greater public protection by becoming involved in initiatives to reduce medical errors and how it might provide assistance”. Their objective now is to meet and define “medical error” and the role of the current disciplinary system.

Agenda Item 12 Wellness Committee Update

Dr. Duruisseau provided an update on the Wellness Committee meeting held in Sacramento on January 23rd, 2008. He stated Dr. Gregg wrote the first article on “Physician Wellness” which appeared in the Board’s newsletter. The committee approved the implementation of a Web page which will list the wellness programs available. This program will be a joint effort of the Board and the medical schools to initiate development of a curriculum that emphasizes healthy lifestyles while allowing this online resource to be available to current licensees. The committee also discussed the possibility of establishing a mentoring program. A representative from Kaiser came to the last meeting and spoke about the success of their mentoring program. The committee discussed doing research for the possibility of having rebates and discounts for medical malpractice and license renewals if the physician took incentives for personal improvement activities.

Agenda Item 13 Public Comments on Items not on the Agenda

Janet Mitchell stated she was alarmed the Board allocated \$500,000 for the scholarship fund while the Enforcement Program is having a large staff turnover, partially due to wages. She also thanked the Board for ending of the Diversion Program. She asked the Board to post any arrest information of a licensee on our Web site so patients can make educated decisions about physicians.

Tina Minasian thanked the Board for abolishing the Diversion Program. She also stated she would like the Board to require all California doctors to tell all patients about the existence of the Board and the Board’s role.

Michelle Ramos spoke to the Board about a doctor who was under the Diversion Program. She stated she wants the Board to go beyond ending the Diversion Program and to end all confidential policies related to the former program and let all records become public.

There being no further business, the meeting adjourned at 5:20 p.m.

Friday, February 1, 2008

Agenda Item 14 Call to Order/Roll Call

Dr. Fantozzi called the meeting to order on February 1, 2008 at 9:00 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.
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

Dr. Fantozzi continued with Public Comment of Non-Agenda Items.

Tara Kittle expressed disappointment of the failure of the Governor's Health Care plan.

Frank Lucido, M.D. provided a copy of his article on medical cannabis, "*Implementation of the Compassionate Use Act in a Family Medical Practice*".

Agenda Item 15 Regulations – Public Hearing

A. Continuing Education Requirements

Dr. Fantozzi explained the Board's proposed regulation to amend Section 1336 in Article 11 of Chapter 1, Division 13, Title 16 of the California Code and Regulations. The Board is seeking to make changes to the Continuing Medical Education requirements to: 1. Direct 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). 2. Change the calculations of CME hours from calendar year to renewal cycle year.

Anita Scuri stated Regulation, Section 1337(d) permits credits over a four-year period for those who take and pass a certifying or recertifying examination administered by a recognized specialty board, she asked to have the language of Section 1336(a) amended as follows:

- Each physician is required to complete not less than 50 hours of approved continuing education during each two-year period, immediately preceding the expiration date of the license except as permitted by Section 1337(d).

It was M/S/C (Yaroslavsky/Wender) to delegate to the executive officer, the authority to adopt the regulation as modified at the expiration of any 15-day comment period provided there are no adverse comments.

B. Delegation of Services – Physician Assistant

Dr. Fantozzi explained the Board proposed new regulations to amend Section 1399.540 in Division 13.8 of Title 16 of the California Code of Regulations.

Kurt Hepler, Staff Counsel, DCA Legal Office, stated this regulation was brought forth by the Physician Assistant Committee. This proposal would formally recognize the writing which delegates the medical services to the physician assistant be known as a “Delegation of Services Agreement” and requires 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 no more than one delegation of services agreement.

Elberta Portman, Executive Officer, Physician Assistant Committee provided the members with a copy of a letter dated January 31, 2008 from the California Academy of Physician’s Assistants in support of this regulation.

Public Comment was heard from James Hay, M.D., CMA who spoke in support of the regulation.

It was M/S/C (Wender/Yaroslavsky) to adopt this regulation as written.

Agenda Item 16 Licensing Chief’s Report

A. Physician Assistant Committee Update

Ms. Portman stated the committee has approximately 6200 licensees and licenses about 58 physician assistants per year. She reported the committee has been working on probation monitoring and the implementation of AB 3 which was put into force on January 1, 2008. She stated the Committee is obtaining a contract to produce pocket license cards similar to the physician and surgeon’s pocket license cards.

B. Midwifery Advisory Council Report

Mr. Qualset stated the forms and instructions for the 2007 California Licensed Midwife Annual Report were mailed to all licensed midwives and are available on the Board’s Web site and can also be linked from the Office of Statewide Health Planning and Development’s (OSHPD) Web site. The reports are due to OSHPD on March 21, 2008.

Mr. Qualset reported remedial and re-entry training to practice programs were discussed by the Council. Faith Gibson, Chair of the Midwifery Advisory Council, stated the National College of Midwifery in New Mexico may be able to provide this training via distance learning.

Mr. Qualset discussed SB 1950 which requires the board to adopt regulations pertaining to the level of physician supervision for midwives. He stated this issue will not be taken up by the council at this point as they are addressing the issues of remedial/re-training.

Anita Scuri commented on a question raised regarding the Board's response to the legislature on SB 1950. She stated the Division of Licensing tried to get clarification from the Attorney General's Office to define what the levels of supervision would be, but were not successful in reaching a satisfactory resolution.

Dr. Fantozzi stated no report was required; however, a letter was sent to Senator Figueroa when the Board was unable to resolve the issue of physician supervision.

C. Research Psychoanalytic Institution Equivalency Report

Kathi Burns, Licensing Program Manager, reported there had been a previous request to the Division of Licensing that they consider a regulation change to allow Psychoanalytic Institutes holding accreditations through the American Board of Accreditations and Psychoanalysis, Inc. (ABAP) be considered equivalent for the purpose of obtaining certification as a research psychoanalyst or student research psychoanalyst in California. She stated staff has received a subsequent letter from ABAP indicating they may not wish to proceed with the process necessary to be included in California regulations at this time. Ms. Burns stated she will clarify this letter with ABAP before proceeding further.

D. Special Programs Update

Mr. Qualset stated the suspensions of new 2111 and 2113 applications have been lifted at two of the three schools that were suspended. He indicated licensing staff is planning a workshop with the medical schools to educate them on the proper use and application process of these Special Programs.

He stated the next Special Faculty Permit Review Committee will be held via teleconference per the committee's request.

E. Licensing Program Update

Mr. Qualset provided an update on the licensing program. He stated there has been a 2% increase in applications received but a 19% decrease in the number processed. He offered reasons such as new staff vacancies and staff learning curve for this anomaly.

F American Board of Cosmetic Surgery (ABCS) vs. MBC Update

Ms. Scuri provided a brief overview of B&P Code section 651 which specifies a physician can use the terms, "board certified or eligible" in their advertising only if he/she is certified by one of the American Board of Medical Specialties (ABMS) boards or a specialty board approved by the

Board as having equivalent requirements. The Board through the DOL has approved four specialty boards and disapproved two.

The DOL disapproved the ABCS. This decision is under judicial review and the Superior Court ruled in September 2006 that ABCS did meet the requirements to be approved and ordered DOL to grant the application. The DOL filed an appeal and the matter is set for argument March 17, 2008.

Dr. Wender stated he would like B&P Code section 651 amended to eliminate the requirement for the Medical Board to approve specialty boards not certified by the ABMS. He requested this be a future agenda item.

Agenda Item 17 Midwifery Advisory Council Appointments

It was M/S/C to re-appoint Carrie Sparrevohn and Barbara Yaroslavsky to the Midwifery Advisory Council.

Carrie Sparrevohn, L.M., stated the single most important issue for midwives giving home birth care is the lack of physician supervision. The standard of care requirements are difficult to obtain because of the need to obtain a physician's signature.

Agenda Item 18 Actions on Recommendations of Special Faculty Permit Review Committee

Dr. Gitnick reported the Committee met on January 10, 2008. They reviewed the qualifications and credentials of candidates Graeme Bydder, M.D., Ian Everall, M.D. Santiago Horgan, M.D. and Felipe Mederios, M.D., and approved appointments pursuant to Section 2168.1 of the Business and Professions Code. The recommendations includes granting a waiver of section 2168.1(a)(5) for Bydder, Everall, and Medeiros.

It was M/S/C (Gitnick/Alexander) to issue these Special Faculty Permits.

Agenda Item 19 Enforcement Chief's Report

Renee Threadgill, Chief of Enforcement, stated the Enforcement Program continues to hire and train investigators but retention problems still exist. She reported staff has met with a vendor to pursue a contract for a pay classification study and are awaiting that proposal. She added enforcement is working on the transition of probation cases from sworn to non-sworn personnel.

Ms. Threadgill stated the spring finance letter for Operation Safe Medicine was submitted. If the finance letter is not approved, staff will submit a Budget Change Proposal (BCP) for FY 2009/2010.

Ms. Threadgill discussed the Expert Program Survey. She reported overall satisfaction of the experts remains high and the survey form has been changed to include questions to evaluate interaction between the Deputy Attorney's General and the experts.

It was M/S/C (Wender/Yaroslavsky) to approve the Orders Restoring License Following Successful Completion of Probation, Orders Issuing Public Letter of Reprimand, and Orders for License Surrender During Probation.

Agenda Item 20 Vertical Enforcement Progress/Update

A. Information Technology Update

Ms. Threadgill directed the members' attention to pages 85 and 86 of their Board packet showing the timelines for the Intermediary Application and the Information Technology Integration, respectively. Ms. Threadgill stated the Board will submit a significant BCP for the new information technology system. She explained this budget item is extremely important and will allow the Board enforcement staff to be more integrated with the Department of Justice.

Ms. Threadgill and Carlos Ramirez, Senior Assistant Attorney General, stated the Board and the Department of Justice will be assembling teams to develop a Joint Operations Manual. Mr. Alexander stated his disappointment at the length of time to develop the Joint Operations Manual. Ms. Threadgill responded to comments regarding the lengthy timeframe by stating it was her understanding that this manual was not to be a revision of an old manual but a completely new joint manual between the two entities which takes much longer than just a mere revision of the existing Enforcement Operations Manual (EOM).

B. Vertical Enforcement Statistics

Ms. Threadgill directed the members' attention to page 88 of their Board packet showing the average days it took in the workflow of Vertical Enforcement in 2007. Ms. Threadgill asked for feedback from the members regarding the data that they would like to have provided to them.

- Dr. Aristeguieta stated he would like to see the statistics quarterly instead of annually. Also, he would like more information on how long it is taking from the filing of accusation and the resolution of the case.
- The members' requested clarification on business days vs. calendar days.
- Mr. Alexander asked Ms. Threadgill to track citations and fines. He directed staff to establish goals to assess how well the VE program is doing.

Agenda Item 21 Consideration of Proposal to Amend Disciplinary Guidelines Regulations

Ms. Kirchmeyer directed the members' attention to page 89-123 of their Board packet. She stated the Manual of Model Disciplinary Orders and Disciplinary Guidelines has been edited to reflect changes that were adopted in the transition plan.

It was M/S/C (Aristeiguieta/Yaroslavsky) to set this matter for a regulatory hearing.

Ms. Kirchmeyer stated several members have commented on the Disciplinary Guidelines and the need for revision. She requested a task force consisting of a physician and a public member be established to meet with her and Ms. Threadgill to revise the Disciplinary Guidelines. Dr. Fantozzi appointed Dr. Aristeiguieta and Ms. Schipske.

Agenda Item 22 Consideration of Proposal to Adjust Initial Licensing and Renewal Fees Pursuant to Sunset of Diversion.

Ms. Kirchmeyer directed the members' attention to page 124 of their Board packet. She stated the expenditures for the Diversion Program will be eliminated on June 30, 2008 and under B&P Code section 2435.2 the licensing fees must be reduced to an amount equivalent to this expenditure.

It was M/S/C to set this to a regulatory hearing to reduce the licensing fee by \$22.00.

Brett Michelin, CMA, supports the staff recommendation to begin the hearing process. He reminded the Board the statute requires the Board to either return the money or send money to a new entity that will do something similar to the Diversion Program.

Agenda Item 23 Diversion Program Report

A. Program/Transition Update

Frank Valine, Diversion Program Manager, provided an update on the Diversion Program. He indicated intakes will continue to decrease. Participants with three years sobriety have been evaluated for release from the program. He stated letters were sent to all participants informing them of the Board's transition plan.

B. Fiscal Report

Mr. Valine directed the Board to the Fiscal Report on page 142 and 143 of the Board packet showing the Diversion Program has encumbered 41% of its annual budget.

Agenda Item 24 Policy Statement on Access to Care/Healthcare Reform

Dr. Fantozzi stated the Executive Committee determined the Board should have a policy statement indicating the Board's responsibility, intention, and support of healthcare reform.

A motion was made and seconded (Wender/Chang) to adopt the Access to Care Policy Statement.

Dr. Aristeiguieta stated he would like to make the following changes:

- Change paragraph five to read, “The Medical Board, in its regulatory and consumer protection role, must evaluate various access-to-care delivery models to ensure consistency with the Medical Practice Act”.
- Change the, “must evaluate” to “may evaluate.”

Public comment was heard by Carrie Sparrevohn, L.M., who stated she would like to see the Board work with the legislature to provide real access to care and that this letter does not do enough.

Following discussion the motion carried.

Agenda Item 25 Laser Forum’s Summary

Janie Cordray, Research Program Manager, stated in 2006 the legislature passed SB 1423 which directed the Board, in conjunction with the Nursing Board and Physician Assistant Committee to review laser issues for cosmetic procedures. Three public forums were convened and testimony was heard regarding the importance of educating and enforcing the related laws for public protection.

It was M/S/C (Chang/Yaroslavsky) to adopt the statements requested in the report.

Tim Madden, California Society of Plastic Surgeons, stated they are in support of the recommendations put forward. They are encouraged by Operation Safe Medicine. Patient/consumer education, and supervision are both very critical moving forward.

John Valencia, American Society for Dermatologic Surgery, stated the testimony at the three forums were very graphic and disturbing. Enforcement and supervision are essential and they intend to submit a regulatory petition to the Board regarding supervision next week.

It was M/S/C (Schipske/Yaroslavsky) to accept the staff’s recommendation and send a letter to the Board of Registered Nursing regarding the serious nature of the laser issue and offering to work with them to resolve the issues.

Dr. Aristeiguieta stated we should contact the Board of Registered Nursing for a definition of their “scope of practice” regarding laser procedures and their supervisory requirements to incorporate in our publications.

Agenda Item 26 Agenda Items for April 2008 Meeting

- B&P Code 651 - approval of specialty boards
- Laser Forum and Safety – review letter being drafted
- Access to Care – presentation of the patient assistance program

- Janet Mitchell asked that AB 2571 be re-addressed

Agenda Item 27 Adjournment

There being no further business, it was M/S/C to adjourn the meeting at 11:45 a.m.

Richard Fantozzi, M.D, President

Cesar Aristeiguieta, M.D., Vice President

Barb Johnston, Executive Director

AGENDA ITEM # 5

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 Sacramento Convention Center, 1400 J Street, Sacramento, CA 95814, at 9:00 a.m., on April 25, 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 April 14, 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 125.3, 2018, 2168.4 and 2436 of the Business and Professions Code, and to implement, interpret or make specific Sections 2125.3, 2168.4, 2435, and 2435.2 of said Code, the Medical Board of California is considering changes to Article 15 of Chapter 1 of Division 13 of Title 16 of the California Code of Regulations as follows:

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Amend Section 1351.5 and Section 1352: Reduction in Initial License Fee and Renewal Fee to Offset Elimination of Diversion Program

Business and Professions Code Sections 2340 et seq., which authorize the Board's Diversion Program, become inoperative July 1, 2008. Section 2435.2 of the B & P Code states that the Board shall reduce license and renewal fees if the Diversion Program is eliminated. Therefore, pursuant to the requirements of the latter section, the board is proposing to amend sections 1351.5 and 1352 to reduce the initial license fee and biennial renewal fee from \$805 to \$783.

FISCAL IMPACT ESTIMATES

Fiscal Impact on Public Agencies Including Costs or Savings to State Agencies or Costs/Savings in Federal Funding to the State: Minor savings. Only those agencies which employ physicians and surgeons and pay for the license or renewal fees will be impacted; it would be a reduction of \$22.00 per physician every two years.

Nondiscretionary Costs/Savings to Local Agencies: Minor savings. Again, only those agencies which employ physicians and surgeons and pay for the license or renewal fees will be impacted; it would be a reduction of \$22.00 per physician every two years.

Local Mandate: None

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

Business Impact: Minor savings. The board has determined that the proposed regulatory action would have minimal economic impact on California businesses and individuals since the fee reduction will be \$22.00 per physician every two years.

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.

AND

The following studies/relevant data were relied upon in making the above determination: 1) The Medical Board's "Budget Summary" (1/18/08), which documents the expiring Diversion Program as -\$1,213,000. 2) The Medical Board's "Workload and Revenue Stats" (8/29/07), which documents 2,000 initial licenses annually, and 53,500 annual license renewals.

Impact on Jobs/New Businesses:

The Medical 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 Medical Board estimates the potential cost impact of the proposed regulations on directly affected private persons or entities to be a reduction of about \$22.00 every two years.

Effect on Housing Costs: None

EFFECT ON SMALL BUSINESS

Minor savings. The board has determined that the proposed regulation would affect small business because a few physicians and surgeons would meet the definition of a small business. The impact would be a reduction of \$22.00 per licensee every two years.

CONSIDERATION OF ALTERNATIVES

The Medical Board must determine that no reasonable alternative considered by it 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 Medical 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 person designated in this Notice under Contact

Person or by accessing the website listed below.

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 designated in this Notice under Contact Person or by accessing the website listed below.

You may obtain a copy of the final statement of reasons once it has been prepared, by making a written request to the person designated in this Notice under Contact Person or by accessing the website listed below.

CONTACT PERSON

Inquiries or comments concerning the substance of the proposed rulemaking may be addressed to:

Name: Kevin A. Schunke
Address: Medical Board of California
1434 Howe Avenue, Suite 92
Sacramento, CA 95825
Tel No.: (916) 263-2368
Fax No.: (916) 263-2387
e-mail: kschunke@medbd.ca.gov

The backup contact person is :

Name: Linda Whitney
Address: Medical Board of California
1434 Howe Avenue, Suite 92
Sacramento, CA 95825
Tel No.: (916) 263-2389
Fax No.: (916) 263-2387
e-mail: lwhitney@medbd.ca.gov

Website Access : Materials regarding this proposal can be found at www.medbd.ca.gov.

**Medical Board of California
Specific Language of Proposed Regulations**

**Reduction in Initial License Fee and Renewal Fee to Offset
Elimination of Diversion Program**

Amend Section 1351.1 and Section 1352, Title 16, California Code of Regulations to read as follows:

Section 1351.5. Initial License Fee.

~~The initial fee for licensure as a physician and surgeon or for a special faculty permit shall be \$600 for licensing periods beginning on or after January 1, 1994. The initial license fee for licensure as a physician or surgeon or for a special faculty permit shall be \$805 for licensing periods beginning on or after January 1, 2007. The initial license fee shall be \$783 for licensing periods beginning on or after November 1, 2008.~~

Note: Authority cited: Sections 125.3, 2018, 2168.4 and 2436, Business and Professions Code. Reference: Sections 125.3, 2168.4 and 2435, Business and Professions Code.

Section 1352. Renewal Fee.

~~The biennial renewal fee for licenses or special faculty permits which expire on or after February 28, 1997 shall be \$600. The biennial renewal fee for licenses or special faculty permits which expire on or after January 1, 2007 shall be \$805. The biennial renewal fee for licenses or special faculty permits which expire on or after November 1, 2008 shall be \$783.~~

Note: Authority cited: Sections 125.3, 2018, 2168.4 and 2436, Business and Professions Code. Reference: Sections 125.3, 2168.4 and 2435, Business and Professions Code.

MEDICAL BOARD OF CALIFORNIA INITIAL STATEMENT OF REASONS

Reduction in Initial License Fee and Renewal Fee to Offset Elimination of Diversion Program

Hearing Date: Friday, April 25, 2008

Subject Matter of Proposed Regulations: Reduction in Initial License Fee and Renewal Fee to Offset Elimination of Diversion Program

Section(s) Affected: Amend Title 16, California Code of Regulations sections 1351.5 and 1352

Specific Purpose

Business and Professions Code Sections 2340 et seq., which authorize the Board's Diversion Program, are inoperative effective July 1, 2008. Section 2435.2 of the B & P Code states that the Board shall reduce license and renewal fees if the Diversion Program is eliminated.

This rulemaking will amend those sections which set forth the initial license fee and the biennial renewal fee.

Factual Basis

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 Diversion Program will be inoperative July 1, 2008. 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 the initial license and for renewals
(The Board has elected to round-off this figure to \$22.00)

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, which represents a reduction of \$22.00 per licensee every two years.

Underlying Data

1) The Medical Board's "Budget Summary" (copy attached, dated 1/18/08), which documents the expiring Diversion Program as -\$1,213,000.

2) The Medical Board's "Workload and Revenue Stats" (copy attached, dated 8/29/07), which documents 2,000 initial licenses annually, and 53,500 annual license renewals.

Business Impact

This regulation will have minimal impact on business. Only those businesses which employ physicians and surgeons and pay for the initial license or for renewal fees will be impacted; it will be a reduction of \$22.00 per licensee every two years.

Specific Technologies or Equipment

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

Consideration of Alternatives

No alternative which was considered would either be more effective than or equally as effective as and less burdensome to affected private persons than the proposed regulation.

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 Sacramento Convention Center, 1400 J Street Sacramento, California, at **9:05 a.m.**, on **April 25, 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 April 14, 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 and 2220 of the Business and Professions Code, and to implement, interpret or make specific Sections 2228, 2229 and 2234 of said Code, as well as Sections 11400.20, 11425.50(e) of the Government 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 16 CCR Section 1361.

Government Code Section 11425.50(e) provides that a penalty in an administrative disciplinary action may not be based on a guideline unless the guideline has been adopted as a regulation. The board has adopted the "Manual of Disciplinary Guidelines and Model Disciplinary Orders," which has been revised over the years, the current version of which is the 9th Edition/2003. This manual sets forth proposed penalties for various violations of the Medical Practice Act.

This proposal would amend the board's regulation section 1361 to incorporate by reference the "Manual of Disciplinary Guidelines and Model Disciplinary Orders" (10th Edition/2008).

Two changes in the law necessitate changes to the 2003 version of the Manual of Disciplinary Guidelines and Model Disciplinary Orders:

1. The manual refers to the Division of Medical Quality, which ceased to exist on January 1, 2008. AB 253 (Eng, Chapter 678, Statutes of 2007) abolished the two divisions of the board. This bill instead provided for the board as a whole to handle the responsibilities of the divisions. This proposal would conform the regulation to this change in law.
2. The manual refers to the board's Diversion Program. Business & Professions Code section 2358 sunsets the Diversion Program effective July 1, 2008. This proposal would delete all references to the Diversion Program and modify the term regarding biological fluid testing.

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.

AND

The following studies/relevant data were relied upon in making the above determination:

There are no costs associated with the proposed regulatory action. The proposed only relates to the legal elimination of the Division of Medical Quality and the Board's Diversion Program.

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.

This proposed regulation only reflects the current law, which eliminates the Diversion Program and the Division of Medical Quality. The proposed regulation does require physicians with substance abuse history to pay for biological fluid testing, however, under the current regulations, physicians are ordered into the Diversion Program, and must currently pay for their laboratory services. For that reason, this proposed regulation has no more impact than the current regulation. The alternative to requiring physicians to pay for their own biological fluid testing would either be: 1) Revoke the physician's license, eliminating the need for biological fluid testing to ensure public safety, or; 2) the Medical Board to pay for the testing, requiring an increase in licensing fees for all physicians to pay for the few offending physicians on probation.

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 regulations reflect two changes in law: 1) the elimination of the Division of Medical Quality as the entity hearing disciplinary cases, replacing them with the full Board (AB 253, Eng, Chap. 678, Stats 2007), and; 2) the elimination of the Diversion Program by B&P Code Section 2358.

The new edition of the *Manual of Disciplinary Guidelines and Model Disciplinary Orders*, incorporated by reference, replace "Division" with "Board" and changes probationary conditions for those with substance abuse violations from referral to the Diversion Program, replacing it with biological fluid testing at an approved laboratory service. Previously, physicians in the Diversion Program paid for their laboratory services, and therefore, there is no anticipated increase in cost than under the existing regulation.

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.

The proposed regulation requires physicians with substance abuse history to pay for biological fluid testing, however, under the current regulations, physicians are ordered into the Diversion Program, and must pay for their laboratory services. For that reason, this proposed regulation has no more impact than the current regulation. There are two reasonable alternatives to requiring physicians to pay for their own biological fluid testing: 1) revoke the physician's license, eliminating the need for biological fluid testing to ensure public safety, or; 2) the Medical Board pay for the tests, requiring an increase in licensing fees for all physicians to pay for the few offending physicians on probation.

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: Janie Cordray
Medical Board of California
Address: 1426 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
Medical Board of California
Address: 1426 Howe Avenue, Suite 92
Sacramento, CA 95825
Telephone No.: (916) 263-2389
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
Disciplinary Guidelines
Specific Language**

Amend section 1361 in Article 4 of Chapter 2, Division 13, to read as follows:

1361. Disciplinary Guidelines.

In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), the ~~Division of Medical Quality of the~~ Medical Board of California shall consider the disciplinary guidelines entitled "Manual of Disciplinary Guidelines and Model Disciplinary Orders" (~~9th Edition/2003~~ 10th Edition/2008) which are hereby incorporated by reference. Deviation from these orders and guidelines, including the standard terms of probation, is appropriate where the ~~Division of Medical Quality of the~~ Medical Board of California in its sole discretion determines by adoption of a proposed decision or stipulation that the facts of the particular case warrant such a deviation -- for example: the presence of mitigating factors; the age of the case; evidentiary problems.

NOTE: Authority cited: Sections 2018, Business and Professions Code; and Section 11400.20, Government Code. Reference: Sections 2227, 2228, 2229, and 2234, Business and Professions Code; and Sections 11400.20 and 11425.50(e), Government Code.

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
20032008
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 Merton, 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.

**MODEL DISCIPLINARY ORDERS
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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 section 11362.5.

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 section 11362.5. 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.

24. 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.

~~34.~~ 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 [29]

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 [44] [13]
3. Ethics Course [47] [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 [44] [13]
5. Prescribing Practices Course [45] [14]
6. Medical Record Keeping Course [46] [15]
7. Ethics Course [47] [16]
8. Clinical Training Program [49] [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 [44] [13]
3. Medical Record Keeping Course [46] [15]
4. Ethics Course [47] [16]
5. Clinical Training Program [49] [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 [44] [13]
3. Ethics Course [47] [16]
4. Professional Boundaries Program [48] [17]
5. Psychiatric Evaluation [24] [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 [24] [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 [44] [13]
2. Prescribing Practices Course [45] [14]
3. Medical Record Keeping Course [46] [15]
4. Ethics Course [47] [16]
5. Clinical Training Program [49] [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 [47] [16]
2. Oral or Written Examination [20] [19]
3. Psychiatric Evaluation [24] [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 [47] [16]
3. Psychiatric Evaluation [24] [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 [47] [16]
2. Oral or Written Examination [20] [19]
3. Psychiatric Evaluation [24] [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 [47] [16]
3. Psychiatric Evaluation [24] [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 [47] [16]
2. Psychiatric Evaluation [24] [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 [44] [13]
9. 8. Prescribing Practices Course [45] [14]
10. 9. Medical Record Keeping Course [46] [15]
11. 10. Ethics Course [47] [16]
12. 11. Oral or Written Examination [20] [19]
13. 12. Psychiatric Evaluation [24] [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 [47] [16]
7. 6. Oral or Written Examination [20] [19]
8. 7. Psychiatric Evaluation [24] [20]
9. 8. Psychotherapy [22] [21]
10. 9. Medical Evaluation and Treatment [23] [22]
14. 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 [44] [13]
5. Prescribing Practices Course [45] [14]
6. Medical Record Keeping Course [46] [15]
7. Ethics Course [47] [16]
8. Clinical Training Program [49] [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 [44] [13]
3. Ethics Course [47] [16]
4. Clinical Training Program [49] [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 [47] [16]
3. Medical Record Keeping Course [46] [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 [44] [13]
3. Ethics Course [47] [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 [24] [20]
7. 6. Psychotherapy [22] [21]
8. 7. Medical Evaluation and Treatment [23] [22]
9. 8. Third Party Chaperone [26] [25]

**MEDICAL BOARD OF CALIFORNIA
INITIAL STATEMENT OF REASONS**

Hearing Date: April 25, 2008

Subject Matter of Proposed Regulations: Disciplinary Guidelines

(1) Section(s) Affected: Amend Section 1361 in Article 4 of Chapter 2, Division 13

Specific purpose of each adoption, amendment, or repeal:

To amend the board's regulation section 1361 to incorporate by reference the "Manual of Disciplinary Guidelines and Model Disciplinary Orders" (10th Edition/2008).

To conform the regulation to changes made to the statutes. Two changes in the law necessitate changes to the 2003 version of the Manual of Disciplinary Guidelines and Model Disciplinary Orders:

1. The manual refers to the Division of Medical Quality, which ceased to exist on January 1, 2008. AB 253 (Eng, Chapter 678, Statutes of 2007) abolished the two divisions of the board. This bill instead provided for the board as a whole to handle the responsibilities of the divisions.
2. The manual refers to the board's Diversion Program. Business & Professions Code section 2358 sunsets the Diversion Program effective July 1, 2008.

Factual Basis/Rationale

The *Manual of Model Disciplinary Orders and Disciplinary Guidelines* referenced by the current regulation must be made consistent with current law, and must reflect the elimination of the Division of Medical Quality by AB 253 (Eng, Chap. 678, Stats 2007) and the elimination of the Diversion Program by B&P Code Section 2358.

As referenced above, the 9th Edition (2003) of the *Manual of Model Disciplinary Orders and Disciplinary Guidelines* referenced in the regulation is obsolete. Due to legislation (AB 253, Eng, Chap. 678, Stats. of 2007), the Division of Medical Quality no longer exists, and instead, the full Medical Board will be responsible for hearing disciplinary cases. For that reason, the 9th Edition deletes all references to the "Division," replacing those references with "Board."

The 9th Edition of the Manual has references to the Diversion Program, which will be eliminated by July 1, 2008, pursuant to Business and Professions Code section 2358. For that reason, all references to the Diversion Program are eliminated, and have been replaced by references to biological fluid testing, which would have been performed by

the Diversion Program. The concept and language was discussed and approved as part of the Board's public discussions on November 2, 2007.

The Board has voted to change probationary conditions for those with substance abuse violations from referral to the Diversion Program, replacing it with biological fluid testing at an approved laboratory service. Previously, physicians in the Diversion Program paid for their laboratory services, and therefore, there is no anticipated increase in cost than under the existing regulation.

Underlying Data

1. Manual of Model Disciplinary Orders and Disciplinary Guidelines, 9th Edition (2003).
2. Manual of Model Disciplinary Orders and Disciplinary Guidelines, 10th Edition (2008).
3. November 2, 2007 Board Meeting Minutes.

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:

This proposed regulation only reflects the current law, which eliminates the Diversion Program and the Division of Medical Quality. The proposed regulation does require physicians with substance abuse history to pay for biological fluid testing; however, under the current regulations, physicians are ordered into the Diversion Program, and must currently pay for their laboratory services. For that reason, this proposed regulation has no more impact than the current regulation.

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.

Agenda Item # 8

AGENDA ITEM # 8

**State Budget Status
and
Budget Expenditures
Status Report**

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	1,896,000	35,696,000	4,334,000	2,855,000	1,397,000	3,078,000	2,750,000	52,006,000
\$ Spent thru 2/29*	1,013,000	22,712,000	3,056,000	1,501,000	811,000	1,912,000	1,069,000	32,074,000 *
Positions Authorized	8.8	147.6	44.5	15.0	14.0	16.0	19.0	264.9

* net expenditures (includes unscheduled reimbursements)

0758 - Medical Board
Analysis of Fund Condition

(Dollars in Thousands)

#1: Planned Budget

	ACTUAL				
	2006-07	2007-08	2008-09	2009-10	2010-11
BEGINNING BALANCE	\$ 12,199	\$ 18,467	\$ 17,144	\$ 15,198	\$ 9,533
Prior Year Adjustment	\$ 576	\$ -	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 12,775	\$ 18,467	\$ 17,144	\$ 15,198	\$ 9,533
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	\$ 816	\$ 748	\$ 454	\$ 111
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	\$ 50,720	\$ 49,872	\$ 49,984	\$ 50,040
Transfers:					
Trans to Steven M. Thompson Phys Corp Loan Repayment Prgm			\$ (500)		
Totals, Revenues and Transfers	\$ 49,688	\$ 50,720	\$ 49,372	\$ 49,984	\$ 50,040
Total Resources	\$ 62,463	\$ 69,187	\$ 66,516	\$ 65,182	\$ 59,573
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			
Proposed BCP: Operation Safe Medicine				\$ 1,490	\$ 1,259
Proposed BCP: Probation Program Expansion				\$ 601	\$ 476
Proposed BCP: Replace IT Infrastructure				\$ 1,250	\$ 2,150
Total Expenditures and Expenditure Adjustments	\$ 43,996	\$ 52,043	\$ 51,318	\$ 55,649	\$ 57,239
FUND BALANCE					
Reserve for economic uncertainties	\$ 18,467	\$ 17,144	\$ 15,198	\$ 9,533	\$ 2,335
Months in Reserve	4.3	4.0	3.3	2.0	0.5

NOTES:

- A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED.
- B. INTEREST ON FUND ESTIMATED AT 5% BEGINNING FY 07/08.

4/11/2008

Medical Board of California
 FY 07/08
 Budget Expenditure Report
 (As of February 29, 2008)
 (66.7% 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	9,082,285	59.3	6,224,223
DEC	24,000	10,600	44.2	13,400
Board Members	31,500	17,600	55.9	13,900
Phy Fitness Incentive Pay	29,623	15,795	53.3	13,828
Temp Help	1,144,410	970,112	84.8	174,298
Allocated Proctor	0	129		(129)
Overtime	12,143	42,758	352.1	(30,615)
Staff Benefits	6,485,271	3,987,331	61.5	2,497,940
Salary Savings	(803,979)			(803,979)
TOTALS, PERS SERVICES	22,229,476	14,126,610	63.5	8,102,866
OPERATING EXP & EQUIP				
General Expense	891,585	261,739	29.4	629,846
Fingerprint Reports	373,448	219,513	58.8	153,935
Printing	835,648	474,384	56.8	361,264
Communications	567,855	195,989	34.5	371,866
Postage	444,459	166,729	37.5	277,730
Insurance	37,956	9,843	25.9	28,113
Travel In-State	421,039	245,921	58.4	175,118
Travel Out-of-State	2,800	432	15.4	2,368
Training	62,910	64,682	102.8	(1,772)
Facilities Operation (Rent)	2,784,152	2,095,276	75.3	688,876
Consult/Prof Services	1,369,919	1,258,925	91.9	110,994
Departmental Prorata	4,028,381	2,682,472	66.6	1,345,909
Consolidated Data Ctr (Teale)	572,639	162,140	28.3	410,499
Data Processing	106,263	141,114	132.8	(34,851)
Central Admin Svcs (Statewide Prorata)	1,793,449	1,345,653	75.0	447,796
Attorney General Services	12,419,270	7,991,694	64.3	4,427,576
Office of Administrative Hearings	1,643,939	955,903	58.1	688,036
Court Reporter Services	160,000	48,094	30.1	111,906
Evidence/Witness	1,676,318	742,963	44.3	933,355
DOI-Investigations	2,434	1,624	66.7	810
Major Equipment	232,300	98,095	42.2	134,205
Minor Equipment	182,300	345,763	189.7	(163,463)
Vehicle Operation/Other Items	242,370	242,102	99.9	268
Special Adjustments (OE&E)	0	(1,362)		1,362
Debt Service-Interest on Settlement	0	2,286		(2,286)
TOTALS, OE&E	30,851,434	19,751,974	64.0	11,099,460
TOTALS, EXPENDITURES	53,080,910	33,878,584	63.8	19,202,326
Scheduled Reimbursements	(384,000)	(227,874)	59.3	(156,126)
Distributed Costs	(691,000)	(489,745)	70.9	(201,255)
NET TOTAL, EXPENDITURES	52,005,910	33,160,965	63.8	18,844,945
Unscheduled Reimbursements		(1,086,971)		
		32,073,994		

**ENFORCEMENT/PROBATION RECEIPTS
MONTHLY PROFILE: JULY 2005 - FEBRUARY 2008**

	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
<i>Invest Cost Recovery Ordered*</i>	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
<i>Invest Cost Recovery Ordered*</i>	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	6,432	14,100	15,947					96,070
Criminal Cost Recovery	0	0	0	0	0	2,975	0	0					2,975
Probation Monitoring	31,949	49,534	24,134	32,231	119,692	140,590	247,147	220,081					865,358
Exam	3,545	4,227	1,248	1,820	1,209	300	905	2,055					15,309
Cite/Fine	1,200	9,100	6,250	4,800	13,440	1,850	1,700	3,500					41,840
MONTHLY TOTAL	51,768	75,586	45,483	49,688	141,445	152,147	263,852	241,583	0	0	0	0	1,021,552
FYTD TOTAL	51,768	127,354	172,837	222,525	363,970	516,117	779,969	1,021,552	1,021,552	1,021,552	1,021,552	1,021,552	

*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 - February 29, 2008

	<i>Per Diem*</i>			<i>TOTAL</i>	<i>Travel</i>	<i>Total</i>	<i>Total</i>
	<i>DEC</i>	<i>JAN</i>	<i>FEB</i>		<i>Expenses*</i>	<i>Dec-Feb</i>	
Mr. Alexander	200	400	500	1,100	1,020.56	2,120.56	4,156.73
Dr. Aristeiguieta	0	0	0	0	0.00	0.00	0.00
Ms. Chang	0	0	0	0	0.00	0.00	158.50
Dr. Chin	0	0	0	0	0.00	0.00	711.25
Dr. Corday	0	0	0	0	0.00	0.00	728.50
Dr. Duruisseau	300	400	400	1,100	424.70	1,524.70	4,103.86
Dr. Fantozzi	1,000	0	800	1,800	3,864.74	5,664.74	11,835.54
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
Dr. Low	0	0	0	0	0.00	0.00	200.00
Dr. Moran	0	0	0	0	0.00	0.00	0.00
Dr. Salomonson	0	0	0	0	0.00	0.00	3,657.58
Ms. Schipske	0	200	300	500	221.70	721.70	2,276.15
Dr. Wender	0	300	200	500	455.08	955.08	2,165.98
Ms. Yaroslavsky	0	0	0	0	0.00	0.00	0.00
Mr. Zerunyan	500	500	400	1,400	90.36	1,490.36	4,801.12
BOARD TOTAL	2,000	1,800	2,600	6,400	6,077.14	12,477.14	36,372.71

*includes claims paid/submitted through March 21, 2008

Board Members Expense Report.xls
Date: March 28, 2008

MEDICAL BOARD OF CALIFORNIA
EXECUTIVE PROGRAM
BUDGET REPORT
JULY 1, 2007 - FEBRUARY 29, 2008

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	642,738	420,441	current
Staff Benefits	<u>258,625</u>	<u>139,735</u>	current
TOTAL PERSONAL SERVICES	901,363	560,176	
OPERATING EXPENSE & EQUIPMENT			
General Expense 1/	70,500	37,234	1-2
Printing	300,000	36,290	1-2
Communications	26,292	6,270	1-2
Postage	181,375	61,023	1-2
Travel In-State	105,455	56,319	1-2
Travel Out-of-State	800	432	current
Training	5,000	5,404	1-2
Facilities Operations 2/	72,000	62,518	current
Consultant & Professional Services	24,000	16,025	1-2
Departmental Services 3/	143,813	96,566	current
Other Items of Expense	0	207	1-2
Data Processing	1,000	5,417	1-2
Central Administrative Services 4/	64,026	48,039	current
DOI-Investigations	0	58	current
Minor Equipment	<u>0</u>	<u>21,448</u>	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	994,261	453,250	
TOTAL BUDGET/EXPENDITURES	1,895,624	1,013,426	

See footnotes on next page

3/27/08
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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 Administration; 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.

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MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2007 - FEBRUARY 29, 2008

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	9,181,962	5,644,355	current
Staff Benefits	<u>3,555,428</u>	<u>2,232,405</u>	current
TOTAL PERSONAL SERVICES	12,737,390	7,876,760	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	256,104	62,640	1-2
Printing	373,148	315,003	1-2
Communications	310,994	112,601	1-2
Postage	101,806	36,716	1-2
Insurance	29,930	7,177	current
Travel In-State	122,358	79,539	1-2
Travel Out-of-State	900	0	current
Training	21,806	38,819	1-2
Facilities Operations	1,622,789	1,496,590	current
Consultant/Professional Services	750,000	636,345	1-2
Departmental Services	2,758,232	1,826,763	current
Data Processing	12,000	8,527	1-2
Central Administrative Services	1,227,975	921,362	current
Attorney General 1/ OAH	12,229,270	7,884,102	current
	1,643,939	955,903	current
Evidence/Witness Fees	1,606,750	718,905	1-2
DOI-Investigations	2,434	1,109	current
Court Reporter Services	160,000	48,094	1-2
Major Equipment	112,800	0	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	72	18,856	1-2
Vehicle Operations	184,098	163,356	1-2
Minor Equipment	65,500	50,164	1-2
Special Adjust-OE&E	0	(1,362)	
Interest-Settlement	<u>0</u>	<u>2,286</u>	
TOTAL OPERATING EXPENSES & EQUIPMENT	23,592,905	15,383,495	
DISTRIBUTED COSTS	(634,562)	(461,527)	
TOTAL BUDGET/EXPENDITURES	35,695,733	22,798,728	
Unscheduled Reimbursements		<u>(86,735)</u>	
		<u>22,711,993</u>	

1/See next page for monthly billing detail

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 07/08
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)
page 1 of 2

		<u>Number of Hours</u>	<u>Rate</u>	<u>Amount</u>
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			<u>990,344.50</u>
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			<u>828.50</u>
				<u>1,103,289.75</u>
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			<u>2,997.12</u>
				<u>1,002,288.62</u>
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			<u>371.88</u>
				<u>1,082,937.88</u>
November	Attorney Services	5,532.25	158.00	874,095.50
	Paralegal Services	253.50	101.00	25,603.50
	Auditor/Analyst	90.50	63.00	5,701.50
	Special Agent Services	10.00	110.00	1,100.00
	Cost of Suit			<u>1,267.04</u>
				<u>907,767.54</u>
December	Attorney Services	5,153.50	158.00	814,253.00
	Paralegal Services	227.75	101.00	23,002.75
	Auditor/Analyst	67.50	63.00	4,252.50
	Cost of Suit			<u>4,315.06</u>
				<u>845,823.31</u>

Revised 3/25/08

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 07/08
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)
page 2 of 2

January	Attorney Services	6,294.25	158.00	994,491.50
	Paralegal Services	277.25	101.00	28,002.25
	Auditor/Analyst	85.75	63.00	5,402.25
	Special Agent Services	5.00	120.00	600.00
	Cost of Suit			<u>3,347.85</u>
				<u>1,031,843.85</u>
February	Attorney Services	5,642.00	158.00	891,436.00
	Paralegal Services	245.75	101.00	24,820.75
	Auditor/Analyst	38.50	63.00	2,425.50
	Cost of Suit			<u>1,124.72</u>
				<u>919,806.97</u>
March	Attorney Services		158.00	0.00
	Paralegal Services		101.00	0.00
	Auditor/Analyst Services		63.00	0.00
	Cost of Suit			<u>0.00</u>
				<u>0.00</u>
April	Attorney Services		158.00	0.00
	Paralegal Services		101.00	0.00
	Auditor/Analyst Services		63.00	0.00
	Cost of Suit			<u>0.00</u>
				<u>0.00</u>
May	Attorney Services		158.00	0.00
	Paralegal Services		101.00	0.00
	Auditor/Analyst Services		63.00	0.00
	Cost of Suit			<u>0.00</u>
				<u>0.00</u>
June	Attorney Services		158.00	0.00
	Paralegal Services		101.00	0.00
	Auditor/Analyst Services		63.00	0.00
	Cost of Suit			<u>0.00</u>
				<u>0.00</u>

Revised 3/25/08
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07/08 FYTD Total = 7,884,102.42
07/08 FY Budget = 12,229,270.00

MEDICAL BOARD OF CALIFORNIA
 LICENSING PROGRAM
 BUDGET REPORT
 JULY 1, 2007 - FEBRUARY 29, 2008

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,858,777	1,208,114	current
Staff Benefits	<u>821,753</u>	<u>526,377</u>	current
TOTAL PERSONAL SERVICES	2,680,530	1,734,491	
OPERATING EXPENSES & EQUIPMENT			
General Expense	44,460	26,676	1-2
Fingerprint Reports*	369,948	216,954	current
Printing	100,000	106,643	1-2
Communications	73,816	36,982	1-2
Postage	137,446	67,780	1-2
Travel In-State	25,000	26,660	1-2
Training	4,000	2,925	1-2
Facilities Operation	185,000	184,871	current
Consult/Professional Services	448,919	587,626	1-2
Departmental Services	331,536	225,332	current
Data Processing	500	149	1-2
Central Administrative Services	147,601	110,757	current
Vehicle Operations	0	71	1-2
Attorney General	190,000	107,592	current
Evidence/Witness Fees	5,000	0	1-2
DOI-Investigations	0	134	current
Minor Equipment	<u>0</u>	<u>1,335</u>	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	2,063,226	1,702,487	
SCHEDULED REIMBURSEMENTS	(384,000)	(227,874)	
DISTRIBUTED COSTS	(26,089)	(13,044)	
TOTAL BUDGET/EXPENDITURES	4,333,667	3,196,060	
Unscheduled Reimbursements		<u>(140,308)</u>	
		3,055,752	

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

MEDICAL BOARD OF CALIFORNIA
ADMINISTRATIVE SERVICES PROGRAM
BUDGET REPORT
JULY 1, 2007 - FEBRUARY 29, 2008

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	830,002	588,585	current
Staff Benefits	<u>409,926</u>	<u>237,271</u>	current
TOTAL PERSONAL SERVICES	1,239,928	825,856	
OPERATING EXPENSE & EQUIPMENT			
General Expense	433,121	92,302	1-2
Printing	30,000	8,885	1-2
Communications	80,435	11,054	1-2
Postage	10,131	229	1-2
Travel In-State	20,000	11,433	1-2
Training	3,000	98	1-2
Facilities Operations	695,363	144,188	current
Consultant & Professional Services	37,000	14,921	1-2
Departmental Services	229,215	155,588	current
Data Processing	1,000	41,374	1-2
Central Administrative Services	102,047	76,567	current
Vehicle Operations/Insurance/Other	2,445	5,290	1-2
DOI-Investigations	0	92	current
Major Equipment	0	42,728	1-2
Minor Equipment	<u>0</u>	<u>84,285</u>	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	1,643,757	689,034	
DISTRIBUTED COSTS	(28,357)	(14,178)	
TOTAL BUDGET/EXPENDITURES	2,855,328	1,500,712	

MEDICAL BOARD OF CALIFORNIA
 DIVERSION PROGRAM
 BUDGET REPORT
 JULY 1, 2007 - FEBRUARY 29, 2008

	FY 07/08 BUDGET	EXPEND/ ENCUMB YR-TO-DATE	PERCENT OF BUDGET EXP/ENCUMB	LAG TIME (MONTHS)
PERSONAL SERVICES				
Salaries & Wages	720,179	427,608	59.4	current
Staff Benefits	<u>319,115</u>	<u>150,138</u>	47.0	current
TOTAL PERSONAL SERVICES	1,039,294	577,746	55.6	
OPERATING EXPENSES & EQUIPMENT				
General Expense	22,000	24,665	112.1	1-2
Printing	10,000	5,174	51.7	1-2
Communications	22,822	6,353	27.8	1-2
Postage	5,255	791	15.1	1-2
Insurance	1,702	516	30.3	current
Travel In-State	75,000	37,915	50.6	1-2
Travel Out-of-State	1,100	0	0.0	current
Training	4,418	616	13.9	1-2
Facilities Operation	30,000	32,978	109.9	current
Departmental Services	109,572	72,426	66.1	current
DP Maint/Supplies	500	0	0.0	1-2
Central Administrative Services	48,782	36,602	75.0	current
Major Equipment	16,000	0	0.0	current
Vehicle Operations	11,000	14,798	134.5	1-2
DOI-Investigations	<u>0</u>	<u>42</u>		
TOTAL OPERATING EXPENSES & EQUIPMENT	358,151	232,876	65.0	
TOTAL BUDGET/EXPENDITURES	1,397,445	810,622	58.0	

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MEDICAL BOARD OF CALIFORNIA
INFORMATION SYSTEMS PROGRAM
BUDGET REPORT
JULY 1, 2007 - FEBRUARY 29, 2008

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,036,606	708,664	current
Staff Benefits	<u>474,219</u>	<u>259,480</u>	current
TOTAL PERSONAL SERVICES	1,510,825	968,144	
OPERATING EXPENSE & EQUIPMENT			
General Expense	38,400	15,019	1-2
Printing	15,000	1,938	1-2
Communications	21,503	8,976	1-2
Postage	5,255	166	1-2
Travel In-State	21,441	4,783	1-2
Training	20,186	16,009	1-2
Facilities Operations	138,000	160,967	current
Consultant/Professional Services	110,000	4,008	1-2
Departmental Services	240,897	160,948	current
Consolidated Data Centers (Teale)	572,639	162,140	current
Data Processing	90,763	85,577	1-2
Central Administrative Services	107,248	80,469	current
Major Equipment	71,500	55,367	1-2
Minor Equipment	116,800	188,532	1-2
DOI-Investigations	<u>0</u>	<u>99</u>	current
TOTAL OPERATING EXPENSES & EQUIPMENT	1,569,632	944,998	
DISTRIBUTED COSTS	(1,992)	(996)	
TOTAL BUDGET/EXPENDITURES	3,078,465	1,912,146	

MEDICAL BOARD OF CALIFORNIA
 PROBATION MONITORING
 BUDGET REPORT
 JULY 1, 2007 - FEBRUARY 29, 2008

	FY 07/08 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,473,940	1,141,511	current
Staff Benefits	<u>646,208</u>	<u>441,926</u>	current
TOTAL PERSONAL SERVICES	2,120,148	1,583,437	
OPERATING EXPENSES & EQUIPMENT			
General Expense	30,500	5,763	1-2
Printing	7,500	452	1-2
Communications	31,993	13,754	1-2
Postage	3,191	24	1-2
Insurance	6,079	0	current
Travel In-State	51,785	29,272	1-2
Training	4,500	810	1-2
Facilities Operation	41,000	13,165	current
Departmental Services	215,116	144,849	current
Data Processing	500	70	1-2
Central/Administrative Services	95,770	71,857	current
Evidence/Witness Fees	64,568	24,057	1-2
DOI-Investigations	0	90	current
Major Equipment	32,000	0	1-2
Vehicle Operations/Other Items	<u>45,000</u>	<u>41,674</u>	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	629,502	345,837	
TOTAL BUDGET/EXPENDITURES	2,749,650	1,929,274	
Unscheduled Reimbursements*		<u>(859,929)</u>	
		1,069,345	

 *no authority to spend

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 3/27/2008

AGENDA ITEM #14

LICENSING PROGRAM
CHIEF'S REPORT

MBC BOARD MEETING
April 25, 2008

FISCAL YEAR 07/08
STATISTICS

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)
April-08	US/CAN	77	96	88
April-08	IMG	36	82	66
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
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	1,727	1,014
4th Quarter		
TOTAL	4,732	3,189

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	6	0	4	4
4th Quarter				
TOTAL	34	1	24	9

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	0	0	0
4th Quarter			
TOTAL	0	1	0

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	16,109	7,193	45%
4th Quarter			
TOTAL	51,040	26,023	NA

LICENSED MIDWIFE ACTIVITY 2007/2008			
Licenses Issued	Applications Received	Applications Pending	Applications Denied
10	11	3	0

Licenses Current/Renewed (as of January 6, 2008)	Licenses Delinquent (as of January 6, 2008)	Licenses Canceled (as of January 6, 2008)
171	24	15

AGENDA ITEM #15

Memorandum

AGENDA ITEM 15C

To: Renée Threadgill, Chief of Enforcement
Medical Board of California

Date: April 1, 2008

From: Susan Goetzinger
Expert Reviewer Program

Subject: Results of the Expert Survey Questionnaires

Questionnaires Sent this quarter (January 1-March 31, 2008)	50
Feedback Received from the questionnaires sent this quarter	44 (88%)
Total Feedback Received for this quarter's report	44

Questions 1-9, *positive response*: Yes
 Question 10, *positive response*: No
 Questions 11, *positive response*: Yes
 Questions 12-14, *positive response*: Yes

1	Were you provided sufficient information/evidence to allow you to render a medical opinion?	93 percent YES 5 percent NO 2 percent did not respond
2	Were you encouraged to render an unbiased opinion?	100 percent YES
3	Was the case directly related to your field of expertise?	100 percent YES
4	Were you given sufficient time to review the case?	100 percent YES
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?	100 percent YES
6	Did the training material provided to you (the Expert Reviewer Guidelines and videotape/DVD) give you adequate information to perform your case review?	93 percent YES 5 percent NO 2 percent N/A
7	Were you given clear, concise, and easy to follow instructions throughout the process?	100 percent YES
8	Was the investigator and/or MBC staff readily available to answer questions or concerns about the case?	96 percent YES 2 percent N/A 2 percent did not respond
9	Is the required written report adequate to cover all aspects of your opinion?	96 percent YES 4 percent NO
10	Do you feel the MBC has requested your services more frequently than you would prefer?	86 percent NO 5 percent YES 7 percent responded N/A 2 percent did not respond

11	Would you be willing to accept more MBC cases for review?	93 percent YES 2 percent N/A 5 percent did not respond
12	If you were required to testify, was the Deputy Attorney General readily available to answer questions and provide direction?	89 percent N/A 9 percent YES 2 percent did not respond
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?	91 percent N/A 6 percent YES 3 percent did not respond
14	Do you feel the reimbursement amount for case review is appropriate for the work you are required to perform?	61 percent YES 34 percent NO 5 percent did not respond
<i>Level of satisfaction with overall experience performing case reviews for MBC</i>		80 percent HIGH 16 percent 4 percent did not respond

SUGGESTIONS FOR IMPROVEMENT TO THE PROGRAM

I think the real issue is convincing practicing physicians that by doing review work, we really are helping the community physicians by providing a balance to the whole process.

Increase reimbursement rate.

If feasible, records in electronic format (pdf, etc. on a CD would be easier)

COMMENTS REGARDING REIMBURSEMENTS

\$150/hr is a bit low given level of expertise required.

\$150/hr is a fairly non-competitive rate for my time & expert opinion. The review takes a significant amount of time away from other activities.

Reimbursement for quality work is somewhat low.

Experts of the same qualification are paid \$500-750/hr in the private sector. The \$150/hr clearly does not come close to customary fees.

If I was doing it for the money it wouldn't be enough. That is not my motivation.

Tradesmen may make more money per hour.

\$150/hr is appropriate, but in some instances, the complexity should receive a higher reimbursement.

GENERAL COMMENTS

Bad photocopies, some narcotic logs were not included.

I was asked to review multiple charts that had been provided by a physician to Health Net and then subpoenaed from Health Net by the Medical Board. Most of these were only partial charts, reflecting only a few months to a couple of years of notes, when the patients had been under the care of that physician for many years. The chart pages were all completely out of order. It would have been better if the Board had obtained original copies of the charts from the physician so that the entire chart could be reviewed.

Have thought an intermediate level of departure from standard would be useful i.e., as well as simple or extreme

The program is excellent. Thank you.

This was the first review I had done and as such requested help from the medical consultant on two occasions by leaving voice messages on her phone and asked for feedback on my completed review via letter to her. All requests went unanswered, so I wish the medical consultant could have been more available/approachable.

I wouldn't mind looking at other cases.

The lack of information on the case was likely caused by the subject of the investigation.

E-mail contact info might be useful in the review process.

Taped interview was not clear.

No more cassette tapes - interviews should be on CD not tape

Medical records missing from CDC (Corrections). The case had voluminous records with unclear accusations in some cases. This was likely due to CDC records problem, not MBC.

Poor quality of audio interview- I had to rewind several times to hear what the doctor was saying.

The Medical Board review process is a slow process by the standards that practicing MDs are familiar with. It would be helpful to finish cases expeditiously; however, I am pleased to review all cases referred to me.

I enjoy the review process. I would like to have more cases if possible.

Very organized records. Very helpful staff-professional. Pleasure to work with San Bernardino District office.

Receiving sample case reports and CD which is compatible would have made process smoother and involved less time.

Guidelines did not arrive with materials.

MBC has used me more in the past.

Some years ago I reviewed a physician who was subsequently sanctioned after a judicial hearing. He then filed a complaint against me with our professional societies. How can I get copies of my prior chart reviews of his cases, in order to defend myself?

I would love more cases. Please feel free to contact me anytime.

Everyone was very helpful. I have always found this a constructive experience - Thanks!

Allow up to 15 hrs if case has large amount of material to review.

I had a very good experience and felt very supported.

**CASES BY SPECIALTY SENT FOR REVIEW
 USE OF EXPERTS BY SPECIALTY
 ACTIVE LIST EXPERTS BY SPECIALTY
 Year to Date (April 2008)**

AGENDA ITEM 15D

SPECIALTY	Number of cases reviewed/sent to Experts Jan-Mar 2008	Number of Experts used and how often utilized Jan-Mar 2008	Active List Experts Y-T-D (TOTAL=1,163 †)
ADDICTION			11
AEROSPACE MEDICINE			1
ALLERGY & IMMUNOLOGY			10
ANESTHESIOLOGY	3	3 list experts	90 †
BIOETHICS			1
COLON & RECTAL SURGERY			5 †
COMPLEMENTARY/ALTERNATIVE MEDICINE			13
CORRECTIONAL MEDICINE	3	3 list experts	9 †
DERMATOLOGY	2	2 list experts	12 †
EMERGENCY	2	2 list experts	65 †
ETHICS	1	1 outside expert	1 †
FAMILY	9	9 list experts	97
HOSPICE & PALLIATIVE CARE			7
INTERNAL General Internal Med & sub-specialties not listed below	9	9 list experts	237 †
INTERNAL - CARDIOLOGY Interventional Cardiology	2	1 list expert 1 outside expert (testified)	32 † [16 †]
INTERNAL-ENDOCRINOLOGY & METABOLISM			9
INTERNAL - GASTROENTEROLOGY			18 †
INTERNAL -INFECTIOUS DISEASES			10 †
INTERNAL - NEPHROLOGY			8 †
INTERNAL - ONCOLOGY			12 †
MEDICAL GENETICS			1
MIDWIFE			12
NEUROLOGICAL SURGERY	3	1 list expert reviewed all 3 cases	15 †
NEUROLOGY			21 †
NEUROLOGY (CHILD)			4 †

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
(YEAR TO DATE - APRIL 2008)

Page 2

OBSTETRICS & GYNECOLOGY	4	4 list experts	88 †
REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY			4
OCCUPATIONAL MEDICINE	1	1 list expert	8
OPHTHALMOLOGY	1	1 list expert	49
ORAL & MAXILLOFACIAL SURGERY			1
ORTHOPAEDIC SURGERY	10	1 list expert reviewed 3 cases 1 list expert reviewed 2 cases 5list experts reviewed 1 case each	49 †
OTOLARYNGOLOGY			33 †
PAIN MEDICINE ((18ABMS†; 12 ABPM = 31)	2	2 list experts	31 †
PATHOLOGY (Anatomic/Clinical-12; Anatomic-1)	1	1 list expert	13
PEDIATRICS			65 †
PEDIATRIC CARDIOLOGY	1	1 list expert	5 †
PEDIATRIC CARDIOTHORACIC SURGERY			0
PEDIATRIC HEMATOLOGY/ONCOLOGY			5 †
PEDIATRIC INFECTIOUS DISEASES (BOARD CERTIFIED)			3 †
PEDIATRIC SURGERY			4
PHYSICAL MEDICINE & REHABILITATION			10 †
PLASTIC SURGERY (Facial Plastic-8)	6	6 list experts	49 †
PSYCHIATRY	7	1 list expert reviewed 2 cases 5list experts reviewed 1 case each	113
PUBLIC HEALTH & GENERAL PREVENTIVE MEDICINE			6
RADIOLOGY (3†) DIAGNOSTIC RADIOLOGY-32 † NUCLEAR MEDICINE-6	3	3 list experts	41 †
VASCULAR/INTERVENTIONAL RADIOLOGY (Board Certified)			2 †
RADIATION ONCOLOGY -4 / THERAPEUTIC RADIOLOGY -2			6
SLEEP MEDICINE			8
SPINE SURGERY (ABSS-MBC APPROVED)			1
SURGERY			56 †

**CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
(YEAR TO DATE - APRIL 2008)**

Page 3

THORACIC SURGERY	3	3 list experts	19 †
VASCULAR SURGERY			6 †
UROLOGY	2	2 list experts	17 †
WORKERS' COMP/QME/IME			7 †

/susan (4/1/08)

Medical Board of California
Investigation & Prosecution Timeframes*

	2005		2006		2007		Q1 2008	
	Prior to VE	All	VE	All	VE	All	VE	
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution								
Average	271	299	138	330	268	355	339	
Median	252	285	134	304	269	332	309	
Record Count	827	703	192	648	539	180	171	
Calendar Day Age from Request to Suspension Order Granted								
Average	51	44	4	34	38	37	37	
Median	17	3	2	22	23	37	37	
Record Count	24	21	11	17	13	2	2	
Calendar Day Age from Request to Receipt of Medical Records								
Average	58	53	37	59	57	69	37	
Median	32	31	26	31	31	29	21	
Record Count	475	376	228	264	259	40	37	
Calendar Day Age from Request to Physician Interview Completed								
Average	48	51	43	52	50	59	58	
Median	36	42	38	37	36	44	44	
Record Count	597	453	172	406	371	101	98	
Calendar Day Age from Request to Receipt of Expert Opinion								
Average	51	47	35	51	43	46	46	
Median	41	35	31	36	35	35	35	
Record Count	519	424	82	344	270	73	69	
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed								
Average	556	554	140	543	340	649	537	
Median	525	504	120	523	339	662	587	
Record Count	187	149	17	198	95	36	25	
Calendar Day Age from Accusation Filed to Disciplinary Outcome**								
Average	608	602	85	576	188	475	192	
Median	526	466	99	426	182	379	197	
Record Count	212	195	3	226	29	67	22	

*Excludes Out of State and Headquarters Cases

**Excludes Outcomes where no Accusation Filed

Medical Board of California
Citations Issued & Civil Actions Filed by Calendar Year

	2005	2006	2007	Q1 2008
Citations Issued*	80	81	76	23
Citations Issued for Failure to Produce Records	0	6	3	0
Civil Actions Filed	3	3	1	0
Civil Actions Filed for Failure to Produce Records	2	2	1	0

*Excludes citations issued for failure to comply with CME audit and for failure to notify Board of change of address

State of California

Department of Consumer Affairs
 Medical Board of California

MEMORANDUM

To: Medical Board of California
 Diversion Committee

Date: April 9, 2008

From: Frank L. Valine 
 Diversion Program Administrator

Subject: Quality Review Report – 3rd 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 January 1, 2008 through March 31, 2008.

INTAKES

A total of 0 physicians contacted the Program during the 2nd Quarter. The following charts reflect the outcomes of contact with these physicians as of March 31, 2008, as well as, other categories of information.

Status at Intake	1 st Qtr	2 nd Qtr	3rd Qtr	4th Qtr	Totals
Active: Approved by DEC & Signed Agreement	0	0	0		0
Accepted; Waiting for Signature:	1	0	0		1
Intake Complete; Awaiting DEC:	5	3	0		8
Contacted Program/Telephone Intake:	6	2	0		8
Ineligible:	0	0	1		1
Not interested in Program:	2	0	1		2
Terminated	0	0	3		3
Out-of-State:	0	0	0		0
Total Contacts	14	5	5		24

Other information	1 st Qtr	2 nd Qtr	3rd Qtr	4th Qtr	Totals
<u>In Treatment</u> ; At intake:	4	5	0		9
Currently:	7	3	0		10
<u>Referral Type</u> ; Board Action:	6	0	0		6
Self-Referral:	8	5	0		13
<u>Impairment</u> ¹ ; Chemical:	9	1	0		10
Dual Disorder:	5	4	0		9
Mental Only:	0	0	0		0
<u>Practicing</u> ; Yes:	3	0	0		3
No:	11	5	0		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.

Table #1: Program Response Times for Intakes, 3rd Quarter FY 2007/2008, January – March 2008

Table #1 shows the average response times for intakes (excluding physicians in treatment and those delayed in entry into the Program) during this period, as well as the Program's target timeframes, from the date the physician initially contacted the Program to the completion of the major steps of the evaluation process. These steps include the first face-to-face contact with Program staff; the intake interview; the initial urine test; and attendance at the first DEC meeting. A total of 0 intakes.

The data in A & B total intakes often does not meet program target dates because in many instances the process is delayed when the participant is in treatment and unavailable for an intake or to begin urine tests.

	Process	Total	Average # of Days	Program Target	Time Periods	Number	Percentage
A	<u>From initial contact to Intake Interview</u>	0	n/a	ASAP	0-7 DAYS 7-14 DAYS 14-21 DAYS 21+ DAYS		
B	<u>From initial contact to 1st urine test</u>	0	n/a	ASAP	0-7 DAYS 7-14 DAYS 14-21 DAYS 21+ DAYS		
C	<u>From initial contact to attendance at 1st DEC Meeting</u> <i>(No Enforcement Activity)</i>	0	n/a	n/a	0-60 DAYS 60-90 DAYS 90+ DAYS		
D	<u>From initial contact to attendance at 1st DEC Meeting</u> <i>(With Enforcement Activity)</i>	0	n/a	n/a	0-60 DAYS 60-90 DAYS 90+ DAYS		

The number of total intakes shown in C & D does not match the actual number of intakes during the reporting quarter because it takes 60-90 days to schedule the DEC meetings and this report does not include updates from the previous quarter.

RELEASES

The table below shows the case details for the 91 participants (for the time period of **January 2008 – March 2008, the 3rd quarter**) who were released from the program; 88 successfully and 3 unsuccessfully.

1st Qtr 2nd Qtr

Type of Referral:	Board Action:	7	27
	Self-Referral:	6	27
Participant Impairment:	Chemical Dependency:	7	33
	Dual Disorder:	6	21
	Mental Only:	0	0
Successful/Unsuccessful:	Successful:	10	45
	Unsuccessful:	3	9
Release Time for Successful Participants in Program:	3-5 years in program:	0	31
	5-6 years in program:	10	12
	6+ years in program:	0	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:	32	
	Self-Referral:	59	
Participant Impairment:	Chemical Dependency:	53	
	Dual Disorder:	37	
	Mental Only:	1	
Successful/Unsuccessful:	Successful:	88	
	Unsuccessful:	3	
Successful Release Time in Program:	4-6 years in program:	30	
	6+ years in program:	3	
	Due to Sunset:	55	
Treatment prior to program:		6	
Treatment while in program:		11	
Relapses while in program:		0	

Totals Qtrs 1-4

Type of Referral:	Board Action:	66
	Self-Referral:	92
Participant Impairment:	Chemical Dependency:	93
	Dual Disorder:	64
	Mental Only:	1
Successful/Unsuccessful:	Successful:	143
	Unsuccessful:	15
Release Time for Successful Participants in Program:	3-5 years in program:	61
	5-6 years in program:	25
	6+ years in program:	
Treatment prior to program:		32
Treatment while in program:		28
Relapses while in program:		4

Physician Diversion Program –
 Releases (91 participants for the time period of Jan 2008 – March 2008, 3rd Quarter, FY07/08)

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time in Program at Release	Relapses(s)	Practice Status at Release
2214	Completed	Self	None	Alcohol	No	4 Yrs	No	Practicing
2273	Completed	Self	None	Alcohol	Yes	3 Yrs	No	Practicing
2193	Completed	Board	SOU	Alcohol, Cocaine	Yes	4 Yrs	No	Practicing
2441	Completed	Self	None	Alcohol	Yes	1 Yr	No	Practicing
2442	Completed	Self	None	Alcohol	Yes	1 Yr	No	Practicing
1841	Completed	Board	SOU	Alcohol	No	8 yrs	No	Practicing
2470	Completed	Self	None	Demerol	No	> 1 Yr	No	Practicing
2166	Completed	Board	SOU	Benzos.	No	4 + Yrs	No	Practicing
2410	Completed	Self	None	Demerol	Yes	1 + Yrs	No	Practicing
2157	Completed	Self	None	Benzos., Opiates	Yes	4 + yrs	No	Practicing
2323	Completed	Self	None	Vicodin	No	2 + Yrs	No	Practicing

Physician Diversion Program –
Releases (91 participants for the time period of Jan 2008 – March 2008, 3rd Quarter, FY07/08)

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time in Program at Release	Relapses(s)	Practice Status at Release
2453	Completed	Self	None	Xanax	Yes	> 1 Yr	No	Practicing
2104	Completed	Self	None	Amphet.	Yes	5 Yrs	No	Practicing
2339	Completed	Self	None	Alcohol	No	2 + Yrs	No	Practicing
2337	Completed	Self	None	Vicodin	No	2 + Yrs	No	Practicing
2480	Completed	Self	None	Alcohol, Vicodin	Yes	> 1 Yr	No	Out of Practice
2412	Completed	Self	None	Alcohol	No	1 + Yrs	No	Practicing
2147	Completed	Self	None	Cocaine, Phent.	Yes	4 + Yrs	No	Practicing
2184	Completed	Board	SOU	Meth.	Yes	4 + Yrs	No	Practicing
2292	Completed	Self	None	Amphet./Food	Yes	3 Yrs	No	Practicing
2174	Completed	Board	SOU	Alcohol	No	4 + Yrs	No	Practicing
2237	Completed	Board	SOU	Alcohol	No	3 + Yrs	No	Practicing

Physician Diversion Program –
 Releases (91 participants for the time period of Jan 2008 – March 2008, 3rd Quarter, FY07/08)

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time in Program at Release	Relapses(s)	Practice Status at Release
2364	Completed	Self	None	Alcohol, Marijuana	Yes	1 + Yrs	No	Practicing
2183	Completed	Board	SOU	Alcohol	Yes	4 + Yrs	No	Practicing
2476	Completed	Self	None	Alcohol	Yes	> 1 Yr	No	Practicing
2425	Completed	Self	None	Alcohol	No	1 + Yrs	No	Practicing
2477	Completed	Self	None	Alcohol, Amphet.	Yes	> 1 Yr	No	Practicing
2358	Completed	Self	None	Alcohol	Yes	> 1 Yr	No	Practicing
2248	Completed	Board	SOU	Ultram	No	3 + Yrs	No	Practicing
2359	Completed	Self	None	Alcohol/Meth.	No	2 Yrs	No	Practicing
2269	Completed	Board	SOU	Alcohol	No	3 Yrs	No	Practicing
2231	Completed	Board	SOU	Opiates	Yes	3 + Yrs	No	Practicing
2251	Completed	Self	None	Alcohol	No	3 + Yrs	No	Practicing

Physician Diversion Program –
Releases (91 participants for the time period of Jan 2008 – March 2008, 3rd Quarter, FY07/08)

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time in Program at Release	Relapses(s)	Practice Status at Release
2252	Completed	Board	SOU	Vicodin	Yes	3 + Yrs	No	Practicing
2388	Completed	Self	None	Vicod./Ambien	No	1 + Yrs	No	Practicing
2457	Completed	Self	None	Vicod./Fent.	No	> 1 Yr	No	Practicing
2275	Completed	Board	SOU	Vicodin	Yes	3 Yrs	No	Practicing
2121	Completed	Self	None	Xanax	Yes	5 Yrs	No	Practicing
2102	Completed	Self	None	Meth.	No	5 Yrs	No	Practicing
2289	Completed	Self	None	Vercet	No	3 Yrs	No	Practicing
2374	Completed	Self	None	Alcohol	No	1 + Yrs	No	Practicing
2481	Completed	Self	None	Alcohol	No	> 1 Yr	No	Practicing
2467	Completed	Self	None	Alcohol	Yes	> 1 Yr	No	Practicing
2432	Completed	Self	None	Alcohol/Hyrdoc	Yes	1 Yr	No	Out of Practice

**Physician Diversion Program –
Releases (91 participants for the time period of Jan 2008 – March 2008, 3rd Quarter, FY07/08)**

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time in Program at Release	Relapses(s)	Practice Status at Release
1977	Completed	Board	SOU	Vicodin/Ultram	Yes	6 + Yrs	No	Practicing
2076	Completed	Board	SOU	Opiates	No	5 + Yrs	No	Practicing
2371	Completed	Self	None	Cocaine	No	1 + Yrs	No	Practicing
2427	Completed	Self	None	Alcohol/Vicodin	No	1 + Yrs	No	Practicing
2350	Completed	Self	None	Alcohol/Ativan/ Ambien	Yes	2 + Yrs	No	Practicing
2479	Completed	Self	None	Alcohol	Yes	> 1 Yr	No	Practicing
2210	Completed	Board	SOU	Alcohol	Yes	4 + Yrs	No	Practicing
2393	Completed	Self	None	Vicodin	No	1 + Yrs	No	Practicing
2177	Completed	Board	SOU	Alcohol/Vicodin	Yes	4 + Yrs	No	Practicing
2150	Completed	Board	SOU	Nubain	No	4 + Yrs	No	Practicing
2208	Completed	Board	SOU	Alcohol/Coc.	Yes	4 Yrs	No	Practicing

Physician Diversion Program –
Releases (91 participants for the time period of Jan 2008 – March 2008, 3rd Quarter, FY07/08)

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time in Program at Release	Relapses(s)	Practice Status at Release
2473	Completed	Self	None	Alcohol	No	> 1 Yr	No	Practicing
2464	Completed	Self	None	Alcohol	No	> 1 Yr	No	Practicing
2276	Completed	Self	None	Marijuana	No	3 Yrs	No	Practicing
2113	Completed	Board	SOU	Alcohol	No	5 Yrs	No	Practicing
2199	Completed	Board	SOU	Alcohol/Coc.	No	4 + Yrs	No	Practicing
2365	Completed	Self	None	Cocaine	Yes	1 + Yrs	No	Practicing
2175	Completed	Self	None	Opiates	Yes	4 Yrs	No	Practicing
2318	Completed	Self	None	Alcohol/Benzos	No	2 + Yrs	No	Practicing
2272	Completed	Board	SOU	Alcohol	No	3 Yrs	No	Practicing
2398	Completed	Self	None	Alcohol	No	1 + Yrs	No	Practicing
2215	Completed	Board	SOU	Herione/Opiat.	No	3 + Yrs	No	Practicing

Physician Diversion Program –
 Releases (91 participants for the time period of Jan 2008 – March 2008, 3rd Quarter, FY07/08)

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time in Program at Release	Relapses(s)	Practice Status at Release
2329	Completed	Self	None	Demerol/Fent.	No	2 + Yrs	No	Practicing
2263	Completed	Board	SOU	Alcohol	Yes	2 + Yrs	No	Practicing
2309	Completed	Self	None	Cocaine/Opiate	No	2 + Yrs	No	Practicing
2072	Completed	Self	None	Alcohol/Vic.	No	5 + Yrs	No	Practicing
2115	Completed	Board	SOU	Alcohol	No	4 + Yrs	No	Practicing
2256	Completed	Board	SOU	Alcohol/Vic.	No	3 + Yrs	No	Practicing
2040	Completed	Self	None	Alcohol/Hydroc	No	5 + Yrs	No	Practicing
2232	Completed	Board	SOU	Alcohol	Yes	3 + Yrs	No	Practicing
2290	Completed	Self	None	Alcohol/Opiate	No	3 Yrs	No	Practicing
2322	Completed	Board	SOU	Bi-Polar	Yes	2 + Yrs	No	Practicing
2143	Completed	Self	None	Alcohol/Valium/ Ultran	No	4 + Yrs	No	Practicing

Physician Diversion Program –
 Releases (91 participants for the time period of Jan 2008 – March 2008, 3rd Quarter, FY07/08)

Case	Release Status	Type of Referral	Enforcement Activity	Drug (s) of Abuse	Mental Health Disorder	Time in Program at Release	Relapses(s)	Practice Status at Release
2123	Completed	Board	SOU	Alcohol/Vicodin	Yes	4 + Yrs	No	Out of Practice
1356	Completed	Board	SOU	Alcohol	Yes	10 + Yrs	No	Practicing
2324	Completed	Self	None	Meth	Yes	2 + Yrs	No	Practicing
2159	Completed	Self	None	Meth/Cocaine	Yes	4 + Yrs	No	Practicing
2222	Completed	Board	SOU	Marijuana/Meth	No	4 Yrs	No	Practicing
2468	Completed	Self	None	Alcohol/Klonop /Ambien	No	> 1 Yr	No	Practicing
2226	Completed	Self	None	Opiates	Yes	3 + Yrs	No	Practicing
2459	Completed	Self	None	Alcohol	No	> 1 Yr	No	Practicing
2286	Completed	Self	None	Alcohol	No	3 Yrs	No	Practicing
2130	Completed	Board	SOU	Floriset	No	4 + Yrs	No	Practicing
2240	Completed	Board	SOU	Alcohol	No	3 + Yrs	No	Practicing

Physician Diversion Program –
 Releases (91 participants for the time period of Jan 2008 – March 2008, 3rd Quarter, FY07/08)

<i>Case</i>	<i>Release Status</i>	<i>Type of Referral</i>	<i>Enforcement Activity</i>	<i>Drug (s) of Abuse</i>	<i>Mental Health Disorder</i>	<i>Time in Program at Release</i>	<i>Relapses(s)</i>	<i>Practice Status at Release</i>
2419	Terminated	Self	Referred	Meth.	Yes	4 yrs	No	Out of Practice
2439	Terminated	Self	Referred	Alcohol, Benzos	Yes	4 mo	No	Practicing
2103	Terminated	Self	Referred	Opiates	No	2 yrs	Yes	Practicing

RELAPSES (0)

The table below shows the case details for total participant relapses during the time period reported. There were 0 relapses during the time frame from January 2008 – March 2008, 3rd Quarter.

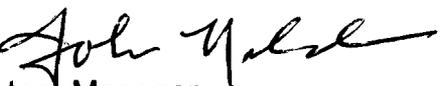
Quarters		1 st	2 nd	3rd	4th	Totals
Type of Referral:	Board Action:	4	5	0		9
	Self- Referral:	4	2	0		6
Participant Impairment:	Chemical Dependency:	5	6	0		11
	Dual Disorder:	3	1	0		4
Length of Time in Program at Relapse:	0-1 year	4	2	0		6
	1-2 years	1	2	0		3
	2-3 years	1	2	0		1
	3-4 years	2	0	0		2
	4-5 years	0	1	0		1
	7-8 years	0	0	0		0
Total with Prior Relapses:		6	2	0		8
Method of Detection:	Random UDS:	7	5	0		12
	Collector Detection:	0	0	0		0
	DUI:	0	0	0		0
	Self Report:	0	0	0		0
	Treatment Center:	1	0	0		1
Practice Restrictions in Response to Relapse:	Stop Practice Initiated:	5	5	0		10
	Stop Practice Continued:	1	1	0		2
Clinical Response to Relapse:	Inpatient treatment:	5	1	0		6
	Increase group/urine tests:	0	0	0		0
	Retesting:	8	5	0		13
	Outpatient Treatment:	0	0	0		0
	DEC further review:	2	0	0		2
	Termination:	0	2	1*		3
	Death:	0	0	0		0
Withdrew from Program:		0	2	0		2

* Relapse that happened in late 12/07 resulted in an early Unsuccessful Termination in early 1/08.

Memorandum

To: Frank Valine 
Diversion Program Administrator

Date: April 9, 2008

From: John Yelchak 
Collection System Manager

Subject: Collection System Status Report for January 2008 – March 2008

Attached are the charts reporting the collective test results for Urine Drug Screen (UDS) samples taken during the 3rd Quarter, January 2008 – March 2008 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:

	<i>Collection to lab receipt</i>	<i>Lab receipt to results reported</i>	<i>Total Time</i>
Averages:	3.8 days	1.4 days	5.2 days

Attachments

UDS Test Results – 3rd Quarter January 2008 – March 2008

POSITIVE TEST RESULTS				
Month 2008	Total # of Tests	Total Positive Results	Number of Positives	Comments
January	637	37	2 1 33 1	Morphine. Re-test was also positive. Participant is no longer in program because of ineligibility. Fentanyl approved patch. Approved prescriptions by case manager for Naltrexone. Positives resulting from alcohol-producing microorganisms associated with participant's diabetes.
February	475	18	18	Approved prescriptions by case manager for Naltrexone.
March	480	22	22	Approved prescriptions by case manager for Naltrexone.
TOTAL	1592	77	77	

NEGATIVE-DILUTE TEST RESULTS				
Month 2008	Total # of Tests	Total Negative- Dilute Results	Number of Negative-Dilute Results	Comments
January	637	0	0	
February	475	2	2	Case Managers notified and retested.
March	480	0	0	
TOTAL	1592	2	2	

UDS Test Results – 3rd Quarter January 2008 – March 2008

INVALID/REJECTED TEST RESULTS				
Month 2008	Total # of Tests	Total Invalid or Rejected Results	Number of Invalid or Rejected Results	Comments
January	637	1	1	Tamper-Evident seal missing. Re-tested.
February	475	9	2 1 2 1 1 2	GC/MS Interference. Re-tested. Donor Signature missing from chain of custody. Collector name/Signature not on Chain of Custody form; Re-tested. The sample leaked in transport; retested. Insufficient volume: lab used entire vial prior to completing the test; retested. Specimen ID# mismatch/missing
March	480	6	1 4 1	Collector name/Signature not on Chain of Custody form; Re-tested. Insufficient volume: lab used entire vial prior to completing the test; Re-tested. Specimen ID# mismatch/missing
TOTAL	1592	16	16	

Action taken on Positive (UDS Test) Results – 3rd Quarter January – March 2008

JANUARY POSITIVE TEST RESULTS (other than Naltrexone)					
	<i>Collection Date</i>	<i>Lab Received Date</i>	<i>Lab Reported Date</i>	<i>Substance</i>	<i>Action Taken/Comments</i>
1	12/29/07	1/2/08	1/15/08	Alcohol, Ethyl (.03 g/dL)	Possible reasoning was diabetes producing alcohol micros. Etc was negative.
2	1/7/08	1/8/08	1/9/08	Morphine (546 ng/mL)	Participant not working and not eligible for the Program.
3	1/10/08	1/14/08	1/16/08	Morphine (361 ng/mL)	Re-test was also positive. Participant denied using on both accounts.
4	1/22/08	1/23/08	1/25/08	Fentanyl (961 pg/mL)	Approved medication after surgery.

Memorandum

Date : April 8, 2008

To : Kimberly Kirchmeyer
Deputy Executive Director

From : Frank Valine 
Diversion Program Administrator

Subject: Program Update

As of March 31, 2008, we have 74 participants currently active in the Diversion Program.

Out-of-State 4 Enforcement Participants

Northern 27 17 Enforcement Referrals and 10 Probation Referrals

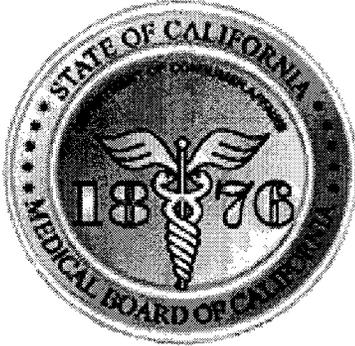
Southern 43 31 Enforcement Referrals and 12 Probation Referrals

Total 74 (48 Enforcement Referrals, 22 Probation Referrals and 4 OS)

There are five Diversion Evaluation Committee (DEC) Meetings to be held. The Southern California DEC meetings will be held on April 16, April 30, May 14, May 28 and the Northern California DEC meeting will be held on May 22, 2008.

Please let me know if you have any questions.

AGENDA ITEM #17



THE MEDICAL BOARD OF CALIFORNIA

Department of Consumer Affairs

Diversion Program Summit Meeting Summary of Public Comments

The Diversion Summit was held on January 24, 2008. Medical Board Members in attendance included: Dr. Richard Fantozzi, Dr. Janet Salomonson, Dr. Ron Wender, and Dr. Cesar Aristeiguieta. Kimberly Kirchmeyer represented the Medical Board staff. The Summit was professionally facilitated by Cheri Douglas, CPF, of Positive Impact Consulting.

By way of introduction, facilitator Cheri Douglas reminded attendees that the current Diversion Program will sunset on June 30, 2008 and the purpose of the Summit was not to reopen debate of that decision. She called attention to posted ground rules designed to assure equal access to each participant, including a limit of one presenter per program or proposal, focus on options for the future, and the five-minute time limit. Participants were also instructed that complaints or comments regarding a specific person would not be allowed and that such comments could compromise the outcomes of cases which might come before the Medical Board in the future.

In opening remarks, Dr. Fantozzi, Medical Board President, set the stage for the Summit:

“Today is a great day for all of California, as well as our physician licensees. It marks the beginning of an endeavor by the Medical Board of California to improve its mission to protect the public, while also attempting to find common ground with others who are interested in a proactive approach to help physicians who need help in the arena of substance abuse.

“This past year, the medical board was faced with a disappointing audit, consistent with past audits that underscored the continued failure of our diversion program. Consumer groups and individuals also expressed their concern that the diversion program, not only did not protect the public, but it was a failed concept, despite 27 years of efforts to improve it.

“The auditors, but more importantly the consumers, spoke and the board listened. Diversion, I want to stress, is not treatment. It is the act of diverting substance-abusing physicians from administrative disciplinary action to a program designed to monitor the impaired physician. The program, based on information from evaluators and diversion evaluation committees, required biologic fluid testing, practice monitors, and group facilitator recommendations, based on individuals’ needs. The evaluators, though required to be licensed in a field of expertise, had no consistent standard by which to base their evaluations.

“Although the intent was to provide a comprehensive plan for recovery, the flaws have been in the human element and the clinical disease being treated. It can be said addiction is a complex disease. Audit after audit showed the plan did not work for some participants. Abuse of the privilege of the program by some participants repeatedly put consumers at risk. Repeat offenders were pointed out in several audits as well the ability for the participants to game the system.”

Dr. Fantozzi explained that after the end of the Diversion Program with discipline as the only option, the board would still recommend that individuals seek treatment but that participation would not be kept confidential from the public. He said that the diversion program has been confidential to encourage more voluntary participation. But, while experts estimate 10,000 – 15,000 California physicians suffer from some degree of substance abuse, the average number of physicians in the diversion program was only 250. There had been very little voluntary participation, despite confidentiality.

Dr. Fantozzi called for new ideas to come from Summit participants to reach out to the thousands of physicians suffering from substance abuse who had been ignored by the diversion program and he affirmed that the Medical Board’s mission of public protection would be its first priority.

The following is a series of selected quotes from participant comments organized by major themes. The purpose of this section is to focus on specific ideas and recommended policies for a new program. This section **excludes** generalities that all or most participants shared, including:

- Patient protection is the highest priority;
- Addiction is a disease that can afflict anyone, from any socio-economic background;
- The Medical Board has a duty to protect the public;
- Several audits of the expiring Diversion Program have exposed serious concerns and deficiencies, and a range of weaknesses and inconsistencies in dealing with physician participants;
- The existing program has failed to protect some patients.

The comment themes are sorted into five issue-categories addressed by the participants:

1. Early detection and intervention;
2. Comments in favor of a confidential program that permits physician participants to continue to practice medicine;
3. Comments in favor of a non-confidential program that prevents or limits continued medical practice by physician participants;
4. Recommendations for the organizational structure and funding of a new program;
5. Presentations of treatment programs by the owners of those programs.

1. Early Detection & Intervention

<p>Jeffrey Uppington California Society of Anesthesiologists</p>	<p>“If managed correctly, an effective diversion program identifies doctors with potential problems early, ensuring they are monitored and get the treatment they need before a problem can endanger patients.”</p> <p>“Shame and fear motivate these physicians to hide their problems and to engage in inappropriate acts. The inability of local peers to recognize or assist them may further endanger the public”</p>
<p>James Hay, M.D. California Medical Association</p>	<p>“Patients will be better protected with a program that focuses on early intervention and assessment and monitoring.”</p>
<p>Jack Shale, M.D. California Psychiatric Association</p>	<p>“Now, the important thing is to intervene early before there is harm. If you wait until someone gets a DUI or someone gets sued or someone has done harm, and it turns out after the fact that it was a result of addiction to alcohol or drugs, then you are too late. You have to intervene early.”</p>
<p>Sharon Levine, M.D. Permanente Medical Group, Northern California</p>	<p>“...our approach at Kaiser Permanente... is the prevention identification and early intervention in a physician who is ill, depressed, who has a predilection for substance abuse, but who has not yet been impaired. I think there is no way we can underemphasize the importance of prevention and early identification and detection.”</p> <p>“We spend a lot of time every year marketing and doing outreach from our well being and our wellness committee, so that every physician in our organization can recognize the signs of trouble in a physician. Everything from changes in attendance, tardiness, changes in demeanor, signals that can signal that a physician whose practice is not yet affected could, down the road, have a problem that is developing. We have 16 professional staff well being committees, with 175 active members of our medical staffs who sit on these committees.”</p>

2. In Favor of a Confidential Program that Permits Physician Participants to Continue to Practice Medicine

<p>James Hay, M.D. California Medical Association</p>	<p>“It must be open to voluntary, as well as board referred participants and be confidential for compliant participants, because if it isn’t, you won’t identify the physicians that have the problems early, you won’t have them in the plan, and you will see only a tip of the iceberg as has been discussed.”</p> <p>“The bottom line is that strong monitoring, together with confidential treatment affords the most protection for the patients of California.”</p>
<p>Shannon Chavez, M.D. UC San Diego</p>	<p>“We share the same message from all UC campuses that the state of California join the Federation of Physician Health Programs to safely monitor physicians confidentially that suffer from the disease of addiction.”</p>
<p>Georgiann Walker Former patient of a physician in the diversion program</p>	<p>“[My doctor] did beautiful work on me. I am more than happy. I would go back to the man in a heartbeat. I feel as though your diversion program not only hurt the doctor by releasing the confidentiality, you really did hurt the patients.”</p> <p>“I deserve to have that confidentiality and not be bothered, not be encouraged by someone who has a vendetta against a doctor to try and encourage me and coerce me into saying things about him...”</p> <p>“We have to let our doctors know that they are safe in a [confidential] program that they are going to be involved in, so that they will come forward.”</p>
<p>Rory Jaffe University of California</p>	<p>“...placing physicians on probation when they enter a diversion program creates a significant disincentive for them to self-report and seek treatment, which in turn increases risk for their patients. For physicians who self report without the protection of confidentiality, the likely outcome is that these physicians would be placed on probation, which could adversely impact their future employability and insurability even after successful treatment.”</p>

<p>Luis Sanchez, M.D. Federation of State Physician Health Programs</p>	<p>“All our programs are confidential. We promote early referrals. We want physicians to identify their issues way before they become impaired.”</p> <p>“...a successful state physician health program should be able to ... issues in a confidential manner, allowing physicians, early on, to pick up the phone and seek help.”</p>
<p>Jack Shale, M.D. California Psychiatric Association</p>	<p>“But, the law is that it takes a high standard of proof to take away somebody’s license. Consequently, most of the people I saw in diversion were people who were volunteers in the sense that somebody said they smelled alcohol on his breath. And, the well being committee at the hospital had a talk with him. They didn’t have enough evidence to take away his privileges. Intervening early is important. The other side of that is you can’t throw away confidentiality entirely.”</p>
<p>Joseph Dunn, California Medical Association</p>	<p>“With respect to the program in question today, the single greatest risk to patient safety is doctors who keep their dependency problems secret. As it was over 25 years ago when the [diversion] program was created as it is today...Without [the diversion] program, no one – not patients, not healthcare professionals, not you the medical board, not we at CMA – are going to know of physicians with dependency programs until it is too late. That is exactly what this program was designed to avoid.</p>

3. In Favor of a Non-confidential Program that Prohibits or Limits Continued Practice of Medicine by Physician Participants

<p>Michel Sucher, M.D. Arizona Medical Board's Physician Health Program</p>	<p>"Our current client list in Arizona - we operate the Arizona Medical Board's Physician Health Program, the Arizona State Board of Dental Examiner's program, by the way, which is completely non-confidential and our last review - 92% five year success rate – comparable to any other program. So, not being confidential, while it has its down sides, is not a barrier to successful recovery."</p>
<p>Tina Minasian Former patient of a participant in the diversion program</p>	<p>"...it was my understanding that you had been told repeatedly throughout the years, no patient has ever been injured by a participant in a diversion program. That statement was absolutely false. I was injured by a participant in the program while he was in the program, and I am just Exhibit A."</p> <p>"I know dozens and dozens of other patients who have been victims of the same physician while he was a participant in the diversion program. In fact, some have died and others are dying."</p> <p>"The doctor that operated on me was a participant in the diversion program. This information was precluded from me because diversion is a secret program. Furthermore, at the same time this doctor treated me, he directed his office manager, who also happened to be his worksite monitor for the diversion program, to lie for him repeatedly."</p> <p>"When a pilot, school bus driver, police officer, or athlete is caught under the influence of drugs or alcohol, they are suspended from their profession. Some of these professions have automatic termination of employment. Why are these doctors' lives and livelihood more important than the lives of patients?"</p> <p>"Doctors should not have the privilege of working while they are in rehab. Doctors who abuse drugs or alcohol should have their licenses suspended or revoked, just like any other profession in America, until they can prove that they can practice medicine safely... Do not let them run a secret diversion program again. You abolished it because it was a failure and public safety was compromised."</p>

<p>Ken Mikulesky Patient Advocate</p>	<p>“Tina Minasian said most of what I had to say. I believe that most of you people are upright and righteous, and you want to do the right thing. But 27 years of failure, and I’ve seen a lot of human destruction up close and personal.</p> <p>“... you don’t tell a doctor you are going to test him at 9:45 and be there to test him and let his nurse take the sample. You must practice what you preach. There are a lot of people getting hurt out there. As I speak right now, there is probably a doctor with an addiction problem that is carving some poor person up. It makes me sick to my stomach. It breaks my heart. You have got to stop this. You got to. That’s all I have to say.”</p>
<p>Judy McDonald Patient Advocate</p>	<p>“In 1999, I had breast cancer. It was stage 0, but it was the third time that I had had it. I was told that I needed a mastectomy... surgery was my only choice. I was referred to a doctor to remove my breast who, in turn, referred me to a plastic surgeon, telling me that he was one of the best.”</p> <p>“And how could I ever know the problem this man was battling with alcohol when he had been recommended to me as one of the best? I went to this doctor with full faith that he would do a fine job on me... However, I ended up with massive, massive infections that took months to heal.”</p> <p>“I have personally met and seen the bodies of other patients who were operated on by this doctor and were all scarred for life. Why? Because we were treated by a doctor who had secret alcohol problems and was in a secret diversion program.”</p> <p>“The expressed purpose of the medical board and diversion program is to protect us, the public. I was not protected. Has the purpose been changed to protect the doctors?”</p> <p>“Doctors who have drug or alcohol problems should not be allowed to take our bodies and lives into their hands. They should have their license revoked until they can prove that they can safely treat you and I – the patient.”</p>

<p>Senator Mark Ridley-Thomas, Chairman of the Committee on Business and Professions</p>	<p>“I felt that the question had to be posed - why some [physicians] could continue to treat patients after having learned some of the things we did about their performance and their state of preparedness as it relates to surgery and other issues that we take seriously.”</p> <p>“I don’t believe patients ought to be in a mode of being unsuspecting about their physicians, feeling in any way that they are at risk or being harmed by them, as a result of those physicians being impaired.”</p>
<p>Linda Starr Patient Advocate</p>	<p>“I have no sympathy for the doctors who supported and continued to support the secrecy. They know the harm, devastation, and death. They know about past and potential harm. They hide information and evidence and send doctors into surgery with loaded guns. These doctors should be held responsible for the negligence and damages caused. But no - secrecy and protection is business as usual.”</p> <p>“If this program is continued with the current secrecy controls, you open it up to criticism. What if teacher groups protected their teachers in this way and allowed pedophiles to go into rehab while teaching our children and we kept it secret? It’s a joke. It’s terrible.”</p> <p>“We need whistleblowers. We need notices posted in the doctor’s office that tells what the board has information about.”</p>
<p>Julie D’Angelo Fellmeth USD, School of Law, Center for Public Interest Law</p>	<p>“Today you have been presented with a number of options as to how you should approach the issue of the impaired physician. Obviously, you have been asked by physician organizations to let them design and run a new program for you, and their proposal contains all of the hallmarks of the failed program, including confidentiality. “</p> <p>“The medical board should not conceal the identities of physicians who are in treatment or recovery and who come to the attention of the board’s enforcement program. None of this is your job.”</p> <p>“You are a government agency. Your job is public protection. You are a regulatory board that patients must be able to trust. Your core functions are licensing and discipline.”</p>

Janet Mitchell
Patient Advocate

“In my eyes, your diversion program is a form of concealment. It is created to hide a doctor’s problems with drugs and alcohol from a patient. I have yet to meet a patient who would knowingly choose a doctor in a drug or alcohol program.”

“Secrets, such as your diversion program, easily become lies. When a patient looks at your Web site and they seek information on a doctor and they see that he is in good standing with you, when in truth he could be in diversion and to me that is every color of deception. By allowing the known fact to be a secret, you have withheld and concealed the truth.”

“Citizens in other professions, they are not allowed to have a diversion program. I’ve called. A nurse is suspended right away until she gets into rehab. I called a representative from Disneyland to ask if you could operate the Dumbo ride if you were having trouble with alcohol and drugs. I got a call back. And they said, ‘You’re kidding.’ ‘You’re asking what?’ And, they said ‘Heavens, no. We wouldn’t want the liability. We wouldn’t want to put our visitors at risk.’”

Ed Howard
Center for Public Interest Law

“You have heard a lot of testimony today, both explicit and alluded to, that the end of the board’s program, which would divert drug and alcohol addicted doctors away from a disciplinary path and into a monitoring path will somehow endanger patients, because it will imperil the motivation of physicians who may have drug or alcohol addiction from coming forward into the program. While the logic of that cannot really be tested in and of itself, we have experience that indicates that that fear simply isn’t warranted.”

“Dr. Fantozzi mentioned those data at the outset of the summit. There are in all, according to the board’s own data, about 200 people in the diversion program at any given time. 75 of those – a minority – are classified as self referrals and if I’ve heard Dr. Fantozzi correctly, there is a question, at the very least, as to how and whether those 75 are, in fact, true self referrals.”

“People who have had an epiphany about their disease and affliction have voluntarily come forward, rather than coming forward one step ahead of a notification of a plea of DUI from a court or because they have been cautioned by their hospital that they had better get help. Likewise, Dr. Fantozzi quoted data at the very beginning that indicated

<p>Ed Howard (continued)</p>	<p>that the secrecy that surrounded the former program was utterly unsuccessful at enticing anywhere close to the number of drug and alcohol addicted doctors that data projects are actually out there.”</p> <p>“So, when you hear those prior folk testify about the importance of secrecy, I caution they did not address those data. “</p> <p>‘Any future program that is secret and secretly allows physicians to continue to practice while in it, means simply this, you are going to be forcing California patients to be unwitting guinea pigs for a proposal that you know has failed, and we would simply submit that that’s inconsistent with the enforcement and licensure role of the Medical Board of California.”</p>
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4. Recommendations for the Organizational Structure and Funding of a New Program

<p>Howard Kornfeld, M.D. Physician in private practice</p>	<p>“The matter of chronic pain management among physicians entering and graduating from a new diversion program must be considered...Some of the physicians in diversion may have developed a problem with opiate pain medicines due to legitimate pain and/or addiction issues.”</p> <p>“I want to suggest that medically related decisions regarding pain and addiction treatment for physicians participating in diversion be made with full participation of physicians experienced in and preferably certified in both pain and addiction medicine.”</p>
<p>James Hay, M.D. California Medical Association</p>	<p>“Our operational recommendations...include that it must be established, as a formal, legislatively sanctioned, not for profit, independent, but publicly accountable entity. It must be regularly audited for clinical quality and fiscal integrity. That is, have better accountability. It must be supported by a stable and continuing source of funds that must come, or should primarily come, from professional licensing fees. And the funding must be adequate to do the job, which it was not in the past. This means doctors are saying we are willing to pay for the program we think needs to be.”</p> <p>“Finally, this program must be governed by a board that is composed of both</p>

<p>James Hay, M.D. (continued)</p>	<p>physicians and non-physicians, but all of whom must have expertise in physician health and impairment, must be managed by a medical director who is knowledgeable and responsive to the board, and must be staffed by individuals with strong clinical training where participant contact is required.”</p>
<p>Shannon Chavez, M.D. UC, San Diego</p>	<p>“On behalf of the UCSD Physician Well Being Committee, as well as the UCSD PACE program, I respectfully urge the Medical Board of California to join all other states to consider a new, improved, non-profit, confidential, physician health program separate from, but reporting to, the Medical Board of California.”</p>
<p>Rory Jaffe University of California</p>	<p>“We strongly agree with the joint CMA, California Psychiatric Association, and Society of Addiction Medicine statement that this program should be structured to provide a continuum of medically based services including comprehensive assessment, triage, and monitoring services for behavioral disorders, as well as support for substance abuse and possibly other medical conditions. We also agree that such a program should be operated by an independent non-profit entity and should be audited regularly for clinical quality and fiscal integrity.”</p>
<p>Elinore McCance-Katz, M.D. American Academy of Addiction Psychiatry</p>	<p>“Monitoring programs are essential to patient safety by providing a mechanism for requiring treatment for those with impairing illness, a mechanism of ongoing review and assessment of participants, and the ability to remove physicians from practice if deemed unsafe or if they violate their monitoring contracts.”</p> <p>“The [Virginia program] enabling legislation... provided immunity from civil liability for those reporting and acting on reports of impairment. The law, in my opinion, should go further and require reimbursement of legal fees should a monitor or reporting individual who made a report in good faith be sued.”</p> <p>“The [Virginia] program was independent of the medical board, but contracted by them. We worked collaboratively with the board, always being careful to give an accurate and straightforward accounting of the monitoring progress of any participant.”</p> <p>“The program had a full time medical director with board certification in addiction psychiatry and training in addiction medicine. This is extremely important to the assessment of substance use disorders and mental disorders and preparation of appropriate recovery monitoring contracts.”</p>

<p>Elinore McCance-Katz, M.D. (continued)</p>	<p>“The program costs were paid from licensing fees, so we were not compelled to negotiate with clients about anything to help ensure adequate program funding.”</p> <p>“...in Virginia...no practitioner with chemical dependence could work while taking mood altering substances.”</p>
<p>Luis Sanchez, M.D., Federation of State Physician Health Programs</p>	<p>“Many of the state programs are non-profit – 501C3’s – where we have a board of directors that provide oversight. Funding is an issue for many of these programs. There are a variety of ways that the programs are funded, through licensing fees, as mentioned, through malpractice carriers. In my state, all the malpractice companies contribute to our organization, feeling that it is a risk management venture, that by being involved with us we are reducing the chances of patient harm that could happen with a physician who is impaired.”</p> <p>“We are also broad in our approach – we are not only focusing on substance use disorders. In Massachusetts, half the physicians that we deal with have substance abuse problems. The other half have a variety of issues – mental health issues, depression, bi-polar illness, fears of malpractice suits, stress, these are all the issues that are impacting on doctors today, and a successful state physician health program should be able to address all these issues in a confidential manner, allowing physicians, early on, to pick up the phone and seek help.”</p>
<p>James Conway, Pacific Assistance Group</p>	<p>“...any future program will need access to the board's information base on consumer complaints.”</p>
<p>Senator Mark Ridley-Thomas Chairman of the Committee on Business and Professions:</p>	<p>“I believe this summit is a first step towards dealing with healthcare practitioners who have substance abuse issues or have mental health problems that affect their ability to practice medicine safely. We need to look at other alternatives and programs that have successes in dealing with impaired healthcare professionals.”</p> <p>“At the same time, there has to be consistency in the way in which all health related boards deal with their licensees that have substance abuse problems and/or challenges. So, therefore, it is my goal to work with all of the boards to develop more uniform standards of enforcement and oversight of medical professionals who may</p>

<p>Senator Mark Ridley-Thomas (continued)</p>	<p>become involved with substance abuse and assure that there will always be appropriate monitoring and restrictions placed on the practice of healthcare under such conditions so that we have the highest level of confidence that we are providing the care that patients have come to expect.”</p> <p>“It is my intent that the legislation that we will introduce will make these important changes and continue seeking input from health boards, the medical profession itself, and experts from successful substance abuse programs to identify other changes, which are necessary. There is a lot of work to be done. I believe in a collaborative approach in doing it. I want to join forces with the medical board with the range of boards that have concerns with the profession itself, those who have been in a diversion program who have success stories to report with the CMA, and the whole range of entities who want to make sure that we come out of this with our heads high, with a full sense of purpose and direction as it relates to providing the kind of leadership and care for both the patients themselves and those who are sworn to an oath to protect those patients and the degree of high quality healthcare services.”</p>
<p>Linda Starr Patient advocate</p>	<p>“I want to say doctors do need help, but again I stress, it needs to be separate and apart [from the Medical Board.] The board needs to refocus and re-identify its role for the protection of the citizens of California.”</p>
<p>Julie D’Angelo Fellmeth USD, School of Law</p>	<p>“Based on the information contained in this and prior reports on the diversion program, the medical board must reevaluate whether the diversion concept is feasible, possible, and protective of the public interest. I suggest to you that the diversion concept is none of those things, and it should never again be on your table.”</p> <p>“...what should you do as the medical board? Having thought about this for 15 years, and having had the unique opportunity to audit the diversion program for a two-year period, I would offer you the following advice. The medical board should not run any kind of monitoring program for substance abusing physicians. That is not your job, nor should you oversee such a program, nor should you pay for such a program.”</p> <p>“The medical board should never again consider diverting substance abusing physicians from discipline. The medical board should not conceal the identities of physicians who are in treatment or recovery and who come to the attention of the</p>

<p>Julie D'Angelo Fellmeth (continued)</p>	<p>board's enforcement program. None of this is your job. You are a government agency. Your job is public protection. You are a regulatory board that patients must be able to trust. Your core functions are licensing and discipline."</p> <p>"Should other people run programs that offer drug treatment monitoring and testing? Absolutely. Others already do. And now that you are out of the picture, I expect new programs to pop up. In fact, they are here today. You have heard from them. Should you anoint one to the exclusion of all others? No, I don't think so. We need a lot of them. Let the private sector handle this. Rather than competing with the private sector, you should focus on researching state of the art standards and requirements for the mechanisms that will replace the diversion program."</p> <p>"What is it that you want your staff to do when a person who has been ordered to undergo drug testing, tests positive? What do you want the attorney general's office to do? You need to answer that question."</p> <p>"The bottom line is that your job as the medical board is to detect an impaired physician and remove or restrict that doctor's medical practice in a way that is transparent to his patients. What happens after that is up to that doctor? That is his business, not yours."</p>
<p>Jack Shale, M.D. California Psychiatric Association</p>	<p>"I also heard from Dr. Hay who made several important comments in my opinion that what replaces [the diversion program] must be independent. It must be non-profit so there is no conflict of interest. It must have adequate resources and authority, and it must monitor effectively."</p> <p>"I actually agree with Mrs. Fellmeth that the board should not run diversion. You should set standards, and the standards must be observed, and you need consequences; you need a hammer."</p> <p>"In law school, one of the first lessons I learned is every story has at least two sides. In medical school, I learned that anecdotes is not evidence....You have a 27-year database. Look at it. You know the rates of complaints and malpractice lawsuits and settlements against doctors in general, by specialty, per capita, and you also know what the rates are against people who successfully completed diversion. Before you move forward, look at that database."</p>

<p>David Pating, M.D. Addiction Psychiatrist</p>	<p>"...my organization, CSAM, wants to look forward of the next solution...we support the creation of a new physician health program, and its essential program elements as described by Dr. Hay. We believe that there should be early intervention, referral, and then monitoring as necessary. If the medical board is really committed to this concept of wellness, you have to realize that for every well physician, somewhere out there is a physician that might be not well. There is a spectrum of services that we need to address. We support the evidence-based practice of the spectrum of care for physicians, as they go from being well to being stressed to perhaps having personal difficulties. And at the moment that they become unsafe, we do recommend that there be issues to make the public safe."</p>
<p>Ed Howard Center for Public Interest Law</p>	<p>"...some of the proposals that we have heard revived today have the hallmarks of the prior failed program. Let me just sketch out what the hallmarks of the prior failed program are: secrecy from patients; diversion away from a disciplinary track; allowing doctors to continue to practice while diverted, where the whole program is run by physicians whose day in and day out practice is caring for alcohol and drug addicted doctors. Such, that the policies that they might impose with their hat on as working with diversion, might actually have an impact on the patients they are seeing at that time."</p>
<p>Joseph Dunn, California Medical Association</p>	<p>"Numerous independent audits and reports have identified, correctly, I believe, some serious deficiencies with the program that may indeed raise the risk to the patients...our sole priority – their safety. We all agree those deficiencies are unacceptable. The question then is how do we deal with this challenge? Do we correct the deficiencies, or do we end the program? The latter magnifies the risk to patient safety. The former minimizes those risks. Our choice is clear in my humble view. Let us minimize those risks and, together, correct the deficiencies." "And I am here to pledge today that we the physicians of California will want and are willing and ready to work with the medical board toward solving those deficiencies and maintaining this program, which is all about patient safety – it remains our one and only true priority." "...walking away is not the answer. Correcting the problem is. Sadly, we all know we are going to continue to see dependency problems in all walks of life. Ending this program on June 1 leads to one inescapable conclusion. We raise the risk to patient safety, which is our only priority. Let us work together, solve the deficiencies, and maintain this patient protection program."</p>

<p>Randal Hagar California Psychiatric Association</p>	<p>“...one of the things I do want to inject into the conversation is, to the extent the program has dealt with physicians who have addictions, it has also not dealt with physicians successfully who have mental illness. This is what the issue that my members have asked me to bring to this forum and raise, and it is just as impairing to have depression, as it is to be a drunk, or to be someone who is abusing substances.”</p> <p>“So, it is very, very important that we do address physicians who are suffering from the mental disorders.”</p>
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5. Presentations of Treatment Programs by the Owners of Those Programs

<p>Michel Sucher, M.D. Arizona Medical Board's Physician Health Program</p>	<p>“We run monitored aftercare programs, we do assessments, we do consulting to hospitals with healthcare systems. We provide MRO services. We do a considerable amount of education and training, and we understand the full range and deal with the full range, including mental health, boundary disorders, disruptive behavior.”</p> <p>“We run the full range of monitoring programs and very much as comprehensive as diversion has been, except we hold people accountable, we do compliance measuring, there are consequences, we have no issue taking unsafe doctors out of practice. We work in collaboration with the medical board very closely to do this. We participate in investigations and in summary suspensions and other appropriate actions. We are fully prepared to help do that in California.”</p>
<p>James Conway Pacific Assistance Group</p>	<p>“Our strengths include unparalleled expertise in the state of California. We are in all the major metropolitan areas of Los Angeles, which gives us a decided strength, in that we are on the ground, we know the resources.”</p>

Background and Credentials of Speakers as Reported at Summit

Shannon Chavez, M.D.	Associate Professor of Psychiatry at UC San Diego, Medical Director of UC San Diego Outpatient Psychiatric Services, Chair of the UCSD Physician Well-Being Committee, and I also hold Diversion Committee membership for the BRN and the State BAR; proud graduate of the California Medical Board Diversion Program
James Conway	Group facilitator with the existing diversion program in the Los Angeles area
Joseph Dunn	Former State Senator and CEO of the California Medical Association
Julie D'Angelo Fellmeth	Center for Public Interest Law, USD School of Law, and former Medical Board Enforcement Officer
Randall Hager	Government Affairs Director, California Psychiatric Association
James Hay, M.D.	Family physician from San Diego and one of the officers of the California Medical Association
Ed Howard	Senior counsel for the Center for Public Interest Law
Rory Jaffe	Executive Director of Medical Services for the University of California, Senior Physician for the UC Health Systems, responsible for licensure and accreditation, quality of care, medical staff governance, risk management, and the provision of clinical services
Dr. Howard Kornfeld	Physician in private practice in Mill Valley; certified and a Fellow of the American Society of Addiction Medicine; Board Certified in pain medicine by the American Board of Emergency Medicine; Faculty, Department of Medicine, University of California, San Francisco; teaches seminars on addiction aspects of pain medicine, UCSF Mt. Zion Pain Management Center; Expert Medical Reviewer, California Medical Board
Sharon Levine, M.D.	Responsible for Physician and Professional Support Services, Permanente Medical Group, Northern California

Background and Credentials of Speakers (Continued)

Elinore McCance-Katz, M.D.	Physician at San Francisco General Hospital Medical Center; Board Certified Addiction Psychiatrist; President of the American Academy of Addiction Psychiatry; Former Medical Director of the Virginia Health Practitioner's Intervention Program
Judy McDonald	Patient Advocate
Ken Mikulesky	Patient Advocate
Tina Minasian	Former patient of a physician who was a participant in the Diversion Program
Janet Mitchell	Patient Advocate; Author of "Taking a Stand"
David Pating, M.D.	Addiction Psychiatrist; Chair of the Diversion Advisory Committee; President of the California Society of Addiction Medicine
Mark Ridley-Thomas	California State Senator; Chairman of the Senate Committee on Business and Professions
Luis Sanchez, M.D.	Board Certified Psychiatrist; President of the Federation of State Physician Health Programs; Director of the Massachusetts Health Program
Jack Shale, M.D.	California Psychiatric Association; Physician and Attorney; former member and Chair of the Diversion Evaluation Committee; Former member of the Lawyer Assistance Program; "19 years, eight months, and a few days of sobriety."
Linda Starr	Cancer Advocate
Michel Sucher, M.D.	Physician; ASAM member; CSAM member; operator of monitored aftercare programs
Jeffrey Uppington	California Society of Anesthesiologists
Georgiann Walker	Former patient of a doctor who was in the diversion program



MEDICAL BOARD OF CALIFORNIA
Diversion Program



Date: April 8, 2008

AGENDA ITEM 17B

To: Members

From: Frank 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 \$1,397,445. Expenditures from July 1, 2007 through February 29, 2008 are \$810,622. As requested by the Diversion Committee, this is 58% of the 2007/2008 FY 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 from January 1, 2008 through March 31, 2008 totaled: \$7,528.05.

Per diem for DEC members from January 2008 through March 2008 totaled \$4,600.

Please let me know if you have any questions.

Attachments

MEDICAL BOARD OF CALIFORNIA
 DIVERSION PROGRAM
 BUDGET REPORT
 JULY 1, 2007 - FEBRUARY 29, 2008

	FY 07/08 BUDGET	EXPEND/ ENCUMB YR-TO-DATE	PERCENT OF BUDGET EXP/ENCUMB	LAG TIME (MONTHS)
PERSONAL SERVICES				
Salaries & Wages	720,179	427,608	59.4	current
Staff Benefits	<u>319,115</u>	<u>150,138</u>	47.0	current
TOTAL PERSONAL SERVICES	1,039,294	577,746	55.6	
OPERATING EXPENSES & EQUIPMENT				
General Expense	22,000	24,665	112.1	1-2
Printing	10,000	5,174	51.7	1-2
Communications	22,822	6,353	27.8	1-2
Postage	5,255	791	15.1	1-2
Insurance	1,702	516	30.3	current
Travel In-State	75,000	37,915	50.6	1-2
Travel Out-of-State	1,100	0	0.0	current
Training	4,418	616	13.9	1-2
Facilities Operation	30,000	32,978	109.9	current
Departmental Services	109,572	72,426	66.1	current
DP Maint/Supplies	500	0	0.0	1-2
Central Administrative Services	48,782	36,602	75.0	current
Major Equipment	16,000	0	0.0	current
Vehicle Operations	11,000	14,798	134.5	1-2
DOI-Investigations	<u>0</u>	<u>42</u>		
TOTAL OPERATING EXPENSES & EQUIPMENT	358,151	232,876	65.0	
TOTAL BUDGET/EXPENDITURES	1,397,445	810,622	58.0	

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 3/27/2008

**Medical Board of California
Tracker - Legislative Bill File
4/21/2008**

<u>BILL</u>	<u>AUTHOR</u>	<u>TITLE</u>	<u>STATUS</u>	<u>POSITION</u>	<u>VERSION</u>	<u>AMENDED</u>
AB 547	Ma	"Cap" on Fees	Sen. B&P	Support if Amended	Amended	1/7/2008
AB 1154	Leno	Diabetes Task Force and Pilot Program	Sen. Health	Support	Amended	1/24/2008
AB 1869	Anderson	Transition DCA Boards to Bureaus	Asm. B&P*	Failed to Pass	Amended	4/3/2008
AB 1944	Swanson	Authorizing District Hospitals to Employ Physicians	Asm. Health (4/22)	Rec: Oppose	Amended	4/9/2008
AB 1951	Hayashi	Psychiatrists: suicide prevention training	Asm. Floor	Rec: Oppose unless amended	Amended	4/8/2008
AB 2398	Nakanishi	Cosmetic Surgery: supervision	Asm. Approps.	Rec: Support	Amended	4/10/2008
AB 2439	De La Torre	Loan Repayment Program: mandatory fees	Asm. Floor	Rec: Oppose unless amended	Amended	4/8/2008
AB 2442	Nakanishi	MBC: peer review proceedings	Asm. Floor	Sponsor/Support	Amended	3/25/2008
AB 2443	Nakanishi	MBC: physician well-being	Asm. Approps. (4/23)	Sponsor/Support	Introduced	
AB 2444	Nakanishi	MBC: PLR with education	Asm. Floor	Sponsor/Support	Introduced	
AB 2445	Nakanishi	MBC: licensing PLR	Asm. Floor	Sponsor/Support	Amended	4/1/2008
AB 2482	Maze	Physician Assistants: continuing education	Asm. Floor	Rec: Support	Introduced	
AB 2516	Mendoza	Prescriptions: electronic transmission	Asm. B&P (4/29)	Rec: Support with amends	Introduced	
AB 2543	Berg	Loan Repayment Program: geriatric workforce	Asm. Approps.	Rec: Support	Amended	4/7/2008
AB 2649	Ma	Medical Assistants: authorized services	Asm. B&P (4/29)	Rec: Neutral	Amended	3/24/2008
AB 2661	Dymally	Telemedicine: without appropriate exam	Asm. Health*	Bill Dropped	Amended	3/24/2008
AB 2721	Fuller	Telemedicine Task Force	Introduced*	Bill Dropped	Introduced	
AB 2734	Krekorian	Advertisements: license # and MBC website	Asm. Approps. (4/23)	Rec: Support	Amended	4/17/2008
AB 2747	Berg	End-of-Life Care	Asm. Jud. (4/29)	Rec: Neutral if amended	Amended	4/7/2008
AB 2841	Ma	Medical Procedures: reusable adipose cannula	Asm. B&P (4/29)	Rec: Oppose	Introduced	
AB 2968	Carter	Cosmetic Surgery: physical examination	Asm. Health (4/29)	Rec: Support if amended	Introduced	
AB 2969	Lieber	Workers' Comp.: med. treat. utilization reviews	Asm. Floor	Rec: Support	Introduced	

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** Amended 4-15-16, not included

**Medical Board of California
Tracker - Legislative Bill File
4/21/2008**

<u>BILL</u>	<u>AUTHOR</u>	<u>TITLE</u>	<u>STATUS</u>	<u>POSITION</u>	<u>VERSION</u>	<u>AMENDED</u>
SB 761	Ridley-Thomas	Diversion and Vertical Prosecution	Asm. App.-Held*	Sponsor/Support	Amended	7/18/2007
SB 797	Ridley-Thomas	VE/P Extension	Asm. Floor	Contained VE/P - Support	Amended	9/7/2007
SB 1125	Denham	Polysomnographic Technologists Licensing	Sen. B&P*	Rec: Neutral	Introduced	
SB 1156	Aanestad	Medical Practice Act: spot bill	Sen Rules*	Bill Dropped	Introduced	
SB 1379	Ducheny	Loan Repayment: permanent funding source	Sen. Approps.*	Rec: Neutral	Introduced	
SB 1379	Ducheny	Loan Repayment: permanent funding source	Sen. Floor	Rec: Support	Introduced	
SB 1394	Lowenthal	Lapses of Consciousness: reports to DMV	Sen. Approps.	Rec: Support	Amended	4/15/2008
SB 1415	Kuehl	Healing Arts: Omnibus	Sen. Approps.*	Rec: Support	Amended	4/16/2008
SB 1427	Calderon	Psychologists: prescribing drugs	Sen. Health*	Held in Committee	Introduced	
SB 1441	Ridley-Thomas	Task Force: address standards for impaired	Sen. Approps.	Rec: Support if amended	Amended	4/7/2008
SB 1454	Ridley-Thomas	Advertising, OSM, Cosmetic Surgery Standards	Sen. Approps.	Rec: Support	Amended	4/7/2008
SB 1526	Perata	Polysomnographic Technologists Registration	Sen. Approps.	Rec: Neutral w/ Bd. Member	Amended	4/16/2008
SB 1535	Kuehl	MBC: medical directors	Sen. B&P*	Bill Dropped	Introduced	
SB 1579	Calderon	Referrals for Hair Restoration	Sen. B&P (4/28)	Rec: Oppose	Amended	3/27/2008
SB 1603	Calderon	Discount Health Care Programs	Sen. Health*	Failed to Pass	Amended	4/7/2008
SB 1640	Ashburn	Employed Physicians: pilot project expansion	Sen. B&P*	Failed to Pass	Amended	3/26/2008
SB 1779	B&P Com.	Healing Arts: Omnibus	Sen. Approps.	Rec: Support MBC Provisions	Amended	4/16/2008
<hr/>						
SJR 19	Ridley-Thomas	Health professionals: torture	Sen. Floor*	Watch	Amended	3/25/2008
ABX1 1	Nunez	Health Care Reform	Sen. Health*	Issue Policy Statement	Amended	1/16/2008
SBX1 19	Cogdill	Medical Corporations	Sen. Health*	Oppose	Introduced	
SBX1 24	Ashburn	Nurse Practitioners: scope of practice	Sen. Health*	Oppose	Introduced	

*

** Amended 4/15-16, not included

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 Senate Business and Professions Committee and has not been set for hearing.

DESCRIPTION OF CURRENT LEGISLATION:

This bill includes 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 pursue a reduction to 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.

The author introduced the current bill without Board sponsorship.

Staff continues to work with the author’s office on an amendment for the reserve fund and to clean up a technical issue allowing the fee to be equal to \$790. These amendments have not been accepted by the author to date.

FISCAL:

Minor and absorbable should the Board pursue regulatory authority to reduce the fee.

POSITION:

Support if amended to provide flexibility in the fund's reserve and fix the technical issue.

April 18, 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.

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

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

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

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

20 (2) Any increase in the amount of investigation and enforcement
21 costs incurred by the board after January 1, 2006, that exceeds the
22 average costs expended for investigation and enforcement costs
23 during the three fiscal years immediately preceding July 1, 2006.
24 When calculating the amount of costs for services for which the
25 board paid an hourly rate, the board shall use the average number
26 of hours for which the board paid for those costs over these prior
27 three fiscal years, multiplied by the hourly rate paid by the board
28 for those costs as of July 1, 2005. Beginning January 1, 2009, the
29 board shall instead use the average number of hours for which it
30 paid for those costs over the three-year period of fiscal years
31 2005–06, 2006–07, and 2007–08, multiplied by the hourly rate
32 paid by the board for those costs as of July 1, 2005. In calculating
33 the increase in the amount of investigation and enforcement costs,
34 the board shall include only those costs for which it was eligible
35 to obtain reimbursement under Section 125.3 and shall not include
36 probation monitoring costs and disciplinary costs, including those
37 associated with the citation and fine process and those required to
38 implement subdivision (b) of Section 12529 of the Government
39 Code.

1 (f) Notwithstanding Section 163.5, the delinquency fee shall be
2 10 percent of the biennial renewal fee.

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

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

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

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

32 ~~12699.64. (a) An applicant may, but is not required to, pay an~~
33 ~~application assistance fee to a person or entity if the following~~
34 ~~conditions are met:~~

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

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

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

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

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

11 ~~(d) "Applicant," for purposes of this section, means the City~~
12 ~~and County of San Francisco and the local initiative that contracts~~
13 ~~with the City and County of San Francisco to provide~~
14 ~~comprehensive health care coverage, as described in Section~~
15 ~~12699.53.~~

16 ~~(e) This section constitutes a pilot program that shall remain in~~
17 ~~effect only until January 1, 2009, and as of that date is repealed,~~
18 ~~unless a later enacted statute, that is enacted before January 1,~~
19 ~~2009, deletes or extends that date.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1154
Author: Leno
Bill Date: January 24, 2008, amended
Subject: Diabetes Task Force and Pilot Program
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Health Committee and has not been set for hearing.

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 would 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.

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. The pilot would be implemented in a minimum number of counties necessary to represent the demographic populations in the state in order to review, analyze, and report on the outcomes from integrative care of diabetes through proactive prevention.

Since the Governor's health care reform proposal did not move forward, this bill provides another option to pursue a best practices model for diabetes care prevention.

FISCAL: None

POSITION: Support

April 15, 2008

AMENDED IN ASSEMBLY JANUARY 24, 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 Task Force on Obesity and Diabetes Causes, which is created by the bill, to develop and administer 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. 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

1 and practices that show evidence-based efficacy in at-risk
2 populations. Proactive prevention programs include incentives for
3 more whole foods, fruits, vegetables, pulses, nuts, seeds, and herbs
4 along with adequate water, regular physical activity, and expression
5 or receipt of appreciation and for the help we can be to ourselves
6 and those in need. All this contributes to better weight maintenance
7 by eating a balanced variety of nourishing foods and drinking
8 adequate amounts of water and herbal teas, choosing moments in
9 which to appreciate what we have, and enjoying the kind of regular
10 activity appropriate to our functional age and abilities.

11 (f) A primary strategy of proactive prevention is to increase
12 access to health enhancing practices, resources, and choices.
13 Reinforcement of healthier choices and reduction of barriers
14 coupled with incentives for use are components of this approach.
15 Incentives for health promoting actions are both financial and
16 emotional.

17 (g) Existing law requires the State Department of Health
18 Services to promote the public health and welfare.

19 (h) It is the intent of the Legislature that the program established
20 pursuant to this act will document the program outcomes in
21 rigorous tests and formal statistical measures, as well as by
22 consumer quality of life outcome surveys performed by the
23 California Health Alliance.

24 (i) It is the intent of the Legislature that the program established
25 pursuant to this act will document the benefits of proactive
26 prevention in diabetes risk mitigation at its cause.

27 (j) It is also the intent of the Legislature for the pilot program
28 established pursuant to this act to improve the health and well-being
29 of at-risk Californians by addressing the causes of diabetes and
30 monitoring the benefits people enjoy through the application of
31 proactive prevention.

32 SEC. 2. Section 131086 is added to the Health and Safety Code,
33 to read:

34 131086. (a) As used in this section:

35 (1) *“At-risk” refers to persons at risk for prediabetes or type*
36 *II diabetes, as defined by accepted clinical standards.*

37 (⊕)

38 (2) *“Department” means the State Department of Public Health.*

39 (3) *“Diabetes” means type II diabetes, as defined by accepted*
40 *clinical standards.*

1 ~~(2)~~

2 (4) “Director” means the state public health officer.

3 ~~(3)~~

4 (5) “Task force” means the Task Force on Obesity and Diabetes
5 Causes.

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

9 (1) A representative of the Californians Health Alliance.

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

12 (3) A representative of Health Studies Collegium.

13 (4) A representative of a community foundation.

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

18 (c) The department shall, in consultation with the task force,
19 develop and administer a diabetes risk reduction pilot program
20 within the minimum number of counties necessary to represent
21 the demographic populations of California to review, analyze, and
22 report on the outcomes from integrative care of diabetes through
23 proactive prevention.

24 (d) The department, in consultation with the task force, shall
25 design the pilot program to include all of the following
26 components:

27 (1) Strategies aimed at diabetes risk reduction that are directed
28 at low-income, at-risk communities and populations. In
29 communities invited to participate in the pilot program, the pilot
30 program shall provide dedicated health professionals and support
31 personnel to implement this pilot program as recommended by the
32 task force’s Diabetes Risk Reduction Update.

33 (2) The department shall provide technical and logistical support
34 as needed and predicated upon funding of the public-private
35 partnership responsible for this pilot program. Nothing in the pilot
36 program shall be in conflict with the federal Diabetes Prevention
37 Guidelines of the Centers for Disease Control and Prevention
38 (CDC). This proactive prevention pilot program shall document
39 the risk and harm reduction as well as the outcomes of this
40 community-based public health initiative.

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

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

15 (e) In developing the pilot program, the department shall
16 consider all of the following:

17 (1) Counties that have above the food stamp average county
18 participation.

19 (2) Counties that have below the food stamp average county
20 participation.

21 (3) Counties with above-average rates of diabetes.

22 (4) Counties with above-average rates of obesity.

23 (5) Counties with above-average rates of cardiovascular diseases.

24 (6) Counties with the highest percentage of Native American
25 population.

26 (7) Counties with the highest percentage of African American
27 population.

28 (8) Counties with the highest percentage of Hispanic population.

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

31 (10) Urban counties.

32 (11) Rural counties.

33 *(f) In developing the pilot program, the department shall*
34 *consider the efforts of other federal, state, private, and clinical*
35 *diabetes programs, such as those of the federal Centers for Disease*
36 *Control and Prevention's National Center for Chronic Disease*
37 *Prevention and Health Promotion, the California Diabetes Project,*
38 *and Champions for Change: Network for a Healthy California.*

39 (†)

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

5 (g)

6 (h) The department shall develop a process for evaluating the
7 effectiveness of the pilot program. The evaluation shall examine
8 the impact of the various strategies employed in the pilot program
9 regarding the use of healthier choices, particularly those aimed at
10 diabetes risk reduction. The evaluation shall also consider options
11 that are appropriate to each community and implement those
12 options with the highest likely benefit for that community. The
13 department shall also conduct and perform real time data collection
14 and prompt data analysis of outcomes. The department shall, at
15 the earliest feasible time, make recommendations to the Legislature
16 regarding the continuation of the pilot program, and shall include
17 a statement of any federal policy changes needed to support the
18 goals of the pilot program.

19 (h)

20 (i) The Diabetes Prevention and Treatment Pilot Program Fund
21 is hereby created in the State Treasury. The department shall
22 deposit any moneys received from the federal government or from
23 private donations, and, notwithstanding Section 16305.7 of the
24 Government Code, any interest earned on moneys in the fund, into
25 the fund to be used, upon appropriation by the Legislature, for the
26 pilot program. *No other state funds shall be used to fund the pilot
27 program created pursuant to this section.*

28 (i)

29 (j) This section shall only be implemented if adequate
30 implementation funds, as determined by the department, are
31 appropriated from the Diabetes Prevention and Treatment Pilot
32 Program Fund in the annual Budget Act or other statute. ~~No other
33 state funds shall be used to fund the pilot program created pursuant
34 to this section.~~

35 (j)

36 (k) This section shall become inoperative on July 1, following
37 the fourth fiscal year after the first appropriation is made for
38 purposes of this section in the annual Budget Act or other statute,
39 and, as of the following January 1, is repealed, unless a later
40 enacted statute, that is enacted before the date on which this section

- 1 is repealed, deletes or extends the dates on which it becomes
- 2 inoperative and is repealed.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1944
Author: Swanson
Bill Date: April 9, 2008, amended
Subject: Authorizing District Hospitals to Employ Physicians
Sponsor: Association of California Healthcare Districts

STATUS OF BILL:

This bill is currently in the Assembly Health Committee and is set for hearing on April 22, 2008.

DESCRIPTION OF CURRENT LEGISLATION:

This bill eliminates a current pilot program which allows for the limited direct employment of physicians by district hospitals, and instead, this bill allows for any health care district to employ the physicians directly, to work at any district facility or clinic.

ANALYSIS:

Current law (commonly referred to as the "Corporate Practice of Medicine" - B&P Code section 2400) generally prohibits corporations or other entities that are not controlled by physicians from practicing medicine, to ensure that lay persons are not controlling or influencing the professional judgment and practice of medicine by physicians.

The Board presently administers a pilot project to provide for the direct employment of physicians by qualified district hospitals; this project is set to expire on January 1, 2011. (Senate Bill 376/Chesbro, Chap. 411, Statutes of 2003). The Board supported SB 376 because the program was created as a limited pilot program, with a final evaluation to assess whether this exemption will promote access to health care.

SB 376 was sponsored by the Association of California Healthcare Districts to enable qualified district hospitals to recruit, hire and employ physicians as full-time paid staff in a rural or underserved community meeting the criteria contained in the bill. Support for this bill was premised upon the belief that the employment of physicians could improve the ability of district hospitals to attract the physicians required to meet the needs of those communities and also help to ensure the continued survival of healthcare district hospitals in rural and underserved communities, without any cost to the state.

Although it was anticipated that this pilot program would bring about significant improvement in access to healthcare in these areas, only five hospitals throughout all of California have participated, employing a total of six physicians. The last date for

physicians to enter into or renew a written employment contract with the qualified district hospital was December 31, 2006, and for a term not in excess of four years.

Current law requires the Board to evaluate the program and to issue a report to the Legislature no later than October 1, 2008. In March, 2008, staff sent letters to the six physicians and five hospital administrators participating in the program, asking each to define the successes, problems, if any, and overall effectiveness of this program for the hospital and on consumer protection. Additional input was sought as to how the program could be strengthened, and the participating physicians were asked to share thoughts on how the program impacted them personally. Responses have been requested by April 15, 2008, and the report will be prepared during this summer. In addition, staff will attempt to contact eligible hospitals that did not participate in order to evaluate other program improvements.

Until the evaluation of the current program was completed, the pilot provided safeguards and limitations. The program provides for the direct employment of no more than 20 physicians in California by qualified district hospitals at any time and limits the total number of physicians employed by such a hospital to no more than two at a time. The Medical Board is notified of any physicians hired under the pilot, and the contracts were limited to four years of service.

This bill eliminates the pilot program and instead would allow *carte blanche* to any health care district to employ physicians at any facility or clinic which it operates. There are no limitations as to which hospitals could participate, as are provided in the current pilot program: 1) the hospital must be located in smaller counties (a population of less than 750,000); 2) the hospital must provide a majority of care to underserved populations; 3) the hospital must notify the Medical Board. Also, while the purpose of the original pilot program was to recruit physicians and surgeons to provide medically necessary services in rural and medically underserved communities, no such intent is made by this bill.

Until the success of the program has been evaluated, this bill seems premature with an unwarranted expansion. Further, although under current law and under this bill the participating hospital is prohibited from interfering with, controlling, or otherwise directing the physician's professional judgment, it is still of concern that there would be an unlimited number of physicians in California who could be employed.

FISCAL: Unable to determine.

POSITION: Recommendation: Oppose. A full evaluation of the pilot program should be completed before such a broad variance to the prohibition against the corporate practice of medicine is allowed.

April 18, 2008

AMENDED IN ASSEMBLY APRIL 9, 2008

AMENDED IN ASSEMBLY MARCH 13, 2008

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL

No. 1944

Introduced by Assembly Member Swanson
(Coauthors: Assembly Members Dymally, Laird, and Portantino)

February 13, 2008

An act to amend Section 2401 of, and to repeal Section 2401.1 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1944, as amended, Swanson. ~~Healing arts—Physicians and surgeons: health care districts.~~

Existing law, the Medical Practice Act, restricts the employment of licensed physicians and surgeons and podiatrists by a corporation or other artificial legal entity, subject to specified exemptions. Existing law establishes until January 1, 2011, a pilot project to allow qualified district hospitals, as defined, to employ a physician and surgeon, if the hospital does not interfere with, control, or otherwise direct the professional judgment of the physician and surgeon. The pilot project authorizes the direct employment of a total of 20 physicians and surgeons by those hospitals and specifies that each qualified district hospital may employ up to 2 physicians and surgeons, subject to specified requirements.

This bill would delete the pilot project and would instead authorize a health care district, as defined, to employ a physician and surgeon if specified requirements are met and the district does not interfere with,

control, or otherwise direct the professional judgment of the physician and surgeon.

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

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

1 SECTION 1. Section 2401 of the Business and Professions
2 Code is amended to read:

3 2401. (a) Notwithstanding Section 2400, a clinic operated
4 primarily for the purpose of medical education by a public or
5 private nonprofit university medical school, which is approved by
6 the Division of Licensing or the Osteopathic Medical Board of
7 California, may charge for professional services rendered to
8 teaching patients by licensees who hold academic appointments
9 on the faculty of the university, if the charges are approved by the
10 physician and surgeon in whose name the charges are made.

11 (b) Notwithstanding Section 2400, a clinic operated under
12 subdivision (p) of Section 1206 of the Health and Safety Code
13 may employ licensees and charge for professional services rendered
14 by those licensees. However, the clinic shall not interfere with,
15 control, or otherwise direct the professional judgment of a
16 physician and surgeon in a manner prohibited by Section 2400 or
17 any other provision of law.

18 (c) Notwithstanding Section 2400, a narcotic treatment program
19 operated under Section 11876 of the Health and Safety Code and
20 regulated by the State Department of Alcohol and Drug Programs,
21 may employ licensees and charge for professional services rendered
22 by those licensees. However, the narcotic treatment program shall
23 not interfere with, control, or otherwise direct the professional
24 judgment of a physician and surgeon in a manner prohibited by
25 Section 2400 or any other provision of law.

26 (d) Notwithstanding Section 2400, a health care district operated
27 pursuant to Division 23 (commencing with Section 32000) of the
28 Health and Safety Code may employ a physician and surgeon; and
29 may charge for professional services rendered by the physician
30 and surgeon, if the physician and surgeon in whose name the
31 charges are made approves the charges. However, the district shall
32 not interfere with, control, or otherwise direct the physician and

- 1 surgeon's professional judgment in a manner prohibited by Section
- 2 2400 or any other provision of law.
- 3 SEC. 2. Section 2401.1 of the Business and Professions Code
- 4 is repealed.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1951
Author: Hayashi
Bill Date: April 8, 2008, amended
Subject: Psychiatrists: suicide prevention training
Sponsor: Author

STATUS OF BILL:

This bill is currently on the Assembly Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require an applicant for licensure as a physician who is intending to specialize in psychiatry who begins medical school on or after January 1, 2010, to complete six hours of coursework in suicide prevention, assessment, intervention, and post intervention strategies. This bill will require physicians specializing in psychiatry who began medical school prior to January 1, 2010 to complete coursework as a condition of renewal.

ANALYSIS:

This bill requires medical students, who begin medical education after January 10, 2010 to meet requirements of six hours of specialized training. This training can be obtained from a variety of sources, some of whom are not currently approved as providers. This will require the Board to review and approve these providers for this specialized training.

This bill, in addition to requiring applicants for licensure as a physician, requires, commencing January 1, 2011, all licensed physicians specializing in psychiatry, who began medical school prior to January 1, 2010, to complete six hours of coursework as a condition of license renewal.

The bill states that the six hours of credit can be obtained from a variety of continuing education providers that are not approved by the Medical Board (Board). These providers are the same who would provide training to initial applicants.

There are several other technical issues with the language in this bill that need to be clarified. The bill allows for an exemption from the requirement. This bill creates workload in evaluating requests for exemptions and in the approval of prior training.

FISCAL: May require one staff person to work on the development of the approval process and to carry out on going workload for the Board.

POSITION: Recommendation: Oppose unless amended to allow the Board to use courses approved by physician continuing education providers or those approved by other Boards.

April 18, 2008

AMENDED IN ASSEMBLY APRIL 8, 2008
AMENDED IN ASSEMBLY MARCH 11, 2008
CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL

No. 1951

**Introduced by Assembly Member Hayashi
(Coauthor: Assembly Member Dymally)**

February 13, 2008

An act to add Sections 2089.8, 2190.6, 2915.8, 2915.9, 4980.415, 4980.416, 4989.23, 4989.35, 4996.27, and 4996.275 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1951, as amended, Hayashi. Mental health professionals: suicide prevention training.

Existing law provides for the licensure and regulation of various professionals who provide mental health-related services, including psychologists, marriage and family therapists, educational psychologists, and clinical social workers. Under existing law, an applicant for licensure in these professions is required to complete certain coursework or training in order to be eligible for a license. Existing law also requires these professionals to participate in continuing education as a prerequisite for renewing their license.

This bill would require ~~that~~ an applicant for licensure as a psychologist, marriage and family therapist, educational psychologist, or clinical social worker, ~~or for renewal of one of those licenses, who begins graduate school on or after January 1, 2010, to complete 6 hours of training in suicide prevention, assessment, intervention, and postintervention strategies, as specified. Commencing January 1, 2011,~~

the bill would require a licensed psychologist, marriage and family therapist, educational psychologist, or clinical social worker who began graduate school prior to January 1, 2010, to complete that coursework as a condition of license renewal.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law requires an applicant for that license to complete a medical curriculum providing instruction in specified subjects. Under existing law, the board is required to adopt and administer standards for the continuing education of licensed physicians and surgeons.

This bill would require an applicant for licensure as a physician and surgeon intending to specialize in psychiatry who begins medical school on or after January 1, 2010, to complete 6 hours of coursework in suicide prevention, assessment, intervention, and postintervention strategies, as specified. Commencing January 1, 2011, the bill would require a licensed physician and surgeon specializing in psychiatry who began medical school prior to January 1, 2010, to complete that coursework as a condition of license renewal.

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 2089.8 is added to the Business and*
- 2 *Professions Code, to read:*
- 3 *2089.8. (a) An applicant for licensure as a physician and*
- 4 *surgeon intending to specialize in psychiatry who began medical*
- 5 *school on or after January 1, 2010, shall complete, as a condition*
- 6 *of licensure, a minimum of six hours of coursework in suicide*
- 7 *prevention, assessment, intervention, and postintervention*
- 8 *strategies. This coursework shall also include training in*
- 9 *community resources and an understanding of cultural factors*
- 10 *that promote help-seeking behavior.*
- 11 *(b) The coursework required by this section shall be obtained*
- 12 *from one of the following:*
- 13 *(1) An approved medical school, as provided in Section 2084.*
- 14 *(2) A continuing education provider approved by the board.*
- 15 *(3) A course sponsored or offered by a professional association*
- 16 *and approved by the board.*

1 (4) A course sponsored or offered by a local, county, or state
2 department of health or mental health and approved by the board.

3 (5) A course offered by a nationally certified nonprofit agency,
4 including, but not limited to, a crisis center or a suicide prevention
5 hotline, provided that the agency is a continuing education
6 provider, has at least five years of experience conducting suicide
7 prevention training, and is approved by the board.

8 (c) Coursework taken in fulfillment of other educational
9 requirements for licensure pursuant to this chapter, or in a
10 separate course of study, may, at the discretion of the board, fulfill
11 the requirements of this section.

12 (d) An applicant shall submit to the board evidence acceptable
13 to the board of the applicant's satisfactory completion of the
14 coursework required by subdivision (a).

15 (e) An applicant may request an exemption from this section if
16 he or she intends to practice in an area where the training required
17 by this section would not be needed.

18 (f) The board shall not issue a license to the applicant until the
19 applicant has met the requirements of this section.

20 SEC. 2. Section 2190.6 is added to the Business and Professions
21 Code, to read:

22 2190.6. (a) A physician and surgeon specializing in psychiatry
23 who began medical school prior to January 1, 2010, shall complete
24 a minimum of six hours of continuing education coursework in
25 suicide prevention, assessment, intervention, and postintervention
26 strategies during his or her first renewal period after the operative
27 date of this section. The coursework shall also include training in
28 community resources and an understanding of cultural factors
29 that promote help-seeking behavior.

30 (b) The coursework required by this section shall be obtained
31 from one of the following:

32 (1) An approved medical school, as provided in Section 2084.

33 (2) A continuing education provider approved by the board.

34 (3) A course sponsored or offered by a professional association
35 and approved by the board.

36 (4) A course sponsored or offered by a local, county, or state
37 department of health or mental health and approved by the board.

38 (5) A course offered by a nationally certified nonprofit agency,
39 including, but not limited to, a crisis center or a suicide prevention
40 hotline, provided that the agency is a continuing education

1 provider, has at least five years of experience conducting suicide
2 prevention training, and is approved by the board.

3 (c) A licensee shall submit to the board evidence acceptable to
4 the board of the licensee's satisfactory completion of the
5 coursework required by subdivision (a).

6 (d) A person seeking to meet the requirements of this section
7 may submit to the board a certificate evidencing completion of
8 equivalent coursework in suicide prevention, assessment,
9 intervention, and postintervention strategies taken prior to the
10 operative date of this section, or proof of equivalent teaching or
11 practice experience. The board, in its discretion, may accept that
12 certification as meeting the requirements of this section.

13 (e) A licensee may request an exemption from this section if he
14 or she practices in an area where the training required by this
15 section is not needed.

16 (f) The board may not renew an applicant's license until the
17 applicant has met the requirements of this section.

18 (g) Continuing education courses taken pursuant to this section
19 shall be applied to the required minimum number of continuing
20 education hours established by regulation.

21 (h) This section shall become operative on January 1, 2011.

22 ~~SECTION 1.~~

23 SEC. 3. Section 2915.8 is added to the Business and Professions
24 Code, to read:

25 2915.8. (a) An applicant for licensure as a psychologist who
26 began graduate study on or after January 1, 2010, shall complete,
27 as a condition of licensure, a minimum of six hours of coursework
28 in suicide prevention, assessment, intervention, and
29 postintervention strategies. This coursework shall also include
30 training in community resources and an understanding of cultural
31 factors that promote help-seeking behavior.

32 (b) ~~Coursework~~ The coursework required by this section shall
33 be obtained from one of the following sources:

34 (1) An accredited or approved educational institution, as defined
35 in Section 2902.

36 (2) A continuing education provider approved by the board.

37 (3) A course sponsored or offered by a professional association
38 and approved by the board.

39 (4) A course sponsored or offered by a local, county, or state
40 department of health or mental health and approved by the board.

1 (5) A course offered by a nationally certified nonprofit agency,
2 including, but not limited to, a crisis center or a suicide prevention
3 hotline, provided that the agency is a continuing education
4 provider, has at least five years of experience conducting suicide
5 prevention training, and is approved by the board.

6 (c) Coursework taken in fulfillment of other educational
7 requirements for licensure pursuant to this chapter, or in a separate
8 course of study, may, at the discretion of the board, fulfill the
9 requirements of this section.

10 (d) An applicant shall submit to the board evidence acceptable
11 to the board of the applicant's satisfactory completion of the
12 coursework required by subdivision (a).

13 (e) An applicant may request an exemption from this section if
14 he or she intends to practice in an area where the training required
15 by this section would not be needed.

16 (f) The board shall not issue a license to the applicant until the
17 applicant has met the requirements of this section.

18 ~~SEC. 2.~~

19 *SEC. 4.* Section 2915.9 is added to the Business and Professions
20 Code, to read:

21 2915.9. (a) A licensee who began graduate study prior to
22 January 1, 2010, shall complete a minimum of six hours of
23 continuing education coursework in suicide prevention, assessment,
24 intervention, and postintervention strategies during his or her first
25 renewal period after the operative date of this section. The
26 coursework shall also include training in community resources
27 and an understanding of cultural factors that promote help-seeking
28 behavior.

29 (b) The coursework required by this section shall be obtained
30 from one of the following:

31 (1) An accredited or approved educational institution, as defined
32 in Section 2902.

33 (2) A continuing education provider approved by the board.

34 (3) A course sponsored or offered by a professional association
35 and approved by the board.

36 (4) A course sponsored or offered by a local, county, or state
37 department of health or mental health and approved by the board.

38 (5) A course offered by a nationally certified nonprofit agency,
39 including, but not limited to, a crisis center or a suicide prevention
40 hotline, provided that the agency is a continuing education

1 provider, has at least five years of experience conducting suicide
2 prevention training, and is approved by the board.

3 (c) A licensee shall submit to the board evidence acceptable to
4 the board of the licensee's satisfactory completion of the
5 coursework required by subdivision (a).

6 (d) A person seeking to meet the requirements of this section
7 may submit to the board a certificate evidencing completion of
8 equivalent coursework in suicide prevention, assessment,
9 intervention, and postintervention strategies taken prior to the
10 operative date of this section, or proof of equivalent teaching or
11 practice experience. The board, in its discretion, may accept that
12 certification as meeting the requirements of this section.

13 (e) A licensee may request an exemption from this section if he
14 or she practices in an area where the training required by this
15 section is not needed.

16 (f) The board may not renew an applicant's license until the
17 applicant has met the requirements of this section.

18 (g) Continuing education courses taken pursuant to this section
19 shall be applied to the 36 hours of approved continuing education
20 required in Section 2915.

21 (h) This section shall become operative on January 1, 2011.

22 ~~SEC. 3:~~

23 *SEC. 5.* Section 4980.415 is added to the Business and
24 Professions Code, to read:

25 4980.415. (a) An applicant for licensure as a marriage and
26 family therapist who began graduate study on or after January 1,
27 2010, shall complete, as a condition of licensure, a minimum of
28 six hours of coursework in suicide prevention, assessment,
29 intervention, and postintervention strategies. This coursework shall
30 also include training in community resources and an understanding
31 of cultural factors that promote help-seeking behavior.

32 (b) ~~Coursework~~ *The coursework* required by this section shall
33 be obtained from one of the following sources:

34 (1) An accredited or approved educational institution, as
35 specified in Section 4980.40.

36 (2) A continuing education provider approved by the board.

37 (3) A course sponsored or offered by a professional association
38 and approved by the board.

39 (4) A course sponsored or offered by a local, county, or state
40 department of health or mental health and approved by the board.

1 (5) A course offered by a nationally certified nonprofit agency,
2 including, but not limited to, a crisis center or a suicide prevention
3 hotline, provided that the agency is a continuing education
4 provider, has at least five years of experience conducting suicide
5 prevention training, and is approved by the board.

6 (c) Coursework taken in fulfillment of other educational
7 requirements for licensure pursuant to this chapter, or in a separate
8 course of study, may, at the discretion of the board, fulfill the
9 requirements of this section.

10 (d) An applicant shall submit to the board evidence acceptable
11 to the board of the applicant's satisfactory completion of the
12 coursework required by subdivision (a).

13 (e) An applicant may request an exemption from this section if
14 he or she intends to practice in an area where the training required
15 by this section would not be needed.

16 (f) The board shall not issue a license to the applicant until the
17 applicant has met the requirements of this section.

18 ~~SEC. 4.~~

19 *SEC. 6.* Section 4980.416 is added to the Business and
20 Professions Code, to read:

21 4980.416. (a) A licensee who began graduate study prior to
22 January 1, 2010, shall complete a minimum of six hours of
23 continuing education coursework in suicide prevention, assessment,
24 intervention, and postintervention strategies during his or her first
25 renewal period after the operative date of this section. The
26 coursework shall also include training in community resources
27 and an understanding of cultural factors that promote help-seeking
28 behavior.

29 (b) The coursework required by this section shall be obtained
30 from one of the following:

31 (1) An accredited or approved educational institution, as
32 specified in Section 4980.40.

33 (2) A continuing education provider approved by the board.

34 (3) A course sponsored or offered by a professional association
35 and approved by the board.

36 (4) A course sponsored or offered by a local, county, or state
37 department of health or mental health and approved by the board.

38 (5) A course offered by a nationally certified nonprofit agency,
39 including, but not limited to, a crisis center or a suicide prevention
40 hotline, provided that the agency is a continuing education

1 provider, has at least five years of experience conducting suicide
2 prevention training, and is approved by the board.

3 (c) A licensee shall submit to the board evidence acceptable to
4 the board of the licensee's satisfactory completion of the
5 coursework required by subdivision (a).

6 (d) A person seeking to meet the requirements of this section
7 may submit to the board a certificate evidencing completion of
8 equivalent coursework in suicide prevention, assessment,
9 intervention, and postintervention strategies taken prior to the
10 operative date of this section, or proof of equivalent teaching or
11 practice experience. The board, in its discretion, may accept that
12 certification as meeting the requirements of this section.

13 (e) A licensee may request an exemption from this section if he
14 or she practices in an area where the training required by this
15 section is not needed.

16 (f) The board may not renew an applicant's license until the
17 applicant has met the requirements of this section.

18 (g) Continuing education courses taken pursuant to this section
19 shall be applied to the 36 hours of approved continuing education
20 required in Section 4980.54.

21 (h) This section shall become operative on January 1, 2011.

22 ~~SEC. 5.~~

23 *SEC. 7.* Section 4989.23 is added to the Business and
24 Professions Code, to read:

25 4989.23. (a) An applicant for licensure as an educational
26 psychologist who began graduate study on or after January 1, 2010,
27 shall complete, as a condition of licensure, a minimum of six hours
28 of coursework in suicide prevention, assessment, intervention, and
29 postintervention strategies. This coursework shall also include
30 training in community resources and an understanding of cultural
31 factors that promote help-seeking behavior.

32 (b) ~~Coursework~~ *The coursework* required by this section shall
33 be obtained from one of the following sources:

34 (1) An educational institution approved by the board, as provided
35 in paragraph (1) of subdivision (a) of Section 4989.20.

36 (2) A continuing education provider approved by the board.

37 (3) A course sponsored or offered by a professional association
38 and approved by the board.

39 (4) A course sponsored or offered by a local, county, or state
40 department of health or mental health and approved by the board.

1 (5) A course offered by a nationally certified nonprofit agency,
2 including, but not limited to, a crisis center or a suicide prevention
3 hotline, provided that the agency is a continuing education
4 provider, has at least five years of experience conducting suicide
5 prevention training, and is approved by the board.

6 (c) Coursework taken in fulfillment of other educational
7 requirements for licensure pursuant to this chapter, or in a separate
8 course of study, may, at the discretion of the board, fulfill the
9 requirements of this section.

10 (d) An applicant shall submit to the board evidence acceptable
11 to the board of the applicant's satisfactory completion of the
12 coursework required by subdivision (a).

13 (e) An applicant may request an exemption from this section if
14 he or she intends to practice in an area where the training required
15 by this section would not be needed.

16 (f) The board shall not issue a license to an applicant until the
17 applicant has met the requirements of this section.

18 ~~SEC. 6.~~

19 *SEC. 8.* Section 4989.35 is added to the Business and
20 Professions Code, to read:

21 4989.35. (a) A licensee who began graduate study prior to
22 January 1, 2010, shall complete a minimum of six hours of
23 continuing education coursework in suicide prevention, assessment,
24 intervention, and postintervention strategies during his or her first
25 renewal period after the operative date of this section. The
26 coursework shall also include training in community resources
27 and an understanding of cultural factors that promote help-seeking
28 behavior.

29 (b) The coursework required by this section shall be obtained
30 from one of the following:

31 (1) An educational institution approved by the board, as provided
32 in paragraph (1) of subdivision (a) of Section 4989.20.

33 (2) A continuing education provider approved by the board.

34 (3) A course sponsored or offered by a professional association
35 and approved by the board.

36 (4) A course sponsored or offered by a local, county, or state
37 department of health or mental health and approved by the board.

38 (5) A course offered by a nationally certified nonprofit agency,
39 including, but not limited to, a crisis center or a suicide prevention
40 hotline, provided that the agency is a continuing education

1 provider, has at least five years of experience conducting suicide
2 prevention training, and is approved by the board.

3 (c) A licensee shall submit to the board evidence acceptable to
4 the board of the ~~person's~~ licensee's satisfactory completion of the
5 coursework required by subdivision (a).

6 (d) A person seeking to meet the requirements of this section
7 may submit to the board a certificate evidencing completion of
8 equivalent coursework in suicide prevention, assessment,
9 intervention, and postintervention strategies taken prior to the
10 operative date of this section, or proof of equivalent teaching or
11 practice experience. The board, in its discretion, may accept that
12 certification as meeting the requirements of this section.

13 (e) A licensee may request an exemption from this section if he
14 or she practices in an area where the training required by this
15 section is not needed.

16 (f) The board may not renew an applicant's license until the
17 applicant has met the requirements of this section.

18 (g) Continuing education courses taken pursuant to this section
19 shall be applied to the 36 hours of approved continuing education
20 required in Section 4989.34.

21 (h) This section shall become operative on January 1, 2011.

22 ~~SEC. 7.~~

23 *SEC. 9.* Section 4996.27 is added to the Business and
24 Professions Code, to read:

25 4996.27. (a) An applicant for licensure as a licensed clinical
26 social worker who began graduate study on or after January 1,
27 2010, shall complete, as a condition of licensure, a minimum of
28 six hours of coursework in suicide prevention, assessment,
29 intervention, and postintervention strategies. This coursework shall
30 also include training in community resources and an understanding
31 of cultural factors that promote help-seeking behavior.

32 (b) ~~Coursework~~ *The coursework* required by this section shall
33 be obtained from one of the following sources:

34 (1) An accredited or approved educational institution, as
35 specified in Section 4996.18.

36 (2) A continuing education provider approved by the board.

37 (3) A course sponsored or offered by a professional association
38 and approved by the board.

39 (4) A course sponsored or offered by a local, county, or state
40 department of health or mental health and approved by the board.

1 (5) A course offered by a nationally certified nonprofit agency,
2 including, but not limited to, a crisis center or a suicide prevention
3 hotline, provided that the agency is a continuing education
4 provider, has at least five years of experience conducting suicide
5 prevention training, and is approved by the board.

6 (c) Coursework taken in fulfillment of other educational
7 requirements for licensure pursuant to this chapter, or in a separate
8 course of study, may, at the discretion of the board, fulfill the
9 requirements of this section.

10 (d) An applicant shall submit to the board evidence acceptable
11 to the board of the ~~person's~~ *applicant's* satisfactory completion of
12 the coursework required by subdivision (a).

13 (e) An applicant may request an exemption from this section if
14 he or she intends to practice in an area where the training required
15 by this section would not be needed.

16 (f) The board shall not issue a license to an applicant until the
17 applicant has met the requirements of this section.

18 ~~SEC. 8.~~

19 *SEC. 10.* Section 4996.275 is added to the Business and
20 Professions Code, to read:

21 4996.275. (a) A licensee who began graduate study prior to
22 January 1, 2010, shall complete a minimum of six hours of
23 continuing education coursework in suicide prevention, assessment,
24 intervention, and postintervention strategies during his or her first
25 renewal period after the operative date of this section. The
26 coursework shall also include training in community resources
27 and an understanding of cultural factors that promote help-seeking
28 behavior.

29 (b) The coursework required by this section shall be obtained
30 from one of the following:

31 (1) An accredited or approved educational institution, as
32 specified in Section 4996.18.

33 (2) A continuing education provider approved by the board.

34 (3) A course sponsored or offered by a professional association
35 and approved by the board.

36 (4) A course sponsored or offered by a local, county, or state
37 department of health or mental health and approved by the board.

38 (5) A course offered by a nationally certified nonprofit agency,
39 including, but not limited to, a crisis center or a suicide prevention
40 hotline, provided that the agency is a continuing education

1 provider, has at least five years of experience conducting suicide
2 prevention training, and is approved by the board.

3 (c) A licensee shall submit to the board evidence acceptable to
4 the board of the ~~person's~~ *licensee's* satisfactory completion of the
5 coursework required by subdivision (a).

6 (d) A person seeking to meet the requirements of this section
7 may submit to the board a certificate evidencing completion of
8 equivalent coursework in suicide prevention, assessment,
9 intervention, and postintervention strategies taken prior to the
10 operative date of this section, or proof of equivalent teaching or
11 practice experience. The board, in its discretion, may accept that
12 certification as meeting the requirements of this section.

13 (e) A licensee may request an exemption from this section if he
14 or she practices in an area where the training required by this
15 section is not needed.

16 (f) The board may not renew an applicant's license until the
17 applicant has met the requirements of this section.

18 (g) Continuing education courses taken pursuant to this section
19 shall be applied to the 36 hours of approved continuing education
20 required in Section 4996.22.

21 (h) This section shall become operative on January 1, 2011.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2398
Author: Nakanishi
Bill Date: April 10, 2008, amended
Subject: Cosmetic Surgery: Supervision
Sponsor: American Society for Dermatological Surgery

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 seeks to address the problem of physicians lending their name and license number to businesses that perform cosmetic surgery for monetary payout by establishing supervision requirements for physicians who delegate the performance of elective cosmetic procedures. This bill allows for license revocation of a physician who violates these provisions.

ANALYSIS:

Current law requires specified disclosures to patients undergoing procedures involving collagen injections. In addition, existing law requires the Medical Board (Board) to adopt standards in regard to body liposuction procedures performed outside of a general acute care hospital. A violation of any of these provisions is a misdemeanor.

According to the author, current state regulatory guidance leaves unclear whether a physician must directly supervise an allied health professional when delegating certain types of cosmetic medical procedures that are provided in 'medi-spas,' including treatment involving lasers and pulse light. The author feels that the existing laws have been unsuccessful in deterring physicians from committing these illegal acts, and additional provisions are necessary.

Legislation such as SB 1423 (Figueroa), which required the Board and the Board of Registered Nursing (BRN) to study the issue of safety with the use of lasers in cosmetic procedures, has been directed at curbing this dangerous practice.

This bill seeks to strengthen current law on this issue and provide greater protection to patients seeking safe and responsible cosmetic care. Specifically, this bill would:

- Require any physician who delegates the performance or administration of any elective cosmetic medical procedure for treatment to a registered nurse must first perform an initial, good faith, and appropriate prior examination of the patient.
- State that direct supervision by the delegating physician to a nurse practitioner, physician assistant, or registered nurse is not required in a physician owned and operated treatment setting.
- Allow the patient to request “direct” supervisions of a procedure which would require the physicians be on site and available for immediate consultation. The bill does not require the practitioner to ask the patients if they desire direct supervision of a delegated procedure, so it is not clear how this provision protects an unaware patient.
- Limit the number and location of settings the physician may have for delegated procedures.
- Require the physician be available within 24 hours for emergent patient issues.
- Allow the Board to revoke the license of physicians, engaged in elective cosmetic medical practice, who knowingly contract to serve as the medical director of a business organization in violation of the prohibition against the corporate practice of medicine. A physician who violates this provision would also be guilty of a public offense punishable by imprisonment for two, three, or five years, or by a fine not exceeding \$50,000.
- Make a violation of these provisions by a person or entity subject to a fine of up to \$25,000 per occurrence pursuant to a civil penalty, or a citation issued by the Board, or imprisonment for up to six months, or both fine and imprisonment.

FISCAL: Minor

POSITION: Recommendation: Support

April 18, 2008

AMENDED IN ASSEMBLY APRIL 10, 2008

AMENDED IN ASSEMBLY APRIL 1, 2008

CALIFORNIA LEGISLATURE—2007—08 REGULAR SESSION

ASSEMBLY BILL

No. 2398

Introduced by Assembly Member Nakanishi

February 21, 2008

An act to amend Section 2417 of, and to add Section 2259.6 to, the Business and Professions Code, relating to the practice of medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 2398, as amended, Nakanishi. Practice of medicine: ~~cosmetic surgery~~; employment of physicians and surgeons.

Existing law, the Medical Practice Act, establishes the Medical Board of California under the Department of Consumer Affairs, which licenses physicians and surgeons and regulates their practice.

Existing law, the Medical Practice Act, requires specified disclosures to patients undergoing procedures involving collagen injections, defined as any substance derived from, or combined with, animal protein. Existing law also requires the board to adopt extraction and postoperative care standards in regard to body liposuction procedures performed by a physician and surgeon outside of a general acute care hospital. Existing law makes a violation of these provisions a misdemeanor.

This bill would require a physician and surgeon who delegates to a registered nurse the performance or administration of any elective cosmetic medical procedure or treatment, as defined, to perform an initial, good faith, and appropriate prior examination of the patient for whom treatment has been delegated and to provide direct supervision

of that procedure or treatment under certain conditions. The bill would prohibit a physician and surgeon from delegating the performance or administration of elective cosmetic medical procedures or treatments to more than 4 separately addressed locations under his or her supervision, which must be located as specified. The bill would provide that a violation of that provision may subject the person or entity that has committed the violation to either a fine of up to \$25,000 per occurrence pursuant to a citation issued by the board or a civil penalty of \$25,000 per occurrence. The bill would also provide that multiple acts by any person or entity in violation of that provision shall be punishable by a fine not to exceed \$25,000 or by imprisonment in a county jail not exceeding 6 months, or by both that fine and imprisonment. The bill would authorize the Attorney General to bring an action to enforce those provisions.

Because multiple violations of those provisions would be a crime, this bill would impose a state-mandated local program.

The Medical Practice Act restricts the employment of licensed physicians and surgeons and podiatrists by a corporation or other artificial legal entity, subject to specified exemptions. Existing law makes it unlawful to knowingly make, or cause to be made, any false or fraudulent claim for payment of a health care benefit, or to aid, abet, solicit, or conspire with any person to do so, and makes a violation of this prohibition a public offense.

This bill would ~~permanently revoke~~ *authorize the revocation of* the license of a physician and surgeon who practices medicine with a business organization knowing that it is owned or operated in violation of the prohibition against employment of licensed physicians and surgeons and podiatrists. The bill would also make a business organization that is owned and operated in violation of the prohibition, and that contracts with or employs a physician and surgeon to facilitate the offer or provision of professional services that may only be provided by a licensed physician and surgeon, guilty of a violation of the prohibition against knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit. Because ~~this~~ *the* bill would expand a public offense, it would impose a state-mandated local program.

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

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

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

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

1 SECTION 1. Section 2259.6 is added to the Business and
2 Professions Code, to read:

3 2259.6. (a) Any physician and surgeon who delegates the
4 performance or administration of any elective cosmetic medical
5 procedure or treatment to a registered nurse shall, pursuant to the
6 requirements of this article, perform an initial, good faith, and
7 appropriate prior examination of the patient for whom treatment
8 has been delegated. Subject to the provisions of subdivision (d),
9 in a physician and surgeon-owned and operated treatment setting,
10 direct supervision is not required upon delegation to a nurse
11 practitioner, physician assistant, or registered nurse. In all
12 circumstances, upon request of the patient, the delegating physician
13 and surgeon shall afford the patient direct supervision of the
14 procedure or treatment.

15 (b) Direct supervision shall mean that the physician and surgeon
16 must be onsite and available for immediate consultation at the time
17 of performance or administration of the procedure or treatment.

18 (c) As used in this section, “elective cosmetic medical procedure
19 or treatment” means a medical procedure or treatment that is
20 performed to alter or reshape normal structures of the body solely
21 in order to improve appearance.

22 (d) In no event may a physician and surgeon delegate the
23 performance or administration of elective cosmetic medical
24 procedures or treatments to more than four separately addressed
25 locations under his or her supervision, one of which shall be his
26 or her primary practice location. These sites shall be located within
27 a radius no greater than that which may be reached within 60
28 minutes from the physician and surgeon’s primary practice
29 location. A delegating physician and surgeon shall be available to
30 attend to emergent patient circumstances within a reasonable time,
31 not to exceed 24 hours from the onset of those circumstances.

32 (e) Notwithstanding any other provision of law, a violation of
33 this section may subject the person or entity that has committed

1 the violation to either a fine of up to twenty-five thousand dollars
2 (\$25,000) per occurrence pursuant to a citation issued by the board
3 or a civil penalty of twenty-five thousand dollars (\$25,000) per
4 occurrence. Section 125.9 shall govern the issuance of this citation
5 and fine except that the fine limitations prescribed in paragraph
6 (3) of subdivision (b) of Section 125.9 shall not apply to a fine
7 under this subdivision.

8 (f) Multiple acts by any person or entity in violation of this
9 section shall be punishable by a fine not to exceed twenty-five
10 thousand dollars (\$25,000) or by imprisonment in a county jail not
11 exceeding six months, or by both that fine and imprisonment.

12 (g) The Attorney General may bring an action to enforce this
13 section and to collect the fines or civil penalties authorized by
14 subdivision (d) or (e).

15 SEC. 2. Section 2417 of the Business and Professions Code is
16 amended to read:

17 2417. (a) If the Department of Insurance has evidence that a
18 business is being operated in violation of this chapter, Part 4
19 (commencing with Section 13400) of Division 3 of the
20 Corporations Code, or Chapter 1 (commencing with Section 1200)
21 of Division 2 of the Health and Safety Code, and that the business
22 may be in violation of Section 1871.4 of the Insurance Code or
23 Section 549 or 550 of the Penal Code, then the department shall
24 report the business, and any physician and surgeon suspected of
25 knowingly providing medical services for that business relative to
26 a violation of Section 1871.4 of the Insurance Code or Section 549
27 or 550 of the Penal Code, to the appropriate regulatory agency.
28 Upon receiving a report from the Department of Insurance of a
29 suspected violation, the regulatory agency shall conduct an
30 investigation. The requirement in subdivision (a) of Section
31 1872.95 of the Insurance Code for investigations to be conducted
32 within existing resources does not apply to investigations required
33 by this section. The Department of Insurance may consult with
34 the appropriate regulatory department or agency prior to making
35 its report to that department or agency, and this consultation shall
36 not be deemed to require the department or agency to conduct an
37 investigation.

38 (b) A physician and surgeon who practices medicine with a
39 business organization knowing that it is owned or operated in
40 violation of Section 1871.4 of the Insurance Code, Section 14107

1 or 14107.2 of the Welfare and Institutions Code, or Section 549
2 or 550 of the Penal Code shall have his or her license to practice
3 permanently revoked.

4 (c) A physician and surgeon who practices medicine with a
5 business organization, knowing that it is owned or operated in
6 violation of Section 2400, ~~shall~~ *may* have his or her license to
7 practice ~~permanently~~ revoked. A physician and surgeon who
8 contracts to serve as, or otherwise allows himself or herself to be
9 employed as, the medical director of a business organization that
10 he or she does not own and that offers to provide or provides
11 professional services that may only be provided by the holder of
12 a valid physician's and surgeon's certificate under this chapter
13 shall be deemed to have knowledge that the business organization
14 is in violation of Section 2400.

15 (d) A business organization that is owned or operated in
16 violation of Section 2400 and that contracts with, or otherwise
17 employs, a physician and surgeon to facilitate its offers to provide,
18 or the provision of, professional services that may only be provided
19 by the holder of a valid physician's and surgeon's certificate is
20 guilty of violating paragraph (6) of subdivision (a) of Section 550
21 of the Penal Code.

22 SEC. 3. No reimbursement is required by this act pursuant to
23 Section 6 of Article XIII B of the California Constitution because
24 the only costs that may be incurred by a local agency or school
25 district will be incurred because this act creates a new crime or
26 infraction, eliminates a crime or infraction, or changes the penalty
27 for a crime or infraction, within the meaning of Section 17556 of
28 the Government Code, or changes the definition of a crime within
29 the meaning of Section 6 of Article XIII B of the California
30 Constitution.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2439
Author: De La Torre
Bill Date: April 8, 2008, amended
Subject: Loan Repayment Program: Mandatory Fees
Sponsor: Author

STATUS OF BILL:

This bill is currently on the Assembly Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Medical Board (Board) to assess an additional \$50 fee for the issuance and bi-annual renewal of a physician's license for the purpose of helping to fund the Steven M. Thompson Physician Corps Loan Repayment Program for the purpose of providing loan repayment awards. In addition, 15% of the funds collected would be dedicated to physicians practicing in geriatric settings.

ANALYSIS:

The Steven M. Thompson Corps Loan Repayment Program (Program) was established in 2002 through AB 982 (Firebaugh). Physicians who participate in this program and practice medicine in underserved communities are provided with a financial contribution to help defray the costs of their student loan debt. Since its inception, 399 physicians have submitted applications to participate in the program. Due to insufficient funding, only 94 applicants have been selected to receive awards through the program. Participants have served in communities including Los Angeles, Oakland, San Bernardino, Sonoma, Woodland, San Diego, San Francisco, and Humboldt.

This bill requires the assessment in addition to the set or waived fees. This means that every physician, including those in a status where renewal fees are waived must pay the \$50 assessment for the program.

This bill directs the Program to direct 15% of the money collected pursuant to this bill to loan repayment applicants working in geriatric settings. This is to encourage physicians to work in those settings and to address the shortages of geriatric physicians.

FISCAL: Minor and absorbable to MBC.

Revenue this will generate for the physicians:

Annual paid renewals:	54,000 x \$50 =	\$2,700,000
Annual fee-exempt renewals:	5,000 x \$50 =	\$250,000
Initial Licenses:	2,000 x \$50 =	\$100,000
Initial Licenses (1/2) fee:	3,400 x \$50 =	\$170,000

TOTAL ADDITIONAL ANNUAL REVENUE = \$3,220,000

POSITION:

Recommendation: Oppose unless amended to require the mandatory fee to apply to only those licensees who are required to pay fees.

Or, oppose unless amended lower the mandatory fee to \$25, which is essentially equal to the proposed reduction in fees for the diversion program (\$22).

April 18, 2008

AMENDED IN ASSEMBLY APRIL 8, 2008
AMENDED IN ASSEMBLY MARCH 28, 2008
CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL

No. 2439

**Introduced by Assembly Member De La Torre
(Coauthor: Assembly Member Berg)**

February 21, 2008

An act to amend Section 2023 of, and to amend and renumber Section 2435.2 of, the Business and Professions Code, *and to amend Section 128553 of the Health and Safety Code*, relating to physicians and surgeons, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 2439, as amended, De La Torre. Steven M. Thompson Physician Corps Loan Repayment Program: fees.

Existing law establishes the Steven M. Thompson Physician Corps Loan Repayment Program in the California Physician Corps Program within the Health and Professions Education Foundation, which provides financial incentives, as specified, to a physician and surgeon for practicing in a medically underserved community. Existing law requires the Medical Board of California to assess an applicant for issuance or renewal of a physician and surgeon's license a voluntary \$50 fee to be deposited into the Medically Underserved Account for Physicians, which is continuously appropriated to provide funding for operations of the loan repayment program.

This bill would make the payment of the \$50 fee mandatory for applicants for issuance or renewal of a physician and surgeon's license. The bill would also provide that at least 15% of the funds collected be

dedicated to loan assistance for physicians and surgeons who agree to practice in geriatric care settings or settings that primarily serve adults over the age of 65 years or adults with disabilities. Because the bill would provide for the deposit of additional fees in a continuously appropriated fund, it would make an appropriation.

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

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

1 SECTION 1. Section 2023 of the Business and Professions
2 Code is amended to read:

3 2023. (a) The board, in conjunction with the Health Professions
4 Education Foundation, shall study the issue of its providing medical
5 malpractice insurance to physicians and surgeons who provide
6 voluntary, unpaid services as described in subdivision (b) of
7 Section 2083, and report its findings to the Legislature on or before
8 January 1, 2008.

9 (b) The report shall include, but not be limited to, a discussion
10 of the following items:

11 (1) The cost of administering a program to provide medical
12 malpractice insurance to the physicians and surgeons and the
13 process for administering the program.

14 (2) The options for providing medical malpractice insurance to
15 the physicians and surgeons and for funding the coverage.

16 (3) Whether the licensure surcharge fee assessed under Section
17 2436.5 is sufficient to fund the provision of medical malpractice
18 insurance for the physicians and surgeons.

19 (c) This section shall be implemented only after the Legislature
20 has made an appropriation from the Contingent Fund of the
21 Medical Board of California to fund the study.

22 SEC. 2. Section 2435.2 of the Business and Professions Code,
23 as added by Section 1 of Chapter 293 of the Statutes of 2005, is
24 amended and renumbered to read:

25 2436.5. (a) In addition to the fees charged for the initial
26 issuance or biennial renewal of a physician and surgeon's certificate
27 pursuant to Section 2435, and at the time those fees are charged,
28 the board shall charge each applicant or renewing licensee an
29 additional fifty-dollar (\$50) fee for the purposes of this section.

1 (b) This fifty-dollar (\$50) fee shall be paid at the time of
2 application for initial licensure or biennial renewal. The fifty-dollar
3 (\$50) fee shall be due and payable along with the fee for the initial
4 certificate or biennial renewal.

5 (c) The board shall transfer all funds collected pursuant to this
6 section, on a monthly basis, to the Medically Underserved Account
7 for Physicians created by Section 128555 of the Health and Safety
8 Code for the Steven M. Thompson Physician Corps Loan
9 Repayment Program.

10 (d) At least 15 percent of the funds collected pursuant this
11 section shall be dedicated to loan assistance for physicians and
12 surgeons who agree to practice in geriatric care settings or settings
13 that primarily serve adults over the age of 65 years or adults with
14 disabilities. Priority consideration shall be given to those physicians
15 and surgeons who are trained in, and practice, geriatrics and who
16 can meet the cultural and linguistic needs and demands of diverse
17 populations of older Californians.

18 *SEC. 3. Section 128553 of the Health and Safety Code is*
19 *amended to read:*

20 128553. (a) Program applicants shall possess a current valid
21 license to practice medicine in this state issued pursuant to Section
22 2050 of the Business and Professions Code.

23 (b) The foundation, in consultation with those identified in
24 subdivision (b) of Section 123551, shall use guidelines developed
25 by the Medical Board of California for selection and placement
26 of applicants until the office adopts other guidelines by regulation.

27 (c) The guidelines shall meet all of the following criteria:

28 (1) Provide priority consideration to applicants that are best
29 suited to meet the cultural and linguistic needs and demands of
30 patients from medically underserved populations and who meet
31 one or more of the following criteria:

32 (A) Speak a Medi-Cal threshold language.

33 (B) Come from an economically disadvantaged background.

34 (C) Have received significant training in cultural and
35 linguistically appropriate service delivery.

36 (D) Have three years of experience working in medically
37 underserved areas or with medically underserved populations.

38 (E) Have recently obtained a license to practice medicine.

39 (2) Include a process for determining the needs for physician
40 services identified by the practice setting and for ensuring that the

1 practice setting meets the definition specified in subdivision (h)
2 of Section 128552.

3 (3) Give preference to applicants who have completed a
4 three-year residency in a primary specialty.

5 (4) Seek to place the most qualified applicants under this section
6 in the areas with the greatest need.

7 (5) Include a factor ensuring geographic distribution of
8 placements.

9 (6) *On and after January 1, 2009, at least 15 percent of the*
10 *funds collected pursuant to Section 2436.5 of the Business and*
11 *Professions Code shall be dedicated to loan assistance for*
12 *physicians and surgeons who agree to practice in geriatric care*
13 *settings or settings that primarily serve adults over the age of 65*
14 *years or adults with disabilities. Priority consideration shall be*
15 *given to those who are trained in, and practice, geriatrics and who*
16 *can meet the cultural and linguistic needs and demands of diverse*
17 *populations of older Californians.*

18 (d) (1) The foundation may appoint a selection committee that
19 provides policy direction and guidance over the program and that
20 complies with the requirements of subdivision (l) of Section
21 128552.

22 (2) The selection committee may fill up to 20 percent of the
23 available positions with program applicants from specialties outside
24 of the primary care specialties.

25 (e) Program participants shall meet all of the following
26 requirements:

27 (1) Shall be working in or have a signed agreement with an
28 eligible practice setting.

29 (2) Shall have full-time status at the practice setting. Full-time
30 status shall be defined by the board and the selection committee
31 may establish exemptions from this requirement on a case-by-case
32 basis.

33 (3) Shall commit to a minimum of three years of service in a
34 medically underserved area. Leaves of absence shall be permitted
35 for serious illness, pregnancy, or other natural causes. The selection
36 committee shall develop the process for determining the maximum
37 permissible length of an absence and the process for reinstatement.
38 Loan repayment shall be deferred until the physician is back to
39 full-time status.

1 (f) The office shall adopt a process that applies if a physician
2 is unable to complete his or her three-year obligation.

3 (g) The foundation, in consultation with those identified in
4 subdivision (b) of Section 128551, shall develop a process for
5 outreach to potentially eligible applicants.

6 (h) The foundation may recommend to the office any other
7 standards of eligibility, placement, and termination appropriate to
8 achieve the aim of providing competent health care services in
9 approved practice settings.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2442
Author: Nakanishi
Bill Date: March 25, 2008, amended
Subject: MBC: Peer Review Proceedings
Sponsor: Medical Board of California
Board Position: Sponsor/Support

STATUS OF BILL:

This bill is currently on the Assembly Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would repeal Business and Professions Code sections 821.5 and 821.6 which require reporting to the Medical Board (Board) diversion program by health entities physicians under investigation with mental and physical illnesses.

ANALYSIS:

Business and Professions Code sections 821.5 and 821.6 were added to law in 1996 to require reporting to the Board's diversion program related to physicians under investigation by health entities with mental and physical illnesses. This provided the diversion program a "heads up" that there maybe an issue and that a physician may be recommended to enter the program.

With the diversion program due to sunset June 30, 2008 those reporting requirements will no longer be necessary. Should the investigation by the health entity lead to actions that rise to a high enough level, then those physicians must be reported to the Board under Business and Professions Code section 805. Therefore these provisions are no longer necessary.

FISCAL: None

POSITION: Sponsor/Support

April 18, 2008

AMENDED IN ASSEMBLY MARCH 25, 2008

CALIFORNIA LEGISLATURE—2007—08 REGULAR SESSION

ASSEMBLY BILL

No. 2442

Introduced by Assembly Member Nakanishi

February 21, 2008

An act to ~~amend~~ *repeal* Sections 821.5 and 821.6 of the Business and Professions Code, relating to healing arts, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 2442, as amended, Nakanishi. Medicine: peer review proceedings.

~~Existing law provides for the licensure and regulation of physicians and surgeons by the Medical Board of California.~~

Existing law requires peer review bodies that review physicians and surgeons to report certain information regarding investigations of physicians and surgeons who may be suffering from a disabling mental or physical condition to the diversion program of the Medical Board of California, *which program becomes inoperative July 1, 2008*, and requires the diversion program administrator to carry out specified duties in this regard. Existing law requires the board to adopt regulations implementing the monitoring responsibility of the diversion program administrator on or before January 1, 1997, as specified. ~~Under existing law, the diversion program becomes inoperative on July 1, 2008.~~

~~This bill would transfer the duties of the diversion program and the diversion program administrator with regard to the peer review body reports to the Medical Board of California and the board's executive director or designee. The bill would require the board to adopt regulations implementing the monitoring responsibility of the executive~~

director or designee on or before January 1, 2009, as specified. The bill would make conforming changes.

This bill would delete these provisions.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: $\frac{2}{3}$. 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 821.5 of the Business and Professions
2 Code is repealed.

3 ~~821.5. (a) A peer review body, as defined in Section 805, that~~
4 ~~reviews physicians and surgeons, shall, within 15 days of initiating~~
5 ~~a formal investigation of a physician and surgeon's ability to~~
6 ~~practice medicine safely based upon information indicating that~~
7 ~~the physician and surgeon may be suffering from a disabling mental~~
8 ~~or physical condition that poses a threat to patient care, report to~~
9 ~~the diversion program of the Medical Board the name of the~~
10 ~~physician and surgeon under investigation and the general nature~~
11 ~~of the investigation. A peer review body that has made a report to~~
12 ~~the diversion program under this section shall also notify the~~
13 ~~diversion program when it has completed or closed an~~
14 ~~investigation.~~

15 ~~(b) The diversion program administrator, upon receipt of a report~~
16 ~~pursuant to subdivision (a), shall contact the peer review body that~~
17 ~~made the report within 60 days in order to determine the status of~~
18 ~~the peer review body's investigation. The diversion program~~
19 ~~administrator shall contact the peer review body periodically~~
20 ~~thereafter to monitor the progress of the investigation. At any time,~~
21 ~~if the diversion program administrator determines that the progress~~
22 ~~of the investigation is not adequate to protect the public, the~~
23 ~~diversion program administrator shall notify the chief of~~
24 ~~enforcement of the Division of Medical Quality of the Medical~~
25 ~~Board of California, who shall promptly conduct an investigation~~
26 ~~of the matter. Concurrently with notifying the chief of enforcement,~~
27 ~~the diversion program administrator shall notify the reporting peer~~
28 ~~review body and the chief executive officer or an equivalent officer~~
29 ~~of the hospital of its decision to refer the case for investigation by~~
30 ~~the chief of enforcement.~~

1 ~~(e) For purposes of this section “formal investigation” means~~
2 ~~an investigation ordered by the peer review body’s medical~~
3 ~~executive committee or its equivalent, based upon information~~
4 ~~indicating that the physician and surgeon may be suffering from~~
5 ~~a disabling mental or physical condition that poses a threat to~~
6 ~~patient care. “Formal investigation” does not include the usual~~
7 ~~activities of the well-being or assistance committee or the usual~~
8 ~~quality assessment and improvement activities undertaken by the~~
9 ~~medical staff of a health facility in compliance with the licensing~~
10 ~~and certification requirements for health facilities set forth in Title~~
11 ~~22 of the California Code of Regulations, or preliminary~~
12 ~~deliberations or inquiries of the executive committee to determine~~
13 ~~whether to order a formal investigation.~~

14 ~~For purposes of this section, “usual activities” of the well-being~~
15 ~~or assistance committee are activities to assist medical staff~~
16 ~~members who may be impaired by chemical dependency or mental~~
17 ~~illness to obtain necessary evaluation and rehabilitation services~~
18 ~~that do not result in referral to the medical executive committee.~~

19 ~~(d) Information received by the diversion program pursuant to~~
20 ~~this section shall be governed by, and shall be deemed confidential~~
21 ~~to the same extent as program records under, Section 2355. The~~
22 ~~records shall not be further disclosed by the diversion program,~~
23 ~~except as provided in subdivision (b).~~

24 ~~(e) Upon receipt of notice from a peer review body that an~~
25 ~~investigation has been closed and that the peer review body has~~
26 ~~determined that there is no need for further action to protect the~~
27 ~~public, the diversion program shall purge and destroy all records~~
28 ~~in its possession pertaining to the investigation unless the diversion~~
29 ~~program administrator has referred the matter to the chief of~~
30 ~~enforcement pursuant to subdivision (b).~~

31 ~~(f) A peer review body that has made a report under subdivision~~
32 ~~(a) shall not be deemed to have waived the protections of Section~~
33 ~~1157 of the Evidence Code. It is not the intent of the Legislature~~
34 ~~in enacting this subdivision to affect pending litigation concerning~~
35 ~~Section 1157 or to create any new confidentiality protection except~~
36 ~~as specified in subdivision (d). “Pending litigation” shall include~~
37 ~~Arnett v. Dal Cielo (No. S048308), pending before the California~~
38 ~~Supreme Court.~~

39 ~~(g) The report required by this section shall be submitted on a~~
40 ~~short form developed by the board. The board shall develop the~~

1 short form, the contents of which shall reflect the requirements of
2 this section, within 30 days of the effective date of this section.
3 The board shall not require the filing of any report until the short
4 form is made available by the board.

5 ~~(h) This section shall become operative on January 1, 1997,~~
6 ~~unless the regulations required to be adopted pursuant to Section~~
7 ~~821.6 are adopted prior to that date, in which case this section shall~~
8 ~~become operative on the effective date of the regulations.~~

9 *SEC. 2. Section 821.6 of the Business and Professions Code*
10 *is repealed.*

11 ~~821.6. The board shall adopt regulations to implement the~~
12 ~~monitoring responsibility of the diversion program administrator~~
13 ~~described in subdivision (b) of Section 821.5, and the short form~~
14 ~~required to be developed pursuant to subdivision (g), on or before~~
15 ~~January 1, 1997.~~

16 *SEC. 3. This act is an urgency statute necessary for the*
17 *immediate preservation of the public peace, health, or safety within*
18 *the meaning of Article IV of the Constitution and shall go into*
19 *immediate effect. The facts constituting the necessity are:*

20 *In order to ensure that reporting requirements administered by*
21 *the diversion program of the Medical Board of California are*
22 *deleted when that program becomes inoperative, it is necessary*
23 *that this act take effect immediately.*

24 ~~SECTION 1. Section 821.5 of the Business and Professions~~
25 ~~Code is amended to read:~~

26 ~~821.5. (a) A peer review body, as defined in Section 805, that~~
27 ~~reviews physicians and surgeons, shall, within 15 days of initiating~~
28 ~~a formal investigation of a physician and surgeon's ability to~~
29 ~~practice medicine safely based upon information indicating that~~
30 ~~the physician and surgeon may be suffering from a disabling mental~~
31 ~~or physical condition that poses a threat to patient care, report to~~
32 ~~the Medical Board the name of the physician and surgeon under~~
33 ~~investigation and the general nature of the investigation. A peer~~
34 ~~review body that has made a report under this section to the~~
35 ~~Medical Board's executive director or designee, who is not in the~~
36 ~~enforcement program, shall also notify the executive director or~~
37 ~~designee when it has completed or closed an investigation.~~

38 ~~(b) The executive director or designee, upon receipt of a report~~
39 ~~pursuant to subdivision (a), shall contact the peer review body that~~
40 ~~made the report within 60 days in order to determine the status of~~

1 the peer review body's investigation. The executive director or
2 designee shall contact the peer review body periodically thereafter
3 to monitor the progress of the investigation. At any time, if the
4 executive director or designee determines that the progress of the
5 investigation is not adequate to protect the public, the executive
6 director or designee shall notify the chief of enforcement of the
7 Medical Board of California, who shall promptly conduct an
8 investigation of the matter. Concurrently with notifying the chief
9 of enforcement, the executive director or designee shall notify the
10 reporting peer review body and the chief executive officer or an
11 equivalent officer of the hospital of its decision to refer the case
12 for investigation by the chief of enforcement.

13 (e) For purposes of this section, "formal investigation" means
14 an investigation ordered by the peer review body's medical
15 executive committee or its equivalent, based upon information
16 indicating that the physician and surgeon may be suffering from
17 a disabling mental or physical condition that poses a threat to
18 patient care. "Formal investigation" does not include the usual
19 activities of the well-being or assistance committee or the usual
20 quality assessment and improvement activities undertaken by the
21 medical staff of a health facility in compliance with the licensing
22 and certification requirements for health facilities set forth in Title
23 22 of the California Code of Regulations, or preliminary
24 deliberations or inquiries of the executive committee to determine
25 whether to order a formal investigation.

26 For purposes of this section, "usual activities" of the well-being
27 or assistance committee are activities to assist medical staff
28 members who may be impaired by chemical dependency or mental
29 illness to obtain necessary evaluation and rehabilitation services
30 that do not result in referral to the medical executive committee.

31 (d) Information received by the board pursuant to this section
32 shall be deemed confidential. The records shall not be further
33 disclosed by the board, except as provided in subdivision (b).

34 (e) Upon receipt of notice from a peer review body that an
35 investigation has been closed and that the peer review body has
36 determined that there is no need for further action to protect the
37 public, the board shall purge and destroy all records in its
38 possession pertaining to the investigation unless the executive
39 director or designee has referred the matter to the chief of
40 enforcement pursuant to subdivision (b).

1 (f) A peer review body that has made a report under subdivision
2 (a) shall not be deemed to have waived the protections of Section
3 1157 of the Evidence Code. It is not the intent of the Legislature
4 in enacting this subdivision to affect pending litigation concerning
5 Section 1157 or to create any new confidentiality protection except
6 as specified in subdivision (d).

7 (g) The report required by this section shall be submitted on a
8 short form developed by the board. The board shall develop the
9 short form, the contents of which shall reflect the requirements of
10 this section, within 30 days of the effective date of this section.
11 The board shall not require the filing of any report until the short
12 form is made available by the board.

13 (h) This section shall become operative on January 1,, unless
14 the regulations required to be adopted pursuant to Section 821.6
15 are adopted prior to that date, in which case this section shall
16 become operative on the effective date of the regulations.

17 SEC. 2. Section 821.6 of the Business and Professions Code
18 is amended to read:

19 821.6. The board shall adopt regulations to implement the
20 monitoring responsibility of the executive director or designee
21 described in subdivision (b) of Section 821.5, and the short form
22 required to be developed pursuant to subdivision (g), on or before
23 January 1, 2009.

24 SEC. 3. This act is an urgency statute necessary for the
25 immediate preservation of the public peace, health, or safety within
26 the meaning of Article IV of the Constitution and shall go into
27 immediate effect. The facts constituting the necessity are:

28 In order to ensure that duties of the diversion program of the
29 Medical Board of California are transferred prior to the inoperative
30 date of that program, it is necessary that this act take effect
31 immediately.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2443
Author: Nakanishi
Bill Date: February 21, 2008, introduced
Subject: MBC: Physician Well-Being
Sponsor: Medical Board of California
Position: Sponsor/Support

STATUS OF BILL:

This bill is currently in the Assembly Appropriations Committee and has been set for hearing on April 23, 2008.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Medical Board (Board) to establish a program to promote the well-being of medical students, post graduate trainees, and licensed physicians. The program should address and prevent illness and burnout due to stress, overworking, and professional dissatisfaction by including an evaluation of wellness education.

ANALYSIS:

Through their extensive education and training, physicians are seen as the preeminent healthcare providers of the world. But the wellness of the patient relies on the wellness of the practitioner, who often gives priority to those under his care before his own well being and that of his family. The stresses of the job are created by a broad spectrum of factors yet can significantly impact the effectiveness of a physician.

Current law does not address the issue of physician wellness. However, since the mission of the Board is to protect healthcare consumers, it must be recognized that this best can be achieved by having healthy physicians care for their patients

During the past year, the Board has been discussing the issue of physician wellness. The focus of the review centered on the benefits that might be derived from the implementation of the program to assist with licensees' well-being. The Board believes that any action which promotes the prevention of physician "unwellness" is a worthwhile effort. This concept was formalized in the creation of a Wellness Committee in summer of 2007.

Concerns have been raised regarding the cost of this program. Staff offered the author amendments to establish the program within existing resources.

FISCAL: None

POSITION: Sponsor/Support

April 18, 2008

ASSEMBLY BILL

No. 2443

Introduced by Assembly Member Nakanishi

February 21, 2008

An act to add Section 2005 to the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 2443, as introduced, Nakanishi. Medical Board of California: physician and surgeon well-being.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and vests the board with certain responsibilities.

This bill would require the board to establish a program to promote the well-being of physicians and surgeons and would require the program to include, but not be limited to, an examination of wellness education for medical students, postgraduate trainees, and licensed physicians and surgeons.

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 2005 is added to the Business and
- 2 Professions Code, to read:
- 3 2005. The board shall establish a program to promote the
- 4 well-being of physicians and surgeons. This program shall include,
- 5 but not be limited to, an examination of wellness education for

- 1 medical students, postgraduate trainees, and licensed physicians
- 2 and surgeons.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2444
Author: Nakanishi
Bill Date: February 21, 2008, introduced
Subject: MBC: Public Letters of Reprimand with Education
Sponsor: Medical Board of California
Board Position: Sponsor/Support

STATUS OF BILL:

This bill is currently on the Assembly Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow the Medical Board (Board) to include requirements for specific education and training as part of rehabilitation for offenses in public letters of reprimand.

ANALYSIS:

Currently, if the Board feels the appropriate level of discipline for a physician is a public letter of reprimand with some required training in ethics or record keeping, the Board must file a formal accusation against a physician in order to require the specific education and training as part of the settlement which includes a public letter of reprimand. This process is time consuming and costly for both the Board and the physician, as the filing of an accusation is a full blown legal proceeding and goes on the public record in this form. If the board were allowed to issue a public letter of reprimand with specified education and training as the only additional requirements being sought by the Board, this would expedite the disciplinary process for both the consumer and the physician.

Allowing the Board to include requirements for specific education and training as part of rehabilitation for offenses in public letters of reprimand would reduce the number of formal accusations filed by Enforcement, while continuing to allow for public disclosure of the fiscal action. This would benefit the consumer by expediting the final action, and the Board and the physician by drastically reducing time and costs. In addition, it would further the mission of consumer protection by providing public disclosure of the discipline and rehabilitation of physicians.

FISCAL: None

POSITION: Sponsor/Support

April 18, 2008

ASSEMBLY BILL

No. 2444

Introduced by Assembly Member Nakanishi

February 21, 2008

An act to amend Section 2233 of the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 2444, as introduced, Nakanishi. Medical Board of California: disciplinary actions.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under existing law, the board is responsible for administering the disciplinary provisions of the act and is authorized to issue public letters of reprimand under specified circumstances, rather than filing or prosecuting a formal accusation.

This bill would allow the board to include in a public letter of reprimand a requirement for specified training.

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 2233 of the Business and Professions
- 2 Code is amended to read:
- 3 2233. (a) ~~The Division of Medical Quality~~ *board* may, by
- 4 stipulation or settlement with the affected physician and surgeon,
- 5 issue a public letter of reprimand after it has conducted an
- 6 investigation or inspection as provided in this article, in lieu of

- 1 filing or prosecuting a formal accusation. The affected physician
2 and surgeon shall indicate agreement or nonagreement in writing
3 within 30 days of formal notification by the ~~division~~ board of its
4 intention to issue the letter. The ~~division~~ board, at its option, may
5 extend the response time. Use of a public reprimand shall be limited
6 to minor violations and shall be issued under guidelines established
7 by regulations of the board. A public letter of reprimand issued
8 pursuant to this section may be disclosed to an inquiring member
9 of the public.
- 10 *(b) Notwithstanding any other provision of law, a public letter*
11 *of reprimand issued pursuant to this section may, at the discretion*
12 *of the board, include a requirement for specified training.*

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2445
Author: Nakanishi
Bill Date: April 1, 2008, amended
Subject: MBC: Licensing Public Letters of Reprimand
Sponsor: Medical Board of California
Board Position: Sponsor/Support

STATUS OF BILL:

This bill is currently on the Assembly Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow the Medical Board (Board) to issue a public letter of reprimand to applicants who have committed lesser violations with regard to unprofessional conduct.

ANALYSIS:

Current law does not allow the Board to issue a public letter of reprimand to an applicant. Applicants who have previous violations are issued a physician's license in a probationary status.

Allowing the Board to issue a public letter of reprimand in lieu of probation to applicants who have committed lesser violations with regard to unprofessional conduct would benefit the Board as well as the physician, while continuing the mission of public protection, as the public letter of reprimand is a public document. The public letter of reprimand would be purged from the licensee's record after three years, the same period of time a probationary license would terminate for the lesser violations.

FISCAL: None

POSITION: Sponsor/Support

April 18, 2008

AMENDED IN ASSEMBLY APRIL 1, 2008

CALIFORNIA LEGISLATURE—2007—08 REGULAR SESSION

ASSEMBLY BILL

No. 2445

Introduced by Assembly Member Nakanishi

February 21, 2008

An act to amend Section 2221 of, and to add Section 2221.05 to, the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 2445, as amended, Nakanishi. Medical Board of California: disciplinary procedures: applicants.

Existing law, the Medical Practice Act, creates the Medical Board of California and makes it responsible for issuing a physician's and surgeon's certificate to qualified applicants. Upon a determination that an applicant is guilty of unprofessional conduct or of any cause that would subject a licensee to revocation or suspension of his or her license, the act authorizes the board to deny his or her application or to issue a probationary certificate that is subject to conditions of probation.

This bill would authorize the board to issue a physician's and surgeon's certificate to an applicant who has committed lesser violations, as specified, and to concurrently issue a public letter of reprimand, *which would be purged 3 years from the date of issuance*.

This bill would also make technical, nonsubstantive, and clarifying changes to a related provision with regard to reapplication procedures and obsolete references, as specified.

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 2221 of the Business and Professions
2 Code is amended to read:

3 2221. (a) The board may deny a physician's and surgeon's
4 certificate to an applicant guilty of unprofessional conduct or of
5 any cause that would subject a licensee to revocation or suspension
6 of his or her license; or, the board in its sole discretion, may issue
7 a probationary physician's and surgeon's certificate to an applicant
8 subject to terms and conditions, including, but not limited to, any
9 of the following conditions of probation:

10 (1) Practice limited to a supervised, structured environment
11 where the licensee's activities shall be supervised by another
12 physician and surgeon.

13 (2) Total or partial restrictions on drug prescribing privileges
14 for controlled substances.

15 (3) Continuing medical or psychiatric treatment.

16 (4) Ongoing participation in a specified rehabilitation program.

17 (5) Enrollment and successful completion of a clinical training
18 program.

19 (6) Abstention from the use of alcohol or drugs.

20 (7) Restrictions against engaging in certain types of medical
21 practice.

22 (8) Compliance with all provisions of this chapter.

23 (9) Payment of the cost of probation monitoring.

24 (b) The board may modify or terminate the terms and conditions
25 imposed on the probationary certificate upon receipt of a petition
26 from the licensee.

27 (c) Enforcement and monitoring of the probationary conditions
28 shall be under the jurisdiction of the board in conjunction with the
29 administrative hearing procedures established pursuant to Sections
30 11371, 11372, 11373, and 11529 of the Government Code, and
31 the review procedures set forth in Section 2335.

32 (d) The board shall deny a physician's and surgeon's certificate
33 to an applicant who is required to register pursuant to Section 290
34 of the Penal Code. This subdivision does not apply to an applicant
35 who is required to register as a sex offender pursuant to Section
36 290 of the Penal Code solely because of a misdemeanor conviction
37 under Section 314 of the Penal Code.

1 (e) An applicant shall not be eligible to reapply for a physician's
2 and surgeon's certificate for a minimum of three years from the
3 effective date of the final decision or action regarding the denial
4 of his or her application, except that the board may, in its discretion
5 and for good cause demonstrated, permit reapplication after not
6 less than one year has elapsed from the effective date of the final
7 decision or action regarding the denial.

8 SEC. 2. Section 2221.05 is added to the Business and
9 Professions Code, to read:

10 2221.05. (a) Notwithstanding subdivision (a) of Section 2221,
11 the board may issue a physician's and surgeon's certificate to an
12 applicant who has committed lesser violations that ~~do not, in the~~
13 ~~board's discretion,~~ *the board deems, in its discretion, do not* merit
14 the denial of a certificate or require probationary status under
15 Section 2221, and may concurrently issue a public letter of
16 reprimand.

17 *(b) A public letter of reprimand issued concurrently with a*
18 *physician's and surgeon's certificate shall be purged three years*
19 *from the date of issuance.*

20 *(c) A public letter of reprimand issued pursuant to this section*
21 *may be disclosed to an inquiring member of the public.*

22 ~~(b)~~

23 *(d) Nothing in this section shall be construed to affect the*
24 *board's authority to issue an unrestricted license.*

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2482
Author: Maze
Bill Date: February 21, 2008, Introduced
Subject: Physician Assistants: continuing education
Sponsor: Author

STATUS OF BILL:

This bill is currently on the Assembly Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would permit the Physician Assistant Committee (PAC) to require, by regulatory action, its licensees to complete up to 50 hours of continuing education in order to renew their licenses. The bill would also give the PAC discretion to accept certification by the National Commission on Certification of Physician Assistants (NCCPA) or another qualified certifying body as evidence of compliance with continuing education requirements.

ANALYSIS:

Current law requires physician assistants to renew their licenses every two years by completing an application form and paying a renewal fee to the PAC. Existing law does not have any requirements for continuing medical education, however, most other states do require continuing education or its equivalent. The PAC believes it is an important public protection to require licensees to keep educated on current medical practices and community care standards.

Although there is no current requirement for continuing education in order to renew a physician assistant license, a physician assistant may choose to be certified by the NCCPA, which permits a designation of Physician Assistant Certified (PA-C). This certification requires 100 hours of continuing education every two years and taking a recertification exam every six years. Approximately 90 percent of physician assistants in California are PA-Cs.

This bill would allow the Committee to set continuing education requirements. Those physician assistants who are also PA-Cs could satisfy both requirements simultaneously.

FISCAL: None

POSITION: Recommendation: Support

April 18, 2008

ASSEMBLY BILL

No. 2482

Introduced by Assembly Members Maze and Bass

February 21, 2008

An act to add Section 3524.5 to the Business and Professions Code, relating to physician assistants.

LEGISLATIVE COUNSEL'S DIGEST

AB 2482, as introduced, Maze. Physician assistants: continuing education.

Existing law, the Physician Assistant Practice Act, establishes the Physician Assistant Committee of the Medical Board of California. Under existing law, the committee licenses physician assistants under the name of the board and regulates the practice of physician assistants. Existing law provides for the renewal of unexpired licenses and certain expired licenses by applying for renewal on a form provided by the committee and paying certain fees, as specified.

This bill would authorize the committee to require a licensee to complete continuing education as a condition of license renewal. The bill would prohibit the committee from requiring more than 50 hours of continuing education every 2 years and would require the committee to, as it deems appropriate, accept certification by a specified commission or another qualified certifying body as evidence of compliance with continuing education requirements.

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 3524.5 is added to the Business and
2 Professions Code, to read:
3 3524.5. The committee may require a licensee to complete
4 continuing education as a condition of license renewal under
5 Section 3523 or 3524. The committee shall not require more than
6 50 hours of continuing education every two years. The committee
7 shall, as it deems appropriate, accept certification by the National
8 Commission on Certification of Physician Assistants (NCCPA),
9 or another qualified certifying body, as determined by the
10 committee, as evidence of compliance with continuing education
11 requirements.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2516
Author: Mendoza
Bill Date: February 21, 2008, introduced
Subject: Prescriptions: electronic transmission
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Assembly Business and Professions Committee and has been set for hearing on April 29, 2008.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require physicians to send prescriptions electronically to a patient's pharmacy of choice.

ANALYSIS:

Electronic prescribing is a safe and efficient system of filling prescriptions that avoids misunderstandings between doctors and pharmacies. Errors caused by paper mix-ups and unclear handwriting have resulted in sickness and death. According to the Institute for Safe Medicine Practices (ISMP), the number of reports of illegible handwriting and incorrect dosages has reached over an estimated 150 million. The ISMP also says that research shows that injuries resulting from medication errors and not the fault of the practitioner, but rather represent the failure of a complex healthcare system.

On January 1, 2010, this bill will require physicians to send prescription notices to a patient's pharmacy with a few exceptions. This will make the process of filling prescriptions simple and fast, but it will require all prescribers to have the capability and security features by 2010. This may be workable for large systems and practices but it may not be realistic for those single practitioner offices or those in outlying areas.

Electronic prescriptions are often filled before the patient arrives at the pharmacy. Currently, Kaiser and UC medical centers are among the many healthcare providers already using the E-prescribing system.

FISCAL: None

POSITION: Recommendation: Support if amended to provide an exception or extended implementation date for special cases appealed to the Pharmacy Board.

April 18, 2008

ASSEMBLY BILL

No. 2516

Introduced by Assembly Member Mendoza

February 21, 2008

An act to add Section 4072.5 to the Business and Professions Code, relating to prescriptions.

LEGISLATIVE COUNSEL'S DIGEST

AB 2516, as introduced, Mendoza. Prescriptions: electronic transmission.

The Pharmacy Law regulates, among other matters, the dispensing by prescription of dangerous drugs and dangerous devices, and sets forth specified requirements for prescriptions. Existing law authorizes a prescriber or his or her authorized agent to electronically transmit a prescription to a pharmacist, subject to certain exceptions. A knowing violation of the Pharmacy Law is a crime.

This bill would, commencing January 1, 2010, require a prescriber to ensure that any prescription issued or made by him or her be electronically transmitted to the patient's pharmacy of choice, except as specified. The bill would provide that a violation of these provisions is not a crime.

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

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

- 1 SECTION 1. Section 4072.5 is added to the Business and
- 2 Professions Code, to read:

1 4072.5. (a) A prescriber shall ensure that any prescription
2 issued or made by him or her be electronically transmitted to the
3 patient's pharmacy of choice, except for any of the following:

4 (1) A prescription required by federal law to be transmitted in
5 another manner.

6 (2) A prescription that is prevented from being transmitted
7 electronically at the time of issuance by an emergency or
8 unexpected technical problem.

9 (3) An order meeting the requirements of Section 4019 if the
10 prescribed drug is to be administered at the hospital.

11 (b) Notwithstanding any other provisions of law, a violation of
12 this section shall not be a crime.

13 (c) This section shall become operative on January 1, 2010.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2543
Author: Berg
Bill Date: April 7, 2008, amended
Subject: Loan Repayment Program: geriatric workforce
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Geriatric and Gerontology Workforce Expansion Act, which would be administered by the Office of Statewide Health Planning, and Development (OSHDP), to provide loan repayment assistance to nurses, social workers, and marriage and family therapists who work in a geriatric care setting.

This bill would also require the Steven M. Thompson Physician Corps Loan Repayment Program, within the Health and Professions Education Foundation, to fill 15% of the available positions with program applicants that agree to practice in a geriatric care setting. These provisions would become operative only if AB 2439 (De La Torre) is enacted and becomes effective on or before January 1, 2009.

ANALYSIS:

California currently faces a severe shortage of professionals needed to operate programs and provide services to older adults. The greatest gaps in the geriatric workforce are shown to be in the medical and social work fields. There are approximately 890 board-certified geriatricians in the state, only one for every 4,000 Californians over the age of 65.

In an attempt to fill the growing workforce gaps in geriatric services, this bill establishes the California Geriatric and Gerontology Workforce Expansion Act of 2008. Administered by the OSHDP, this act would set up loan repayment assistance for physicians, nurses, social workers, and marriage and family therapists.

For physicians, this bill would require the Steven M. Thompson Physician Corps Loan Repayment Program under the Health and Professions Education Foundation to fill 15% of the available positions within the program with applicants who agree to practice in a geriatric care setting.

FISCAL: None to the Board.

POSITION: Recommendation: Support

April 18, 2008

AMENDED IN ASSEMBLY APRIL 7, 2008
AMENDED IN ASSEMBLY MARCH 25, 2008
AMENDED IN ASSEMBLY MARCH 24, 2008
CALIFORNIA LEGISLATURE—2007—08 REGULAR SESSION

ASSEMBLY BILL

No. 2543

**Introduced by Assembly Member Berg
(Coauthor: Assembly Member De La Torre)**

February 22, 2008

An act to add Sections 2815.2, 4984.75, and 4996.66 to the Business and Professions Code, and to amend Sections 128552 and 128553 of, to add Article 5 (commencing with Section 128305) and Article 6 (commencing with Section 128310) to Chapter 4 of Part 3 of Division 107 of, and to add Chapter 6 (commencing with Section 128559) to Part 3 of Division 107 of, the Health and Safety Code, relating to loan assistance, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 2543, as amended, Berg. Geriatric and Gerontology Workforce Expansion Act.

(1) Existing law provides for the licensure and regulation of nurses, social workers, and marriage and family therapists by specified boards. Existing law requires those persons to pay licensing and renewal fees for licensure, as specified.

This bill would establish the Geriatric and Gerontology Workforce Expansion Act, which would be administered by the Office of Statewide Health Planning and Development to provide loan repayment assistance to nurses, social workers, and marriage and family therapists who work in a geriatric care setting, as specified. For those purposes, the bill would

raise the licensing and renewal fees of these licensees by \$10, as specified, for deposit into the continuously appropriated funds of the boards described above, thereby making an appropriation.

This bill would also establish the California Geriatric and Gerontology Student Loan Assistance Program of 2008, which would be administered by the Office of Statewide Health Planning and Development for purposes of providing loan assistance to students who intend to become employed as licensed health care professionals, social workers, or marriage and family therapists in a geriatric care setting, as specified. Those provisions would only become operative if appropriate funding, as determined by the office, is made available. The bill would require the office to report annually to the Legislature with regard to the program, as specified.

(2) Existing law establishes the Steven M. Thompson Physician Corps Loan Repayment Program in the California Physician Corps Program within the Health and Professions Education Foundation, which provides financial incentives, as specified, to a physician and surgeon for practicing in a medically underserved community. Existing law authorizes the foundation to appoint a selection committee to provide policy direction and guidance over the program.

This bill would require that selection committee to fill 15% of the available positions with program applicants that agree to practice in a geriatric care setting. These provisions would become operative only if AB 2439 is enacted and becomes effective on or before January 1, 2009.

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

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 Geriatric and Gerontology Workforce Expansion Act.
- 3 SEC. 2. The Legislature finds and declares all of the following:
- 4 (a) The population of California is aging at an exponential rate
- 5 with Californians who are 65 years of age or over reaching 6.5
- 6 million by 2010, which is over 14 percent of the total population,
- 7 and reaching over 9 million by 2020.
- 8 (b) The greatest growth within the aging population will be
- 9 those who are 85 years of age or older who will, by 2030, comprise
- 10 one in five of California's older residents.

1 (c) As California ages, it will become more racially and
2 ethnically diverse, with African Americans, Latinos, and Asian
3 Americans exceeding 40 percent of the older adult population,
4 many of whom were born outside the United States; meaning,
5 therefore, that there is a greater need for those providing services
6 to older adults to be bilingual or multilingual.

7 (d) It is the policy of the Mello-Granlund Older Californians
8 Act (Division 8.5 (commencing with Section 9000) of the Welfare
9 and Institutions Code) that older adults and those with disabilities
10 live as independent from institutions as much as possible and as
11 long as possible.

12 (e) It is the policy of the Mello-Granlund Older Californians
13 Act (Division 8.5 (commencing with Section 9000) of the Welfare
14 and Institutions Code) that to live independently, older Californians
15 must have an array of home and community-based services, in
16 conjunction with the federal Older Americans Act (42 U.S.C. Sec.
17 3001 et seq.), that support a quality of life and saves taxpayer
18 dollars in contrast to the cost of institutionalization.

19 (f) In order to sustain an independent lifestyle for older adults,
20 there must be trained gerontologists and health care professionals
21 trained in geriatrics to address the social and health needs of older
22 adults as they age.

23 (g) At present, California faces a severe shortage of professional
24 and paraprofessional gerontologists and geriatricians needed to
25 operate programs and provide services for older adults. Currently,
26 there is only one board-certified physician geriatrician per 4,000
27 Californians who are 65 years of age or older; and currently, only
28 5 percent of social workers are trained in gerontology or geriatrics,
29 yet 62 percent of licensed social workers have, or have had, care
30 management responsibilities.

31 (h) Incentives for recruiting students into training for careers in
32 gerontology and geriatrics must be developed in order to fill the
33 gap between workforce supply and demand lest the state incur the
34 greater cost of institutionalization and the quality of life for older
35 Californians suffers.

36 (i) Student loan forgiveness programs are a proven method of
37 inducing health care professionals to pursue stipulated career fields
38 for a specified time in exchange for loan assistance.

39 SEC. 3. Section 2815.2 is added to the Business and Professions
40 Code, to read:

1 2815.2. In addition to the fees charged for initial issuance or
2 biennial renewal of a license pursuant to Section 2815, and at the
3 time those fees are charged, the board shall charge each applicant
4 or licensee an additional fee of ten dollars (\$10) for the purposes
5 of the California Geriatric Registered Nurses Loan Assistance
6 Program of 2008 (Article 5 (commencing with Section 128305)
7 of Chapter 4 of Part 3 of Division 107 of the Health and Safety
8 Code). Payment of this ten-dollar (\$10) fee shall be made at the
9 time of application for initial licensure or biennial renewal. All
10 fees collected pursuant to this section shall be deposited in the
11 Geriatric Registered Nurses Account, as provided in Section
12 128305.4 of the Health and Safety Code.

13 SEC. 4. Section 4984.75 is added to the Business and
14 Professions Code, to read:

15 4984.75. In addition to the fees charged for initial issuance or
16 biennial renewal of a license pursuant to Section 4984.7, and at
17 the time those fees are charged, the board shall charge each
18 applicant or licensee an additional fee of ten dollars (\$10) for the
19 purposes of the California Geriatric Social Workers and Marriage
20 and Family Therapists Loan Assistance Program of 2008 (Article
21 6 (commencing with Section 128310) of Chapter 4 of Part 3 of
22 Division 107 of the Health and Safety Code). Payment of this
23 ten-dollar (\$10) fee shall be made at the time of application for
24 initial licensure or biennial renewal. All fees collected pursuant to
25 this section shall be deposited in the Geriatric Social Workers and
26 Marriage and Family Therapists Account, as provided in Section
27 128310.4 of the Health and Safety Code.

28 SEC. 5. Section 4996.66 is added to the Business and
29 Professions Code, to read:

30 4996.66. In addition to the fees charged for initial issuance or
31 biennial renewal of a license pursuant to Section 4996.3, and at
32 the time those fees are charged, the board shall charge each
33 applicant or licensee an additional fee of ten dollars (\$10) for the
34 purposes of the California Geriatric Social Workers and Marriage
35 and Family Therapists Loan Assistance Program of 2008 (Article
36 6 (commencing with Section 128310) of Chapter 4 of Part 3 of
37 Division 107 of the Health and Safety Code). Payment of this
38 ten-dollar (\$10) fee shall be made at the time of application for
39 initial licensure or biennial renewal. All fees collected pursuant to
40 this section shall be deposited in the Geriatric Social Workers and

1 Marriage and Family Therapists Account, as provided in Section
2 128310.4 of the Health and Safety Code.

3 SEC. 6. Article 5 (commencing with Section 128305) is added
4 to Chapter 4 of Part 3 of Division 107 of the Health and Safety
5 Code, to read:

6

7 Article 5. California Geriatric Registered Nurses Loan
8 Assistance Program of 2008
9

10 128305. There is hereby established in the Office of Statewide
11 Health Planning and Development, the California Geriatric
12 Registered Nurses Loan Assistance Program of 2008.

13 128305.1. It is the intent of this article that the office, in
14 consultation with the board, the medical community, including
15 representatives of ethnic minority groups, medical schools, health
16 advocates, primary care clinics, public hospitals and health care
17 systems, statewide agencies administering state and federally
18 funded health programs targeting communities of older
19 Californians, and members of the public with health care issue-area
20 expertise, shall develop and implement the California Geriatric
21 Registered Nurses Loan Assistance Program of 2008.

22 128305.2. For purposes of this article, the following terms have
23 the following meanings:

24 (a) "Account" means the Geriatric Registered Nurses Account
25 that is contained within the fund.

26 (b) "Board" means the Board of Registered Nursing.

27 (c) "Fund" means the Board of Registered Nursing Fund.

28 (d) "Geriatrics" means the practice of nursing, with training in,
29 and application to, older adults who are 65 years of age or older
30 or those with disabilities.

31 (e) "Office" means the Office of Statewide Health Planning and
32 Development.

33 (f) "Program" means the California Geriatric Registered Nurses
34 Loan Assistance Program of 2008.

35 128305.3. (a) Program applicants shall possess a current valid
36 license to practice registered nursing in this state issued by the
37 board pursuant to Section 2742 of the Business and Professions
38 Code.

- 1 (b) The office shall develop the guidelines for selection and
2 placement of applicants. The guidelines shall do all of the
3 following:
- 4 (1) Provide priority consideration to applicants who are trained
5 in, and practice, geriatric nursing, including, but not limited to,
6 nurses with doctorate degrees in gerontology, geriatric nurse
7 practitioners, and geriatric nurse clinicians, and who can meet the
8 cultural and linguistic needs and demands of diverse populations
9 of older Californians.
- 10 ~~(2) Provide priority consideration to applicants who are~~
11 ~~recognized as geriatric nurse practitioners or geriatric nurse~~
12 ~~clinicians and that have recently obtained their license to practice~~
13 ~~as a registered nurse.~~
- 14 ~~(3)~~
- 15 (2) Give preference to applicants who have completed a
16 residency in nursing.
- 17 ~~(4)~~
- 18 (3) Seek to place the most qualified applicants under this section
19 in the areas with the greatest need.
- 20 ~~(5)~~
- 21 (4) Include a factor ensuring geographic distribution of
22 placements.
- 23 ~~(6)~~
- 24 (5) Ensure that applicants may not discriminate against those
25 who cannot pay for medical services or those who are funded, in
26 part or in whole, by Medicare or Medi-Cal.
- 27 (c) Program participants shall be working in, or have a signed
28 agreement with, an eligible practice setting. The program
29 participant shall have full-time status, as defined by the office. The
30 office may establish exemptions to this requirement on a
31 case-by-case basis.
- 32 (d) Program participants shall commit to a minimum of three
33 years of service in a geriatric care setting. Leaves of absence shall
34 be permitted for serious illnesses, pregnancy, or other natural
35 causes. The office shall develop the process for determining the
36 maximum permissible length of an absence and the process for
37 reinstatement. Loan repayment shall be deferred until the nurse is
38 back to full-time status.

1 (e) The office shall develop the process *to reconcile the loan*
2 should a nurse be unable to complete his or her three-year
3 obligation.

4 (f) The office shall develop a process for outreach to potentially
5 eligible applicants.

6 (g) The office may adopt any other standards of eligibility,
7 placement, or termination appropriate to achieve the aim of
8 providing competent health care services in geriatrics.

9 128305.4. (a) The Geriatric Registered Nurses Account is
10 hereby created in the fund.

11 (b) Funding for the account shall be from fees paid at the time
12 of initial licensure or renewal pursuant to Section 2815.2 of the
13 Business and Professions Code.

14 (c) Funds placed into the account shall be used by the office to
15 repay the loans of program participants pursuant to agreements
16 made under the program.

17 (1) Funds paid out for loan repayment may have a funding match
18 from foundation or other private sources.

19 (2) Loan repayments shall not exceed thirty thousand dollars
20 (\$30,000) per program participant.

21 (3) Loan repayments shall not exceed the amount of the
22 educational loans incurred by the program participant.

23 (d) Notwithstanding Section 11005 of the Government Code,
24 the office may seek and receive matching funds from foundations
25 and private sources to be placed into the account. The office also
26 may contract with an exempt foundation for the receipt of matching
27 funds to be transferred to the account for use by this program.

28 128305.5. The terms of loan repayment granted under this
29 article shall be as follows:

30 (a) After a program participant has completed one year of
31 providing services as a registered nurse in a geriatric setting, the
32 office shall provide up to seven thousand five hundred dollars
33 (\$7,500) for loan repayment.

34 (b) After a program participant has completed two consecutive
35 years of providing services as a registered nurse in a geriatric
36 setting, the office shall provide up to an additional ten thousand
37 dollars (\$10,000) of loan repayment, for a total loan repayment of
38 up to seventeen thousand five hundred dollars (\$17,500).

39 (c) After a program participant has completed three consecutive
40 years of providing services as a registered nurse in a geriatric

1 setting, the office shall provide up to a maximum of an additional
2 twelve thousand five hundred dollars (\$12,500) of loan repayment,
3 for a total loan repayment of up to thirty thousand dollars
4 (\$30,000).

5 128305.6. (a) On and after January 1, 2010, applications from
6 registered nurses for program participation may be submitted.

7 (b) The office may work in conjunction with the Health
8 Professions Education Foundation for the implementation and
9 administration of this program.

10 (c) The office may promulgate emergency regulations to
11 implement the program.

12 SEC. 7. Article 6 (commencing with Section 128310) is added
13 to Chapter 4 of Part 3 of Division 107 of the Health and Safety
14 Code, to read:

15

16 Article 6. California Geriatric Social Workers and Marriage
17 and Family Therapists Loan Assistance Program of 2008

18

19 128310. There is hereby established in the Office of Statewide
20 Health Planning and Development, the California Geriatric Social
21 Workers and Marriage and Family Therapists Loan Assistance
22 Program of 2008.

23 128310.1. It is the intent of this article that the office, in
24 consultation with the board, the medical community, including
25 representatives of ethnic minority groups, schools of social work,
26 health advocates, primary care clinics, public hospitals and health
27 care systems, statewide agencies administering state and federally
28 funded health programs targeting communities of older
29 Californians, and members of the public with health care issue-area
30 expertise, shall develop and implement the California Geriatric
31 Social Workers and Marriage and Family Therapists Loan
32 Assistance Program of 2008.

33 128310.2. For purposes of this article, the following terms have
34 the following meanings:

35 (a) "Account" means the Geriatric Social Workers and Marriage
36 and Family Therapists Account that is contained within the fund.

37 (b) "Board" means the Board of Behavioral Sciences.

38 (c) "Fund" means the Behavioral Sciences Fund.

39 (d) "Geriatrics" means the practice of ~~medicine~~ *social work or*
40 *marriage and family therapy*, with training in, and application to,

1 older adults who are 65 years of age or older or those with
2 disabilities.

3 (e) "Office" means the Office of Statewide Health Planning and
4 Development.

5 (f) "Program" means the California Geriatric Social Workers
6 and Marriage and Family Therapists Loan Assistance Program of
7 2008.

8 128310.3. (a) Program applicants shall be registered associate
9 clinical social workers receiving supervision or shall possess a
10 current valid license to practice social work or marriage and family
11 therapy in this state issued by the board pursuant to Section 4980.30
12 or 4996.1 of the Business and Professions Code.

13 (b) The office shall develop the guidelines for selection and
14 placement of applicants. The guidelines shall do all of the
15 following:

16 (1) Provide priority consideration to applicants who are trained
17 in, and practice, geriatric social work or marriage and family
18 therapy, and who can meet the cultural and linguistic needs and
19 demands of diverse populations of older Californians.

20 (2) Provide priority consideration to applicants who have
21 recently obtained their license to practice marriage and family
22 therapy or clinical social work or be a registered associate clinical
23 social worker receiving supervision.

24 (3) Give preference to applicants who have completed an
25 internship in geriatric social work or marriage and family therapy.

26 (4) Seek to place the most qualified applicants under this section
27 in the areas with the greatest need.

28 (5) Include a factor ensuring geographic distribution of
29 placements.

30 (6) Ensure that applicants may not discriminate against those
31 who cannot pay for medical services or those who are funded, in
32 part or in whole, by Medicare or Medi-Cal.

33 (c) Program participants shall be working in, or have a signed
34 agreement with, an eligible practice setting. The program
35 participant shall have full-time status, as defined by the office. The
36 office may establish exemptions to this requirement on a
37 case-by-case basis.

38 (d) Program participants shall commit to a minimum of three
39 years of service in a geriatric care setting. Leaves of absence shall
40 be permitted for serious illnesses, pregnancy, or other natural

1 causes. The office shall develop the process for determining the
2 maximum permissible length of an absence and the process for
3 reinstatement. Loan repayment shall be deferred until the
4 participant is back to full-time status.

5 (e) The office shall develop the process *to reconcile the loan*
6 should a participant be unable to complete his or her three-year
7 obligation.

8 (f) The office shall develop a process for outreach to potentially
9 eligible applicants.

10 (g) The office may adopt any other standards of eligibility,
11 placement, or termination appropriate to achieve the aim of
12 providing competent social services in geriatrics.

13 128310.4. (a) The Geriatric Social Workers and Marriage and
14 Family Therapists Account is hereby created in the fund.

15 (b) Funding for the account shall be from fees paid at the time
16 of initial licensure or renewal pursuant to Sections 4984.75 and
17 4996.66 of the Business and Professions Code.

18 (c) Funds placed into the account shall be used by the office to
19 repay the loans of program participants pursuant to agreements
20 made under the program.

21 (1) Funds paid out for loan repayment may have a funding match
22 from foundation or other private sources.

23 (2) Loan repayments shall not exceed thirty thousand dollars
24 (\$30,000) per program participant.

25 (3) Loan repayments shall not exceed the amount of the
26 educational loans incurred by the program participant.

27 (d) Notwithstanding Section 11005 of the Government Code,
28 the office may seek and receive matching funds from foundations
29 and private sources to be placed into the account. The office also
30 may contract with an exempt foundation for the receipt of matching
31 funds to be transferred to the account for use by this program.

32 128310.5. The terms of loan repayment granted under this
33 article shall be as follows:

34 (a) After a program participant has completed one year of
35 providing services as a licensed marriage and family therapist or
36 a licensed or associate clinical social worker in a geriatric setting,
37 the office shall provide up to seven thousand five hundred dollars
38 (\$7,500) for loan repayment.

39 (b) After a program participant has completed two consecutive
40 years of providing services as a licensed marriage and family

1 therapist or a licensed or associate clinical social worker in a
2 geriatric setting, the office shall provide up to an additional ten
3 thousand dollars (\$10,000) of loan repayment, for a total loan
4 repayment of up to seventeen thousand five hundred dollars
5 (\$17,500).

6 (c) After a program participant has completed three consecutive
7 years of providing services as a licensed marriage and family
8 therapist or a licensed or associate clinical social worker in a
9 geriatric setting, the office shall provide up to a maximum of an
10 additional twelve thousand five hundred dollars (\$12,500) of loan
11 repayment, for a total loan repayment of up to thirty thousand
12 dollars (\$30,000).

13 128310.6. (a) On and after January 1, 2010, applications from
14 marriage and family therapists, registered associate social workers,
15 and licensed social workers for program participation may be
16 submitted.

17 (b) The office may work in conjunction with the Health
18 Professions Education Fund in the implementation and
19 administration of this program.

20 (c) The office may promulgate emergency regulations to
21 implement the program.

22 SEC. 8. Section 128552 of the Health and Safety Code is
23 amended to read:

24 128552. For purposes of this article, the following definitions
25 shall apply:

26 (a) "Account" means the Medically Underserved Account for
27 Physicians established within the Health Professions Education
28 Fund pursuant to this article.

29 (b) "Foundation" means the Health Professions Education
30 Foundation.

31 (c) "Fund" means the Health Professions Education Fund.

32 (d) "Medi-Cal threshold languages" means primary languages
33 spoken by limited-English-proficient (LEP) population groups
34 meeting a numeric threshold of 3,000, eligible LEP Medi-Cal
35 beneficiaries residing in a county, 1,000 Medi-Cal eligible LEP
36 beneficiaries residing in a single ZIP Code, or 1,500 LEP Medi-Cal
37 beneficiaries residing in two contiguous ZIP Codes.

38 (e) "Medically underserved area" means an area defined as a
39 health professional shortage area in Part 5 of Subchapter A of
40 Chapter 1 of Title 42 of the Code of Federal Regulations or an

1 area of the state where unmet priority needs for physicians exist
2 as determined by the California Healthcare Workforce Policy
3 Commission pursuant to Section 128225.

4 (f) “Medically underserved population” means the Medi-Cal
5 program, Healthy Families Program, and uninsured populations.

6 (g) “Office” means the Office of Statewide Health Planning and
7 Development (OSHPD).

8 (h) “Physician Volunteer Program” means the Physician
9 Volunteer Registry Program established by the Medical Board of
10 California.

11 (i) “Practice setting” means either of the following:

12 (1) A community clinic as defined in subdivision (a) of Section
13 1204 and subdivision (c) of Section 1206, a clinic owned or
14 operated by a public hospital and health system, or a clinic owned
15 and operated by a hospital that maintains the primary contract with
16 a county government to fulfill the county’s role pursuant to Section
17 17000 of the Welfare and Institutions Code, which is located in a
18 medically underserved area and at least 50 percent of whose
19 patients are from a medically underserved population.

20 (2) A medical practice located in a medically underserved area
21 and at least 50 percent of whose patients are from a medically
22 underserved population.

23 (j) “Primary specialty” means family practice, internal medicine,
24 pediatrics, geriatrics, or obstetrics/gynecology.

25 (k) “Program” means the Steven M. Thompson Physician Corps
26 Loan Repayment Program.

27 (l) “Selection committee” means a minimum three-member
28 committee of the board, that includes a member that was appointed
29 by the Medical Board of California.

30 SEC. 9. Section 128553 of the Health and Safety Code is
31 amended to read:

32 128553. (a) Program applicants shall possess a current valid
33 license to practice medicine in this state issued pursuant to Section
34 2050 of the Business and Professions Code.

35 (b) The foundation, in consultation with those identified in
36 subdivision (b) of Section 123551, shall use guidelines developed
37 by the Medical Board of California for selection and placement
38 of applicants until the office adopts other guidelines by regulation.

39 (c) The guidelines shall meet all of the following criteria:

- 1 (1) Provide priority consideration to applicants that are best
- 2 suited to meet the cultural and linguistic needs and demands of
- 3 patients from medically underserved populations and who meet
- 4 one or more of the following criteria:
 - 5 (A) Speak a Medi-Cal threshold language.
 - 6 (B) Come from an economically disadvantaged background.
 - 7 (C) Have received significant training in cultural and
 - 8 linguistically appropriate service delivery.
 - 9 (D) Have three years of experience working in medically
 - 10 underserved areas or with medically underserved populations.
 - 11 (E) Have recently obtained a license to practice medicine.
- 12 (2) Include a process for determining the needs for physician
- 13 services identified by the practice setting and for ensuring that the
- 14 practice setting meets the definition specified in subdivision (h)
- 15 of Section 128552.
- 16 (3) Give preference to applicants who have completed a
- 17 three-year residency in a primary specialty.
- 18 (4) Seek to place the most qualified applicants under this section
- 19 in the areas with the greatest need.
- 20 (5) Include a factor ensuring geographic distribution of
- 21 placements.
 - 22 (d) (1) The foundation may appoint a selection committee that
 - 23 provides policy direction and guidance over the program and that
 - 24 complies with the requirements of subdivision (l) of Section
 - 25 128552.
 - 26 (2) The selection committee may fill up to 20 percent of the
 - 27 available positions with program applicants from specialties outside
 - 28 of the primary care specialties.
 - 29 (3) The selection committee shall fill 15 percent of the available
 - 30 positions with program applicants that agree to practice in a
 - 31 geriatric care setting. Priority consideration shall be given to
 - 32 applicants who are trained in, and practice, geriatrics, and who can
 - 33 meet the cultural and linguistic needs and demands of diverse
 - 34 populations of older Californians.
 - 35 (e) Program participants shall meet all of the following
 - 36 requirements:
 - 37 (1) Shall be working in or have a signed agreement with an
 - 38 eligible practice setting.
 - 39 (2) Shall have full-time status at the practice setting. Full-time
 - 40 status shall be defined by the board and the selection committee

1 may establish exemptions from this requirement on a case-by-case
2 basis.

3 (3) Shall commit to a minimum of three years of service in a
4 medically underserved area. Leaves of absence shall be permitted
5 for serious illness, pregnancy, or other natural causes. The selection
6 committee shall develop the process for determining the maximum
7 permissible length of an absence and the process for reinstatement.
8 Loan repayment shall be deferred until the physician is back to
9 full-time status.

10 (f) The office shall adopt a process ~~that applies if a physician~~
11 ~~is to reconcile the loan should a physician be unable to complete~~
12 his or her three-year obligation.

13 (g) The foundation, in consultation with those identified in
14 subdivision (b) of Section 128551, shall develop a process for
15 outreach to potentially eligible applicants.

16 (h) The foundation may recommend to the office any other
17 standards of eligibility, placement, and termination appropriate to
18 achieve the aim of providing competent health care services in
19 approved practice settings.

20 SEC. 10. Chapter 6 (commencing with Section 128559) is
21 added to Part 3 of Division 107 of the Health and Safety Code, to
22 read:

23

24 CHAPTER 6. CALIFORNIA GERIATRIC AND GERONTOLOGY
25 STUDENT LOAN ASSISTANCE PROGRAM OF 2008

26

27 128559. This chapter shall be known and may be cited as the
28 California Geriatric and Gerontology Student Loan Assistance
29 Program of 2008.

30 128559.1. It is the intent of this chapter that the Office of
31 Statewide Health Planning and Development, in consultation with
32 the Medical Board of California, state allied health professional
33 and behavioral sciences licensing boards, postsecondary schools
34 of health sciences and social work, health advocates representing
35 diverse ethnic communities, primary care clinics, public hospitals
36 and health care systems, statewide agencies administering state
37 and federally funded programs targeting treatment and services
38 for older adults, and members of the public with health care
39 issue-area expertise, shall develop and implement the program.

1 128559.2. (a) There is hereby established in the Office of
2 Statewide Health Planning and Development, the California
3 Geriatric and Gerontology Student Loan Assistance Program of
4 2008.

5 (b) The Office of Statewide Health Planning and Development
6 shall operate the program in accordance with, but not limited to,
7 the following:

8 (1) Increased efforts in educating students trained in geriatrics
9 and gerontology of the need for health care and social work
10 professionals to meet the demands of the exponential increase in
11 the older adult population, and of programs that are available that
12 provide incentives, financial and otherwise, to practice in settings
13 and areas in need.

14 (2) Strategic collaboration with California postsecondary schools
15 of health sciences and social work to better prepare health care
16 professionals and social workers to meet the distinctive cultural
17 and medical needs of California's older adult populations.

18 (3) Establish, encourage, and expand programs for students of
19 the health care and social work professions for mentoring at
20 primary and secondary schools, and college levels to increase the
21 number of students entering the studies of health professions and
22 social work with a concentration in geriatrics or gerontology.

23 (4) Administer financial or other incentives to encourage new
24 or experienced health care professionals and social workers to
25 practice in the fields of geriatrics and gerontology.

26 128559.3. For purposes of this chapter:

27 (a) "Office" means the Office of Statewide Health Planning and
28 Development.

29 (b) "Program" means the California Geriatric and Gerontology
30 Student Loan Assistance Program of 2008.

31 128559.4. (a) The office shall administer the program. Any
32 individual enrolled in an institution of postsecondary education
33 participating in the programs set forth in this chapter may be
34 eligible to receive a conditional warrant for loan repayment, to be
35 redeemed upon becoming employed as a licensed health
36 professional, marriage and family therapist, or social worker or
37 registered associate social worker in a setting serving primarily
38 older adult populations. In order to be eligible to receive a
39 conditional loan repayment warrant, an applicant shall satisfy all
40 of the following conditions:

- 1 (1) The applicant has been judged by his or her postsecondary
2 institution to have outstanding ability on the basis of criteria that
3 may include, but not be limited to, any of the following:
- 4 (A) Grade point average.
 - 5 (B) Test scores.
 - 6 (C) Faculty evaluations.
 - 7 (D) Interviews.
 - 8 (E) Other recommendations.
- 9 (2) In order to meet the costs associated with obtaining a health
10 professional or social work degree, the applicant has received, or
11 is approved to receive, a loan under one or more of the following
12 designated loan programs:
- 13 (A) The Federal Family Education Loan Program (10 U.S.C.
14 Sec. 1071 et seq.).
 - 15 (B) Any loan program approved by the Student Aid
16 Commission.
- 17 (3) The applicant has agreed to provide services as a licensed
18 health professional, marriage and family therapist, or social worker,
19 or to be registered as an associate clinical social worker with
20 satisfactory progress toward licensure, for up to three consecutive
21 years, after obtaining a license or associate registration from the
22 applicable state health professional or behavioral ~~science~~ *sciences*
23 licensing board, in a setting providing health or social services
24 primarily to older adults.
- 25 (4) The applicant has agreed that he or she shall not discriminate
26 against any patient or client who cannot pay for services or those
27 who are funded, in part or in whole, by Medicare or Medi-Cal.
- 28 (b) The office shall ensure that priority consideration be given
29 to applicants who are best suited to meet the cultural and linguistic
30 needs and demands of geriatric populations and who meet one or
31 more of the following criteria:
- 32 (1) Have received significant training in cultural and
33 linguistically appropriate service delivery.
 - 34 (2) Have done a clinical rotation or social work internship, of
35 at least two semesters, serving older adult populations.
 - 36 (c) A person participating in the program pursuant to this chapter
37 shall not receive more than one warrant.
 - 38 (d) The office shall adopt rules and regulations regarding the
39 reallocation of warrants if a participating institution is unable to

1 utilize its allocated warrants or is unable to distribute them within
2 a reasonable time period.

3 128559.5. (a) The office shall develop the process to redeem
4 an applicant's warrant and commence loan repayment.

5 (b) The office shall distribute student applications to participate
6 in the program to postsecondary institutions eligible to participate
7 in the state and federal financial aid programs and that have a
8 program of professional preparation for health care professionals,
9 social workers, or marriage and family therapists.

10 (c) Each participating institution shall sign an institutional
11 agreement with the office, certifying its intent to administer the
12 program according to all applicable published rules, regulations,
13 and guidelines, and shall make special efforts to notify students
14 regarding the availability of the program particularly to
15 economically disadvantaged students.

16 (d) To the extent feasible, the office and each participating
17 institution shall coordinate this program with other existing
18 programs designed to recruit or encourage students to enter the
19 health care, social work, or marriage and family therapy profession.
20 These programs shall include, but not be limited to, the following:

21 (1) The Song-Brown Family Physician Training Act (Article 1
22 commencing with Section 128200) of Chapter 4).

23 (2) The Health Education and Academic Loan Act (Article 2
24 commencing with Section 128250) of Chapter 4).

25 (3) The National Health Service Corps.

26 128559.6. (a) The office shall administer the program and
27 shall adopt rules and regulations for that purpose. The rules and
28 regulations shall include, but not be limited to, provisions regarding
29 the period of time for which a warrant shall remain valid, the
30 reallocation of warrants that are not utilized, and the development
31 of projections for funding purposes.

32 (b) The office shall work in conjunction with lenders
33 participating in federal or similar loan programs to develop a
34 streamlined application process for participation in the program.

35 128559.7. (a) The office shall establish a fund to utilize for
36 the purposes of this chapter.

37 (b) The office may seek matching funds from foundations and
38 private sources. The office may also contract with an exempt
39 foundation for the receipt of matching funds to be transferred to
40 the fund for use by this program.

1 (c) The provisions of this chapter shall not become operative
2 unless appropriate funding, as determined by the office, is made
3 available.

4 128559.8. (a) On or before January 31 of each year, the office
5 shall provide an annual report to the Legislature regarding the
6 program that includes all of the following:

7 (1) The number of program participants by profession.

8 (2) Practice locations.

9 (3) The amount expended for the program.

10 (4) Information on annual performance reviews by the practice
11 setting and program participants.

12 (5) An evaluation of the program's effectiveness in improving
13 access to health and social services for older adults.

14 (6) Recommendations for maintaining or expanding the program.

15 (b) This section shall become operative on January 1, 2010.

16 SEC. 11. Sections 8 and 9 of this act shall become operative
17 only if Assembly Bill 2439 of the 2007–08 Regular Session is
18 enacted and becomes effective on or before January 1, 2009.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2649
Author: Ma
Bill Date: March 24, 2008, amended
Subject: Medical Assistants: authorized services
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Assembly Business and Professions Committee and has been set for hearing on April 29, 2008.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would specify that the provisions that allow a medical assistant to perform services relating to the administration of medication and performance of skin tests and simple routine medical tasks under the supervision of a physician do not authorize a medical assistant to trim the nails of, or debride in an manner using a scalpel, paring instrument, or other object the corns, bunions, or callus of, a patient who is diabetic or suffers from any form of circulatory disorder affecting the extremities.

ANALYSIS:

Current law authorizes a medical assistant to perform specified services relating to administration of medication and performance of skin tests and simple routine tasks and procedures under the supervision of a physician. Regulations allow medical assistants to cut the nails of an otherwise health person (Code of regulations Section 1366(b)(12)).

This bill would specify that these provisions do not authorize a medical assistant to trim the nails of, or debride in any manner using a scalpel, paring instrument, or other object the corns, bunions, or callus of, a patient who is diabetic or suffers from any form of circulatory disorder affecting the extremities.

This appears to clarify existing laws and regulations, although it may be unnecessary.

FISCAL: None

POSITION: Recommendation: Neutral

April 18, 2008

AMENDED IN ASSEMBLY MARCH 24, 2008

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL

No. 2649

Introduced by Assembly Member ~~Carter Ma~~

February 22, 2008

~~An act to amend Section 100 of the Business and Professions Code, relating to business.~~ *An act to amend Section 2069 of the Business and Professions Code, relating to healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2649, as amended, ~~Carter Ma. Department of Consumer Affairs.~~ *Medical assistants: authorized services.*

Existing law authorizes a medical assistant to perform specified services relating to administration of medication and performance of skin tests and simple routine medical tasks and procedures upon specific authorization from and under the supervision of a licensed physician and surgeon or podiatrist, or a physician and surgeon or podiatrist group or corporation.

This bill would specify that these provisions do not authorize a medical assistant to trim the nails of, or debride in any manner using a scalpel, paring instrument, or other object the corns, bunions, or callus of, any patient who is diabetic or suffers from any form of circulatory disorder affecting the extremities.

~~Existing law creates the Department of Consumer Affairs in the State and Consumer Services Agency.~~

~~This bill would make a nonsubstantive change to these provisions.~~

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

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

1 SECTION 1. Section 2069 of the Business and Professions
2 Code is amended to read:

3 2069. (a) (1) Notwithstanding any other provision of law, a
4 medical assistant may administer medication only by intradermal,
5 subcutaneous, or intramuscular injections and perform skin tests
6 and additional technical supportive services upon the specific
7 authorization and supervision of a licensed physician and surgeon
8 or a licensed podiatrist. A medical assistant may also perform all
9 these tasks and services in a clinic licensed pursuant to subdivision
10 (a) of Section 1204 of the Health and Safety Code upon the specific
11 authorization of a physician assistant, a nurse practitioner, or a
12 nurse-midwife.

13 (2) The supervising physician and surgeon at a clinic described
14 in paragraph (1) may, at his or her discretion, in consultation with
15 the nurse practitioner, nurse-midwife, or physician assistant provide
16 written instructions to be followed by a medical assistant in the
17 performance of tasks or supportive services. These written
18 instructions may provide that the supervisory function for the
19 medical assistant for these tasks or supportive services may be
20 delegated to the nurse practitioner, nurse-midwife, or physician
21 assistant within the standardized procedures or protocol, and that
22 tasks may be performed when the supervising physician and
23 surgeon is not onsite, so long as the following apply:

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

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

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

35 (1) "Medical assistant" means a person who may be unlicensed,
36 who performs basic administrative, clerical, and technical
37 supportive services in compliance with this section and Section
38 2070 for a licensed physician and surgeon or a licensed podiatrist,

1 or group thereof, for a medical or podiatry corporation, for a
2 physician assistant, a nurse practitioner, or a nurse-midwife as
3 provided in subdivision (a), or for a health care service plan, who
4 is at least 18 years of age, and who has had at least the minimum
5 amount of hours of appropriate training pursuant to standards
6 established by the Division of Licensing. The medical assistant
7 shall be issued a certificate by the training institution or instructor
8 indicating satisfactory completion of the required training. A copy
9 of the certificate shall be retained as a record by each employer of
10 the medical assistant.

11 (2) "Specific authorization" means a specific written order
12 prepared by the supervising physician and surgeon or the
13 supervising podiatrist, or the physician assistant, the nurse
14 practitioner, or the nurse-midwife as provided in subdivision (a),
15 authorizing the procedures to be performed on a patient, which
16 shall be placed in the patient's medical record, or a standing order
17 prepared by the supervising physician and surgeon or the
18 supervising podiatrist, or the physician assistant, the nurse
19 practitioner, or the nurse-midwife as provided in subdivision (a),
20 authorizing the procedures to be performed, the duration of which
21 shall be consistent with accepted medical practice. A notation of
22 the standing order shall be placed on the patient's medical record.

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

28 (A) A licensed physician and surgeon.

29 (B) A licensed podiatrist.

30 (C) A physician assistant, nurse practitioner, or nurse-midwife
31 as provided in subdivision (a).

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

38 (c) Nothing in this section shall be construed as authorizing the
39 licensure of medical assistants. Nothing in this section shall be
40 construed as authorizing the administration of local anesthetic

1 agents by a medical assistant. Nothing in this section shall be
2 construed as authorizing the division to adopt any regulations that
3 violate the prohibitions on diagnosis or treatment in Section 2052.

4 (d) Notwithstanding any other provision of law, a medical
5 assistant may not be employed for inpatient care in a licensed
6 general acute care hospital as defined in subdivision (a) of Section
7 1250 of the Health and Safety Code.

8 (e) Nothing in this section shall be construed as authorizing a
9 medical assistant to perform any clinical laboratory test or
10 examination for which he or she is not authorized by Chapter 3
11 (commencing with Section 1206.5). Nothing in this section shall
12 be construed as authorizing a nurse practitioner, nurse-midwife,
13 or physician assistant to be a laboratory director of a clinical
14 laboratory, as those terms are defined in paragraph (7) of
15 subdivision (a) of Section 1206 and subdivision (a) of Section
16 1209.

17 (f) *Nothing in this section shall be construed as authorizing a*
18 *medical assistant to trim the nails of, or debride in any manner*
19 *using a scalpel, paring instrument, or other object the corns,*
20 *bunions, or callus of, any patient who is diabetic or suffers from*
21 *any form of circulatory disorder affecting the extremities.*

22 ~~SECTION 1. Section 100 of the Business and Professions Code~~
23 ~~is amended to read:~~

24 ~~100. There is in the state government, within the State and~~
25 ~~Consumer Services Agency, a Department of Consumer Affairs.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2734
Author: Krekorian
Bill Date: April 17, 2008, amended
Subject: Advertisements: license # and MBC website
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Assembly Appropriations Committee and has been set for hearing on April 23, 2008.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require on July 1, 2009, business cards of physicians to include the licensing agency and a valid license # or fictitious name permit (FNP) #. It would prohibit, effective July 1, 2009, a physician from advertising unless that advertising contains the physician's name, a valid license number, and the FNP #. All required information must appear in close proximity to the physician's name. This bill would also require, commencing July 1, 2009, any advertising by physicians to contain the licensing agency, the physician's valid license number, and the current Website for the licensing agency.

ANALYSIS:

Current law imposes limitations on advertising by health care practitioners. The author of this bill believes that, in the interests of public protection, consumers need the ability to verify that healthcare practitioners are properly licensed and in good standing with their respective licensing authorities.

This bill would require all business cards for physicians to contain the physician's licensing agency immediately followed by the valid license number. The business cards must also contain the FNP #, if applicable.

This bill would require all advertisements and promotional material disseminated by a licensed physician to include the physician's name immediately followed by a valid license number for that physician, the current Website for the Board, and, in the case of an entity other than an individual, the fictitious name permit. This bill also prohibits the willful and intentional use of a license number that is not current and valid, and makes a violation of this is punishable by a fine for the first occurrence up to one thousand dollars

(\$1,000) and for a second offense up to ten thousand dollars (\$10,000), imprisonment for up to one year, or both. This bill also states that an intentional violation constitutes unprofessional conduct and grounds for suspension or revocation of the physician's license.

FISCAL: None

POSITION: Recommendation: Support

April 18, 2008

AMENDED IN ASSEMBLY APRIL 17, 2008

CALIFORNIA LEGISLATURE—2007—08 REGULAR SESSION

ASSEMBLY BILL

No. 2734

Introduced by Assembly Member Krekorian

February 22, 2008

An act to add Section 605 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2734, as amended, Krekorian. Health care practitioners: *business cards and advertisements.*

Existing law provides for the licensure and regulation of the practice of medicine by the Medical Board of California and provides for the licensure and regulation of the practice of dentistry by the Dental Board of California. Existing law imposes certain limitations on advertising by health care practitioners.

This bill would ~~require a public communication, as defined, by, commencing July 1, 2009, require a business card or professional card disseminated by or caused to be disseminated by a licensed physician and surgeon, dentist, chiropractor, or osteopath, or a person required to be licensed as such, in connection with the practice of medicine, dentistry, chiropractic, or osteopathy to include a valid license number or a fictitious name permit number. The bill would also, commencing July 1, 2009, prohibit a licensed physician and surgeon, dentist, chiropractor, or osteopath, or a person required to be licensed as such, to include a valid license number, contact information for the appropriate licensing agency, a notice to contact the agency for further licensing details, and, in the case of an entity other than an individual, the fictitious name permit number, as specified~~ *from disseminating or causing to be*

disseminated an advertisement or promotional material that does not contain specified information, except that this prohibition would not apply until January 1, 2010, to any advertising or promotional material that is published annually and prior to July 1, 2009. The bill would also, commencing January 1, 2009, prohibit the willful and intentional use of a license number that is not the person’s current, valid license number. The bill would make a violation of these provisions a crime, punishable as specified, and would make specified violations a crime. The bill would also make an intentional violation unprofessional conduct and grounds for suspension or revocation of a license, as specified.

Because this bill would create new crimes, it would impose a state-mandated local program.

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

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

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

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

1 SECTION 1. Section 605 is added to the Business and
2 Professions Code, to read:

3 605. (a) ~~No~~ *On and after July 1, 2009, no person licensed or*
4 *required to be licensed pursuant to Chapter 4 (commencing with*
5 *Section 1600) or Chapter 5 (commencing with Section 2000) or*
6 *under any initiative act referred to in this division shall disseminate,*
7 *or cause to be disseminated, any form of public communication*
8 *for the purpose of or likely to induce, directly or indirectly, the*
9 *rendering of professional services or furnishing of products*
10 *business card or professional card in connection with the*
11 *professional practice or business for which a license is required*
12 *pursuant to Chapter 4 (commencing with Section 1600), Chapter*
13 *5 (commencing with Section 2000), or an initiative act referred to*
14 *in this division, unless the card contains the applicable state*
15 *licensing agency immediately followed by the valid license number*
16 *issued to that person in the following form:*

17 “(insert state agency) License number: (insert valid license
18 number)”

1 *The following abbreviations may be used: "CA" or "Calif."*
2 *may be substituted for "State," "Med." may be substituted for*
3 *"Medical," "Dent." may be substituted for "Dental," "Bd." may*
4 *be substituted for "Board," "Bur." may be substituted for*
5 *"Bureau," "Lic." may be substituted for "License" and "No." or*
6 *"#" may be substituted for "number."*

7 *A business card or professional card on behalf of, in whole or*
8 *part, a person practicing under a fictitious business name shall*
9 *include the fictitious name permit number issued by the applicable*
10 *state licensing agency.*

11 *(b) On and after July 1, 2009, no person licensed or required*
12 *to be licensed pursuant to Chapter 4 (commencing with Section*
13 *1600) or Chapter 5 (commencing with Section 2000) or under any*
14 *initiative act referred to in this division shall disseminate, or cause*
15 *to be disseminated, any form of advertisement or promotional*
16 *material in connection with the professional practice or business*
17 *for which a license is required pursuant to Chapter 4 (commencing*
18 *with Section 1600), Chapter 5 (commencing with Section 2000),*
19 *or an initiative act referred to in this division, unless that*
20 *dissemination clearly and conspicuously contains all of the*
21 *following information:*

22 ~~*(1) A valid license number issued by the applicable licensing*~~
23 ~~*authority for the person offering the services or products, the Web*~~
24 ~~*site and telephone number of the licensing authority, and a notice*~~
25 ~~*to contact that agency for further licensing information.*~~

26 ~~*(2) If the dissemination is on behalf of, in whole or part, any*~~
27 ~~*person other than an individual, the dissemination shall also include*~~
28 ~~*the person's fictitious name permit number.*~~

29 ~~*(1) The name of the person or the fictitious business name of*~~
30 ~~*the person as approved by the licensing authority.*~~

31 ~~*(2) (A) If the dissemination is oral and contains no written or*~~
32 ~~*visual component, the applicable state licensing agency*~~
33 ~~*immediately followed by the valid license number issued to that*~~
34 ~~*person.*~~

35 ~~*(B) For all other forms of dissemination, the applicable state*~~
36 ~~*licensing agency immediately followed by both the valid license*~~
37 ~~*number issued to that person and the current valid Internet Web*~~
38 ~~*site of the applicable state licensing agency, all of which shall*~~
39 ~~*appear in close proximity to the name of the person and in the*~~
40 ~~*following form:*~~

1 “(Name of state agency) License number: _____” “www. _____”

2 The following abbreviations may be used: “CA” or “Calif.”
3 may be substituted for “State,” or for “California,” “Med.” may
4 be substituted for “Medical,” “Dent.” may be substituted for
5 “Dental,” “Bd.” may be substituted for “Board,” “Bur.” may be
6 substituted for “Bureau,” “Lic.” may be substituted for “License”
7 and “No.” or “#” may be substituted for “number.”

8 (3) An advertisement or promotional material on behalf of, in
9 whole or part, a person practicing under a fictitious business name
10 shall include the fictitious name permit number issued by the
11 applicable state licensing agency.

12 this subdivision shall not apply until January 1, 2010, to any
13 advertisement or promotional material that is published annually
14 and prior to July 1, 2009.

15 (b)

16 (c) For purposes of this section, the following terms have the
17 following meanings:

18 (1) “Person” means any individual, partnership, corporation,
19 limited liability company, or other organization, or any combination
20 thereof.

21 (2) ~~A “public communication”~~—An “advertisement” or
22 “promotional material” includes, but is not limited to,
23 communication by means of mail, television, radio, motion picture,
24 newspaper, book, ~~business card, list or directory of healing arts~~
25 ~~practitioners directory~~, Internet, or other electronic communication.
26 It does not include a directory listing that contains no additional
27 information other than the licensee’s name, address, and telephone
28 number.

29 ~~(c) A violation of this section constitutes a misdemeanor and is~~
30 ~~punishable by imprisonment in the county jail for not more than~~
31 ~~six months, or by a fine not exceeding two thousand five hundred~~
32 ~~dollars (\$2,500), or by both that fine and imprisonment.~~

33 (d) (1) A violation of this section by a licensed person described
34 in subdivision (a) or (b) is punishable by a fine not exceeding one
35 thousand dollars (\$1,000). A second or subsequent violation of
36 this section by a licensed person described in subdivision (a) or
37 (b) is a misdemeanor punishable by a fine not exceeding ten
38 thousand dollars (\$10,000).

39 (2) A violation of this section by a person described in
40 subdivision (a) or (b) who has no license, or who has a license

1 *that is suspended or revoked, is a misdemeanor offense, punishable*
 2 *by imprisonment in the county jail for not more than six months,*
 3 *or by a fine not exceeding two thousand five hundred dollars*
 4 *(\$2,500), or by both that fine and imprisonment.*

5 ~~(d)~~

6 (e) Any person described in subdivision (a) or (b) who willfully
 7 and intentionally uses a license number that does not correspond
 8 to the number on a currently valid license held by that person, is
 9 punishable by a fine not exceeding ten thousand dollars (\$10,000),
 10 or by imprisonment in the county jail for not more than one year,
 11 or by both that fine and imprisonment. The penalty provided by
 12 this section is cumulative to the penalties available under all other
 13 laws.

14 ~~(e) A~~

15 (f) *An intentional violation of this section in the case of a*
 16 *licensed person described in subdivision (a) or (b) constitutes*
 17 *unprofessional conduct and grounds for suspension or revocation*
 18 *of his or her license by the board by whom he or she is licensed,*
 19 *or if a license has been issued in connection with a place of*
 20 *business, then for the suspension or revocation of the place of*
 21 *business in connection with which the violation occurs. The*
 22 *proceedings for suspension or revocation shall be conducted in*
 23 *accordance with Chapter 5 (commencing with Section 11500) of*
 24 *Part 1 of Division 3 of Title 2 of the Government Code, and each*
 25 *board shall have all the powers granted therein.*

26 SEC. 2. No reimbursement is required by this act pursuant to
 27 Section 6 of Article XIII B of the California Constitution because
 28 the only costs that may be incurred by a local agency or school
 29 district will be incurred because this act creates a new crime or
 30 infraction, eliminates a crime or infraction, or changes the penalty
 31 for a crime or infraction, within the meaning of Section 17556 of
 32 the Government Code, or changes the definition of a crime within
 33 the meaning of Section 6 of Article XIII B of the California
 34 Constitution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2747
Author: Berg
Bill Date: April 7, 2008, amended
Subject: End-of-Life Care
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Assembly Judiciary Committee and has been set for hearing on April 29, 2008.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require that when an attending physician makes a diagnosis that a patient has a terminal illness the physician must provide the patient an opportunity to receive information and counseling regarding all legal end-of-life care options if the patient requests the information.

ANALYSIS:

Information and counseling regarding end-of-life care options are essential for many terminally ill patients and their families. Patients need to know how to weigh all of their options and make informed decisions. It gives the physician an opportunity to discuss the benefits and disadvantages of all available treatments and it can facilitate earlier access to hospice care.

AB 2747 requires attending physicians who diagnose a patient as terminally ill to provide the patient an opportunity to receive information and counseling regarding end-of-life care. It appears this “opportunity” applies if the patient requests the information. If physicians do not wish to comply with the patient’s choice of end-of-life options, they must refer the patients to another health care provider or provide them with information on procedures to transfer to another provider.

The current language of the bill does not address from where the physicians obtain the information on end-of-life care options, although it does state this information need not be in writing.

FISCAL: None

POSITION: Recommendation: Neutral if amended to clarify what materials or information should be provided.

April 18, 2008

AMENDED IN ASSEMBLY APRIL 7, 2008
AMENDED IN ASSEMBLY MARCH 25, 2008
CALIFORNIA LEGISLATURE—2007—08 REGULAR SESSION

ASSEMBLY BILL

No. 2747

Introduced by Assembly Members Berg and Levine

February 22, 2008

An act to add Part 1.8 (commencing with Section 442) to Division 1 of the Health and Safety Code, relating to end-of-life care.

LEGISLATIVE COUNSEL'S DIGEST

AB 2747, as amended, Berg. End-of-life care.

Existing law provides for the licensure and regulation of health facilities and hospices by the State Department of Public Health. Existing law provides for the regulation and licensing of physicians and surgeons by the Medical Board of California.

This bill would provide that when an attending physician makes a diagnosis that a patient has a terminal illness or makes a prognosis that a patient has less than one year to live, the health care provider shall provide the patient with the opportunity to receive information and counseling regarding legal end-of-life options, as specified, and provide for the referral or transfer of a patient if the patient's physician does not wish to comply with the patient's choice of end-of-life options.

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:

3 (a) Palliative and hospice care are invaluable resources for
4 terminally ill Californians in need of comfort and support at the
5 end of life.

6 (b) Palliative care and conventional medical treatment should
7 be thoroughly integrated rather than viewed as separate entities.

8 (c) Even though Californians with a prognosis of six months or
9 less to live are eligible for hospice care, nearly two-thirds of them
10 receive hospice services for less than one month.

11 (d) Many patients benefit from being referred to hospice care
12 earlier, where they receive better pain and symptom management
13 and have an improved quality of life.

14 (e) Significant information gaps may exist between health care
15 providers and their patients on end-of-life care options potentially
16 leading to delays to, or lack of, referrals to hospice care for
17 terminally ill patients. The sharing of important information
18 regarding specific treatment options in a timely manner by health
19 care providers is a key component of quality end-of-life care.
20 Information that is helpful to patients and their families includes,
21 but is not limited to, the availability of hospice care, the efficacy
22 and potential side effects of continued curative treatment, and
23 withholding or withdrawal of life sustaining treatments.

24 (f) Terminally ill and dying patients rely on their health care
25 providers to give them timely and informative data. Research
26 shows a lack of communication between health care providers and
27 their terminally ill patients can cause problems, including poor
28 availability of, and lack of clarity regarding, advanced health care
29 directives and patients' end-of-life care preferences. This lack of
30 information and poor adherence to patient choices ~~results~~ *result*
31 in "bad deaths" that cause needless physical and psychological
32 suffering to patients and their families.

33 (g) Those problems are complicated by social issues, such as
34 cultural and religious pressures for the providers, patients, and
35 their family members. A recent survey found that providers that
36 object to certain practices are less likely than others to believe they
37 have an obligation to present all of the options to patients and refer
38 patients to other providers, if necessary.

1 (h) Every medical school in California is required to include
2 end-of-life care issues in its curriculum and every physician in
3 California is required to complete continuing education courses
4 in end-of-life care.

5 (i) Palliative care is not a one-size-fits-all approach. Patients
6 have a range of diseases and respond differently to treatment
7 options. A key benefit of palliative care is that it customizes
8 treatment to meet the needs of each individual person.

9 (j) Informed patient choices will help terminally ill patients and
10 their families cope with one of life's most challenging situations.

11 SEC. 2. Part 1.8 (commencing with Section 442) is added to
12 Division 1 of the Health and Safety Code, to read:

13
14 PART 1.8. END-OF-LIFE CARE

15
16 442. For the purposes of this part, the following definitions
17 shall apply:

18 (a) "Curative treatment" means treatment intended to cure or
19 alleviate symptoms of a given disease or condition.

20 (b) "Hospice" means a specialized form of interdisciplinary
21 health care that is designed to provide palliative care, alleviate the
22 physical, emotional, social, and spiritual discomforts of an
23 individual who is experiencing the last phases of life due to the
24 existence of a terminal disease, and provide supportive care to the
25 primary caregiver and the family of the hospice patient, and that
26 meets all of the criteria specified in subdivision (b) of Section
27 1746.

28 (c) "Palliative care" means medical treatment, interdisciplinary
29 care, or consultation provided to a patient or family members, or
30 both, that has as its primary purpose the prevention of, or relief
31 from, suffering and the enhancement of the quality of life, rather
32 than treatment aimed at investigation and intervention for the
33 purpose of cure or prolongation of life as described in subdivision
34 (b) of Section 1339.31.

35 (d) "Palliative sedation" means the use of sedative medications
36 to relieve extreme suffering by making the patient unaware and
37 unconscious, while artificial food and hydration are withheld,
38 during the progression of the disease leading to the death of the
39 patient.

1 (e) “Refusal or withdrawal of life sustaining treatment” means
2 forgoing treatment or medical procedures that replace or support
3 an essential bodily function, including, but not limited to,
4 cardiopulmonary resuscitation, mechanical ventilation, artificial
5 nutrition and hydration, dialysis, and any other treatment or
6 discontinuing any or all of those treatments after they have been
7 used for a reasonable time.

8 (f) “Voluntary stopping of eating and drinking” or “VSED”
9 means the voluntary refusal of a patient to eat and drink in order
10 to alleviate his or her suffering, and includes the withholding or
11 withdrawal of life-sustaining treatment at the request of the patient.

12 442.5. When an attending physician makes a diagnosis that a
13 patient has a terminal illness or makes a prognosis that a patient
14 has less than one year to live, the physician, ~~or in the case of a~~
15 ~~patient in a health facility, as defined in Section 1250, the health~~
16 ~~facility,~~ shall provide the patient with the opportunity to receive
17 comprehensive information and counseling regarding legal
18 end-of-life care options. *When a patient is in a health facility, as*
19 *defined in Section 1250, the attending physician or medical director*
20 *may refer the patient to a hospice provider or private or public*
21 *agencies and community-based organizations that specialize in*
22 *end-of-life care case management and consultation to receive*
23 *information and counseling regarding legal end-of-life care*
24 *options.*

25 (a) If the patient indicates a desire to receive the information
26 and counseling, the information shall include, but not be limited
27 to, the following:

28 (1) Hospice care at home or in a health care setting.

29 (2) A prognosis with and without the continuation of curative
30 treatment.

31 (3) The patient’s right to refusal *of* or withdrawal from
32 life-sustaining treatment.

33 (4) The patient’s right to continue to pursue curative treatment
34 while receiving palliative care.

35 (5) The patient’s right to comprehensive pain and symptom
36 management at the end of life, including, but not limited to,
37 adequate pain medication, treatment of nausea, palliative
38 chemotherapy, relief of shortness of breath and fatigue, VSED,
39 and palliative sedation.

1 (b) The information described in subdivision (a) may, but is not
2 required to be, in writing.

3 (c) Counseling may include, but not be limited to, discussions
4 about the outcomes on the patient and his or her family, based on
5 the interest of the patient.

6 442.7. If a physician does not wish to comply with his or her
7 patient's choice of end-of-life options, the health care provider
8 shall do both of the following:

9 (a) Refer or transfer a patient to an alternative health care
10 provider.

11 (b) Provide the patient with information on procedures to
12 transfer to an alternative health care provider.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2841
Author: Ma
Bill Date: February 22, 2008, introduced
Subject: Medical Procedures: reusable adipose cannula
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Assembly Business and Professions Committee and has been set for hearing on April 29, 2008.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require that patients be notified through written disclosure prior to any medical procedure in which a reusable adipose cannula is to be used for the second time, and for each use thereafter. Patient signature is required on the disclosure form and must be maintained in the patients' medical record.

ANALYSIS:

Current law requires specified disclosures to patients undergoing procedures involving collagen injections and silicone implants under the Medical Practice Act. Additionally, the Medical Board is required to adopt extraction and postoperative care standards in regard to body liposuction procedures performed by a physician when performed outside of a general acute care hospital.

According to the author, a large number of the adipose cannulas that are used in procedures are reusable. Although they are regulated by the United States Food and Drug Administration, there are no regulations or laws regarding the number of times that a reusable cannula may be used, number of patients that a reusable cannula can be used on, or the number of years that as adipose cannula can be used before it needs to be discarded.

As it is currently written, the bill does not identify a significant problem related to the use of reusable adipose cannulas relative to any other piece of surgical equipment that would warrant these disclosures. The California Society of Plastic Surgeons notes that the majority of all surgical instruments used during a procedure are used again and again. Sterilization procedures, when correctly followed, can prevent all risk of infection.

This bill would require the disclosure of a common practice that may cause more concern or confusion for patients, rather than providing better consumer protection. In addition, the disclosure must include the number of times the cannula has been used on other patients, the length of time the cannula has been in use, and how it has been sterilized. Much of this data is not currently maintained by the physician. The disclosure must contain information on alternatives to the disposable instrument.

The bill only applies to physician use of this instrument.

FISCAL: Minor and absorbable.

POSITION: Recommendation: Oppose

April 18, 2008

ASSEMBLY BILL

No. 2841

Introduced by Assembly Member Ma

February 22, 2008

An act to add Section 2259.9 to the Business and Professions Code, relating to medical procedures.

LEGISLATIVE COUNSEL'S DIGEST

AB 2841, as introduced, Ma. Medical procedures: reusable adipose cannula.

Existing law, the Medical Practice Act, establishes the Medical Board of California under the Department of Consumer Affairs, which licenses physicians and surgeons and regulates their practice. Existing law requires specified disclosures to patients undergoing procedures involving collagen injections, defined as any substance derived from, or combined with, animal protein. Existing law also requires the board to adopt extraction and postoperative care standards in regard to body liposuction procedures performed by a physician and surgeon outside of a general acute care hospital. Existing law makes a violation of these provisions a misdemeanor.

This bill would enact the Reusable Adipose Cannula Full Disclosure Act, which would require a physician and surgeon to provide specified written disclosures to a patient prior to that patient undergoing any adipose medical procedure, as defined, for which a reusable adipose cannula, as defined, is to be used. The bill would define adipose as tissue made up of fat cells located beneath the skin, and adipose cannula, generally, as the device used to remove adipose from, or inject adipose into, a patient. The bill would also provide that a violation of these provisions would not constitute a crime.

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

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

1 SECTION 1. This act shall be known and may be cited as the
2 Reusable Adipose Cannula Full Disclosure Act.

3 SEC. 2. Section 2259.9 is added to the Business and Professions
4 Code, to read:

5 2259.9. (a) Prior to any adipose medical procedure in which
6 a reusable adipose cannula is to be used, the physician and surgeon
7 performing the procedure or a member of his or her staff shall, in
8 writing, disclose to the patient or legal guardian of a minor patient
9 all of the following:

10 (1) The reusable adipose cannula has been used on other patients
11 to perform an adipose medical procedure.

12 (2) The number of patients for which the reusable adipose
13 cannula has been used to perform adipose medical procedures.

14 (3) The length of time that the reusable adipose cannula has
15 been in use by the physician and surgeon.

16 (4) The process by which the reusable adipose cannula has been
17 cleaned, sterilized, and stored after each adipose medical procedure.

18 (5) That an alternative to reusable adipose cannulas may be
19 available for the adipose medical procedure in the form of
20 disposable adipose cannulas.

21 (b) The disclosure required in subdivision (a) shall be signed
22 by the patient or the legal guardian of a minor patient prior to the
23 adipose medical procedure being performed. The signed disclosure
24 shall be maintained in the patient’s medical records file.

25 (c) The disclosure described in subdivision (a) shall not be
26 required if the reusable adipose cannula is being used for the first
27 time.

28 (d) Section 2314 shall not apply to this section.

29 (e) For purposes of this section:

30 (1) “Adipose” means tissue made up of fat cells located beneath
31 the skin.

32 (2) “Adipose cannula” means any device that is inserted into
33 the body of a patient for the removal of adipose from, or for the
34 injection of adipose into, the body of that patient.

1 (3) “Adipose medical procedure” means any procedure to
2 remove adipose from the body of a patient or to inject a patient’s
3 own adipose into the body of that patient.

4 (4) “Disposable adipose cannula” means an adipose cannula
5 that is used on a patient during an adipose medical procedure
6 followed by disposal of that cannula. A disposable adipose cannula
7 is not used on more than one patient.

8 (5) “Patient” means a natural person.

9 (6) “Reusable adipose cannula” means an adipose cannula that
10 is used on multiple patients, followed by cleaning, sterilization,
11 and storage after each adipose medical procedure.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2968
Author: Carter
Bill Date: February 22, 2008, introduced
Subject: Cosmetic Surgery: physical examination
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Assembly Health Committee and has been set for hearing on April 29, 2008.

DESCRIPTION OF CURRENT LEGISLATION:

This bill enacts the Donda West Law, which would prohibit elective cosmetic surgery on a patient unless, prior to surgery, the patient has completed a physical examination by, and has received written clearance for the procedure from, a physician.

ANALYSIS:

According to the author, better consumer protections are needed regarding unnecessary bodily trauma that could result from elective cosmetic surgery for patients who are not physically fit to undergo these procedures. This bill comes from the author's "It Ought to Be a Law" contest. Many plastic surgeons require their patients to have a medical clearance before they will perform elective cosmetic surgery, however, it is not a requirement in law. This bill would address those health care providers who may not require the physical examination clearance.

This bill would, through enactment of the Donda West Law, prohibit elective cosmetic surgery on a patient unless the patient has completed a physical examination by a licensed physician and has received written clearance for the procedure prior to surgery.

The bill states that only a physician is authorized to complete the physical examination that would be required in law for a patient seeking elective cosmetic surgery. Current law allows physician assistants and nurse practitioners to complete physical examinations and they should be included in this bill as authorized to complete physicals for patients seeking cosmetic procedures.

The requirement for a physical already exists in law, but it is not applied in many cases especially in medi-spas. This will clarify that a prior examination is necessary prior to elective cosmetic surgery.

Since Dentists with a special permit are now authorized to perform facial cosmetic surgery, are they qualified and should they be authorized to perform a physical examination?

FISCAL: None

POSITION: Recommendation: Support if amended to allow all healthcare practitioners who are authorized to perform physical examinations to be able to complete physical examinations for patients seeking elective cosmetic surgery.

April 18, 2008

ASSEMBLY BILL

No. 2968

Introduced by Assembly Member Carter

February 22, 2008

An act to add Section 2259.8 to the Business and Professions Code, relating to cosmetic surgery.

LEGISLATIVE COUNSEL'S DIGEST

AB 2968, as introduced, Carter. Cosmetic surgery.

Existing law, the Medical Practice Act, establishes the Medical Board of California under the Department of Consumer Affairs, which licenses physicians and surgeons and regulates their practice.

Existing law, the Medical Practice Act, requires specified disclosures to patients undergoing procedures involving collagen injections, defined as any substance derived from, or combined with, animal protein. Existing law also requires the board to adopt extraction and postoperative care standards in regard to body liposuction procedures performed by a physician and surgeon outside of a general acute care hospital. Existing law makes a violation of these provisions a misdemeanor.

This bill would enact the Donda West Law, which would prohibit the performance of an elective cosmetic surgery procedure on a patient unless, prior to surgery, the patient has completed a physical examination by, and has received written clearance for the procedure from, a licensed physician and surgeon. The bill would also provide that a violation of these provisions would not constitute a crime.

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

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

1 SECTION 1. This act shall be known and may be cited as the
2 Donda West Law.

3 SEC. 2. Section 2259.8 is added to the Business and Professions
4 Code, to read:

5 2259.8. (a) Notwithstanding any other provision of law, a
6 cosmetic surgery procedure may not be performed on a patient
7 unless, prior to surgery, the patient has completed a physical
8 examination by, and has received written clearance for the
9 procedure from, a licensed physician and surgeon.

10 (b) "Cosmetic surgery" means an elective surgery that is
11 performed to alter or reshape normal structures of the body in order
12 to improve the patient's appearance, including, but not limited to,
13 liposuction and elective facial cosmetic surgery.

14 (c) Section 2314 shall not apply to this section.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2969
Author: Lieber
Bill Date: February 22, 2008, introduced
Subject: Workers' Comp.: medical treatment utilization reviews
Sponsor: Author

STATUS OF BILL:

This bill is currently on the Assembly Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require a physician who is conducting utilization review to be licensed in California.

ANALYSIS:

Current law does not require physicians who perform utilization reviews of workers' compensation claims to be licensed in California as long as the physicians are licensed in another state.

The author and proponents of this bill believe that out-of-state physicians are making inappropriate decisions regarding these utilization reviews in part because there is no regulatory agency holding them accountable.

This bill would ensure that any physician performing a utilization review in California would be regulated by the Medical Board (Board) by requiring all physicians performing these reviews to be licensed in this state.

FISCAL: None

POSITION: Recommendation: Support

April 18, 2008

ASSEMBLY BILL

No. 2969

**Introduced by Assembly Member Lieber
(Coauthors: Assembly Members Beall and Ruskin)**

February 22, 2008

An act to amend Section 4610 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 2969, as introduced, Lieber. Workers' compensation: medical treatment utilization reviews.

Existing law establishes a workers' compensation system to compensate an employee for injuries sustained in the course of his or her employment, and requires an employer to pay for all reasonable costs of medical services necessary to care for or relieve work-related injuries. Existing law requires every employer to establish a medical treatment utilization review process, in compliance with specified requirements, either directly or through its insurer or an entity with which the employer or insurer contracts for these services. Existing law provides that no person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

This bill would require that any licensed physician who is conducting such an evaluation be licensed in California.

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

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

1 SECTION 1. Section 4610 of the Labor Code is amended to
2 read:

3 4610. (a) For purposes of this section, “utilization review”
4 means utilization review or utilization management functions that
5 prospectively, retrospectively, or concurrently review and approve,
6 modify, delay, or deny, based in whole or in part on medical
7 necessity to cure and relieve, treatment recommendations by
8 physicians, as defined in Section 3209.3, prior to, retrospectively,
9 or concurrent with the provision of medical treatment services
10 pursuant to Section 4600.

11 (b) Every employer shall establish a utilization review process
12 in compliance with this section, either directly or through its insurer
13 or an entity with which an employer or insurer contracts for these
14 services.

15 (c) Each utilization review process shall be governed by written
16 policies and procedures. These policies and procedures shall ensure
17 that decisions based on the medical necessity to cure and relieve
18 of proposed medical treatment services are consistent with the
19 schedule for medical treatment utilization adopted pursuant to
20 Section 5307.27. Prior to adoption of the schedule, these policies
21 and procedures shall be consistent with the recommended standards
22 set forth in the American College of Occupational and
23 Environmental Medicine Occupational Medical Practice
24 Guidelines. These policies and procedures, and a description of
25 the utilization process, shall be filed with the administrative director
26 and shall be disclosed by the employer to employees, physicians,
27 and the public upon request.

28 (d) If an employer, insurer, or other entity subject to this section
29 requests medical information from a physician in order to
30 determine whether to approve, modify, delay, or deny requests for
31 authorization, the employer shall request only the information
32 reasonably necessary to make the determination. The employer,
33 insurer, or other entity shall employ or designate a medical director
34 who holds an unrestricted license to practice medicine in this state
35 issued pursuant to Section 2050 or Section 2450 of the Business
36 and Professions Code. The medical director shall ensure that the
37 process by which the employer or other entity reviews and
38 approves, modifies, delays, or denies requests by physicians prior

1 to, retrospectively, or concurrent with the provision of medical
2 treatment services, complies with the requirements of this section.
3 Nothing in this section shall be construed as restricting the existing
4 authority of the Medical Board of California.

5 (e) No person other than a ~~licensed~~ physician *licensed in*
6 *California* who is competent to evaluate the specific clinical issues
7 involved in the medical treatment services, and where these
8 services are within the scope of the physician's practice, requested
9 by the physician may modify, delay, or deny requests for
10 authorization of medical treatment for reasons of medical necessity
11 to cure and relieve.

12 (f) The criteria or guidelines used in the utilization review
13 process to determine whether to approve, modify, delay, or deny
14 medical treatment services shall be all of the following:

15 (1) Developed with involvement from actively practicing
16 physicians.

17 (2) Consistent with the schedule for medical treatment utilization
18 adopted pursuant to Section 5307.27. Prior to adoption of the
19 schedule, these policies and procedures shall be consistent with
20 the recommended standards set forth in the American College of
21 Occupational and Environmental Medicine Occupational Medical
22 Practice Guidelines.

23 (3) Evaluated at least annually, and updated if necessary.

24 (4) Disclosed to the physician and the employee, if used as the
25 basis of a decision to modify, delay, or deny services in a specified
26 case under review.

27 (5) Available to the public upon request. An employer shall
28 only be required to disclose the criteria or guidelines for the
29 specific procedures or conditions requested. An employer may
30 charge members of the public reasonable copying and postage
31 expenses related to disclosing criteria or guidelines pursuant to
32 this paragraph. Criteria or guidelines may also be made available
33 through electronic means. No charge shall be required for an
34 employee whose physician's request for medical treatment services
35 is under review.

36 (g) In determining whether to approve, modify, delay, or deny
37 requests by physicians prior to, retrospectively, or concurrent with
38 the provisions of medical treatment services to employees all of
39 the following requirements must be met:

1 (1) Prospective or concurrent decisions shall be made in a timely
2 fashion that is appropriate for the nature of the employee's
3 condition, not to exceed five working days from the receipt of the
4 information reasonably necessary to make the determination, but
5 in no event more than 14 days from the date of the medical
6 treatment recommendation by the physician. In cases where the
7 review is retrospective, the decision shall be communicated to the
8 individual who received services, or to the individual's designee,
9 within 30 days of receipt of information that is reasonably
10 necessary to make this determination.

11 (2) When the employee's condition is such that the employee
12 faces an imminent and serious threat to his or her health, including,
13 but not limited to, the potential loss of life, limb, or other major
14 bodily function, or the normal timeframe for the decisionmaking
15 process, as described in paragraph (1), would be detrimental to the
16 employee's life or health or could jeopardize the employee's ability
17 to regain maximum function, decisions to approve, modify, delay,
18 or deny requests by physicians prior to, or concurrent with, the
19 provision of medical treatment services to employees shall be made
20 in a timely fashion that is appropriate for the nature of the
21 employee's condition, but not to exceed 72 hours after the receipt
22 of the information reasonably necessary to make the determination.

23 (3) (A) Decisions to approve, modify, delay, or deny requests
24 by physicians for authorization prior to, or concurrent with, the
25 provision of medical treatment services to employees shall be
26 communicated to the requesting physician within 24 hours of the
27 decision. Decisions resulting in modification, delay, or denial of
28 all or part of the requested health care service shall be
29 communicated to physicians initially by telephone or facsimile,
30 and to the physician and employee in writing within 24 hours for
31 concurrent review, or within two business days of the decision for
32 prospective review, as prescribed by the administrative director.
33 If the request is not approved in full, disputes shall be resolved in
34 accordance with Section 4062. If a request to perform spinal
35 surgery is denied, disputes shall be resolved in accordance with
36 subdivision (b) of Section 4062.

37 (B) In the case of concurrent review, medical care shall not be
38 discontinued until the employee's physician has been notified of
39 the decision and a care plan has been agreed upon by the physician
40 that is appropriate for the medical needs of the employee. Medical

1 care provided during a concurrent review shall be care that is
2 medically necessary to cure and relieve, and an insurer or
3 self-insured employer shall only be liable for those services
4 determined medically necessary to cure and relieve. If the insurer
5 or self-insured employer disputes whether or not one or more
6 services offered concurrently with a utilization review were
7 medically necessary to cure and relieve, the dispute shall be
8 resolved pursuant to Section 4062, except in cases involving
9 recommendations for the performance of spinal surgery, which
10 shall be governed by the provisions of subdivision (b) of Section
11 4062. Any compromise between the parties that an insurer or
12 self-insured employer believes may result in payment for services
13 that were not medically necessary to cure and relieve shall be
14 reported by the insurer or the self-insured employer to the licensing
15 board of the provider or providers who received the payments, in
16 a manner set forth by the respective board and in such a way as to
17 minimize reporting costs both to the board and to the insurer or
18 self-insured employer, for evaluation as to possible violations of
19 the statutes governing appropriate professional practices. No fees
20 shall be levied upon insurers or self-insured employers making
21 reports required by this section.

22 (4) Communications regarding decisions to approve requests
23 by physicians shall specify the specific medical treatment service
24 approved. Responses regarding decisions to modify, delay, or deny
25 medical treatment services requested by physicians shall include
26 a clear and concise explanation of the reasons for the employer's
27 decision, a description of the criteria or guidelines used, and the
28 clinical reasons for the decisions regarding medical necessity.

29 (5) If the employer, insurer, or other entity cannot make a
30 decision within the timeframes specified in paragraph (1) or (2)
31 because the employer or other entity is not in receipt of all of the
32 information reasonably necessary and requested, because the
33 employer requires consultation by an expert reviewer, or because
34 the employer has asked that an additional examination or test be
35 performed upon the employee that is reasonable and consistent
36 with good medical practice, the employer shall immediately notify
37 the physician and the employee, in writing, that the employer
38 cannot make a decision within the required timeframe, and specify
39 the information requested but not received, the expert reviewer to
40 be consulted, or the additional examinations or tests required. The

1 employer shall also notify the physician and employee of the
2 anticipated date on which a decision may be rendered. Upon receipt
3 of all information reasonably necessary and requested by the
4 employer, the employer shall approve, modify, or deny the request
5 for authorization within the timeframes specified in paragraph (1)
6 or (2).

7 (h) Every employer, insurer, or other entity subject to this section
8 shall maintain telephone access for physicians to request
9 authorization for health care services.

10 (i) If the administrative director determines that the employer,
11 insurer, or other entity subject to this section has failed to meet
12 any of the timeframes in this section, or has failed to meet any
13 other requirement of this section, the administrative director may
14 assess, by order, administrative penalties for each failure. A
15 proceeding for the issuance of an order assessing administrative
16 penalties shall be subject to appropriate notice to, and an
17 opportunity for a hearing with regard to, the person affected. The
18 administrative penalties shall not be deemed to be an exclusive
19 remedy for the administrative director. These penalties shall be
20 deposited in the Workers' Compensation Administration Revolving
21 Fund.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 797
Author: Ridley-Thomas
Bill Date: September 7, 2007, amended
Subject: VE/P Extension
Sponsor: Author
Board Position: Support MBC Provisions

STATUS OF BILL:

This bill is currently on 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.

ANALYSIS:

This bill carries the provisions the Board requested with exception of the reclassification to retain investigators. The Board has contracted for a study to review this request.

This bill is supposed to be amended to include an urgency clause so that the provisions take effect immediately however, this amendment has not been made to date.

FISCAL: Within existing resources.

POSITION: Support MBC provisions.

April 15, 2008

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 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~~

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

7 (c) A conviction within the meaning of this section means a plea
8 or verdict of guilty or a conviction following a plea of nolo
9 contendere. Any action ~~which~~ that a board is permitted to take
10 following the establishment of a conviction may be taken when
11 the time for appeal has elapsed, or the judgment of conviction has
12 been affirmed on appeal, or when an order granting probation is
13 made suspending the imposition of sentence, irrespective of a
14 subsequent order under the provisions of Section 1203.4 of the
15 Penal Code.

16 (d) The Legislature hereby finds and declares that the
17 application of this section has been made unclear by the holding
18 in *Petropoulos v. Department of Real Estate* (2006) 142
19 Cal.App.4th 554, and that the holding in that case has placed a
20 significant number of statutes and regulations in question, resulting
21 in potential harm to the consumers of California from licensees
22 who have been convicted of crimes. Therefore, the Legislature
23 finds and declares that this section establishes an independent
24 basis for a board to impose discipline upon a licensee, and that
25 the amendments to this section made by Senate Bill 797 of the
26 2007–08 Regular Session do not constitute a change to, but rather
27 are declaratory of, existing law.

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

30 490. ~~A~~(a) In addition to any other action that a board is
31 permitted to take against a licensee, a board may suspend or revoke
32 a license on the ground that the licensee has been convicted of a
33 crime, if the crime is substantially related to the qualifications,
34 functions, or duties of the business or profession for which the
35 license was issued. ~~A~~

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

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

3 (c) A conviction within the meaning of this section means a plea
4 or verdict of guilty or a conviction following a plea of nolo
5 contendere. Any action ~~which~~ *that* a board is permitted to take
6 following the establishment of a conviction may be taken when
7 the time for appeal has elapsed, or the judgment of conviction has
8 been affirmed on appeal, or when an order granting probation is
9 made suspending the imposition of sentence, ~~irrespective of a~~
10 ~~subsequent order under the provisions of Section 1203.4 of the~~
11 ~~Penal Code.~~

12 (d) *No license shall be suspended or revoked based solely on*
13 *any criminal conviction that has been dismissed pursuant to Section*
14 *1203.4 or 1203.4a of the Penal Code, since that dismissal creates*
15 *a presumption of rehabilitation for purposes of this section, unless*
16 *the board provides substantial evidence to the contrary in writing*
17 *to the person justifying the board's suspension or revocation of*
18 *the license based solely on his or her dismissed conviction that is*
19 *substantially related to the qualifications, functions, or duties of*
20 *the business or profession for which the license was made.*

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

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

37 SEC. 2. *Section 2006 of the Business and Professions Code is*
38 *amended to read:*

39 2006. (a) On and after January 1, 2006, any reference in this
40 chapter to an investigation by the board, or one of its divisions,

1 shall be deemed to refer to an investigation ~~conducted~~ *directed* by
2 employees of the Department of Justice.

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

8 *SEC. 3. Section 2531 of the Business and Professions Code is*
9 *amended to read:*

10 2531. There is in the Department of Consumer Affairs a
11 Speech-Language Pathology and Audiology Board in which the
12 enforcement and administration of this chapter is vested. The
13 Speech-Language Pathology and Audiology Board shall consist
14 of nine members, three of whom shall be public members.

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

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

23 2531.75. (a) The board may appoint a person exempt from
24 civil service who shall be designated as an executive officer and
25 who shall exercise the powers and perform the duties delegated
26 by the board and vested in him or her by this chapter.

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

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

34 2841. There is in the Department of Consumer Affairs a Board
35 of Vocational Nursing and Psychiatric Technicians of the State of
36 California, consisting of 11 members.

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

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

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

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

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

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

20 22259. This chapter shall be subject to the review required by
21 Division 1.2 (commencing with Section 473).

22 This chapter shall become inoperative on July 1, ~~2008~~ 2009,
23 and, as of January 1, ~~2009~~ 2010, is repealed, unless a later enacted
24 statute, which becomes effective on or before January 1, ~~2009~~
25 2010, deletes or extends that date on which it becomes inoperative
26 and is repealed.

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

30 12529. (a) There is in the Department of Justice the Health
31 Quality Enforcement Section. The primary responsibility of the
32 section is to investigate and prosecute proceedings against licensees
33 and applicants within the jurisdiction of the Medical Board of
34 California including all committees under the jurisdiction of the
35 board or a division of the board, including the Board of Podiatric
36 Medicine, and the Board of Psychology.

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

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

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

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

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

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

26 12529. (a) There is in the Department of Justice the Health
27 Quality Enforcement Section. The primary responsibility of the
28 section is to investigate and prosecute proceedings against licensees
29 and applicants within the jurisdiction of the Medical Board of
30 California ~~including all committees, the California Board of~~
31 ~~Podiatric Medicine, the Board of Psychology, or any committee~~
32 ~~under the jurisdiction of the board Medical Board of California~~
33 ~~or a division of the board, including the Board of Podiatric~~
34 ~~Medicine, and the Board of Psychology.~~

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

1 management and supervision of attorneys performing those
2 functions.

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

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

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

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

24 12529. (a) There is in the Department of Justice the Health
25 Quality Enforcement Section. The primary responsibility of the
26 section is to prosecute proceedings against licensees and applicants
27 within the jurisdiction of the Medical Board of California including
28 all committees under the jurisdiction of the board or a division of
29 the board, including the Board of Podiatric Medicine, and the
30 Board of Psychology, and to provide ongoing review of the
31 investigative activities conducted in support of those prosecutions,
32 as provided in subdivision (b) of Section 12529.5.

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

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

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

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

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

18 12529. (a) There is in the Department of Justice the Health
19 Quality Enforcement Section. The primary responsibility of the
20 section is to prosecute proceedings against licensees and applicants
21 within the jurisdiction of the Medical Board of California ~~including~~
22 ~~all committees, the California Board of Podiatric Medicine, the~~
23 ~~Board of Psychology, or any committee~~ under the jurisdiction of
24 ~~the board~~ Medical Board of California or a division of the board;
25 ~~including the Board of Podiatric Medicine, and the Board of~~
26 ~~Psychology~~, and to provide ongoing review of the investigative
27 activities conducted in support of those prosecutions, as provided
28 in subdivision (b) of Section 12529.5.

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

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

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

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

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

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

15 12529.5. (a) All complaints or relevant information concerning
16 licensees that are within the jurisdiction of the Medical Board of
17 California or the Board of Psychology shall be made available to
18 the Health Quality Enforcement Section.

19 (b) The Senior Assistant Attorney General of the Health Quality
20 Enforcement Section shall assign attorneys to work on location at
21 the intake unit of the boards described in subdivision (d) of Section
22 12529 to assist in evaluating and screening complaints and to assist
23 in developing uniform standards and procedures for processing
24 complaints.

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

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

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

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

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

6 12529.5. (a) All complaints or relevant information concerning
7 licensees that are within the jurisdiction of the Medical Board of
8 California, *the California Board of Podiatric Medicine*, or the
9 Board of Psychology shall be made available to the Health Quality
10 Enforcement Section.

11 (b) The Senior Assistant Attorney General of the Health Quality
12 Enforcement Section shall assign attorneys to work on location at
13 the intake unit of the boards described in subdivision (d) of Section
14 12529 to assist in evaluating and screening complaints and to assist
15 in developing uniform standards and procedures for processing
16 complaints.

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

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

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

35 *SEC. 24. Section 12529.5 of the Government Code, as added*
36 *by Section 27 of Chapter 674 of the Statutes of 2005, is amended*
37 *to read:*

38 12529.5. (a) All complaints or relevant information concerning
39 licensees that are within the jurisdiction of the Medical Board of

1 California or the Board of Psychology shall be made available to
2 the Health Quality Enforcement Section.

3 (b) The Senior Assistant Attorney General of the Health Quality
4 Enforcement Section shall assign attorneys to assist the division
5 and the boards in intake and investigations and to direct
6 discipline-related prosecutions. Attorneys shall be assigned to
7 work closely with each major intake and investigatory unit of the
8 boards, to assist in the evaluation and screening of complaints from
9 receipt through disposition and to assist in developing uniform
10 standards and procedures for the handling of complaints and
11 investigations.

12 A deputy attorney general of the Health Quality Enforcement
13 Section shall frequently be available on location at each of the
14 working offices at the major investigation centers of the boards,
15 to provide consultation and related services and engage in case
16 review with the boards' investigative, medical advisory, and intake
17 staff. The Senior Assistant Attorney General and deputy attorneys
18 general working at his or her direction shall consult as appropriate
19 with the investigators of the boards, medical advisors, and
20 executive staff in the investigation and prosecution of disciplinary
21 cases.

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

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

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

36 *SEC. 24.5 Section 12529.5 of the Government Code, as added*
37 *by Section 27 of Chapter 674 of the Statutes of 2005, is amended*
38 *to read:*

39 12529.5. (a) All complaints or relevant information concerning
40 licensees that are within the jurisdiction of the Medical Board of

1 California, *the California Board of Podiatric Medicine*, or the
2 Board of Psychology shall be made available to the Health Quality
3 Enforcement Section.

4 (b) The Senior Assistant Attorney General of the Health Quality
5 Enforcement Section shall assign attorneys to assist the division
6 and the boards in intake and investigations and to direct
7 discipline-related prosecutions. Attorneys shall be assigned to
8 work closely with each major intake and investigatory unit of the
9 boards, to assist in the evaluation and screening of complaints from
10 receipt through disposition and to assist in developing uniform
11 standards and procedures for the handling of complaints and
12 investigations.

13 A deputy attorney general of the Health Quality Enforcement
14 Section shall frequently be available on location at each of the
15 working offices at the major investigation centers of the boards,
16 to provide consultation and related services and engage in case
17 review with the boards' investigative, medical advisory, and intake
18 staff. The Senior Assistant Attorney General and deputy attorneys
19 general working at his or her direction shall consult as appropriate
20 with the investigators of the boards, medical advisors, and
21 executive staff in the investigation and prosecution of disciplinary
22 cases.

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

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

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

37 *SEC. 26. Section 12529.6 of the Government Code is amended*
38 *to read:*

39 12529.6. (a) The Legislature finds and declares that the
40 Medical Board of California, by ensuring the quality and safety

1 of medical care, performs one of the most critical functions of state
2 government. Because of the critical importance of the board's
3 public health and safety function, the complexity of cases involving
4 alleged misconduct by physicians and surgeons, and the evidentiary
5 burden in the board's disciplinary cases, the Legislature finds and
6 declares that using a vertical *enforcement and* prosecution model
7 for those investigations is in the best interests of the people of
8 California.

9 (b) Notwithstanding any other provision of law, as of January
10 1, 2006, each complaint that is referred to a district office of the
11 board for investigation shall be simultaneously and jointly assigned
12 to an investigator and to the deputy attorney general in the Health
13 Quality Enforcement Section responsible for prosecuting the case
14 if the investigation results in the filing of an accusation. The joint
15 assignment of the investigator and the deputy attorney general
16 shall exist for the duration of the disciplinary matter. During the
17 assignment, the investigator so assigned shall, under the direction
18 *but not the supervision* of the deputy attorney general, be
19 responsible for obtaining the evidence required to permit the
20 Attorney General to advise the board on legal matters such as
21 whether the board should file a formal accusation, dismiss the
22 complaint for a lack of evidence required to meet the applicable
23 burden of proof, or take other appropriate legal action.

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

28 (d) This section does not affect the requirements of Section
29 12529.5 as applied to the Medical Board of California where
30 complaints that have not been assigned to a field office for
31 investigation are concerned.

32 (e) *It is the intent of the Legislature to enhance the vertical*
33 *enforcement and prosecution model as set forth in subdivision (a).*
34 *The Medical Board of California shall do both of the following:*

35 (1) *Increase its computer capabilities and compatibilities with*
36 *the Health Quality Enforcement Section in order to share case*
37 *information.*

38 (2) *Establish and implement a plan to locate its enforcement*
39 *staff and the staff of the Health Quality Enforcement Section in*

1 *the same offices, as appropriate, in order to carry out the intent*
2 *of the vertical enforcement and prosecution model.*

3 ~~(e)~~

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

8 *SEC. 27. Section 12529.7 of the Government Code is amended*
9 *to read:*

10 12529.7. By July 1, ~~2007~~ 2009, the Medical Board of
11 California, in consultation with the Department of Justice, the
12 Department of Consumer Affairs, the Department of Finance, and
13 the Department of Personnel Administration, shall report and make
14 recommendations to the Governor and the Legislature on the
15 vertical enforcement and prosecution model created under Section
16 12529.6.

17 *SEC. 28. Section 1.5 of this bill incorporates amendments to*
18 *Section 490 of the Business and Professions Code proposed by*
19 *both this bill and AB 1025. It shall only become operative if (1)*
20 *both bills are enacted and become effective on or before January*
21 *1, 2008, (2) each bill amends Section 490 of the Business and*
22 *Professions Code, and (3) this bill is enacted after AB 1025, in*
23 *which case Section 1 of this bill shall not become operative.*

24 *SEC. 29. Sections 21.5 and 22.5 of this bill incorporate*
25 *amendments to Section 12529 of the Government Code proposed*
26 *by both this bill and SB 1048. They shall only become operative*
27 *if (1) both bills are enacted and become effective on or before*
28 *January 1, 2008, (2) each bill amends Section 12529 of the*
29 *Government Code, and (3) this bill is enacted after SB 1048, in*
30 *which case Sections 21 and 22 of this bill shall not become*
31 *operative.*

32 *SEC. 30. Sections 23.5 and 24.5 of this bill incorporate*
33 *amendments to Section 12529.5 of the Government Code proposed*
34 *by both this bill and SB 1048. They shall only become operative*
35 *if (1) both bills are enacted and become effective on or before*
36 *January 1, 2008, (2) each bill amends Section 12529.5 of the*
37 *Government Code, and (3) this bill is enacted after SB 1048, in*
38 *which case Sections 23 and 24 of this bill shall not become*
39 *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.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1379
Author: Ducheny
Bill Date: February 21, 2008, introduced
Subject: Loan Repayment: permanent funding source
Sponsor: Author

STATUS OF BILL:

This bill is currently on the Assembly Floor and has not been set for hearing.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would prohibit the Department of Managed Health Care (DMHC) from using fines and penalty revenues to reduce assessments levied on health care service plans and redirects these penalty revenues to the Physician Corps Loan Repayment Program.

ANALYSIS:

The Department of Managed Health Care (DMHC) regulates the operations of health plans to assure access to medical care and to protect the interests of consumers and providers. The department has an annual budget of approximately \$44 million with three hundred employees supported entirely by an assessment on licensed health plans. The department is authorized to levy fines and administrative penalties against plans for violations of the Knox-Keene Act, and under current practice, the department now deposits any resulting fine revenue into its operating budget. The fiscal effect of depositing these revenues is to reduce the assessments of health plans. Penalty revenues vary from year to year. In 2005, penalties totaled \$1.5 million, in 2006 fines generated \$ 3.3 million, and in 2007 the department collected \$ 4.8 million. At present, roughly \$2.5 million in fines are challenged by the plans and are outstanding.

This bill would redirect the fine revenue from the DMHC's budget to the Steven M. Thompson Physician Loan Repayment Program. The program has been funded from a variety of sources, currently has less than \$1 million in funding and has eligible requests for more than \$15 million.

FISCAL: None to MBC.

POSITION: Recommendation: Support

April 17, 2008

Introduced by Senator DuchenyFebruary 21, 2008

An act to amend Sections 1367.01, 1367.03, 1368, 1368.04, 1374.9, 1374.34, 1393.6, and 128555 of, and to add Section 1341.45 to, the Health and Safety Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

SB 1379, as introduced, Ducheny. Fines and penalties: physician loan repayment.

Existing law establishes the Medically Underserved Account for Physicians within the Health Professions Education Fund that is managed by the Health Professions Education Foundation and the Office of Statewide Health Planning and Development. Under existing law, the primary purpose of the account is to fund the Steven M. Thompson Physician Corps Loan Repayment Program, which provides for the repayment of educational loans, as specified, obtained by a physician and surgeon who practices in a medically underserved area of the state, as defined. Under existing law, funds placed in the account for those purposes are continuously appropriated.

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. Existing law subjects health care service plans to various fines and administrative penalties for failing to comply with specified provisions of the act and requires that certain administrative penalties be deposited in the Managed Care Fund. Existing law also requires health care service plans to pay specified assessments each fiscal year as a reimbursement of their share of the costs and expenses reasonably incurred in the administration of the act. Existing law requires the adjustment of those assessments and

other charges set forth in the act if the director of the department determines that they are in excess of the amount necessary, or are insufficient, to meet the expenses of the act.

This bill would prohibit using the fines and administrative penalties authorized by the act to reduce those assessments. The bill would also require that the fines and administrative penalties authorized pursuant to the act be paid to the Medically Underserved Account for Physicians to be used, upon appropriation by the Legislature, for the purposes of the Physician Corps Loan Repayment Program. The bill would specify that those funds are not continuously appropriated.

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 1341.45 is added to the Health and Safety
2 Code, to read:
3 1341.45. The fines and administrative penalties authorized
4 pursuant to this chapter shall be paid to the Medically Underserved
5 Account for Physicians within the Health Professions Education
6 Fund and shall, upon appropriation by the Legislature, be used for
7 the purposes of the Steven M. Thompson Physician Corps Loan
8 Repayment Program, as specified in Article 5 (commencing with
9 Section 128550) of Chapter 5 of Part 3 of Division 107 and,
10 notwithstanding Section 128555, shall not be used to provide
11 funding for the Physician Volunteer Program. Notwithstanding
12 Section 1356.1, these fines and penalties shall not be used to reduce
13 the assessments imposed on health care service plans pursuant to
14 Section 1356.
15 SEC. 2. Section 1367.01 of the Health and Safety Code is
16 amended to read:
17 1367.01. (a) A health care service plan and any entity with
18 which it contracts for services that include utilization review or
19 utilization management functions, that prospectively,
20 retrospectively, or concurrently reviews and approves, modifies,
21 delays, or denies, based in whole or in part on medical necessity,
22 requests by providers prior to, retrospectively, or concurrent with
23 the provision of health care services to enrollees, or that delegates
24 these functions to medical groups or independent practice

1 associations or to other contracting providers, shall comply with
2 this section.

3 (b) A health care service plan that is subject to this section shall
4 have written policies and procedures establishing the process by
5 which the plan prospectively, retrospectively, or concurrently
6 reviews and approves, modifies, delays, or denies, based in whole
7 or in part on medical necessity, requests by providers of health
8 care services for plan enrollees. These policies and procedures
9 shall ensure that decisions based on the medical necessity of
10 proposed health care services are consistent with criteria or
11 guidelines that are supported by clinical principles and processes.
12 These criteria and guidelines shall be developed pursuant to Section
13 1363.5. These policies and procedures, and a description of the
14 process by which the plan reviews and approves, modifies, delays,
15 or denies requests by providers prior to, retrospectively, or
16 concurrent with the provision of health care services to enrollees,
17 shall be filed with the director for review and approval, and shall
18 be disclosed by the plan to providers and enrollees upon request,
19 and by the plan to the public upon request.

20 (c) A health care service plan subject to this section, except a
21 plan that meets the requirements of Section 1351.2, shall employ
22 or designate a medical director who holds an unrestricted license
23 to practice medicine in this state issued pursuant to Section 2050
24 of the Business and Professions Code or pursuant to the
25 Osteopathic Act, or, if the plan is a specialized health care service
26 plan, a clinical director with California licensure in a clinical area
27 appropriate to the type of care provided by the specialized health
28 care service plan. The medical director or clinical director shall
29 ensure that the process by which the plan reviews and approves,
30 modifies, or denies, based in whole or in part on medical necessity,
31 requests by providers prior to, retrospectively, or concurrent with
32 the provision of health care services to enrollees, complies with
33 the requirements of this section.

34 (d) If health plan personnel, or individuals under contract to the
35 plan to review requests by providers, approve the provider's
36 request, pursuant to subdivision (b), the decision shall be
37 communicated to the provider pursuant to subdivision (h).

38 (e) No individual, other than a licensed physician or a licensed
39 health care professional who is competent to evaluate the specific
40 clinical issues involved in the health care services requested by

1 the provider, may deny or modify requests for authorization of
2 health care services for an enrollee for reasons of medical necessity.
3 The decision of the physician or other health care professional
4 shall be communicated to the provider and the enrollee pursuant
5 to subdivision (h).

6 (f) The criteria or guidelines used by the health care service
7 plan to determine whether to approve, modify, or deny requests
8 by providers prior to, retrospectively, or concurrent with, the
9 provision of health care services to enrollees shall be consistent
10 with clinical principles and processes. These criteria and guidelines
11 shall be developed pursuant to the requirements of Section 1363.5.

12 (g) If the health care service plan requests medical information
13 from providers in order to determine whether to approve, modify,
14 or deny requests for authorization, the plan shall request only the
15 information reasonably necessary to make the determination.

16 (h) In determining whether to approve, modify, or deny requests
17 by providers prior to, retrospectively, or concurrent with the
18 provision of health care services to enrollees, based in whole or
19 in part on medical necessity, a health care service plan subject to
20 this section shall meet the following requirements:

21 (1) Decisions to approve, modify, or deny, based on medical
22 necessity, requests by providers prior to, or concurrent with the
23 provision of health care services to enrollees that do not meet the
24 requirements for the 72-hour review required by paragraph (2),
25 shall be made in a timely fashion appropriate for the nature of the
26 enrollee's condition, not to exceed five business days from the
27 plan's receipt of the information reasonably necessary and
28 requested by the plan to make the determination. In cases where
29 the review is retrospective, the decision shall be communicated to
30 the individual who received services, or to the individual's
31 designee, within 30 days of the receipt of information that is
32 reasonably necessary to make this determination, and shall be
33 communicated to the provider in a manner that is consistent with
34 current law. For purposes of this section, retrospective reviews
35 shall be for care rendered on or after January 1, 2000.

36 (2) When the enrollee's condition is such that the enrollee faces
37 an imminent and serious threat to his or her health, including, but
38 not limited to, the potential loss of life, limb, or other major bodily
39 function, or the normal timeframe for the decisionmaking process,
40 as described in paragraph (1), would be detrimental to the enrollee's

1 life or health or could jeopardize the enrollee's ability to regain
2 maximum function, decisions to approve, modify, or deny requests
3 by providers prior to, or concurrent with, the provision of health
4 care services to enrollees, shall be made in a timely fashion
5 appropriate for the nature of the enrollee's condition, not to exceed
6 72 hours after the plan's receipt of the information reasonably
7 necessary and requested by the plan to make the determination.
8 Nothing in this section shall be construed to alter the requirements
9 of subdivision (b) of Section 1371.4. Notwithstanding Section
10 1371.4, the requirements of this division shall be applicable to all
11 health plans and other entities conducting utilization review or
12 utilization management.

13 (3) Decisions to approve, modify, or deny requests by providers
14 for authorization prior to, or concurrent with, the provision of
15 health care services to enrollees shall be communicated to the
16 requesting provider within 24 hours of the decision. Except for
17 concurrent review decisions pertaining to care that is underway,
18 which shall be communicated to the enrollee's treating provider
19 within 24 hours, decisions resulting in denial, delay, or
20 modification of all or part of the requested health care service shall
21 be communicated to the enrollee in writing within two business
22 days of the decision. In the case of concurrent review, care shall
23 not be discontinued until the enrollee's treating provider has been
24 notified of the plan's decision and a care plan has been agreed
25 upon by the treating provider that is appropriate for the medical
26 needs of that patient.

27 (4) Communications regarding decisions to approve requests
28 by providers prior to, retrospectively, or concurrent with the
29 provision of health care services to enrollees shall specify the
30 specific health care service approved. Responses regarding
31 decisions to deny, delay, or modify health care services requested
32 by providers prior to, retrospectively, or concurrent with the
33 provision of health care services to enrollees shall be
34 communicated to the enrollee in writing, and to providers initially
35 by telephone or facsimile, except with regard to decisions rendered
36 retrospectively, and then in writing, and shall include a clear and
37 concise explanation of the reasons for the plan's decision, a
38 description of the criteria or guidelines used, and the clinical
39 reasons for the decisions regarding medical necessity. Any written
40 communication to a physician or other health care provider of a

1 denial, delay, or modification of a request shall include the name
2 and telephone number of the health care professional responsible
3 for the denial, delay, or modification. The telephone number
4 provided shall be a direct number or an extension, to allow the
5 physician or health care provider easily to contact the professional
6 responsible for the denial, delay, or modification. Responses shall
7 also include information as to how the enrollee may file a grievance
8 with the plan pursuant to Section 1368, and in the case of Medi-Cal
9 enrollees, shall explain how to request an administrative hearing
10 and aid paid pending under Sections 51014.1 and 51014.2 of Title
11 22 of the California Code of Regulations.

12 (5) If the health care service plan cannot make a decision to
13 approve, modify, or deny the request for authorization within the
14 timeframes specified in paragraph (1) or (2) because the plan is
15 not in receipt of all of the information reasonably necessary and
16 requested, or because the plan requires consultation by an expert
17 reviewer, or because the plan has asked that an additional
18 examination or test be performed upon the enrollee, provided the
19 examination or test is reasonable and consistent with good medical
20 practice, the plan shall, immediately upon the expiration of the
21 timeframe specified in paragraph (1) or (2) or as soon as the plan
22 becomes aware that it will not meet the timeframe, whichever
23 occurs first, notify the provider and the enrollee, in writing, that
24 the plan cannot make a decision to approve, modify, or deny the
25 request for authorization within the required timeframe, and specify
26 the information requested but not received, or the expert reviewer
27 to be consulted, or the additional examinations or tests required.
28 The plan shall also notify the provider and enrollee of the
29 anticipated date on which a decision may be rendered. Upon receipt
30 of all information reasonably necessary and requested by the plan,
31 the plan shall approve, modify, or deny the request for authorization
32 within the timeframes specified in paragraph (1) or (2), whichever
33 applies.

34 (6) If the director determines that a health care service plan has
35 failed to meet any of the timeframes in this section, or has failed
36 to meet any other requirement of this section, the director may
37 assess, by order, administrative penalties for each failure. A
38 proceeding for the issuance of an order assessing administrative
39 penalties shall be subject to appropriate notice to, and an
40 opportunity for a hearing with regard to, the person affected, in

1 accordance with subdivision (a) of Section 1397. The
2 administrative penalties shall not be deemed an exclusive remedy
3 for the director. ~~These penalties shall be paid to the State Managed~~
4 ~~Care Fund.~~

5 (i) A health care service plan subject to this section shall
6 maintain telephone access for providers to request authorization
7 for health care services.

8 (j) A health care service plan subject to this section that reviews
9 requests by providers prior to, retrospectively, or concurrent with,
10 the provision of health care services to enrollees shall establish,
11 as part of the quality assurance program required by Section 1370,
12 a process by which the plan's compliance with this section is
13 assessed and evaluated. The process shall include provisions for
14 evaluation of complaints, assessment of trends, implementation
15 of actions to correct identified problems, mechanisms to
16 communicate actions and results to the appropriate health plan
17 employees and contracting providers, and provisions for evaluation
18 of any corrective action plan and measurements of performance.

19 (k) The director shall review a health care service plan's
20 compliance with this section as part of its periodic onsite medical
21 survey of each plan undertaken pursuant to Section 1380, and shall
22 include a discussion of compliance with this section as part of its
23 report issued pursuant to that section.

24 (l) This section shall not apply to decisions made for the care
25 or treatment of the sick who depend upon prayer or spiritual means
26 for healing in the practice of religion as set forth in subdivision
27 (a) of Section 1270.

28 (m) Nothing in this section shall cause a health care service plan
29 to be defined as a health care provider for purposes of any provision
30 of law, including, but not limited to, Section 6146 of the Business
31 and Professions Code, Sections 3333.1 and 3333.2 of the Civil
32 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the
33 Code of Civil Procedure.

34 SEC. 3. Section 1367.03 of the Health and Safety Code is
35 amended to read:

36 1367.03. (a) Not later than January 1, 2004, the department
37 shall develop and adopt regulations to ensure that enrollees have
38 access to needed health care services in a timely manner. In
39 developing these regulations, the department shall develop

1 indicators of timeliness of access to care and, in so doing, shall
2 consider the following as indicators of timeliness of access to care:

3 (1) Waiting times for appointments with physicians, including
4 primary care and specialty physicians.

5 (2) Timeliness of care in an episode of illness, including the
6 timeliness of referrals and obtaining other services, if needed.

7 (3) Waiting time to speak to a physician, registered nurse, or
8 other qualified health professional acting within his or her scope
9 of practice who is trained to screen or triage an enrollee who may
10 need care.

11 (b) In developing these standards for timeliness of access, the
12 department shall consider the following:

13 (1) Clinical appropriateness.

14 (2) The nature of the specialty.

15 (3) The urgency of care.

16 (4) The requirements of other provisions of law, including
17 Section 1367.01 governing utilization review, that may affect
18 timeliness of access.

19 (c) The department may adopt standards other than the time
20 elapsed between the time an enrollee seeks health care and obtains
21 care. If the department chooses a standard other than the time
22 elapsed between the time an enrollee first seeks health care and
23 obtains it, the department shall demonstrate why that standard is
24 more appropriate. In developing these standards, the department
25 shall consider the nature of the plan network.

26 (d) The department shall review and adopt standards, as needed,
27 concerning the availability of primary care physicians, specialty
28 physicians, hospital care, and other health care, so that consumers
29 have timely access to care. In so doing, the department shall
30 consider the nature of physician practices, including individual
31 and group practices as well as the nature of the plan network. The
32 department shall also consider various circumstances affecting the
33 delivery of care, including urgent care, care provided on the same
34 day, and requests for specific providers. If the department finds
35 that health care service plans and health care providers have
36 difficulty meeting these standards, the department may make
37 recommendations to the Assembly Committee on Health and the
38 Senate Committee on Insurance of the Legislature pursuant to
39 subdivision (i).

1 (e) In developing standards under subdivision (a), the department
2 shall consider requirements under federal law, requirements under
3 other state programs, standards adopted by other states, nationally
4 recognized accrediting organizations, and professional associations.
5 The department shall further consider the needs of rural areas,
6 specifically those in which health facilities are more than 30 miles
7 apart and any requirements imposed by the State Department of
8 Health *Care* Services on health care service plans that contract
9 with the State Department of Health *Care* Services to provide
10 Medi-Cal managed care.

11 (f) (1) Contracts between health care service plans and health
12 care providers shall assure compliance with the standards
13 developed under this section. These contracts shall require
14 reporting by health care providers to health care service plans and
15 by health care service plans to the department to ensure compliance
16 with the standards.

17 (2) Health care service plans shall report annually to the
18 department on compliance with the standards in a manner specified
19 by the department. The reported information shall allow consumers
20 to compare the performance of plans and their contracting providers
21 in complying with the standards, as well as changes in the
22 compliance of plans with these standards.

23 (g) (1) When evaluating compliance with the standards, the
24 department shall focus more upon patterns of noncompliance rather
25 than isolated episodes of noncompliance.

26 (2) The director may investigate and take enforcement action
27 against plans regarding noncompliance with the requirements of
28 this section. Where substantial harm to an enrollee has occurred
29 as a result of plan noncompliance, the director may, by order,
30 assess administrative penalties subject to appropriate notice of,
31 and the opportunity for, a hearing in accordance with Section 1397.
32 The plan may provide to the director, and the director may
33 consider, information regarding the plan's overall compliance with
34 the requirements of this section. The administrative penalties shall
35 not be deemed an exclusive remedy available to the director. ~~These~~
36 ~~penalties shall be paid to the State Managed Care Fund.~~ The
37 director shall periodically evaluate grievances to determine if any
38 audit, investigative, or enforcement actions should be undertaken
39 by the department.

1 (3) The director may, after appropriate notice and opportunity
2 for hearing in accordance with Section 1397, by order, assess
3 administrative penalties if the director determines that a health
4 care service plan has knowingly committed, or has performed with
5 a frequency that indicates a general business practice, either of the
6 following:

7 (A) Repeated failure to act promptly and reasonably to assure
8 timely access to care consistent with this chapter.

9 (B) Repeated failure to act promptly and reasonably to require
10 contracting providers to assure timely access that the plan is
11 required to perform under this chapter and that have been delegated
12 by the plan to the contracting provider when the obligation of the
13 plan to the enrollee or subscriber is reasonably clear.

14 (C) The administrative penalties available to the director
15 pursuant to this section are not exclusive, and may be sought and
16 employed in any combination with civil, criminal, and other
17 administrative remedies deemed warranted by the director to
18 enforce this chapter.

19 ~~(4) The administrative penalties authorized pursuant to this~~
20 ~~section shall be paid to the State Managed Care Fund.~~

21 (h) The department shall work with the patient advocate to
22 assure that the quality of care report card incorporates information
23 provided pursuant to subdivision (f) regarding the degree to which
24 health care service plans and health care providers comply with
25 the requirements for timely access to care.

26 (i) The department shall report to the Assembly Committee on
27 Health and the Senate Committee on Insurance of the Legislature
28 on March 1, 2003, and on March 1, 2004, regarding the progress
29 toward the implementation of this section.

30 (j) Every three years, the department shall review information
31 regarding compliance with the standards developed under this
32 section and shall make recommendations for changes that further
33 protect enrollees.

34 SEC. 4. Section 1368 of the Health and Safety Code is amended
35 to read:

36 1368. (a) Every plan shall do all of the following:

37 (1) Establish and maintain a grievance system approved by the
38 department under which enrollees may submit their grievances to
39 the plan. Each system shall provide reasonable procedures in
40 accordance with department regulations that shall ensure adequate

1 consideration of enrollee grievances and rectification when
2 appropriate.

3 (2) Inform its subscribers and enrollees upon enrollment in the
4 plan and annually thereafter of the procedure for processing and
5 resolving grievances. The information shall include the location
6 and telephone number where grievances may be submitted.

7 (3) Provide forms for grievances to be given to subscribers and
8 enrollees who wish to register written grievances. The forms used
9 by plans licensed pursuant to Section 1353 shall be approved by
10 the director in advance as to format.

11 (4) (A) Provide for a written acknowledgment within five
12 calendar days of the receipt of a grievance, except as noted in
13 subparagraph (B). The acknowledgment shall advise the
14 complainant of the following:

15 (i) That the grievance has been received.

16 (ii) The date of receipt.

17 (iii) The name of the plan representative and the telephone
18 number and address of the plan representative who may be
19 contacted about the grievance.

20 (B) Grievances received by telephone, by facsimile, by e-mail,
21 or online through the plan's Web site pursuant to Section 1368.015,
22 that are not coverage disputes, disputed health care services
23 involving medical necessity, or experimental or investigational
24 treatment and that are resolved by the next business day following
25 receipt are exempt from the requirements of subparagraph (A) and
26 paragraph (5). The plan shall maintain a log of all these grievances.
27 The log shall be periodically reviewed by the plan and shall include
28 the following information for each complaint:

29 (i) The date of the call.

30 (ii) The name of the complainant.

31 (iii) The complainant's member identification number.

32 (iv) The nature of the grievance.

33 (v) The nature of the resolution.

34 (vi) The name of the plan representative who took the call and
35 resolved the grievance.

36 (5) Provide subscribers and enrollees with written responses to
37 grievances, with a clear and concise explanation of the reasons for
38 the plan's response. For grievances involving the delay, denial, or
39 modification of health care services, the plan response shall
40 describe the criteria used and the clinical reasons for its decision,

1 including all criteria and clinical reasons related to medical
2 necessity. If a plan, or one of its contracting providers, issues a
3 decision delaying, denying, or modifying health care services based
4 in whole or in part on a finding that the proposed health care
5 services are not a covered benefit under the contract that applies
6 to the enrollee, the decision shall clearly specify the provisions in
7 the contract that exclude that coverage.

8 (6) Keep in its files all copies of grievances, and the responses
9 thereto, for a period of five years.

10 (b) (1) (A) After either completing the grievance process
11 described in subdivision (a), or participating in the process for at
12 least 30 days, a subscriber or enrollee may submit the grievance
13 to the department for review. In any case determined by the
14 department to be a case involving an imminent and serious threat
15 to the health of the patient, including, but not limited to, severe
16 pain, the potential loss of life, limb, or major bodily function, or
17 in any other case where the department determines that an earlier
18 review is warranted, a subscriber or enrollee shall not be required
19 to complete the grievance process or to participate in the process
20 for at least 30 days before submitting a grievance to the department
21 for review.

22 (B) A grievance may be submitted to the department for review
23 and resolution prior to any arbitration.

24 (C) Notwithstanding subparagraphs (A) and (B), the department
25 may refer any grievance that does not pertain to compliance with
26 this chapter to the State Department of Health Services, the
27 California Department of Aging, the federal Health Care Financing
28 Administration, or any other appropriate governmental entity for
29 investigation and resolution.

30 (2) If the subscriber or enrollee is a minor, or is incompetent or
31 incapacitated, the parent, guardian, conservator, relative, or other
32 designee of the subscriber or enrollee, as appropriate, may submit
33 the grievance to the department as the agent of the subscriber or
34 enrollee. Further, a provider may join with, or otherwise assist, a
35 subscriber or enrollee, or the agent, to submit the grievance to the
36 department. In addition, following submission of the grievance to
37 the department, the subscriber or enrollee, or the agent, may
38 authorize the provider to assist, including advocating on behalf of
39 the subscriber or enrollee. For purposes of this section, a “relative”
40 includes the parent, stepparent, spouse, adult son or daughter,

1 grandparent, brother, sister, uncle, or aunt of the subscriber or
2 enrollee.

3 (3) The department shall review the written documents submitted
4 with the subscriber's or the enrollee's request for review, or
5 submitted by the agent on behalf of the subscriber or enrollee. The
6 department may ask for additional information, and may hold an
7 informal meeting with the involved parties, including providers
8 who have joined in submitting the grievance or who are otherwise
9 assisting or advocating on behalf of the subscriber or enrollee. If
10 after reviewing the record, the department concludes that the
11 grievance, in whole or in part, is eligible for review under the
12 independent medical review system established pursuant to Article
13 5.55 (commencing with Section 1374.30), the department shall
14 immediately notify the subscriber or enrollee, or agent, of that
15 option and shall, if requested orally or in writing, assist the
16 subscriber or enrollee in participating in the independent medical
17 review system.

18 (4) If after reviewing the record of a grievance, the department
19 concludes that a health care service eligible for coverage and
20 payment under a health care service plan contract has been delayed,
21 denied, or modified by a plan, or by one of its contracting
22 providers, in whole or in part due to a determination that the service
23 is not medically necessary, and that determination was not
24 communicated to the enrollee in writing along with a notice of the
25 enrollee's potential right to participate in the independent medical
26 review system, as required by this chapter, the director shall, by
27 order, assess administrative penalties. A proceeding for the issuance
28 of an order assessing administrative penalties shall be subject to
29 appropriate notice of, and the opportunity for, a hearing with regard
30 to the person affected in accordance with Section 1397. The
31 administrative penalties shall not be deemed an exclusive remedy
32 available to the director. ~~These penalties shall be paid to the State~~
33 ~~Managed Care Fund.~~

34 (5) The department shall send a written notice of the final
35 disposition of the grievance, and the reasons therefor, to the
36 subscriber or enrollee, the agent, to any provider that has joined
37 with or is otherwise assisting the subscriber or enrollee, and to the
38 plan, within 30 calendar days of receipt of the request for review
39 unless the director, in his or her discretion, determines that
40 additional time is reasonably necessary to fully and fairly evaluate

1 the relevant grievance. In any case not eligible for the independent
2 medical review system established pursuant to Article 5.55
3 (commencing with Section 1374.30), the department's written
4 notice shall include, at a minimum, the following:

5 (A) A summary of its findings and the reasons why the
6 department found the plan to be, or not to be, in compliance with
7 any applicable laws, regulations, or orders of the director.

8 (B) A discussion of the department's contact with any medical
9 provider, or any other independent expert relied on by the
10 department, along with a summary of the views and qualifications
11 of that provider or expert.

12 (C) If the enrollee's grievance is sustained in whole or part,
13 information about any corrective action taken.

14 (6) In any department review of a grievance involving a disputed
15 health care service, as defined in subdivision (b) of Section
16 1374.30, that is not eligible for the independent medical review
17 system established pursuant to Article 5.55 (commencing with
18 Section 1374.30), in which the department finds that the plan has
19 delayed, denied, or modified health care services that are medically
20 necessary, based on the specific medical circumstances of the
21 enrollee, and those services are a covered benefit under the terms
22 and conditions of the health care service plan contract, the
23 department's written notice shall do either of the following:

24 (A) Order the plan to promptly offer and provide those health
25 care services to the enrollee.

26 (B) Order the plan to promptly reimburse the enrollee for any
27 reasonable costs associated with urgent care or emergency services,
28 or other extraordinary and compelling health care services, when
29 the department finds that the enrollee's decision to secure those
30 services outside of the plan network was reasonable under the
31 circumstances.

32 The department's order shall be binding on the plan.

33 (7) Distribution of the written notice shall not be deemed a
34 waiver of any exemption or privilege under existing law, including,
35 but not limited to, Section 6254.5 of the Government Code, for
36 any information in connection with and including the written
37 notice, nor shall any person employed or in any way retained by
38 the department be required to testify as to that information or
39 notice.

1 (8) The director shall establish and maintain a system of aging
2 of grievances that are pending and unresolved for 30 days or more
3 that shall include a brief explanation of the reasons each grievance
4 is pending and unresolved for 30 days or more.

5 (9) A subscriber or enrollee, or the agent acting on behalf of a
6 subscriber or enrollee, may also request voluntary mediation with
7 the plan prior to exercising the right to submit a grievance to the
8 department. The use of mediation services shall not preclude the
9 right to submit a grievance to the department upon completion of
10 mediation. In order to initiate mediation, the subscriber or enrollee,
11 or the agent acting on behalf of the subscriber or enrollee, and the
12 plan shall voluntarily agree to mediation. Expenses for mediation
13 shall be borne equally by both sides. The department shall have
14 no administrative or enforcement responsibilities in connection
15 with the voluntary mediation process authorized by this paragraph.

16 (c) The plan's grievance system shall include a system of aging
17 of grievances that are pending and unresolved for 30 days or more.
18 The plan shall provide a quarterly report to the director of
19 grievances pending and unresolved for 30 or more days with
20 separate categories of grievances for Medicare enrollees and
21 Medi-Cal enrollees. The plan shall include with the report a brief
22 explanation of the reasons each grievance is pending and
23 unresolved for 30 days or more. The plan may include the
24 following statement in the quarterly report that is made available
25 to the public by the director:

26 "Under Medicare and Medi-Cal law, Medicare enrollees and
27 Medi-Cal enrollees each have separate avenues of appeal that
28 are not available to other enrollees. Therefore, grievances
29 pending and unresolved may reflect enrollees pursuing their
30 Medicare or Medi-Cal appeal rights."

31 If requested by a plan, the director shall include this statement in
32 a written report made available to the public and prepared by the
33 director that describes or compares grievances that are pending
34 and unresolved with the plan for 30 days or more. Additionally,
35 the director shall, if requested by a plan, append to that written
36 report a brief explanation, provided in writing by the plan, of the
37 reasons why grievances described in that written report are pending
38 and unresolved for 30 days or more. The director shall not be
39 required to include a statement or append a brief explanation to a

1 written report that the director is required to prepare under this
2 chapter, including Sections 1380 and 1397.5.

3 (d) Subject to subparagraph (C) of paragraph (1) of subdivision
4 (b), the grievance or resolution procedures authorized by this
5 section shall be in addition to any other procedures that may be
6 available to any person, and failure to pursue, exhaust, or engage
7 in the procedures described in this section shall not preclude the
8 use of any other remedy provided by law.

9 (e) Nothing in this section shall be construed to allow the
10 submission to the department of any provider grievance under this
11 section. However, as part of a provider's duty to advocate for
12 medically appropriate health care for his or her patients pursuant
13 to Sections 510 and 2056 of the Business and Professions Code,
14 nothing in this subdivision shall be construed to prohibit a provider
15 from contacting and informing the department about any concerns
16 he or she has regarding compliance with or enforcement of this
17 chapter.

18 SEC. 5. Section 1368.04 of the Health and Safety Code is
19 amended to read:

20 1368.04. (a) The director shall investigate and take
21 enforcement action against plans regarding grievances reviewed
22 and found by the department to involve noncompliance with the
23 requirements of this chapter, including grievances that have been
24 reviewed pursuant to the independent medical review system
25 established pursuant to Article 5.55 (commencing with Section
26 1374.30). Where substantial harm to an enrollee has occurred as
27 a result of plan noncompliance, the director shall, by order, assess
28 administrative penalties subject to appropriate notice of, and the
29 opportunity for, a hearing with regard to the person affected in
30 accordance with Section 1397. The administrative penalties shall
31 not be deemed an exclusive remedy available to the director. ~~These~~
32 ~~penalties shall be paid to the State Managed Care Fund.~~ The
33 director shall periodically evaluate grievances to determine if any
34 audit, investigative, or enforcement actions should be undertaken
35 by the department.

36 (b) The director may, after appropriate notice and opportunity
37 for hearing in accordance with Section 1397, by order, assess
38 administrative penalties if the director determines that a health
39 care service plan has knowingly committed, or has performed with

1 a frequency that indicates a general business practice, either of the
2 following:

3 (1) Repeated failure to act promptly and reasonably to
4 investigate and resolve grievances in accordance with Section
5 1368.01.

6 (2) Repeated failure to act promptly and reasonably to resolve
7 grievances when the obligation of the plan to the enrollee or
8 subscriber is reasonably clear.

9 (c) The administrative penalties available to the director pursuant
10 to this section are not exclusive, and may be sought and employed
11 in any combination with civil, criminal, and other administrative
12 remedies deemed warranted by the director to enforce this chapter.

13 ~~(d) The administrative penalties authorized pursuant to this
14 section shall be paid to the State Managed Care Fund.~~

15 SEC. 6. Section 1374.9 of the Health and Safety Code is
16 amended to read:

17 1374.9. For violations of Section 1374.7, the director may,
18 after appropriate notice and opportunity for hearing, by order, levy
19 administrative penalties as follows:

20 (a) Any health care service plan that violates Section 1374.7,
21 or that violates any rule or order adopted or issued pursuant to this
22 section, is liable for administrative penalties of not less than two
23 thousand five hundred dollars (\$2,500) for each first violation, and
24 of not less than five thousand dollars (\$5,000) nor more than ten
25 thousand dollars (\$10,000) for each second violation, and of not
26 less than fifteen thousand dollars (\$15,000) and not more than one
27 hundred thousand dollars (\$100,000) for each subsequent violation.

28 ~~(b) The administrative penalties shall be paid to the Managed
29 Health Care Fund.~~

30 ~~(c)~~

31 (b) The administrative penalties available to the director pursuant
32 to this section are not exclusive, and may be sought and employed
33 in any combination with civil, criminal, and other administrative
34 remedies deemed advisable by the director to enforce the provisions
35 of this chapter.

36 SEC. 7. Section 1374.34 of the Health and Safety Code is
37 amended to read:

38 1374.34. (a) Upon receiving the decision adopted by the
39 director pursuant to Section 1374.33 that a disputed health care
40 service is medically necessary, the plan shall promptly implement

1 the decision. In the case of reimbursement for services already
2 rendered, the plan shall reimburse the provider or enrollee,
3 whichever applies, within five working days. In the case of services
4 not yet rendered, the plan shall authorize the services within five
5 working days of receipt of the written decision from the director,
6 or sooner if appropriate for the nature of the enrollee's medical
7 condition, and shall inform the enrollee and provider of the
8 authorization in accordance with the requirements of paragraph
9 (3) of subdivision (h) of Section 1367.01.

10 (b) A plan shall not engage in any conduct that has the effect
11 of prolonging the independent review process. The engaging in
12 that conduct or the failure of the plan to promptly implement the
13 decision is a violation of this chapter and, in addition to any other
14 fines, penalties, and other remedies available to the director under
15 this chapter, the plan shall be subject to an administrative penalty
16 of not less than five thousand dollars (\$5,000) for each day that
17 the decision is not implemented. ~~Administrative penalties shall be
18 deposited in the State Managed Care Fund.~~

19 (c) The director shall require the plan to promptly reimburse
20 the enrollee for any reasonable costs associated with those services
21 when the director finds that the disputed health care services were
22 a covered benefit under the terms and conditions of the health care
23 service plan contract, and the services are found by the independent
24 medical review organization to have been medically necessary
25 pursuant to Section 1374.33, and either the enrollee's decision to
26 secure the services outside of the plan provider network was
27 reasonable under the emergency or urgent medical circumstances,
28 or the health care service plan contract does not require or provide
29 prior authorization before the health care services are provided to
30 the enrollee.

31 (d) In addition to requiring plan compliance regarding
32 subdivisions (a), (b), and (c) the director shall review individual
33 cases submitted for independent medical review to determine
34 whether any enforcement actions, including penalties, may be
35 appropriate. In particular, where substantial harm, as defined in
36 Section 3428 of the Civil Code, to an enrollee has already occurred
37 because of the decision of a plan, or one of its contracting
38 providers, to delay, deny, or modify covered health care services
39 that an independent medical review determines to be medically

1 necessary pursuant to Section 1374.33, the director shall impose
2 penalties.

3 (e) Pursuant to Section 1368.04, the director shall perform an
4 annual audit of independent medical review cases for the dual
5 purposes of education and the opportunity to determine if any
6 investigative or enforcement actions should be undertaken by the
7 department, particularly if a plan repeatedly fails to act promptly
8 and reasonably to resolve grievances associated with a delay,
9 denial, or modification of medically necessary health care services
10 when the obligation of the plan to provide those health care services
11 to enrollees or subscribers is reasonably clear.

12 SEC. 8. Section 1393.6 of the Health and Safety Code is
13 amended to read:

14 1393.6. For violations of Article 3.1 (commencing with Section
15 1357) and Article 3.15 (commencing with Section 1357.50), the
16 director may, after appropriate notice and opportunity for hearing,
17 by order levy administrative penalties as follows:

18 (a) Any person, solicitor, or solicitor firm, other than a health
19 care service plan, who willfully violates any provision of this
20 chapter, or who willfully violates any rule or order adopted or
21 issued pursuant to this chapter, is liable for administrative penalties
22 of not less than two hundred fifty dollars (\$250) for each first
23 violation, and of not less than one thousand dollars (\$1,000) and
24 not more than two thousand five hundred dollars (\$2,500) for each
25 subsequent violation.

26 (b) Any health care service plan that willfully violates any
27 provision of this chapter, or that willfully violates any rule or order
28 adopted or issued pursuant to this chapter, is liable for
29 administrative penalties of not less than two thousand five hundred
30 dollars (\$2,500) for each first violation, and of not less than five
31 thousand dollars (\$5,000) nor more than ten thousand dollars
32 (\$10,000) for each second violation, and of not less than fifteen
33 thousand dollars (\$15,000) and not more than one hundred
34 thousand dollars (\$100,000) for each subsequent violation.

35 ~~(c) The administrative penalties shall be paid to the Managed
36 Health Care Fund.~~

37 ~~(d)~~

38 (c) The administrative penalties available to the director pursuant
39 to this section are not exclusive, and may be sought and employed
40 in any combination with civil, criminal, and other administrative

1 remedies deemed advisable by the director to enforce the provisions
2 of this chapter.

3 SEC. 9. Section 128555 of the Health and Safety Code is
4 amended to read:

5 128555. (a) The Medically Underserved Account for
6 Physicians is hereby established within the Health Professions
7 Education Fund. The primary purpose of this account is to provide
8 funding for the ongoing operations of the Steven M. Thompson
9 Physician Corps Loan Repayment Program provided for under
10 this article. This account also may be used to provide funding for
11 the Physician Volunteer Program provided for under this article.

12 (b) All moneys in the Medically Underserved Account contained
13 within the Contingent Fund of the Medical Board of California
14 shall be transferred to the Medically Underserved Account for
15 Physicians on July 1, 2006.

16 (c) Funds in the account shall be used to repay loans as follows
17 per agreements made with physicians:

18 (1) Funds paid out for loan repayment may have a funding match
19 from foundations or other private sources.

20 (2) Loan repayments may not exceed one hundred five thousand
21 dollars (\$105,000) per individual licensed physician.

22 (3) Loan repayments may not exceed the amount of the
23 educational loans incurred by the physician participant.

24 (d) Notwithstanding Section 11105 of the Government Code,
25 effective January 1, 2006, the foundation may seek and receive
26 matching funds from foundations and private sources to be placed
27 in the account. "Matching funds" shall not be construed to be
28 limited to a dollar-for-dollar match of funds.

29 (e) Funds placed in the account for purposes of this article,
30 including funds received pursuant to subdivision (d), are,
31 notwithstanding Section 13340 of the Government Code,
32 continuously appropriated for the repayment of loans. *This*
33 *subdivision shall not apply to funds placed in the account pursuant*
34 *to Section 1341.45.*

35 (f) The account shall also be used to pay for the cost of
36 administering the program and for any other purpose authorized
37 by this article. The costs for administration of the program may
38 be up to 5 percent of the total state appropriation for the program
39 and shall be subject to review and approval annually through the

1 state budget process. This limitation shall only apply to the state
2 appropriation for the program.
3 (g) The office and the foundation shall manage the account
4 established by this section prudently in accordance with the other
5 provisions of law.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1394
Author: Lowenthal
Bill Date: April 15, 2008, amended
Subject: Lapses of Consciousness: reports to DMV
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee and has not been set for hearing.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize a physician to report to the Department of Motor Vehicles (DMV) specified information relating to a patient whom the physician has diagnosed as having suffered a lapse of consciousness. This would be reported if the physician reasonably believes that reporting the patient will serve the public interest. This bill exempts physicians from civil and criminal liability for making these reports. The DMV would be required, upon receiving a report from a physician pursuant to this bill, to reexamine the person's qualifications to operate a vehicle and make a determination whether to restrict, make subject to terms and conditions of probation, revoke, or suspend a license based on the assessment by the reporting physician.

ANALYSIS:

Current law requires physicians to report in writing immediately to the local health officer any patient at least 14 years of age or older who the physician has diagnosed as having a disorder characterized by lapses of consciousness. The Department of Public Health (DPH) defines disorders characterized by lapses of consciousness. The local health officers are responsible for reporting the information received from physicians regarding patient diagnoses of disorders characterized by lapses of consciousness to the DMV.

This bill would instead require physicians to report directly to the DMV the specified information relating to patients whom the physician has diagnosed as having suffered a lapse of consciousness. The physician only need report if, in his or her professional judgment, the risk of reoccurrence. Thus reporting the patient will serve the public interest.

The bill specified conditions when reporting is not necessary.

In addition, this bill would require physicians to report to the DMV, in writing, regarding patients the physician has diagnosed with Alzheimer's disease and another dementia disorder.

This bill would exempt physician from civil and criminal liability for making a report authorized or required by this bill.

The provisions of this bill would commence January 1, 2010 and the DMV would be required to develop physician reporting forms on or before July 1 2009 and adopt regulations by January 1, 2010 that define disorders characterized by recurrent lapses of consciousness and listing those disorders that do not require reporting under this bill.

FISCAL: None

POSITION: Recommendation: Support

April 17, 2008

AMENDED IN SENATE APRIL 15, 2008

AMENDED IN SENATE APRIL 3, 2008

SENATE BILL

No. 1394

Introduced by Senator Lowenthal

February 21, 2008

An act to repeal Section 103900 of the Health and Safety Code, and to amend Section 12818 of, and to add Article 6 (commencing with Section 13010) to Chapter 1 of Division 6 of, the Vehicle Code, relating to lapses in consciousness.

LEGISLATIVE COUNSEL'S DIGEST

SB 1394, as amended, Lowenthal. Lapses of consciousness: reports to the Department of Motor Vehicles.

Under existing law, a physician and surgeon is required to report in writing immediately to the local health officer, the name, date of birth, and address of every patient at least 14 years of age or older whom the physician and surgeon has diagnosed as having a disorder characterized by lapses of consciousness. Existing law requires the State Department of Public Health, in cooperation with the Department of Motor Vehicles, to define disorders characterized by lapses of consciousness, and to include within the defined disorders Alzheimer's disease and related disorders that are severe enough to be likely to impair a person's ability to operate a motor vehicle. Existing law further requires the local health officer to provide this information to the Department of Motor Vehicles, for the information of that department in enforcing the Vehicle Code.

This bill would delete these existing provisions and instead would authorize a physician and surgeon to report to the Department of Motor Vehicles (DMV), in good faith, specified information relating to a patient at least 15 years of age, or 14 years of age if the patient has a

junior permit, whom the physician and surgeon has diagnosed as having suffered a lapse of consciousness, if the physician and surgeon reasonably believes that reporting the patient will serve the public interest.

This bill, commencing with January 1, 2010, would require a physician and surgeon to report specified information to the DMV, in writing, regarding certain patients the physician and surgeon has diagnosed with Alzheimer's disease or another dementia disorder, or with a disorder characterized by lapses of consciousness within the previous 6 months, as specified. The bill would excuse a physician and surgeon from these mandatory reporting requirements relating to lapse of consciousness disorders under designated circumstances.

This bill would exempt a physician and surgeon from civil and criminal liability for making a report authorized or required by the bill. The bill, commencing January 1, 2010, would require the DMV, upon receipt of a report made pursuant to the bill, to reexamine the person's qualifications to operate a vehicle, as prescribed, and make a determination whether to restrict, make subject to terms and conditions of probation, revoke, or suspend a license based on the evaluation, reexamination, and assessment provided by the reporting physician.

This bill would require the DMV to develop physician reporting forms on or before July 1, 2009, and, in cooperation with the State Department of Public Health and in consultation with appropriate professional medical organizations, to adopt regulations by January 1, 2010, defining disorders characterized by recurrent lapses of consciousness and listing those disorders that do not require reporting under the bill.

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 103900 of the Health and Safety Code
- 2 is repealed.
- 3 SEC. 2. Section 12818 of the Vehicle Code, as amended by
- 4 Section 13 of Chapter 985 of the Statutes of 2000, is amended to
- 5 read:
- 6 12818. (a) Upon receipt of a request for reexamination and
- 7 presentation of a legible copy of a notice of reexamination by a
- 8 person issued the notice pursuant to Section 21061, or upon receipt
- 9 of a report from a local health officer issued pursuant to subdivision

1 (b) of Section 103900 of the Health and Safety Code, the
2 department shall reexamine the person's qualifications to operate
3 a motor vehicle, including a demonstration of the person's ability
4 to operate a motor vehicle as described in Section 12804.9.

5 (b) Based on the department's reexamination of the person's
6 qualifications pursuant to subdivision (a), the department shall
7 determine if either of the following actions should be taken:

8 (1) Suspend or revoke the driving privilege of that person if the
9 department finds that any of the grounds exist which authorize the
10 refusal to issue a license.

11 (2) Restrict, make subject to terms and conditions of probation,
12 suspend, or revoke the driving privilege of that person based upon
13 the records of the department as provided in Chapter 3
14 (commencing with Section 13800).

15 (c) As an alternative to subdivision (a), the department may
16 suspend or revoke the person's driving privilege as provided under
17 Article 2 (commencing with Section 13950) of Chapter 3.

18 (d) Upon request, the department shall notify the law
19 enforcement agency which employs the traffic officer who issued
20 the notice of reexamination described in subdivision (a) of the
21 results of the reexamination.

22 (e) This section shall remain in effect only until January 1, 2010,
23 and as of that date is repealed, unless a later enacted statute, that
24 is enacted before January 1, 2010, deletes or extends that date.

25 SEC. 3. Section 12818 of the Vehicle Code, as added by
26 Section 14 of Chapter 985 of the Statutes of 2000, is amended to
27 read:

28 12818. (a) Upon receipt of a request for reexamination and
29 presentation of a legible copy of a notice of reexamination by a
30 person issued the notice pursuant to Section 21061, the department
31 shall reexamine the person's qualifications to operate a motor
32 vehicle pursuant to Section 13801, notwithstanding the notice
33 requirement of Section 13801.

34 (b) Based on the department's reexamination of the person's
35 qualifications pursuant to subdivision (a), the department shall
36 determine if either of the following actions should be taken:

37 (1) Suspend or revoke the driving privilege of that person if the
38 department finds that any of the grounds exist which authorize the
39 refusal to issue a license.

1 (2) Restrict, make subject to terms and conditions of probation,
2 suspend, or revoke the driving privilege of that person based upon
3 the records of the department as provided in Chapter 3
4 (commencing with Section 13800).

5 (c) As an alternative to subdivision (a), the department may
6 suspend or revoke the person’s driving privilege as provided under
7 Article 2 (commencing with Section 13950) of Chapter 3.

8 (d) Upon request, the department shall notify the law
9 enforcement agency that employs the traffic officer who issued
10 the notice of reexamination of the results of the reexamination.

11 (e) Upon receipt of a report made pursuant to Section 13010 or
12 13011, the department shall reexamine the reported person’s
13 qualifications to operate a motor vehicle, including requiring a
14 road examination pursuant to Section 12804.9. The department
15 shall make a determination to restrict, make subject to terms and
16 conditions of probation, revoke, or suspend a license based upon
17 the evaluation and assessment provided by the reporting physician
18 and surgeon, a road examination pursuant to Section 12804.9, and
19 the factors enumerated in Section 110.01 of Title 13 of the
20 California Code of Regulations.

21 (f) This section shall become operative on January 1, 2010.

22 SEC. 4. Article 6 (commencing with Section 13010) is added
23 to Chapter 1 of Division 6 of the Vehicle Code, to read:

24
25 Article 6. Physician and Surgeon Reporting of Medical
26 Conditions
27

28 13010. (a) A physician and surgeon shall report immediately
29 to the department, in writing, the name, date of birth, and address
30 of every patient at least 15 years of age, or 14 years of age if the
31 patient has a junior permit, whom the physician and surgeon has
32 diagnosed with Alzheimer’s disease or another dementia disorder;
33 or the physician and surgeon has diagnosed as suffering from a
34 single lapse of consciousness within the previous six months, if
35 the patient suffers from a disorder identified in Section 2806 of
36 Title 17 of the California Code of Regulations, and the physician
37 and surgeon believes, in his or her professional judgment, that the
38 risk of recurrence is sufficient to pose a threat to public safety; or
39 the physician and surgeon has diagnosed the patient as previously
40 suffering multiple lapses of consciousness, and whose medical

1 condition is identified in Section 2806 of Title 17 of the California
2 Code of Regulations, if substantial medical evidence suggests a
3 recurrence of a lapse of consciousness or that the condition
4 adversely affects the patient's ability to operate a motor vehicle.

5 (b) ~~(1)~~ *Except as provided in paragraph (2), a physician and*
6 *surgeon is not required to make a report pursuant to this section*
7 *if any of the following occurs:*

8 ~~(1)~~

9 (A) Within the previous six months, the physician and surgeon
10 previously made a report pursuant to this section for this patient,
11 and the condition has not substantially changed.

12 ~~(2)~~

13 (B) Within the previous six months, the patient's condition was
14 initially diagnosed by another physician and surgeon, and the
15 physician and surgeon has knowledge that the prior physician and
16 surgeon either determined that a report was not required under this
17 chapter, or made a report to the department, unless there is
18 substantial medical evidence that the condition has substantially
19 changed and may adversely affect the person's ability to drive.

20 ~~(3)~~

21 (C) The physician and surgeon making the initial diagnosis,
22 relying on substantial medical evidence, determines both of the
23 following:

24 ~~(A)~~

25 (i) That the disorder can and likely will be controlled and
26 stabilized within 30 days of the initial diagnosis by medication,
27 therapy, surgery, a restriction on activities, or devices, and the
28 treatment has been prescribed, administered, or referred.

29 ~~(B)~~

30 (ii) That the patient's condition during the 30-day period does
31 not pose an undue risk to public safety while operating a motor
32 vehicle.

33 (2) *If, during the 30-day period described in subparagraph (C)*
34 *of paragraph (1), the physician and surgeon determines that the*
35 *patient poses an imminent risk to public safety while operating a*
36 *motor vehicle or the patient's impairment or disorder has not been*
37 *controlled and stabilized at the conclusion of the 30-day period*
38 *described in subparagraph (C) of paragraph (1), the physician*
39 *and surgeon shall report immediately to the department in*
40 *accordance with subdivision (a).*

1 (c) A physician and surgeon shall not be civilly or criminally
2 liable to the reported patient for making any report required or
3 authorized by this section.

4 (d) For purposes of this section, “disorders characterized by
5 lapses of consciousness” means those disorders defined pursuant
6 to paragraph (1) of subdivision (a) of Section 13012.

7 (e) This section shall become operative on January 1, 2010.

8 13011. (a) A physician and surgeon may report immediately
9 to the Department of Motor Vehicles, in writing, the name, date
10 of birth, and address of every patient at least 15 years of age or
11 older, or 14 years of age if the person has a junior permit, whom
12 the physician and surgeon has diagnosed as having a disorder
13 characterized by lapses of consciousness, if a physician and surgeon
14 reasonably and in good faith believes that reporting the patient
15 will serve the public interest. The physician and surgeon may report
16 a patient’s condition even if it may not be required under the
17 department’s definition of disorders characterized by lapses of
18 consciousness pursuant to this article.

19 (b) A physician and surgeon who reports a patient pursuant to
20 this article shall contemporaneously complete and transmit to the
21 department the form prepared by the department for this purpose,
22 and shall address each of the factors specified in Section 110.01
23 of Title 13 of the California Code of Regulations of which the
24 physician and surgeon has knowledge.

25 (c) The reports transmitted pursuant to this article shall be for
26 use by the department only, and shall be kept confidential and used
27 solely by the department for the purpose of determining the
28 eligibility of any person to operate a motor vehicle on the highways
29 of this state, or for the purpose of a bona fide research project, if
30 the data is solely provided by the department in anonymous form.

31 (d) A physician and surgeon shall not be civilly or criminally
32 liable to the reported patient for making any report required or
33 authorized by this section.

34 (e) For purposes of this section, “disorders characterized by
35 lapses of consciousness” shall be those disorders defined pursuant
36 to paragraph (1) of subdivision (a) of Section 13012.

37 (f) This section shall become operative on January 1, 2010.

38 13011.5. On or before July 1, 2009, the department shall
39 develop a physician reporting form that incorporates the factors
40 contained in Section 110.01 of Title 13 of the California Code of

1 Regulations. The form shall be made available on the department's
2 official Internet Web site for use by all physicians and surgeons.

3 13012. (a) The department, in cooperation with the State
4 Department of Public Health, by January 1, 2010, shall adopt
5 regulations that do all of the following:

6 (1) Define disorders characterized by recurrent lapses of
7 consciousness, based upon existing clinical standards for that
8 definition for purposes of this article, and shall include in that
9 definition Alzheimer's disease and those related disorders that are
10 severe enough to result in recurrent lapses of consciousness and
11 are likely to impair a person's ability to operate a motor vehicle.

12 (2) List circumstances that shall not require reporting pursuant
13 to Section 13011, because the patient is unable to ever operate a
14 motor vehicle or is otherwise unlikely to represent a danger that
15 requires reporting.

16 (3) List circumstances that do not require reporting pursuant to
17 this section.

18 (b) The department shall consult with professional medical
19 organizations whose members have specific expertise in treatment
20 of those impairments, conditions, and disorders, including, but not
21 limited to, those associations related to epilepsy, in the
22 development of any required definitions and necessary reporting
23 guidelines to ensure that cases reported pursuant to this section
24 are limited to impairments, conditions, and disorders that are
25 characterized by a recurrent lapse of consciousness and that
26 compromise a patient's ability to safely operate a motor vehicle.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1441
Author: Ridley-Thomas
Bill Date: April 7, 2008, amended
Subject: Task Force: address standards for impaired
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee and has not been set for hearing.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would specify legislative intent that the Bureau of State Audits (BSA) conduct a thorough performance audit of the diversion programs to evaluate the effectiveness and efficiency of the programs and providers chosen by the DCA to manage the programs. This bill would establish the Diversion Coordination Committee (DCC) and the Licensee Drug and Alcohol Addiction Coordination Committee (LDAACC) within DCA responsible for establishing guidelines and recommendations relating to licentiates with alcohol and drug problems.

ANALYSIS:

This bill addresses the issue of impaired licensees in various professions in the wake of the Medical Board's (Board) failed audits of the physician diversion program, which is due to sunset June 30, 2008. The bill is also in response to the fact that no audits or reviews have been conducted on the other health care licensing boards that maintain and operate diversion programs for licensees that suffer from chemical dependency. The purpose of this bill is to increase public protection and restore public confidence by establishing and maintaining common and uniform standards governing the different health care licensing boards' diversion programs.

Many boards outsource their diversion functions. DCA currently manages a master contract with Maximus, a publicly traded corporation for six boards and one committee's diversion programs. The individual boards oversee the programs but Maximus provides the services. The boards' diversion programs follow the same general principles of the Board's diversion program. DCA's master contract standardizes certain tasks, such as designing and implementing a case management system, maintaining 24-hours access lines,

and providing initial intake in in-person assessments. Each board specifies its own policies and procedures regarding its program.

In addition to specifying intent to have performance audits conducted, this bill establishes the DCC for those Boards with programs to issue a set of best practices and recommendations to govern the boards' diversion programs and diversion evaluation committees. The bill also establishes the LDAACC responsible for issuing a set of best practices and recommendations to govern those boards within DCA that do not establish and maintain diversion programs or evaluation committees. (This would include the Board) Both the DCC and the LDAACC would be comprised of the executive officers of the boards and the Director of DCA would act as chair of both committees.

A concern raised at the committee hearing was the lack of addiction healthcare expertise on these committees.

FISCAL: None

POSITION: Recommendation: Support if amended to require both committees to have provider expertise.

April 17, 2008

AMENDED IN SENATE APRIL 7, 2008

SENATE BILL

No. 1441

Introduced by Senator Ridley-Thomas

February 21, 2008

An act to amend Section 2307 of the Business and Professions Code, relating to medicine. ~~An act to add Article 3.6 (commencing with Section 315) to Chapter 4 of Division 1 of the Business and Professions Code, relating to health care.~~

LEGISLATIVE COUNSEL'S DIGEST

SB 1441, as amended, Ridley-Thomas. ~~Physicians and surgeons: disciplinary procedures.~~ *Healing arts practitioners: alcohol and drug abuse.*

Existing law requires various healing arts licensing boards to establish and administer diversion programs or diversion evaluation committees for the rehabilitation of healing arts practitioners whose competency is impaired due to the abuse of drugs or alcohol.

This bill would establish in the Department of Consumer Affairs the Diversion Coordination Committee, which would be comprised of the executive officers of those healing arts boards, as specified, that establish and maintain a diversion program or diversion evaluation committee, and would establish in the department the Licensee Drug and Alcohol Addiction Coordination Committee, which would be comprised of the executive officers of all other healing arts boards. The bill would require these committees to meet periodically at the discretion of the department and to each issue, by an unspecified date, a set of best practices and recommendations, as specified.

~~Existing law, the Medical Practice Act, creates the Medical Board of California and makes it responsible for disciplining a physician and~~

surgeon for acts of unprofessional conduct. Under the act, a physician and surgeon whose certificate is revoked, suspended, or placed on probation for unprofessional conduct may petition for reinstatement or modification after a specified time period. Existing law requires that petition to be accompanied by at least two verified recommendations from physicians and surgeons licensed by the board who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

~~This bill would also allow those recommendations to be made by physicians and surgeons licensed in other states. The bill would also make other technical, nonsubstantive changes to obsolete references.~~

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

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

1 SECTION 1. *It is the intent of the Legislature that the Bureau*
 2 *of State Audits conduct a thorough performance audit of the*
 3 *diversion programs created pursuant to this act in order to evaluate*
 4 *the effectiveness and efficiency of the programs and the providers*
 5 *chosen by the Department of Consumer Affairs to manage the*
 6 *programs, and to make recommendations regarding the*
 7 *continuation of the programs and any changes or reforms required*
 8 *to ensure that individuals participating in the programs are*
 9 *appropriately monitored, and the public is protected from health*
 10 *practitioners who are impaired due to alcohol or drug abuse or*
 11 *mental or physical illness. The department and its staff shall*
 12 *cooperate with the audit, and shall provide data, information, and*
 13 *case files as requested by the auditor to perform all of his or her*
 14 *duties. The provision of confidential data, information, and case*
 15 *files from health care-related boards to the auditor shall not*
 16 *constitute a waiver of any exemption from disclosure or discovery*
 17 *or of any confidentiality protection or privilege otherwise provided*
 18 *by law that is applicable to the data, information, or case files.*
 19 SEC. 2. *Article 3.6 (commencing with Section 315) is added*
 20 *to Chapter 4 of Division 1 of the Business and Professions Code,*
 21 *to read:*

1 *Article 3.6 Healing Arts Licensee Addiction and Diversion*

2
3 315. (a) *There is established in the Department of Consumer*
4 *Affairs the Diversion Coordination Committee. The committee*
5 *shall be comprised of the executive officers of those healing arts*
6 *licensing boards within the department that establish and maintain*
7 *diversion programs or diversion evaluation committees. The*
8 *Director of Consumer Affairs shall act as the chair of the*
9 *committee.*

10 (b) *The committee shall meet periodically at the discretion of*
11 *the director and shall, no later than _____, issue a set of best*
12 *practices and recommendations to govern those healing arts*
13 *licensing boards' diversion programs or diversion evaluation*
14 *committees. These recommendations shall propose best practices,*
15 *regulations, or changes in law, as are necessary, and shall include,*
16 *but shall not be limited to, recommendations addressing all of the*
17 *following issues:*

18 (1) *When a licensee is to be irrevocably terminated from the*
19 *diversion program and referred for disciplinary action.*

20 (2) *Periodic audits of the program.*

21 (3) *Whether a licensee enrolled in the program who may pose*
22 *a risk to patients may continue to practice while in the program*
23 *without the knowledge or consent of patients.*

24 (4) *How best to ensure that drug tests are random, accurate,*
25 *and reliable, and that results for those tests are obtained quickly.*

26 (5) *Whether there should be criteria for entry into the program,*
27 *such as criteria that differentiate between licensees who the board*
28 *has reason to believe pose a risk to patients and those where the*
29 *risk is speculative.*

30 316. (a) *There is established in the Department of Consumer*
31 *Affairs the Licensee Drug and Alcohol Addiction Coordination*
32 *Committee. The committee shall be comprised of the executive*
33 *officers of the healing arts licensing boards within the department*
34 *that do not establish and maintain diversion programs or diversion*
35 *evaluation committees. The Director of Consumer Affairs shall*
36 *act as the chair of the committee.*

37 (b) *The committee shall meet periodically at the discretion of*
38 *the department and shall, no later than _____, issue a set of best*
39 *practices and recommendations to govern those healing arts*
40 *licensing boards' disciplinary programs as they relate to*

1 *disciplinary matters relating to drug or alcohol addiction. These*
2 *recommendations shall propose best practices, regulations, or*
3 *changes in law, as are necessary, and shall include, but shall not*
4 *be limited to, recommendations addressing all of the following*
5 *issues, related to drug or alcohol abuse:*

6 (1) *Criteria for placing a licensee on probation and related*
7 *criteria for reporting and monitoring the probation.*

8 (2) *Criteria for refusing a request for probation.*

9 (3) *Criteria for imposition of discipline and the level of*
10 *discipline.*

11 (4) *Criteria for restoration of a license.*

12 317. *For purposes of this article, "healing arts licensing*
13 *board" means any board established pursuant to Division 2*
14 *(commencing with Section 500), the State Board of Chiropractic*
15 *Examiners, or the Osteopathic Medical Board of California.*

16 SECTION 1. ~~Section 2307 of the Business and Professions~~
17 ~~Code is amended to read:~~

18 ~~2307. (a) A person whose certificate has been surrendered~~
19 ~~while under investigation or while charges are pending or whose~~
20 ~~certificate has been revoked or suspended or placed on probation;~~
21 ~~may petition the board for reinstatement or modification of penalty,~~
22 ~~including modification or termination of probation.~~

23 ~~(b) The person may file the petition after a period of not less~~
24 ~~than the following minimum periods have elapsed from the~~
25 ~~effective date of the surrender of the certificate or the decision~~
26 ~~ordering that disciplinary action:~~

27 ~~(1) At least three years for reinstatement of a license surrendered~~
28 ~~or revoked for unprofessional conduct, except that the board may,~~
29 ~~for good cause shown, specify in a revocation order that a petition~~
30 ~~for reinstatement may be filed after two years.~~

31 ~~(2) At least two years for early termination of probation of three~~
32 ~~years or more:~~

33 ~~(3) At least one year for modification of a condition, or~~
34 ~~reinstatement of a license surrendered or revoked for mental or~~
35 ~~physical illness, or termination of probation of less than three years.~~

36 ~~(c) The petition shall state any facts as may be required by the~~
37 ~~board. The petition shall be accompanied by at least two verified~~
38 ~~recommendations from physicians and surgeons licensed in any~~
39 ~~state who have personal knowledge of the activities of the petitioner~~
40 ~~since the disciplinary penalty was imposed.~~

1 (d) The petition may be heard by a panel of the board. The board
2 may assign the petition to an administrative law judge designated
3 in Section 11371 of the Government Code. After a hearing on the
4 petition, the administrative law judge shall provide a proposed
5 decision to the board or the California Board of Podiatric Medicine,
6 as applicable, which shall be acted upon in accordance with Section
7 2335.

8 (e) The panel of the board or the administrative law judge
9 hearing the petition may consider all activities of the petitioner
10 since the disciplinary action was taken, the offense for which the
11 petitioner was disciplined, the petitioner's activities during the
12 time the certificate was in good standing, and the petitioner's
13 rehabilitative efforts, general reputation for truth, and professional
14 ability. The hearing may be continued from time to time as the
15 administrative law judge designated in Section 11371 of the
16 Government Code finds necessary.

17 (f) The administrative law judge designated in Section 11371
18 of the Government Code reinstating a certificate or modifying a
19 penalty may recommend the imposition of any terms and conditions
20 deemed necessary.

21 (g) No petition shall be considered while the petitioner is under
22 sentence for any criminal offense, including any period during
23 which the petitioner is on court-imposed probation or parole. No
24 petition shall be considered while there is an accusation or petition
25 to revoke probation pending against the person. The board may
26 deny without a hearing or argument any petition filed pursuant to
27 this section within a period of two years from the effective date
28 of the prior decision following a hearing under this section.

29 (h) This section is applicable to and may be carried out with
30 regard to licensees of the California Board of Podiatric Medicine.
31 In lieu of two verified recommendations from physicians and
32 surgeons, the petition shall be accompanied by at least two verified
33 recommendations from podiatrists licensed by the board who have
34 personal knowledge of the activities of the petitioner since the date
35 the disciplinary penalty was imposed.

36 (i) Nothing in this section shall be deemed to alter Sections 822
37 and 823.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1454
Author: Ridley-Thomas
Bill Date: April 7, 2008, amended
Subject: Advertising, OSM, Cosmetic Surgery Standards
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee and has not been set for hearing.

DESCRIPTION OF CURRENT LEGISLATION:

This bill requires health care practitioners to provide the type of license under which the licensee is practicing and the type of degree received on all advertisements. This bill requires a health care practitioner who is practicing in an outpatient setting to wear a name tag which includes his or her name and license status. This bill requires the Medical Board (Board) to adopt regulations on the appropriate level of physician supervision necessary within clinics using laser or intense pulse light devices for elective cosmetic surgery. This bill requires the Board post on its website a fact sheet to educate the public about cosmetic surgery and the risks involved with such surgeries.

ANALYSIS:

This bill aims to further public protection by strengthening the regulation and oversight of surgical centers and clinics performing cosmetic procedures, and to ensure that quality of care standards are in place at these clinics and they are monitored by the appropriate credentialing agency.

The American Society of Plastic Surgeons (ASPS) reports that the top five surgical procedures of the almost 12 million cosmetic procedures performed in 2007 were breast augmentation, liposuction, nose reshaping, eyelid surgery, and tummy tuck. Less invasive procedures such as laser surgery and Botox are increasingly becoming popular as well. As a result, consumers are inundated with advertisements for these services. Although the federal Food and Drug Administration oversees the safety of machines and skin-care products used, there is little regulation of these medical spas to guarantee that patients are aware of the potential risks associated with all treatments.

Many physicians who are performing cosmetic surgery have not been trained specifically in that field, and are conducting increasingly complex procedures in settings outside of hospitals, such as outpatient surgery centers and doctors' offices. It is also common for doctors performing cosmetic surgeries to receive their training only from weekend courses and instructional videos. Currently, there are no uniform standards for

physician training related to cosmetic surgery. The author believes regulation of allied health professionals in outpatient settings and the settings themselves needs to be strengthened as well.

Prior attempts to regulate the practice of cosmetic surgery have included SB 1423 (Figueroa) Chapter 873, Statutes of 2006, which required the Board in conjunction with the Board of Registered Nursing to promulgate regulations to implement changes relating to the use of laser or intense pulse light devices for cosmetic procedures by physicians, nurses, and physician assistants. SB 835 (Figueroa) of 1999, would have enacted the Cosmetic Surgery Patient Disclosure Act, which would have required physicians who perform cosmetic surgery to provide the Board with information on their training, board certifications, and the number of procedures performed. SB 836 (Figueroa) Chapter 856, Statutes of 1999, expanded and revised the prohibition against fraudulent advertising by health practitioners.

This bill would require the following:

- Advertising by a physician and other health care practitioners must include the type of license under which the licensee is practicing and the type of degree received upon graduation from professional training. This will provide to consumers information to understand the type of healthcare practitioner advertising services.
- Health care practitioners who work in an outpatient setting clinic must wear a name tag which includes their name and license status. Currently, if the license is displayed in the office, name tags are not required.
- The Board must make investigation of unlicensed activity or corporate practice of medicine violations in outpatient clinics one of its priorities.
- The Board must adopt regulations regarding the appropriate level of physician supervision for health professionals needed within clinics or other settings using laser or intense pulse light devices.
- The Board must post on its website a fact sheet to educate the public about cosmetic surgery and its risks.
- The Board must additionally notify the public whether a setting is licensed, or that the setting's status is in revocation, suspension, or probation.
- The Board or the accrediting agency must periodically inspect every outpatient setting. Cycles should be set in regulation. The results of these inspections must be kept on file and shall be available for public inspection.
- The Board must evaluate the performance of an approved accreditation agency no less than every three years, this section is currently permissive.

The author intends to continue to strengthen the laws for outpatient surgery settings as the bill moves through the process.

FISCAL: None

POSITION: Recommendation: Support

April 17, 2008

Introduced by Senator Ridley-Thomas

February 21, 2008

An act to amend Sections 651, 680, and 2023.5 of, and to add Section ~~2218~~ 2027.5 to, the Business and Professions Code, and to ~~add Section 1249 to~~ amend Sections 1248.15, 1248.2, 1248.25, 1248.35, and 1248.5 of the Health and Safety Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1454, as amended, Ridley-Thomas. Healing arts: *outpatient settings*.

Existing

(1) *Existing* law provides that it is unlawful for healing arts licensees to disseminate or cause to be disseminated any form of public communication, as defined, containing a false, fraudulent, misleading, or deceptive statement; or image to induce the provision of services or the rendering of products relating to a professional practice or business for which he or she is licensed. Existing law authorizes advertising by these healing arts licensees to include certain general information. A violation of these provisions is a misdemeanor.

This bill would impose specific advertising requirements on certain healing arts licensees. By changing the definition of a crime, this bill would impose a state-mandated local program.

Existing

(2) *Existing* law requires a health care practitioner to disclose, while working, his or her name and license status, on a specified name tag. However, existing law exempts from this requirement a health care

practitioner whose license is prominently displayed in a practice or office.

This bill would ~~delete that exemption~~ *exclude from that exemption a health care practitioner working in an outpatient clinic.*

Existing

(3) *Existing* law requires the Medical Board of California, in conjunction with the Board of Registered Nursing, and in consultation with the Physician Assistant Committee and professionals in the field, to review issues and problems relating to the use of laser or intense light pulse devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants.

This bill would require the Medical Board of California to establish, as a priority, the investigation of unlicensed activity or other specified violations in clinics *or other settings* using laser or intense pulse light devices. *The bill would also require the board to adopt regulations by July 1, 2009, regarding the appropriate level of physician supervision needed within clinics or other settings using laser or intense pulse light devices for elective cosmetic procedures.*

~~Existing law prohibits physicians and surgeons from performing procedures in an outpatient setting using anesthesia, except as specified, and existing law imposes other personnel and security requirements for the performance of these procedures. Existing law also requires outpatient settings to meet certain standards.~~

~~This bill would require physicians and surgeons performing procedures in an outpatient setting and outpatient settings to establish standardized procedures and protocols to be followed in the event of serious complications or side effects from cosmetic surgery that would place a patient at high risk for injury or harm and to govern emergency and urgent care situations. By changing the definition of a crime, this bill would impose a state-mandated local program.~~

(4) *Existing law requires the Medical Board of California to post on the Internet specified information regarding licensed physicians and surgeons.*

This bill would require the board to post on its Web site an easy to understand factsheet to educate the public about cosmetic surgery and procedures, as specified.

(5) *Existing law requires the Medical Board of California, as successor to the Division of Licensing of the Medical Board of California, to adopt standards for accreditation of outpatient settings, as defined, and, in approving accreditation agencies to perform*

accreditation of outpatient settings, ensure that the certification program shall, at a minimum, include standards for specified aspects of the settings' operations.

This bill would include, among those specified aspects, the submission for approval by an accrediting agency at the time of accreditation, a detailed plan, standardized procedures, and protocols to be followed in the event of serious complications or side effects from surgery, as specified.

(6) Existing law also requires the Medical Board of California to obtain and maintain a list of all accredited, certified, and licensed outpatient settings, and to notify the public, upon inquiry, whether a setting is accredited, certified, or licensed, or whether the setting's accreditation, certification, or license has been revoked.

This bill would require the board to notify the public whether a setting is accredited, certified, or licensed, or the setting's accreditation, certification, or license has been revoked, suspended or placed on probation, or the setting has received a reprimand by the accreditation agency.

(7) Existing law requires accreditation of an outpatient setting to be denied by the accreditation agency if the setting does not meet specified standards. An outpatient setting may reapply for accreditation at any time after receiving notification of the denial.

This bill would require the accrediting agency to immediately report to the Medical Board of California if the outpatient setting's certificate for accreditation has been denied.

(8) Existing law authorizes the Medical Board of California or an accreditation agency to, upon reasonable prior notice and presentation of proper identification, enter and inspect any outpatient setting that is accredited by an accreditation agency at any reasonable time to ensure compliance with, or investigate an alleged violation of, any standard of the accreditation agency or any provision of the specified law.

This bill would delete the requirement that the board give reasonable prior notice and presentation of proper identification to perform those inspections. The bill would also require that every outpatient setting that is accredited be periodically inspected by the board or the accreditation agency, as specified.

(9) Existing law authorizes the Medical Board of California to evaluate the performance of an approved accreditation agency no less than every three years, or in response to complaints against an agency,

or complaints against one or more outpatient settings accreditation by an agency that indicates noncompliance by the agency with the standards approved by the board.

This bill would make that evaluation mandatory.

The

(10) 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 651 of the Business and Professions Code
2 is amended to read:

3 651. (a) It is unlawful for any person licensed under this
4 division or under any initiative act referred to in this division to
5 disseminate or cause to be disseminated any form of public
6 communication containing a false, fraudulent, misleading, or
7 deceptive statement, claim, or image for the purpose of or likely
8 to induce, directly or indirectly, the rendering of professional
9 services or furnishing of products in connection with the
10 professional practice or business for which he or she is licensed.

11 A “public communication” as used in this section includes, but is
12 not limited to, communication by means of mail, television, radio,
13 motion picture, newspaper, book, list or directory of healing arts
14 practitioners, Internet, or other electronic communication.

15 (b) A false, fraudulent, misleading, or deceptive statement,
16 claim, or image includes a statement or claim that does any of the
17 following:

18 (1) Contains a misrepresentation of fact.

19 (2) Is likely to mislead or deceive because of a failure to disclose
20 material facts.

21 (3) (A) Is intended or is likely to create false or unjustified
22 expectations of favorable results, including the use of any
23 photograph or other image that does not accurately depict the
24 results of the procedure being advertised or that has been altered

1 in any manner from the image of the actual subject depicted in the
2 photograph or image.

3 (B) Use of any photograph or other image of a model without
4 clearly stating in a prominent location in easily readable type the
5 fact that the photograph or image is of a model is a violation of
6 subdivision (a). For purposes of this paragraph, a model is anyone
7 other than an actual patient, who has undergone the procedure
8 being advertised, of the licensee who is advertising for his or her
9 services.

10 (C) Use of any photograph or other image of an actual patient
11 that depicts or purports to depict the results of any procedure, or
12 presents “before” and “after” views of a patient, without specifying
13 in a prominent location in easily readable type size what procedures
14 were performed on that patient is a violation of subdivision (a).
15 Any “before” and “after” views (i) shall be comparable in
16 presentation so that the results are not distorted by favorable poses,
17 lighting, or other features of presentation, and (ii) shall contain a
18 statement that the same “before” and “after” results may not occur
19 for all patients.

20 (4) Relates to fees, other than a standard consultation fee or a
21 range of fees for specific types of services, without fully and
22 specifically disclosing all variables and other material factors.

23 (5) Contains other representations or implications that in
24 reasonable probability will cause an ordinarily prudent person to
25 misunderstand or be deceived.

26 (6) Makes a claim either of professional superiority or of
27 performing services in a superior manner, unless that claim is
28 relevant to the service being performed and can be substantiated
29 with objective scientific evidence.

30 (7) Makes a scientific claim that cannot be substantiated by
31 reliable, peer reviewed, published scientific studies.

32 (8) Includes any statement, endorsement, or testimonial that is
33 likely to mislead or deceive because of a failure to disclose material
34 facts.

35 (c) Any price advertisement shall be exact, without the use of
36 phrases, including, but not limited to, “as low as,” “and up,”
37 “lowest prices,” or words or phrases of similar import. Any
38 advertisement that refers to services, or costs for services, and that
39 uses words of comparison shall be based on verifiable data
40 substantiating the comparison. Any person so advertising shall be

1 prepared to provide information sufficient to establish the accuracy
2 of that comparison. Price advertising shall not be fraudulent,
3 deceitful, or misleading, including statements or advertisements
4 of bait, discount, premiums, gifts, or any statements of a similar
5 nature. In connection with price advertising, the price for each
6 product or service shall be clearly identifiable. The price advertised
7 for products shall include charges for any related professional
8 services, including dispensing and fitting services, unless the
9 advertisement specifically and clearly indicates otherwise.

10 (d) Any person so licensed shall not compensate or give anything
11 of value to a representative of the press, radio, television, or other
12 communication medium in anticipation of, or in return for,
13 professional publicity unless the fact of compensation is made
14 known in that publicity.

15 (e) Any person so licensed may not use any professional card,
16 professional announcement card, office sign, letterhead, telephone
17 directory listing, medical list, medical directory listing, or a similar
18 professional notice or device if it includes a statement or claim
19 that is false, fraudulent, misleading, or deceptive within the
20 meaning of subdivision (b).

21 (f) Any person so licensed who violates this section is guilty of
22 a misdemeanor. A bona fide mistake of fact shall be a defense to
23 this subdivision, but only to this subdivision.

24 (g) Any violation of this section by a person so licensed shall
25 constitute good cause for revocation or suspension of his or her
26 license or other disciplinary action.

27 (h) Advertising by any person so licensed may include the
28 following:

29 (1) A statement of the name of the practitioner.

30 (2) A statement of addresses and telephone numbers of the
31 offices maintained by the practitioner.

32 (3) A statement of office hours regularly maintained by the
33 practitioner.

34 (4) A statement of languages, other than English, fluently spoken
35 by the practitioner or a person in the practitioner's office.

36 (5) (A) A statement that the practitioner is certified by a private
37 or public board or agency or a statement that the practitioner limits
38 his or her practice to specific fields.

39 (i) For the purposes of this section, a dentist licensed under
40 Chapter 4 (commencing with Section 1600) may not hold himself

1 or herself out as a specialist, or advertise membership in or
2 specialty recognition by an accrediting organization, unless the
3 practitioner has completed a specialty education program approved
4 by the American Dental Association and the Commission on Dental
5 Accreditation, is eligible for examination by a national specialty
6 board recognized by the American Dental Association, or is a
7 diplomate of a national specialty board recognized by the American
8 Dental Association.

9 (ii) A dentist licensed under Chapter 4 (commencing with
10 Section 1600) shall not represent to the public or advertise
11 accreditation either in a specialty area of practice or by a board
12 not meeting the requirements of clause (i) unless the dentist has
13 attained membership in or otherwise been credentialed by an
14 accrediting organization that is recognized by the board as a bona
15 fide organization for that area of dental practice. In order to be
16 recognized by the board as a bona fide accrediting organization
17 for a specific area of dental practice other than a specialty area of
18 dentistry authorized under clause (i), the organization shall
19 condition membership or credentialing of its members upon all of
20 the following:

21 (I) Successful completion of a formal, full-time advanced
22 education program that is affiliated with or sponsored by a
23 university based dental school and is beyond the dental degree at
24 a graduate or postgraduate level.

25 (II) Prior didactic training and clinical experience in the specific
26 area of dentistry that is greater than that of other dentists.

27 (III) Successful completion of oral and written examinations
28 based on psychometric principles.

29 (iii) Notwithstanding the requirements of clauses (i) and (ii), a
30 dentist who lacks membership in or certification, diplomate status,
31 other similar credentials, or completed advanced training approved
32 as bona fide either by an American Dental Association recognized
33 accrediting organization or by the board, may announce a practice
34 emphasis in any other area of dental practice only if the dentist
35 incorporates in capital letters or some other manner clearly
36 distinguishable from the rest of the announcement, solicitation, or
37 advertisement that he or she is a general dentist.

38 (iv) A statement of certification by a practitioner licensed under
39 Chapter 7 (commencing with Section 3000) shall only include a
40 statement that he or she is certified or eligible for certification by

1 a private or public board or parent association recognized by that
2 practitioner's licensing board.

3 (B) A physician and surgeon licensed under Chapter 5
4 (commencing with Section 2000) by the Medical Board of
5 California may include a statement that he or she limits his or her
6 practice to specific fields, but shall not include a statement that he
7 or she is certified or eligible for certification by a private or public
8 board or parent association, including, but not limited to, a
9 multidisciplinary board or association, unless that board or
10 association is (i) an American Board of Medical Specialties
11 member board, (ii) a board or association with equivalent
12 requirements approved by that physician and surgeon's licensing
13 board, or (iii) a board or association with an Accreditation Council
14 for Graduate Medical Education approved postgraduate training
15 program that provides complete training in that specialty or
16 subspecialty. A physician and surgeon licensed under Chapter 5
17 (commencing with Section 2000) by the Medical Board of
18 California who is certified by an organization other than a board
19 or association referred to in clause (i), (ii), or (iii) shall not use the
20 term "board certified" in reference to that certification, unless the
21 physician and surgeon is also licensed under Chapter 4
22 (commencing with Section 1600) and the use of the term "board
23 certified" in reference to that certification is in accordance with
24 subparagraph (A). A physician and surgeon licensed under Chapter
25 5 (commencing with Section 2000) by the Medical Board of
26 California who is certified by a board or association referred to in
27 clause (i), (ii), or (iii) shall not use the term "board certified" unless
28 the full name of the certifying board is also used and given
29 comparable prominence with the term "board certified" in the
30 statement.

31 For purposes of this subparagraph, a "multidisciplinary board
32 or association" means an educational certifying body that has a
33 psychometrically valid testing process, as determined by the
34 Medical Board of California, for certifying medical doctors and
35 other health care professionals that is based on the applicant's
36 education, training, and experience.

37 For purposes of the term "board certified," as used in this
38 subparagraph, the terms "board" and "association" mean an
39 organization that is an American Board of Medical Specialties
40 member board, an organization with equivalent requirements

1 approved by a physician and surgeon's licensing board, or an
2 organization with an Accreditation Council for Graduate Medical
3 Education approved postgraduate training program that provides
4 complete training in a specialty or subspecialty.

5 The Medical Board of California shall adopt regulations to
6 establish and collect a reasonable fee from each board or
7 association applying for recognition pursuant to this subparagraph.
8 The fee shall not exceed the cost of administering this
9 subparagraph. Notwithstanding Section 2 of Chapter 1660 of the
10 Statutes of 1990, this subparagraph shall become operative July
11 1, 1993. However, an administrative agency or accrediting
12 organization may take any action contemplated by this
13 subparagraph relating to the establishment or approval of specialist
14 requirements on and after January 1, 1991.

15 (C) A doctor of podiatric medicine licensed under Chapter 5
16 (commencing with Section 2000) by the Medical Board of
17 California may include a statement that he or she is certified or
18 eligible or qualified for certification by a private or public board
19 or parent association, including, but not limited to, a
20 multidisciplinary board or association, if that board or association
21 meets one of the following requirements: (i) is approved by the
22 Council on Podiatric Medical Education, (ii) is a board or
23 association with equivalent requirements approved by the
24 California Board of Podiatric Medicine, or (iii) is a board or
25 association with the Council on Podiatric Medical Education
26 approved postgraduate training programs that provide training in
27 podiatric medicine and podiatric surgery. A doctor of podiatric
28 medicine licensed under Chapter 5 (commencing with Section
29 2000) by the Medical Board of California who is certified by a
30 board or association referred to in clause (i), (ii), or (iii) shall not
31 use the term "board certified" unless the full name of the certifying
32 board is also used and given comparable prominence with the term
33 "board certified" in the statement. A doctor of podiatric medicine
34 licensed under Chapter 5 (commencing with Section 2000) by the
35 Medical Board of California who is certified by an organization
36 other than a board or association referred to in clause (i), (ii), or
37 (iii) shall not use the term "board certified" in reference to that
38 certification.

39 For purposes of this subparagraph, a "multidisciplinary board
40 or association" means an educational certifying body that has a

1 psychometrically valid testing process, as determined by the
2 California Board of Podiatric Medicine, for certifying doctors of
3 podiatric medicine that is based on the applicant's education,
4 training, and experience. For purposes of the term "board certified,"
5 as used in this subparagraph, the terms "board" and "association"
6 mean an organization that is a Council on Podiatric Medical
7 Education approved board, an organization with equivalent
8 requirements approved by the California Board of Podiatric
9 Medicine, or an organization with a Council on Podiatric Medical
10 Education approved postgraduate training program that provides
11 training in podiatric medicine and podiatric surgery.

12 The California Board of Podiatric Medicine shall adopt
13 regulations to establish and collect a reasonable fee from each
14 board or association applying for recognition pursuant to this
15 subparagraph, to be deposited in the State Treasury in the Podiatry
16 Fund, pursuant to Section 2499. The fee shall not exceed the cost
17 of administering this subparagraph.

18 (6) A statement that the practitioner provides services under a
19 specified private or public insurance plan or health care plan.

20 (7) A statement of names of schools and postgraduate clinical
21 training programs from which the practitioner has graduated,
22 together with the degrees received.

23 (8) A statement of publications authored by the practitioner.

24 (9) A statement of teaching positions currently or formerly held
25 by the practitioner, together with pertinent dates.

26 (10) A statement of his or her affiliations with hospitals or
27 clinics.

28 (11) A statement of the charges or fees for services or
29 commodities offered by the practitioner.

30 (12) A statement that the practitioner regularly accepts
31 installment payments of fees.

32 (13) Otherwise lawful images of a practitioner, his or her
33 physical facilities, or of a commodity to be advertised.

34 (14) A statement of the manufacturer, designer, style, make,
35 trade name, brand name, color, size, or type of commodities
36 advertised.

37 (15) An advertisement of a registered dispensing optician may
38 include statements in addition to those specified in paragraphs (1)
39 to (14), inclusive, provided that any statement shall not violate
40 subdivision (a), (b), (c), or (e) or any other section of this code.

1 (16) A statement, or statements, providing public health
2 information encouraging preventative or corrective care.

3 (17) Any other item of factual information that is not false,
4 fraudulent, misleading, or likely to deceive.

5 (i) Advertising by any person licensed under Chapter 2
6 (commencing with Section 1000), Chapter 4 (commencing with
7 Section 1600), Chapter 5 (commencing with Section 2000), Chapter
8 6 (commencing with Section 2700), Chapter 6.5 (commencing
9 with Section 2840), Chapter 6.6 (commencing with Section 2900),
10 Chapter 7 (commencing with Section 3000), Chapter 7.7
11 (commencing with Section 3500), and Chapter 8 (commencing
12 with Section 3600) shall include all of the following information:

13 (1) The type of license under which the licensee is practicing.

14 (2) The type of degree received upon graduation from
15 professional training.

16 (j) Each of the healing arts boards and examining committees
17 within Division 2 shall adopt appropriate regulations to enforce
18 this section in accordance with Chapter 3.5 (commencing with
19 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
20 Code.

21 Each of the healing arts boards and committees and examining
22 committees within Division 2 shall, by regulation, define those
23 efficacious services to be advertised by businesses or professions
24 under their jurisdiction for the purpose of determining whether
25 advertisements are false or misleading. Until a definition for that
26 service has been issued, no advertisement for that service shall be
27 disseminated. However, if a definition of a service has not been
28 issued by a board or committee within 120 days of receipt of a
29 request from a licensee, all those holding the license may advertise
30 the service. Those boards and committees shall adopt or modify
31 regulations defining what services may be advertised, the manner
32 in which defined services may be advertised, and restricting
33 advertising that would promote the inappropriate or excessive use
34 of health services or commodities. A board or committee shall not,
35 by regulation, unreasonably prevent truthful, nondeceptive price
36 or otherwise lawful forms of advertising of services or
37 commodities, by either outright prohibition or imposition of
38 onerous disclosure requirements. However, any member of a board
39 or committee acting in good faith in the adoption or enforcement

1 of any regulation shall be deemed to be acting as an agent of the
2 state.

3 (k) The Attorney General shall commence legal proceedings in
4 the appropriate forum to enjoin advertisements disseminated or
5 about to be disseminated in violation of this section and seek other
6 appropriate relief to enforce this section. Notwithstanding any
7 other provision of law, the costs of enforcing this section to the
8 respective licensing boards or committees may be awarded against
9 any licensee found to be in violation of any provision of this
10 section. This shall not diminish the power of district attorneys,
11 county counsels, or city attorneys pursuant to existing law to seek
12 appropriate relief.

13 (l) A physician and surgeon or doctor of podiatric medicine
14 licensed pursuant to Chapter 5 (commencing with Section 2000)
15 by the Medical Board of California who knowingly and
16 intentionally violates this section may be cited and assessed an
17 administrative fine not to exceed ten thousand dollars (\$10,000)
18 per event. Section 125.9 shall govern the issuance of this citation
19 and fine except that the fine limitations prescribed in paragraph
20 (3) of subdivision (b) of Section 125.9 shall not apply to a fine
21 under this subdivision.

22 SEC. 2. Section 680 of the Business and Professions Code is
23 amended to read:

24 680. (a) Except as otherwise provided in this section, a health
25 care practitioner shall disclose, while working, his or her name
26 and practitioner's license status, as granted by this state, on a name
27 tag in at least 18-point type. *A health care practitioner in a practice
28 or an office, whose license is prominently displayed, may opt to
29 not wear a name tag unless the health care practitioner is working
30 in a clinic accredited pursuant to Chapter 1.3 (commencing with
31 Section 1248) of Division 2 of the Health and Safety Code.* If a
32 health care practitioner or a licensed clinical social worker is
33 working in a psychiatric setting or in a setting that is not licensed
34 by the state, the employing entity or agency shall have the
35 discretion to make an exception from the name tag requirement
36 for individual safety or therapeutic concerns. In the interest of
37 public safety and consumer awareness, it shall be unlawful for any
38 person to use the title "nurse" in reference to himself or herself
39 and in any capacity, except for an individual who is a registered
40 nurse or a licensed vocational nurse, or as otherwise provided in

1 Section 2800. Nothing in this section shall prohibit a certified nurse
2 assistant from using his or her title.

3 (b) Facilities licensed by the State Department of Social
4 Services, the State Department of Mental Health, or the State
5 Department of ~~Health Care Services~~ *Public Health* shall develop
6 and implement policies to ensure that health care practitioners
7 providing care in those facilities are in compliance with subdivision
8 (a). The State Department of Social Services, the State Department
9 of Mental Health, and the State Department of ~~Health Care Services~~
10 *Public Health* shall verify through periodic inspections that the
11 policies required pursuant to subdivision (a) have been developed
12 and implemented by the respective licensed facilities.

13 (c) For purposes of this article, “health care practitioner” means
14 any person who engages in acts that are the subject of licensure
15 or regulation under this division or under any initiative act referred
16 to in this division.

17 SEC. 3. Section 2023.5 of the Business and Professions Code
18 is amended to read:

19 2023.5. (a) The board, in conjunction with the Board of
20 Registered Nursing, and in consultation with the Physician
21 Assistant Committee and professionals in the field, shall review
22 issues and problems surrounding the use of laser or intense light
23 pulse devices for elective cosmetic procedures by physicians and
24 surgeons, nurses, and physician assistants. The review shall include,
25 but need not be limited to, all of the following:

- 26 (1) The appropriate level of physician supervision needed.
- 27 (2) The appropriate level of training to ensure competency.
- 28 (3) Guidelines for standardized procedures and protocols that
29 address, at a minimum, all of the following:
 - 30 (A) Patient selection.
 - 31 (B) Patient education, instruction, and informed consent.
 - 32 (C) Use of topical agents.
 - 33 (D) Procedures to be followed in the event of complications or
34 side effects from the treatment.
 - 35 (E) Procedures governing emergency and urgent care situations.

36 (b) On or before January 1, 2009, the board and the Board of
37 Registered Nursing shall promulgate regulations to implement
38 changes determined to be necessary with regard to the use of laser
39 or intense pulse light devices for elective cosmetic procedures by
40 physicians and surgeons, nurses, and physician assistants.

1 (c) *On or before July 1, 2009, the board shall adopt regulations*
2 *regarding the appropriate level of physician supervision needed*
3 *within clinics or other settings using laser or intense pulse light*
4 *devices for elective cosmetic procedures.*

5 ~~(e)~~

6 (d) The board shall establish, as one of its priorities, the
7 investigation of unlicensed activity or corporate practice of
8 medicine violations in clinics *or other settings* using laser or intense
9 pulse light devices.

10 ~~SEC. 4. Section 2218 is added to the Business and Professions~~
11 ~~Code, to read:~~

12 ~~2218. Physicians and surgeons performing procedures in an~~
13 ~~outpatient setting shall establish standardized procedures and~~
14 ~~protocols to be followed in the event of serious complications or~~
15 ~~side effects from cosmetic surgery that would place a patient at~~
16 ~~high risk for injury or harm and to govern emergency and urgent~~
17 ~~care situations.~~

18 ~~SEC. 5. Section 1249 is added to the Health and Safety Code,~~
19 ~~to read:~~

20 ~~1249. Outpatient settings shall establish standardized~~
21 ~~procedures and protocols to be followed in the event of serious~~
22 ~~complications or side effects from cosmetic surgery that would~~
23 ~~place a patient at high risk for injury or harm and to govern~~
24 ~~emergency and urgent care situations.~~

25 ~~SEC. 4. Section 2027.5 is added to the Business and Professions~~
26 ~~Code, to read:~~

27 ~~2027.5. The board shall post on its Web site an easy to~~
28 ~~understand factsheet to educate the public about cosmetic surgery~~
29 ~~and procedures, including their risks. Included with the factsheet~~
30 ~~shall be a comprehensive list of questions for patients to ask their~~
31 ~~physician and surgeon regarding cosmetic surgery.~~

32 ~~SEC. 5. Section 1248.15 of the Health and Safety Code is~~
33 ~~amended to read:~~

34 1248.15. (a) The division shall adopt standards for
35 accreditation and, in approving accreditation agencies to perform
36 accreditation of outpatient settings, shall ensure that the
37 certification program shall, at a minimum, include standards for
38 the following aspects of the settings' operations:

39 (1) Outpatient setting allied health staff shall be licensed or
40 certified to the extent required by state or federal law.

1 (2) (A) Outpatient settings shall have a system for facility safety
2 and emergency training requirements.

3 (B) There shall be onsite equipment, medication, and trained
4 personnel to facilitate handling of services sought or provided and
5 to facilitate handling of any medical emergency that may arise in
6 connection with services sought or provided.

7 (C) In order for procedures to be performed in an outpatient
8 setting as defined in Section 1248, the outpatient setting shall do
9 one of the following:

10 (i) Have a written transfer agreement with a local accredited or
11 licensed acute care hospital, approved by the facility's medical
12 staff.

13 (ii) Permit surgery only by a licensee who has admitting
14 privileges at a local accredited or licensed acute care hospital, with
15 the exception that licensees who may be precluded from having
16 admitting privileges by their professional classification or other
17 administrative limitations, shall have a written transfer agreement
18 with licensees who have admitting privileges at local accredited
19 or licensed acute care hospitals.

20 ~~(iii) Submit~~

21 *(D) Submission for approval by an accrediting agency of a*
22 *detailed procedural plan for handling medical emergencies that*
23 *shall be reviewed at the time of accreditation. No reasonable plan*
24 *shall be disapproved by the accrediting agency.*

25 *(E) Submission for approval by an accrediting agency at the*
26 *time of accreditation of a detailed plan, standardized procedures,*
27 *and protocols to be followed in the event of serious complications*
28 *or side effects from surgery that would place a patient at high risk*
29 *for injury or harm and to govern emergency and urgent care*
30 *situations.*

31 ~~(F)~~

32 *(F) All physicians and surgeons transferring patients from an*
33 *outpatient setting shall agree to cooperate with the medical staff*
34 *peer review process on the transferred case, the results of which*
35 *shall be referred back to the outpatient setting, if deemed*
36 *appropriate by the medical staff peer review committee. If the*
37 *medical staff of the acute care facility determines that inappropriate*
38 *care was delivered at the outpatient setting, the acute care facility's*
39 *peer review outcome shall be reported, as appropriate, to the*
40 *accrediting body, the Health Care Financing Administration, the*

1 State Department of Health Services, and the appropriate licensing
2 authority.

3 (3) The outpatient setting shall permit surgery by a dentist acting
4 within his or her scope of practice under Chapter 4 (commencing
5 with Section 1600) of *Division 2 of the Business and Professions*
6 *Code* or physician and surgeon, osteopathic physician and surgeon,
7 or podiatrist acting within his or her scope of practice under
8 Chapter 5 (commencing with Section 2000) of *Division 2 of the*
9 *Business and Professions Code* or the Osteopathic Initiative Act.
10 The outpatient setting may, in its discretion, permit anesthesia
11 service by a certified registered nurse anesthetist acting within his
12 or her scope of practice under Article 7 (commencing with Section
13 2825) of Chapter 6 of *Division 2 of the Business and Professions*
14 *Code*.

15 (4) Outpatient settings shall have a system for maintaining
16 clinical records.

17 (5) Outpatient settings shall have a system for patient care and
18 monitoring procedures.

19 (6) (A) Outpatient settings shall have a system for quality
20 assessment and improvement.

21 (B) Members of the medical staff and other practitioners who
22 are granted clinical privileges shall be professionally qualified and
23 appropriately credentialed for the performance of privileges
24 granted. The outpatient setting shall grant privileges in accordance
25 with recommendations from qualified health professionals, and
26 credentialing standards established by the outpatient setting.

27 (C) Clinical privileges shall be periodically reappraised by the
28 outpatient setting. The scope of procedures performed in the
29 outpatient setting shall be periodically reviewed and amended as
30 appropriate.

31 (7) Outpatient settings regulated by this chapter that have
32 multiple service locations governed by the same standards may
33 elect to have all service sites surveyed on any accreditation survey.
34 Organizations that do not elect to have all sites surveyed shall have
35 a sample, not to exceed 20 percent of all service sites, surveyed.
36 The actual sample size shall be determined by the division. The
37 accreditation agency shall determine the location of the sites to be
38 surveyed. Outpatient settings that have five or fewer sites shall
39 have at least one site surveyed. When an organization that elects

1 to have a sample of sites surveyed is approved for accreditation,
2 all of the organizations' sites shall be automatically accredited.

3 (8) Outpatient settings shall post the certificate of accreditation
4 in a location readily visible to patients and staff.

5 (9) Outpatient settings shall post the name and telephone number
6 of the accrediting agency with instructions on the submission of
7 complaints in a location readily visible to patients and staff.

8 (10) Outpatient settings shall have a written discharge criteria.

9 (b) Outpatient settings shall have a minimum of two staff
10 persons on the premises, one of whom shall either be a licensed
11 physician and surgeon or a licensed health care professional with
12 current certification in advanced cardiac life support (ACLS), as
13 long as a patient is present who has not been discharged from
14 supervised care. Transfer to an unlicensed setting of a patient who
15 does not meet the discharge criteria adopted pursuant to paragraph
16 (10) of subdivision (a) shall constitute unprofessional conduct.

17 (c) An accreditation agency may include additional standards
18 in its determination to accredit outpatient settings if these are
19 approved by the division to protect the public health and safety.

20 (d) No accreditation standard adopted or approved by the
21 division, and no standard included in any certification program of
22 any accreditation agency approved by the division, shall serve to
23 limit the ability of any allied health care practitioner to provide
24 services within his or her full scope of practice. Notwithstanding
25 this or any other provision of law, each outpatient setting may limit
26 the privileges, or determine the privileges, within the appropriate
27 scope of practice, that will be afforded to physicians and allied
28 health care practitioners who practice at the facility, in accordance
29 with credentialing standards established by the outpatient setting
30 in compliance with this chapter. Privileges may not be arbitrarily
31 restricted based on category of licensure.

32 *SEC. 6. Section 1248.2 of the Health and Safety Code is*
33 *amended to read:*

34 1248.2. (a) Any outpatient setting may apply to an
35 accreditation agency for a certificate of accreditation. Accreditation
36 shall be issued by the accreditation agency solely on the basis of
37 compliance with its standards as approved by the division under
38 this chapter.

39 (b) The division shall obtain and maintain a list of all accredited,
40 certified, and licensed outpatient settings from the information

1 provided by the accreditation, certification, and licensing agencies
2 approved by the division, and shall notify the public, ~~upon inquiry,~~
3 whether a setting is accredited, certified, or licensed, or ~~whether~~
4 the setting's accreditation, certification, or license has been
5 revoked, *suspended or placed on probation, or the setting has*
6 *received a reprimand by the accreditation agency.*

7 *SEC. 7. Section 1248.25 of the Health and Safety Code is*
8 *amended to read:*

9 1248.25. If an outpatient setting does not meet the standards
10 approved by the division, accreditation shall be denied by the
11 accreditation agency, which shall provide the outpatient setting
12 notification of the reasons for the denial. An outpatient setting may
13 reapply for accreditation at any time after receiving notification
14 of the denial. *The accrediting agency shall immediately report to*
15 *the division if the outpatient setting's certificate for accreditation*
16 *has been denied.*

17 *SEC. 8. Section 1248.35 of the Health and Safety Code is*
18 *amended to read:*

19 1248.35. (a) *Every outpatient setting which is accredited shall*
20 *be periodically inspected by the Division of Medical Quality or*
21 *the accreditation agency. The frequency of inspections shall depend*
22 *upon the type and complexity of the outpatient setting to be*
23 *inspected. Inspections shall be conducted no less often than once*
24 *every three years and as often as necessary to ensure the quality*
25 *of care provided. The Division of Medical Quality or ~~an~~ the*
26 *accreditation agency may, ~~upon reasonable prior notice and~~*
27 *~~presentation of proper identification,~~ enter and inspect any*
28 *outpatient setting that is accredited by an accreditation agency at*
29 *any reasonable time to ensure compliance with, or investigate an*
30 *alleged violation of, any standard of the accreditation agency or*
31 *any provision of this chapter.*

32 (b) If an accreditation agency determines, as a result of its
33 inspection, that an outpatient setting is not in compliance with the
34 standards under which it was approved, the accreditation agency
35 may do any of the following:

36 (1) Issue a reprimand.

37 (2) Place the outpatient setting on probation, during which time
38 the setting shall successfully institute and complete a plan of
39 correction, approved by the division or the accreditation agency,
40 to correct the deficiencies.

1 (3) Suspend or revoke the outpatient setting's certification of
2 accreditation.

3 (c) Except as is otherwise provided in this subdivision, before
4 suspending or revoking a certificate of accreditation under this
5 chapter, the accreditation agency shall provide the outpatient setting
6 with notice of any deficiencies and *the outpatient setting shall*
7 *agree with the accreditation agency on a plan of correction that*
8 *shall give the outpatient setting reasonable time to supply*
9 *information demonstrating compliance with the standards of the*
10 *accreditation agency in compliance with this chapter, as well as*
11 *the opportunity for a hearing on the matter upon the request of the*
12 *outpatient center. During that allotted time, a list of deficiencies*
13 *and the plan of correction shall be conspicuously posted in a clinic*
14 *location accessible to public view. The accreditation agency may*
15 *immediately suspend the certificate of accreditation before*
16 *providing notice and an opportunity to be heard, but only when*
17 *failure to take the action may result in imminent danger to the*
18 *health of an individual. In such cases, the accreditation agency*
19 *shall provide subsequent notice and an opportunity to be heard.*

20 (d) If the division determines that deficiencies found during an
21 inspection suggests that the accreditation agency does not comply
22 with the standards approved by the division, the division may
23 conduct inspections, as described in this section, of other settings
24 accredited by the accreditation agency to determine if the agency
25 is accrediting settings in accordance with Section 1248.15.

26 (e) *Reports on the results of each inspection shall be kept on*
27 *file with the division or the accrediting agency along with the plan*
28 *of correction and the outpatient setting comments. The inspection*
29 *report may include a recommendation for reinspection. All*
30 *inspection reports, lists of deficiencies, and plans of correction*
31 *shall be public records open to public inspection.*

32 (f) *The accrediting agency shall immediately report to the*
33 *division if the outgoing patient setting has been issued a reprimand*
34 *or if the outpatient setting's certification of accreditation has been*
35 *suspended or revoked or if the outpatient setting has been placed*
36 *on probation.*

37 SEC. 9. Section 1248.5 of the Health and Safety Code is
38 amended to read:

39 1248.5. The division ~~may~~ shall evaluate the performance of
40 an approved accreditation agency no less than every three years,

1 or in response to complaints against an agency, or complaints
2 against one or more outpatient settings accreditation by an agency
3 that indicates noncompliance by the agency with the standards
4 approved by the division.

5 ~~SEC. 6.~~

6 *SEC. 10.* No reimbursement is required by this act pursuant to
7 Section 6 of Article XIII B of the California Constitution because
8 the only costs that may be incurred by a local agency or school
9 district will be incurred because this act creates a new crime or
10 infraction, eliminates a crime or infraction, or changes the penalty
11 for a crime or infraction, within the meaning of Section 17556 of
12 the Government Code, or changes the definition of a crime within
13 the meaning of Section 6 of Article XIII B of the California
14 Constitution.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1526
Author: Perata
Bill Date: April 16, 2008, amended
Subject: Polysomnographic Technologists
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee and not been set for hearing.

DESCRIPTION OF CURRENT LEGISLATION:

This bill requires the Medical Board (Board) to adopt regulations by July 1, 2009, to establish qualifications for certified polysomnographic technologists. This bill authorizes persons who meet the specified education, examination, and certifications requirements to use the title “certified polysomnographic technologist” and engage in the practice of polysomnography under the supervision and direction of a licensed physician.

ANALYSIS:

This bill is sponsored by the American Academy of Sleep Medicine for the purpose of establishing criteria for individuals assisting licensed physicians in the practice of sleep medicine. Respiratory Care Board (RCB) feels that polysomnography is the unlicensed practice of respiratory care and has threatened to issue fines against those involved in the practice of sleep medicine. This has caused significant concern and uncertainty among the trained medical professionals practicing sleep medicine and has threatened the availability of these important medical services. This bill places no limitations on other health care practitioners acting within their own scope of practice.

SB 1526 does not establish a full licensing practice act. It is a proposal to require those who engage in the practice of polysomnography or use the title “certified polysomnographic technologist” to meet certain education, examination, and certification requirements, work under the supervision and direction of a physician, and undergo a criminal record clearance.

The Board would be required to adopt regulations regarding the qualifications for polysomnographic technologists and approve the entity that credentials practitioners, approve educational programs, and approve the certifying examination.

The author will be presenting proposed amendments which clarify the meaning of “supervision” under the bill. The amendment would require the supervising physician to be available, either in person or by telephone or electronic means, at the time the polysomnographic services are provided.

The author does not want to impose a burdensome program on the Medical Board and is willing to consider a registration fee to support the work required to implement and maintain the program.

FISCAL: A one time set up cost plus staff for a year and minimal ongoing costs to MBC.

POSITION: Recommendation: Neutral while bill is in development. Assign a board member to work with staff and interested parties in the development of this final bill.

April 18, 2008

AMENDED IN SENATE APRIL 16, 2008
AMENDED IN SENATE MARCH 28, 2008

SENATE BILL

No. 1526

Introduced by Senator Perata
(Coauthor: Senator Denham)

February 22, 2008

An act to add Chapter 7.8 (commencing with Section 3575) to Division 2 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1526, as amended, Perata. Polysomnographic technologists: sleep and wake disorders.

Existing law, the Physician Assistant Practice Act, provides for the licensure and regulation of physician assistants by the Physician Assistant Committee of the Medical Board of California. Existing law prescribes the medical services that may be performed by a physician assistant under the supervision of a licensed physician and surgeon.

Existing law, the Respiratory Care Practice Act, provides for the licensure and regulation of respiratory professionals by the Respiratory Care Board of California. Existing law defines the practice of respiratory therapy, and prohibits its practice without a license issued by the board, subject to certain exceptions.

This bill would require the Medical Board of California to adopt regulations by July 1, 2009, to establish qualifications for certified polysomnographic technologists, including requiring those technologists to be credentialed by a board-approved national accrediting agency, to have graduated from a board-approved educational program, and to have passed a board-approved national certifying examination. The bill

would require a certified polysomnographic technologist to be supervised by a licensed physician and surgeon and to undergo criminal record clearance by the Department of Justice. The bill would define polysomnography to mean the treatment, management, diagnostic testing, research, control, education, and care of patients with sleep and wake disorders, as specified. The bill would further require the board to adopt regulations related to the employment of polysomnographic technicians and trainees.

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. Chapter 7.8 (commencing with Section 3575) is
2 added to Division 2 of the Business and Professions Code, to read:

3

4 CHAPTER 7.8. POLYSOMNOGRAPHIC TECHNOLOGISTS

5

6 3575. (a) As used in this section, “board” means the Medical
7 Board of California.

8 (b) The board shall promulgate regulations by July 1, 2009,
9 relative to the qualifications for designation of an individual as a
10 certified polysomnographic technologist. Those qualifications shall
11 include all of the following:

12 (1) He or she shall have valid, current credentials as a
13 polysomnographic technologist by a national accrediting agency
14 approved by the board.

15 (2) He or she shall have graduated from a polysomnographic
16 educational program that has been approved by the board.

17 (3) He or she shall have passed a national certifying examination
18 that has been approved by the board.

19 (c) Notwithstanding any other provision of law, an individual
20 may use the title “certified polysomnographic technologist” and
21 may engage in the practice of polysomnography only under the
22 following circumstances:

23 (1) He or she works under the supervision and direction of a
24 licensed physician and surgeon.

25 (2) He or she has submitted electronic fingerprint images and
26 related information to the Department of Justice for a criminal
27 record clearance. The results of that criminal record clearance shall

1 be provided to the facility employing the polysomnographic
2 technologist.

3 (3) He or she meets the requirements of this section.

4 (d) "Polysomnography" means the treatment, management,
5 diagnostic testing, research, control, education, and care of patients
6 with sleep and wake disorders. Polysomnography shall include,
7 but not be limited to, the process of analysis, monitoring, and
8 recording of physiologic data during sleep and wakefulness to
9 assist in the treatment and research of disorders, syndromes, and
10 dysfunctions that are sleep-related, manifest during sleep, or disrupt
11 normal sleep and wake cycles and activities. Polysomnography
12 shall also include, but not be limited to, the therapeutic and
13 diagnostic use of oxygen, the use of positive airway pressure
14 including continuous positive airway pressure (CPAP) and bilevel
15 modalities, and maintenance of nasal and oral airways that do not
16 extend into the trachea.

17 (e) The board shall adopt regulations by July 1, 2009, that
18 establish the means and circumstances in which a licensed
19 physician and surgeon may employ polysomnographic technicians
20 and polysomnographic trainees.

21 ~~(f) As used in this section, "supervision" shall not be construed~~
22 ~~to require the physical presence of the supervising physician and~~
23 ~~surgeon.~~

24 *(f) As used in this section, "supervision" means that the*
25 *supervising physician and surgeon shall remain available, either*
26 *in person or through telephonic or electronic means, at the time*
27 *that the polysomnographic services are provided.*

28 (g) This section shall not apply to the following:

29 (1) Allied health professionals providing in-home diagnostic
30 testing and the set up, education, and training of patients requiring
31 positive airway pressure treatment to maintain their upper airways.

32 (2) Respiratory care practitioners working within the scope of
33 practice of their license.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1579
Author: Calderon
Bill Date: March 27, 2008, amended
Subject: Referrals for Hair Restoration
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Business and Professions Committee and has been set for hearing on April 28, 2008.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow physicians to offer compensation to licensed barbers or cosmetologists for providing general hair restoration information or education to a client, including referring or recommending the client to a physician for consultation regarding hair restoration.

ANALYSIS:

Current law prohibits the offer, receipt, or acceptance of any rebate, commission, preference, discount, or other compensation by any healing arts licensee as compensation or an inducement for referring patients to any person. Current law also prohibits a person, partnership, or corporation from referring or recommending a person for profit to a physician, hospital, or health-related facility for any form of medical care or treatment of any ailment or physical condition.

Allowing barbers and cosmetologists to be compensated by physicians for referring patients for hair restoration and related medical services could lead to the encouragement of referrals for unnecessary medical care. In addition, there are no checks and balances provided related to quality of care. Consumers could be at great risk of being unnecessarily recommended to seek treatment for hair loss and related conditions because of monetary incentives. Consumers could be preyed upon by unscrupulous practitioners who are in cahoots with barbers and cosmetologists.

FISCAL: None

POSITION: Recommendation: Oppose

April 17, 2008

AMENDED IN SENATE MARCH 27, 2008

SENATE BILL

No. 1579

Introduced by Senator Calderon

February 22, 2008

~~An act to add Section 650.03 to the Business and Professions Code, relating to physicians and surgeons.~~ *An act to add Section 7318.5 to the Business and Professions Code, relating to barbering and cosmetology.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1579, as amended, Calderon. ~~Physicians and surgeons: referrals.~~ *Medical referrals.*

Existing law, with certain exceptions, prohibits the offer, delivery, receipt, or acceptance by any healing arts licensee regulated by the Business and Professions Code or under the Chiropractic Initiative Act, of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, as compensation or an inducement for referring patients, clients, or customers to any person. *Existing law prohibits a person, firm, partnership, association, or corporation, or an agent or employee thereof, from referring or recommending a person for profit to a physician, hospital, health-related facility, or dispensary for any form of medical care or treatment of any ailment or physical condition, and specifies that the imposition of a fee or charge for any such referral or recommendation creates a presumption that the referral or recommendation is for profit.*

This bill would authorize a licensed physician and surgeon to offer or deliver, and a licensed barber or cosmetologist to receive, consideration for providing general hair restoration information or education to a client, including referring or recommending the client

to the licensed physician and surgeon for consultation regarding hair restoration.

~~This bill would provide that it is not unlawful for a physician and surgeon to provide consideration for a referral.~~

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

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

1 SECTION 1. Section 7318.5 is added to the Business and
2 Professions Code, to read:

3 7318.5. (a) Notwithstanding Section 445 of the Health and
4 Safety Code, it shall be lawful for a licensed barber or
5 cosmetologist to receive consideration from a licensed physician
6 or surgeon for providing general hair restoration information or
7 education to a client, including referring or recommending the
8 client to the licensed physician and surgeon for consultation
9 regarding hair restoration.

10 (b) Notwithstanding Section 650, it shall be lawful for a licensed
11 physician and surgeon to offer or deliver consideration to a
12 licensed barber or cosmetologist for the barber's or
13 cosmetologist's provision of general hair restoration information
14 or education to a client, including the referral or recommendation
15 of the client to the physician and surgeon for consultation
16 regarding hair restoration.

17 ~~SECTION 1. Section 650.03 is added to the Business and~~
18 ~~Professions Code, to read:~~

19 ~~650.03. Notwithstanding Section 650, or any other provision~~
20 ~~of law, it shall not be unlawful for a physician and surgeon licensed~~
21 ~~under this division to provide consideration for a referral.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1779
Author: Senate Business and Professions Committee
Bill Date: April 16, 2008, amended
Subject: Healing Arts: Omnibus
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee and has not been set for hearing.

DESCRIPTION OF CURRENT LEGISLATION:

This bill will be the vehicle by which omnibus legislation will be carried by the Senate Business and Professions Committee. Some provisions, although non-substantive, will impact statutes governing the Medical Practices Act.

ANALYSIS:

This bill is proposing non-substantive and non-controversial changes to law. The provisions relating to the Medical Board are in the Business and Professions Code and are as follows:

- 2089.5 – Specify type of residency programs; and technical changes.
- 2096 – Specify type of residency programs; and technical changes.
- 2102 – Federation of State Medical Boards (FSMB) will not test anyone without a state license; and technical changes.
- 2107 – Technical changes.
- 2135 –
 - *Subdivision (a)(1)* – Specifying degree of Medical Doctor to clarify and ensure understanding.
 - *Subdivision (d)* – Maintaining consistency between all licensing pathways.
 - Technical changes.

- 2172 – Repeal; board no longer administers examinations.
- 2173 – Repeal; board no longer administers examinations.
- 2174 – Repeal; board no longer administers examinations.
- 2175 – Repeal; board no longer administers examinations.
- 2307 – Specify that recommendations can come from physicians licensed in any state; and technical changes.
- 2335 – Re-amending section from AB 253 due to subsequent section amendments signed later.

FISCAL: None

POSITION: Recommendation: Support the technical provisions regarding the Medical Board.

April 17, 2008

AMENDED IN SENATE APRIL 16, 2008

SENATE BILL

No. 1779

Introduced by Committee on Business, Professions and Economic Development (Senators Ridley-Thomas (Chair), Aanestad, Calderon, Corbett, Denham, Florez, Harman, Simitian, and Yee)

March 13, 2008

An act to amend Sections 683, 733, 800, 2089.5, 2096, 2102, 2107, 2135, 2175, 2307, 2335, 2486, 2488, 2570.5, 2760.1, 3625, 3633.1, 3635, 3636, 3685, 3750.5, 3753.5, 3773, 4022.5, 4027, 4040, 4051, 4059.5, 4060, 4062, 4076, 4081, 4110, 4111, 4126.5, 4174, 4231, 4301, 4305, 4329, and 4330 of, to amend and renumber Section 2570.185 of, to add Sections 2570.35, 2570.36, 4036.5, and 4990.09 to, and to repeal Sections 2172, 2173, and 2174 of, the Business and Professions Code, to amend Section 8659 of the Government Code, and to amend Sections 11150 and 11165 of the Health and Safety Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1779, as amended, Committee on Business, Professions and Economic Development. Healing arts.

(1) Existing law requires specified licensure boards to report to the State Department of Health Care Services the name and license number of a person whose license has been revoked, suspended, surrendered, made inactive, or otherwise restricted, and requires specified licensure boards to create and maintain a central file of the names of all persons who hold a license from the board, and to prescribe and promulgate written complaint forms, as specified.

This bill would also subject the California Board of Occupational Therapy to these requirements, and would subject the Acupuncture

Board to the requirement to create and maintain a central file of the names of its licensees and to prescribe and promulgate written complaint forms, as specified.

(2) Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California, in the Department of Consumer Affairs. The act requires each applicant for a physician and surgeon's license to meet specified training and examinations requirements, authorizes the appointment of examination commissioners, requires that examinations be conducted in English, except as specified, allows the examinations to be conducted in specified locations, requires notice of examinations to contain certain information, and requires examination records to be kept on file for a period of 2 years or more. The act authorizes a person whose certificate has been surrendered, revoked, suspended, or placed on probation, as specified, to petition for reinstatement of the certificate or modification of the penalty if specified requirements are met.

This bill would ~~specify that certain training required~~ *revise the training requirements* for a physician and surgeon's license ~~must be approved by, or in programs approved by, the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada,~~ and would delete the requirement of passage of a clinical competency examination that is applicable to certain applicants. The bill would delete the provisions related to the appointment of examination commissioners, examinations being conducted in English and examination interpreters, the location of examinations, and examination notices. The bill would also delete the requirement that the board keep examination records on file for at least 2 years, and would instead require the board to keep state examination records on file until June 2069. The bill would revise the requirements for a petition for reinstatement or modification, as specified.

Existing law provides for the licensure and regulation of podiatrists by the Board of Podiatric Medicine in the Medical Board of California. Existing law authorizes the Board of Podiatric Medicine to issue an order of nonadoption of a proposed decision or interim order of the Medical Quality Hearing Panel within 90 calendar days. Existing law requires an applicant for a certificate to practice podiatric medicine to meet specified application procedures.

This bill would instead authorize the Board of Podiatric Medicine to issue an order of nonadoption of a proposed decision or interim order of the Medical Quality Hearing Panel within 100 calendar days. The

bill would revise the application procedures for a certificate to practice podiatric medicine, as specified.

(3) Existing law, the Occupational Therapy Practice Act, provides for the licensure and regulation of occupational therapists by the California Board of Occupational Therapy. Existing law requires an occupational therapist to document his or her evaluation, goals, treatment plan, and summary of treatment in a patient record. Existing law authorizes a limited permit to practice occupational therapy to be granted if specified education and examination requirements are met, but provides that if the person fails to qualify for or pass the first announced licensure examination, all limited permit privileges automatically cease upon due notice.

This bill would require an occupational therapy assistant to document in a patient record the services provided to the patient, and would require an occupational therapist or assistant to document and sign a patient record legibly. The bill would revise the provisions related to limited permit privileges to instead provide that a person's failure to pass the licensure examination during the initial eligibility period would cause the privileges to automatically cease upon due notice. The bill would require an employer of an occupational therapy practitioner to report to the board the suspension or termination for cause of any practitioner in its employ, or be subject to a specified administrative fine, and would require a licensee to report to the board violations of the Occupational Therapy Practice Act by licensees or applicants for licensure and to cooperate with the board, as specified.

(4) Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurses by the Board of Registered Nursing in the Department of Consumer Affairs. Existing law authorizes a registered nurse whose license is revoked or suspended, or who is placed on probation, to petition for reinstatement of his or her license or modification of the penalty after a specified time period.

This bill would require a petition by a registered nurse whose initial license application is subject to a disciplinary decision to be filed after a specified time period from the date upon which his or her initial license was issued.

(5) Existing law, the Naturopathic Doctors Act, provides for the licensure and regulation of naturopathic doctors by the Bureau of Naturopathic Medicine in the Department of Consumer Affairs. Existing law authorizes the bureau to grant a license to a person meeting certain requirements who has graduated from training prior to 1986 if the

application is received prior to 2008, and requires licensees to obtain continuing education through specified continuing education courses. Existing law requires a licensee on inactive status to meet certain requirements in order to restore his or her license to active status, including paying a reactivation fee.

This bill would require an application for licensure by a person who graduated from training prior to 1986 to be received by the bureau prior to 2011, and would revise the standards for continuing education courses. The bill would delete the requirement that a licensee on inactive status pay a reactivation fee in order to restore his or her license to active status, and would instead require him or her to be current with all licensing fees.

Existing law authorizes the Director of Consumer Affairs to establish an advisory council related to naturopathic doctors composed of members who receive no compensation, travel allowances, or reimbursement of expenses.

This bill would delete the requirement that the members of the advisory council receive no compensation, travel allowances, or reimbursement of expenses.

(6) Existing law provides for the licensure and regulation of respiratory care practitioners by the Respiratory Care Board of California. Existing law authorizes the board to deny, suspend, or revoke a license to practice respiratory therapy if the licensee obtains or possesses in violation of the law, except as directed by a licensed physician and surgeon, dentist, or podiatrist, or furnishes or administers or uses a controlled substance or dangerous drug, as defined. Existing law authorizes the board to direct a practitioner or applicant who is found to have violated the law to pay the costs of investigation and prosecution. Existing law requires an applicant for renewal of a respiratory care practitioner license to notify the board of specified information.

This bill would revise the board's authority to deny, suspend, or revoke a license to practice respiratory therapy for obtaining, possessing, using, administering, or furnishing controlled substances or dangerous drugs, and would also authorize the board to deny, suspend, or revoke a license if a licensee uses any controlled substance, dangerous drug, or alcoholic beverage to an extent or manner dangerous or injurious to himself or herself, the public, or another person, or to the extent that it impairs his or her ability to practice safely. The bill would also authorize the board to direct a practitioner or applicant who is found to have

violated a term or condition of board probation to pay the costs for investigation and prosecution. The bill would require an applicant for renewal of a respiratory care practitioner license to cooperate in furnishing additional information to the board, as requested, and would provide that, if a licensee fails to furnish the information within 30 days of a request, his or her license would become inactive until the information is received.

Existing law exempts certain healing arts practitioners from liability for specified services rendered during a state of war, state of emergency, or local emergency.

This bill would also exempt respiratory care practitioners from liability for the provision of specified services rendered during a state of war, state of emergency, or local emergency.

(7) Existing law, the Pharmacy Law, the knowing violation of which is a crime, provides for the licensure and regulation of pharmacists and pharmacies by the California State Board of Pharmacy in the Department of Consumer Affairs.

Existing law authorizes a pharmacy to furnish dangerous drugs only to specified persons or entities, and subjects certain pharmacies and persons who violate the provision to specified fines.

This bill would provide that any violation of this provision by any person or entity would subject the person to the fine.

Existing law requires a pharmacy or pharmacist who is in charge of or manages a pharmacy to notify the board within 30 days of termination of employment of the pharmacist-in-charge or acting as manager, and provides that a violation of this provision is grounds for disciplinary action.

This bill would instead provide that failure by a pharmacist-in-charge or a pharmacy to notify the board in writing that the pharmacist-in-charge has ceased to act as pharmacist-in-charge within 30 days constitutes grounds for disciplinary action, and would also provide that the operation of the pharmacy for more than 30 days without the supervision or management by a pharmacist-in-charge constitutes grounds for disciplinary action. The bill would revise the definition of a designated representative or designated representative-in-charge, and would define a pharmacist-in-charge.

Existing law makes a nonpharmacist owner of a pharmacy who commits acts that would subvert or tend to subvert the efforts of a pharmacist-in-charge to comply with the Pharmacy Law guilty of a misdemeanor.

This bill would apply this provision to any pharmacy owner.

The bill would require the board, during a declared federal, state, or local emergency, to allow for the employment of a mobile pharmacy in impacted areas under specified conditions, and would authorize the board to allow the temporary use of a mobile pharmacy when a pharmacy is destroyed or damaged under specified conditions. The bill would authorize the board, if a pharmacy fails to provide documentation substantiating continuing education requirements as part of a board investigation or audit, to cancel an active pharmacy license and issue an inactive pharmacy license, and would allow a pharmacy to reobtain an active pharmacy license if it meets specified requirements.

Because this bill would impose new requirements and prohibitions under the Pharmacy Law, the knowing violation of which would be a crime, it would impose a state-mandated local program.

Existing law requires pharmacies to provide information regarding certain controlled substances prescriptions to the Department of Justice on a weekly basis.

This bill would also require a clinic to provide this information to the Department of Justice on a weekly basis.

(8) Existing law provides for the licensure and regulation of psychologists, social workers, and marriage and family therapists by the Board of Behavioral Sciences. Existing law generally provides for a system of citations and fines that are applicable to healing arts licensees.

This bill would prohibit the board from publishing on the Internet final determinations of a citation and fine of \$1,500 or less for more than 5 years from the date of issuance of the citation.

(9) 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 683 of the Business and Professions Code
2 is amended to read:

1 683. (a) A board shall report, within 10 working days, to the
2 State Department of Health Care Services the name and license
3 number of a person whose license has been revoked, suspended,
4 surrendered, made inactive by the licensee, or placed in another
5 category that prohibits the licensee from practicing his or her
6 profession. The purpose of the reporting requirement is to prevent
7 reimbursement by the state for Medi-Cal and Denti-Cal services
8 provided after the cancellation of a provider's professional license.

9 (b) "Board," as used in this section, means the Dental Board of
10 California, the Medical Board of California, the Board of
11 Psychology, the State Board of Optometry, the California State
12 Board of Pharmacy, the Osteopathic Medical Board of California,
13 the State Board of Chiropractic Examiners, and the California
14 Board of Occupational Therapy.

15 SEC. 2. Section 733 of the Business and Professions Code is
16 amended to read:

17 733. (a) No licentiate shall obstruct a patient in obtaining a
18 prescription drug or device that has been legally prescribed or
19 ordered for that patient. A violation of this section constitutes
20 unprofessional conduct by the licentiate and shall subject the
21 licentiate to disciplinary or administrative action by his or her
22 licensing agency.

23 (b) Notwithstanding any other provision of law, a licentiate
24 shall dispense drugs and devices, as described in subdivision (a)
25 of Section 4024, pursuant to a lawful order or prescription unless
26 one of the following circumstances exists:

27 (1) Based solely on the licentiate's professional training and
28 judgment, dispensing pursuant to the order or the prescription is
29 contrary to law, or the licentiate determines that the prescribed
30 drug or device would cause a harmful drug interaction or would
31 otherwise adversely affect the patient's medical condition.

32 (2) The prescription drug or device is not in stock. If an order,
33 other than an order described in Section 4019, or prescription
34 cannot be dispensed because the drug or device is not in stock, the
35 licentiate shall take one of the following actions:

36 (A) Immediately notify the patient and arrange for the drug or
37 device to be delivered to the site or directly to the patient in a
38 timely manner.

39 (B) Promptly transfer the prescription to another pharmacy
40 known to stock the prescription drug or device that is near enough

1 to the site from which the prescription or order is transferred, to
2 ensure the patient has timely access to the drug or device.

3 (C) Return the prescription to the patient and refer the patient.
4 The licentiate shall make a reasonable effort to refer the patient to
5 a pharmacy that stocks the prescription drug or device that is near
6 enough to the referring site to ensure that the patient has timely
7 access to the drug or device.

8 (3) The licentiate refuses on ethical, moral, or religious grounds
9 to dispense a drug or device pursuant to an order or prescription.
10 A licentiate may decline to dispense a prescription drug or device
11 on this basis only if the licentiate has previously notified his or
12 her employer, in writing, of the drug or class of drugs to which he
13 or she objects, and the licentiate's employer can, without creating
14 undue hardship, provide a reasonable accommodation of the
15 licentiate's objection. The licentiate's employer shall establish
16 protocols that ensure that the patient has timely access to the
17 prescribed drug or device despite the licentiate's refusal to dispense
18 the prescription or order. For purposes of this section, "reasonable
19 accommodation" and "undue hardship" shall have the same
20 meaning as applied to those terms pursuant to subdivision (l) of
21 Section 12940 of the Government Code.

22 (c) For the purposes of this section, "prescription drug or device"
23 has the same meaning as the definition in Section 4022.

24 (d) The provisions of this section shall apply to the drug therapy
25 described in Section 4052.3.

26 (e) This section imposes no duty on a licentiate to dispense a
27 drug or device pursuant to a prescription or order without payment
28 for the drug or device, including payment directly by the patient
29 or through a third-party payer accepted by the licentiate or payment
30 of any required copayment by the patient.

31 (f) The notice to consumers required by Section 4122 shall
32 include a statement that describes patients' rights relative to the
33 requirements of this section.

34 SEC. 3. Section 800 of the Business and Professions Code is
35 amended to read:

36 800. (a) The Medical Board of California, the Board of
37 Psychology, the Dental Board of California, the Osteopathic
38 Medical Board of California, the State Board of Chiropractic
39 Examiners, the Board of Registered Nursing, the Board of
40 Vocational Nursing and Psychiatric Technicians, the State Board

1 of Optometry, the Veterinary Medical Board, the Board of
2 Behavioral Sciences, the Physical Therapy Board of California,
3 the California State Board of Pharmacy, the Speech-Language
4 Pathology and Audiology Board, the California Board of
5 Occupational Therapy, and the Acupuncture Board shall each
6 separately create and maintain a central file of the names of all
7 persons who hold a license, certificate, or similar authority from
8 that board. Each central file shall be created and maintained to
9 provide an individual historical record for each licensee with
10 respect to the following information:

11 (1) Any conviction of a crime in this or any other state that
12 constitutes unprofessional conduct pursuant to the reporting
13 requirements of Section 803.

14 (2) Any judgment or settlement requiring the licensee or his or
15 her insurer to pay any amount of damages in excess of three
16 thousand dollars (\$3,000) for any claim that injury or death was
17 proximately caused by the licensee's negligence, error or omission
18 in practice, or by rendering unauthorized professional services,
19 pursuant to the reporting requirements of Section 801 or 802.

20 (3) Any public complaints for which provision is made pursuant
21 to subdivision (b).

22 (4) Disciplinary information reported pursuant to Section 805.

23 (b) Each board shall prescribe and promulgate forms on which
24 members of the public and other licensees or certificate holders
25 may file written complaints to the board alleging any act of
26 misconduct in, or connected with, the performance of professional
27 services by the licensee.

28 If a board, or division thereof, a committee, or a panel has failed
29 to act upon a complaint or report within five years, or has found
30 that the complaint or report is without merit, the central file shall
31 be purged of information relating to the complaint or report.

32 Notwithstanding this subdivision, the Board of Psychology, the
33 Board of Behavioral Sciences, and the Respiratory Care Board of
34 California shall maintain complaints or reports as long as each
35 board deems necessary.

36 (c) The contents of any central file that are not public records
37 under any other provision of law shall be confidential except that
38 the licensee involved, or his or her counsel or representative, shall
39 have the right to inspect and have copies made of his or her
40 complete file except for the provision that may disclose the identity

1 of an information source. For the purposes of this section, a board
2 may protect an information source by providing a copy of the
3 material with only those deletions necessary to protect the identity
4 of the source or by providing a comprehensive summary of the
5 substance of the material. Whichever method is used, the board
6 shall ensure that full disclosure is made to the subject of any
7 personal information that could reasonably in any way reflect or
8 convey anything detrimental, disparaging, or threatening to a
9 licensee's reputation, rights, benefits, privileges, or qualifications,
10 or be used by a board to make a determination that would affect
11 a licensee's rights, benefits, privileges, or qualifications. The
12 information required to be disclosed pursuant to Section 803.1
13 shall not be considered among the contents of a central file for the
14 purposes of this subdivision.

15 The licensee may, but is not required to, submit any additional
16 exculpatory or explanatory statement or other information that the
17 board shall include in the central file.

18 Each board may permit any law enforcement or regulatory
19 agency when required for an investigation of unlawful activity or
20 for licensing, certification, or regulatory purposes to inspect and
21 have copies made of that licensee's file, unless the disclosure is
22 otherwise prohibited by law.

23 These disclosures shall effect no change in the confidential status
24 of these records.

25 SEC. 4. Section 2089.5 of the Business and Professions Code
26 is amended to read:

27 2089.5. (a) Clinical instruction in the subjects listed in
28 subdivision (b) of Section 2089 shall meet the requirements of this
29 section and shall be considered adequate if the requirements of
30 subdivision (a) of Section 2089 and the requirements of this section
31 are satisfied.

32 (b) Instruction in the clinical courses shall total a minimum of
33 72 weeks in length.

34 (c) Instruction in the core clinical courses of surgery, medicine,
35 family medicine, pediatrics, obstetrics and gynecology, and
36 psychiatry shall total a minimum of 40 weeks in length with a
37 minimum of eight weeks instruction in surgery, eight weeks in
38 medicine, six weeks in pediatrics, six weeks in obstetrics and
39 gynecology, a minimum of four weeks in family medicine, and
40 four weeks in psychiatry.

1 (d) Of the instruction required by subdivision (b), including all
2 of the instruction required by subdivision (c), 54 weeks shall be
3 performed in a hospital that sponsors the instruction and shall meet
4 one of the following:

5 (1) Is a formal part of the medical school or school of
6 osteopathic medicine.

7 (2) Has a residency program, approved by the Accreditation
8 Council for Graduate Medical Education (ACGME) or the Royal
9 College of Physicians and Surgeons of Canada (RCPSC), in family
10 practice or in the clinical area of the instruction for which credit
11 is being sought.

12 (3) Is formally affiliated with an approved medical school or
13 school of osteopathic medicine located in the United States or
14 Canada. If the affiliation is limited in nature, credit shall be given
15 only in the subject areas covered by the affiliation agreement.

16 (4) Is formally affiliated with a medical school or a school of
17 osteopathic medicine located outside the United States or Canada.

18 (e) If the institution, specified in subdivision (d), is formally
19 affiliated with a medical school or a school of osteopathic medicine
20 located outside the United States or Canada, it shall meet the
21 following:

22 (1) The formal affiliation shall be documented by a written
23 contract detailing the relationship between the medical school, or
24 a school of osteopathic medicine, and hospital and the
25 responsibilities of each.

26 (2) The school and hospital shall provide to the board a
27 description of the clinical program. The description shall be in
28 sufficient detail to enable the board to determine whether or not
29 the program provides students an adequate medical education. The
30 board shall approve the program if it determines that the program
31 provides an adequate medical education. If the board does not
32 approve the program, it shall provide its reasons for disapproval
33 to the school and hospital in writing specifying its findings about
34 each aspect of the program that it considers to be deficient and the
35 changes required to obtain approval.

36 (3) The hospital, if located in the United States, shall be
37 accredited by the Joint Commission on Accreditation of Hospitals,
38 and if located in another country, shall be accredited in accordance
39 with the law of that country.

1 (4) The clinical instruction shall be supervised by a full-time
2 director of medical education, and the head of the department for
3 each core clinical course shall hold a full-time faculty appointment
4 of the medical school or school of osteopathic medicine and shall
5 be board certified or eligible, or have an equivalent credential in
6 that specialty area appropriate to the country in which the hospital
7 is located.

8 (5) The clinical instruction shall be conducted pursuant to a
9 written program of instruction provided by the school.

10 (6) The school shall supervise the implementation of the
11 program on a regular basis, documenting the level and extent of
12 its supervision.

13 (7) The hospital-based faculty shall evaluate each student on a
14 regular basis and shall document the completion of each aspect of
15 the program for each student.

16 (8) The hospital shall ensure a minimum daily census adequate
17 to meet the instructional needs of the number of students enrolled
18 in each course area of clinical instruction, but not less than 15
19 patients in each course area of clinical instruction.

20 (9) The board, in reviewing the application of a foreign medical
21 graduate, may require the applicant to submit a description of the
22 clinical program, if the board has not previously approved the
23 program, and may require the applicant to submit documentation
24 to demonstrate that the applicant's clinical training met the
25 requirements of this subdivision.

26 (10) The medical school or school of osteopathic medicine shall
27 bear the reasonable cost of any site inspection by the board or its
28 agents necessary to determine whether the clinical program offered
29 is in compliance with this subdivision.

30 SEC. 5. Section 2096 of the Business and Professions Code is
31 amended to read:

32 2096. In addition to other requirements of this chapter, before
33 ~~a physician~~ *physician's* and surgeon's license may be issued, each
34 applicant, including an applicant applying pursuant to Article 5
35 (commencing with Section 2100), shall show by evidence
36 satisfactory to the board that he or she has satisfactorily completed
37 at least one year of postgraduate training, which includes at least
38 four months of general medicine, in a postgraduate training
39 program approved by the Accreditation Council for Graduate

1 Medical Education (ACGME) or Royal College of Physicians and
2 Surgeons of Canada (RCPSC).

3 The amendments made to this section at the 1987 portion of the
4 1987–88 session of the Legislature shall not apply to applicants
5 who completed their one year of postgraduate training on or before
6 July 1, 1990.

7 SEC. 6. Section 2102 of the Business and Professions Code is
8 amended to read:

9 2102. Any applicant whose professional instruction was
10 acquired in a country other than the United States or Canada shall
11 provide evidence satisfactory to the board of compliance with the
12 following requirements to be issued a ~~physician~~ *physician's* and
13 surgeon's certificate:

14 (a) Completion in a medical school or schools of a resident
15 course of professional instruction equivalent to that required by
16 Section 2089 and issuance to the applicant of a document
17 acceptable to the board that shows final and successful completion
18 of the course. However, nothing in this section shall be construed
19 to require the board to evaluate for equivalency any coursework
20 obtained at a medical school disapproved by the board pursuant
21 to this section.

22 (b) Certification by the Educational Commission for Foreign
23 Medical Graduates, or its equivalent, as determined by the board.
24 This subdivision shall apply to all applicants who are subject to
25 this section and who have not taken and passed the written
26 examination specified in subdivision (d) prior to June 1, 1986.

27 (c) Satisfactory completion of the postgraduate training required
28 under Section 2096. An applicant shall be required to have
29 substantially completed the professional instruction required in
30 subdivision (a) and shall be required to make application to the
31 board and have passed steps 1 and 2 of the written examination
32 relating to biomedical and clinical sciences prior to commencing
33 any postgraduate training in this state. In its discretion, the board
34 may authorize an applicant who is deficient in any education or
35 clinical instruction required by Sections 2089 and 2089.5 to make
36 up any deficiencies as a part of his or her postgraduate training
37 program, but that remedial training shall be in addition to the
38 postgraduate training required for licensure.

39 (d) Pass the written examination as provided under Article 9
40 (commencing with Section 2170). An applicant shall be required

1 to meet the requirements specified in subdivision (b) prior to being
2 admitted to the written examination required by this subdivision.

3 Nothing in this section prohibits the board from disapproving
4 any foreign medical school or from denying an application if, in
5 the opinion of the board, the professional instruction provided by
6 the medical school or the instruction received by the applicant is
7 not equivalent to that required in Article 4 (commencing with
8 Section 2080).

9 SEC. 7. Section 2107 of the Business and Professions Code is
10 amended to read:

11 2107. (a) The Legislature intends that the board shall have the
12 authority to substitute postgraduate education and training to
13 remedy deficiencies in an applicant's medical school education
14 and training. The Legislature further intends that applicants who
15 substantially completed their clinical training shall be granted that
16 substitute credit if their postgraduate education took place in an
17 accredited program.

18 (b) To meet the requirements for licensure set forth in Sections
19 2089 and 2089.5, the board may require an applicant under this
20 article to successfully complete additional education and training.
21 In determining the content and duration of the required additional
22 education and training, the board shall consider the applicant's
23 medical education and performance on standardized national
24 examinations, and may substitute approved postgraduate training
25 in lieu of specified undergraduate requirements. Postgraduate
26 training substituted for undergraduate training shall be in addition
27 to the postgraduate training required by Sections 2102 and 2103.

28 SEC. 8. Section 2135 of the Business and Professions Code is
29 amended to read:

30 2135. The ~~Division of Licensing~~ *board* shall issue a physician
31 and surgeon's certificate to an applicant who meets all of the
32 following requirements:

33 (a) The applicant holds an unlimited license as a physician and
34 surgeon in another state or states, or in a Canadian province or
35 Canadian provinces, which was issued upon:

36 (1) Successful completion of a resident course of professional
37 instruction *leading to a degree of medical doctor* equivalent to
38 that specified in Section 2089. However, nothing in this section
39 shall be construed to require the ~~division~~ *board* to evaluate for
40 equivalency any coursework obtained at a medical school

1 disapproved by the ~~division~~ *board* pursuant to Article 4
2 (commencing with Section 2080).

3 (2) Taking and passing a written examination that is recognized
4 by the division to be equivalent in content to that administered in
5 California.

6 (b) The applicant has held an unrestricted license to practice
7 medicine, in a state or states, in a Canadian province or Canadian
8 provinces, or as a member of the active military, United States
9 Public Health Services, or other federal program, for a period of
10 at least four years. Any time spent by the applicant in an approved
11 postgraduate training program or clinical fellowship acceptable to
12 the ~~division~~ *board* shall not be included in the calculation of this
13 four-year period.

14 (c) The ~~division~~ *board* determines that no disciplinary action
15 has been taken against the applicant by any medical licensing
16 authority and that the applicant has not been the subject of adverse
17 judgments or settlements resulting from the practice of medicine
18 that the division determines constitutes evidence of a pattern of
19 negligence or incompetence.

20 (d) The applicant (1) *has satisfactorily completed at least one*
21 *year of approved postgraduate training and* is certified by a
22 specialty board approved by the American Board of Medical
23 Specialties or approved by the division pursuant to subdivision (h)
24 of Section 651; (2) has satisfactorily completed at least two years
25 of approved postgraduate training; or (3) *has satisfactorily*
26 *completed at least one year of approved postgraduate training*
27 *and* takes and passes the clinical competency written examination.

28 (e) The applicant has not committed any acts or crimes
29 constituting grounds for denial of a certificate under Division 1.5
30 (commencing with Section 475) or Article 12 (commencing with
31 Section 2220).

32 (f) Any application received from an applicant who has held an
33 unrestricted license to practice medicine, in a state or states, or
34 Canadian province or Canadian provinces, or as a member of the
35 active military, United States Public Health Services, or other
36 federal program for four or more years shall be reviewed and
37 processed pursuant to this section. Any time spent by the applicant
38 in an approved postgraduate training program or clinical fellowship
39 acceptable to the ~~division~~ *board* shall not be included in the
40 calculation of this four-year period. This subdivision does not

1 apply to applications that may be reviewed and processed pursuant
2 to Section 2151.

3 ~~SEC. 8.~~

4 ~~SEC. 9.~~ Section 2172 of the Business and Professions Code is
5 repealed.

6 ~~SEC. 9.~~

7 ~~SEC. 10.~~ Section 2173 of the Business and Professions Code
8 is repealed.

9 ~~SEC. 10.~~

10 ~~SEC. 11.~~ Section 2174 of the Business and Professions Code
11 is repealed.

12 ~~SEC. 11.~~

13 ~~SEC. 12.~~ Section 2175 of the Business and Professions Code
14 is amended to read:

15 2175. State examination records shall be kept on file by the
16 board until June 1, 2069. Examinees shall be known and designated
17 by number only, and the name attached to the number shall be kept
18 secret until the examinee is sent notification of the results of the
19 examinations.

20 ~~SEC. 12.~~

21 ~~SEC. 13.~~ Section 2307 of the Business and Professions Code
22 is amended to read:

23 2307. (a) A person whose certificate has been surrendered
24 while under investigation or while charges are pending or whose
25 certificate has been revoked or suspended or placed on probation,
26 may petition the board for reinstatement or modification of penalty,
27 including modification or termination of probation.

28 (b) The person may file the petition after a period of not less
29 than the following minimum periods have elapsed from the
30 effective date of the surrender of the certificate or the decision
31 ordering that disciplinary action:

32 (1) At least three years for reinstatement of a license surrendered
33 or revoked for unprofessional conduct, except that the board may,
34 for good cause shown, specify in a revocation order that a petition
35 for reinstatement may be filed after two years.

36 (2) At least two years for early termination of probation of three
37 years or more.

38 (3) At least one year for modification of a condition, or
39 reinstatement of a license surrendered or revoked for mental or
40 physical illness, or termination of probation of less than three years.

1 (c) The petition shall state any facts as may be required by the
2 board. The petition shall be accompanied by at least two verified
3 recommendations from physicians and surgeons licensed in any
4 state who have personal knowledge of the activities of the petitioner
5 since the disciplinary penalty was imposed.

6 (d) The petition may be heard by a panel of the board. The board
7 may assign the petition to an administrative law judge designated
8 in Section 11371 of the Government Code. After a hearing on the
9 petition, the administrative law judge shall provide a proposed
10 decision to the board or the California Board of Podiatric Medicine,
11 as applicable, which shall be acted upon in accordance with Section
12 2335.

13 (e) The panel of the board or the administrative law judge
14 hearing the petition may consider all activities of the petitioner
15 since the disciplinary action was taken, the offense for which the
16 petitioner was disciplined, the petitioner's activities during the
17 time the certificate was in good standing, and the petitioner's
18 rehabilitative efforts, general reputation for truth, and professional
19 ability. The hearing may be continued from time to time as the
20 administrative law judge designated in Section 11371 of the
21 Government Code finds necessary.

22 (f) The administrative law judge designated in Section 11371
23 of the Government Code reinstating a certificate or modifying a
24 penalty may recommend the imposition of any terms and conditions
25 deemed necessary.

26 (g) No petition shall be considered while the petitioner is under
27 sentence for any criminal offense, including any period during
28 which the petitioner is on court-imposed probation or parole. No
29 petition shall be considered while there is an accusation or petition
30 to revoke probation pending against the person. The board may
31 deny without a hearing or argument any petition filed pursuant to
32 this section within a period of two years from the effective date
33 of the prior decision following a hearing under this section.

34 (h) This section is applicable to and may be carried out with
35 regard to licensees of the California Board of Podiatric Medicine.
36 In lieu of two verified recommendations from physicians and
37 surgeons, the petition shall be accompanied by at least two verified
38 recommendations from podiatrists licensed in any state who have
39 personal knowledge of the activities of the petitioner since the date
40 the disciplinary penalty was imposed.

1 (i) Nothing in this section shall be deemed to alter Sections 822
2 and 823.

3 ~~SEC. 13.~~

4 *SEC. 14.* Section 2335 of the Business and Professions Code
5 is amended to read:

6 2335. (a) All proposed decisions and interim orders of the
7 Medical Quality Hearing Panel designated in Section 11371 of the
8 Government Code shall be transmitted to the executive director
9 of the board, or the executive director of the California Board of
10 Podiatric Medicine as to the licensees of that board, within 48
11 hours of filing.

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

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

19 (1) When considering a proposed decision, the board or panel
20 and the California Board of Podiatric Medicine shall give great
21 weight to the findings of fact of the administrative law judge,
22 except to the extent those findings of fact are controverted by new
23 evidence.

24 (2) The board's staff or the staff of the California Board of
25 Podiatric Medicine shall poll the members of the board or panel
26 or of the California Board of Podiatric Medicine by written mail
27 ballot concerning the proposed decision. The mail ballot shall be
28 sent within 10 calendar days of receipt of the proposed decision,
29 and shall poll each member on whether the member votes to
30 approve the decision, to approve the decision with an altered
31 penalty, to refer the case back to the administrative law judge for
32 the taking of additional evidence, to defer final decision pending
33 discussion of the case by the panel or board as a whole, or to
34 nonadopt the decision. No party to the proceeding, including
35 employees of the agency that filed the accusation, and no person
36 who has a direct or indirect interest in the outcome of the
37 proceeding or who presided at a previous stage of the decision,
38 may communicate directly or indirectly, upon the merits of a
39 contested matter while the proceeding is pending, with any member
40 of the panel or board, without notice and opportunity for all parties

1 to participate in the communication. The votes of a majority of the
2 board or of the panel, and a majority of the California Board of
3 Podiatric Medicine, are required to approve the decision with an
4 altered penalty, to refer the case back to the administrative law
5 judge for the taking of further evidence, or to nonadopt the
6 decision. The votes of two members of the panel or board are
7 required to defer final decision pending discussion of the case by
8 the panel or board as a whole. If there is a vote by the specified
9 number to defer final decision pending discussion of the case by
10 the panel or board as a whole, provision shall be made for that
11 discussion before the 100-day period specified in paragraph (3)
12 expires, but in no event shall that 100-day period be extended.

13 (3) If a majority of the board or of the panel, or a majority of
14 the California Board of Podiatric Medicine vote to do so, the board
15 or the panel or the California Board of Podiatric Medicine shall
16 issue an order of nonadoption of a proposed decision within 100
17 calendar days of the date it is received by the board. If the board
18 or the panel or the California Board of Podiatric Medicine does
19 not refer the case back to the administrative law judge for the
20 taking of additional evidence or issue an order of nonadoption
21 within 100 days, the decision shall be final and subject to review
22 under Section 2337. Members of the board or of any panel or of
23 the California Board of Podiatric Medicine who review a proposed
24 decision or other matter and vote by mail as provided in paragraph
25 (2) shall return their votes by mail to the board within 30 days
26 from receipt of the proposed decision or other matter.

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

31 (5) A vote of a majority of the board or of a panel, or a majority
32 of the California Board of Podiatric Medicine, are required to
33 increase the penalty from that contained in the proposed
34 administrative law judge's decision. No member of the board or
35 panel or of the California Board of Podiatric Medicine may vote
36 to increase the penalty except after reading the entire record and
37 personally hearing any additional oral argument and evidence
38 presented to the panel or board.

**Medical Board of California
2008 Tracker II - Legislative Bills
4/18/2008**

<u>BILL</u>	<u>AUTHOR</u>	<u>TITLE</u>	<u>STATUS</u>	<u>AMENDED</u>	<u>POSITION</u>
AB 54	Dymally	Health Care Coverage: acupuncture	Sen. Health	03/03/08	
AB 55	Laird	Referral Fee: technology and services	Sen. Health	03/03/08	
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	Sen. Health	01/24/08	
AB 638	Bass	Physician Assistants: educational loan program	Sen. Health	01/18/08	
AB 865	Davis	State Agencies: live customer service agents	Sen. G.O.	01/22/08	
AB 1057	Beall	Health Care: traumatic brain injury: pilot program	Sen. Health	07/03/07	
AB 1137	Eng	Chiropractors	Sen. B&P	06/04/07	
AB 1390	Huffman	Health Care Service Plans: unfair payment patterns	Sen. Health	Introduced	
AB 1436	Hernandez	Nurse Practitioners	Sen. B&P	01/07/08	
AB 1486	Calderon	Licensed Professional Counselors	Sen. B&P	06/26/07	
AB 1861	Emmerson	State Board of Chiropractic Examiners	Asm. Approps.	03/28/08	
AB 1922	Hernandez	Healing Arts Practitioners: peer review	Sen. Rules	Introduced	
AB 1925	Eng	Franchise Tax Board: business and prof. licenses	Asm. Approps.	04/07/08	
AB 1940	DeVore	Temporary Disabled Persons' Placards: pregnancy	Asm. Approps.	Introduced	
AB 2049	Saldana	Sexual Batter: healing professionals	Asm. Approps.	04/09/08	
AB 2111	Smyth	Physical Therapists	Asm. Approps. (4/23)	04/14/08	
AB 2117	Evans	Dependent Children: psychotropic medications	Asm. Approps.-susp	03/28/08	
AB 2120	Galgiani	Medical Telemedicine	Asm. Approps.	04/03/08	
AB 2122	Plescica	Surgical Clinics: licensure	Asm. Approps.-susp	03/24/08	
AB 2207	Lieu	Emergency Rooms: overcrowding	Asm. Approps.	04/03/08	
AB 2210	Price	Dentistry: emergency services	Asm. Floor	03/25/08	
AB 2234	Portantino	Health Care Coverage: breast conditions	Asm. Approps.	Introduced	
AB 2351	Garrick	Workers' Comp.: medical treatment utilization reviews	Asm. Ins. (4/30)	Introduced	
AB 2423	Bass	Professions and Vocations: Licensure	Asm. Approps.	Introduced	
AB 2539	Strickland	State Boards and Commissions: salaries: suspension	Asm. B&P	03/10/08	

**Medical Board of California
2008 Tracker II - Legislative Bills
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<u>BILL</u>	<u>AUTHOR</u>	<u>TITLE</u>	<u>STATUS</u>	<u>AMENDED</u>	<u>POSITION</u>
AB 2542	Nakanishi	Patient Safety	Introduced	Introduced	
AB 2690	Krekorian	Prod. Liability Actions: pres. pharmaceutical products	Asm. Jud. (4/29)	Introduced	
AB 2697	Huffman	Hospitals: emergency medical services	Asm. Approps.	04/15/08	
AB 2702	Nunez	Maddy Emerg. Med. Serv. Fund: phys. reimburs.: LA county	Asm. Health (4/28)	Introduced	
AB 2787	Arambula	Clinics: licensing: hours of operation	Asm. Approps.-susp	Introduced	
AB 2794	Blakeslee	Diagnostic Imaging Services	Asm. Approps.	04/09/08	
AB 2807	Adams	Department of Consumer Affairs	Introduced	Introduced	
AB 2811	Bass	Physician Assistant Practice Act	Introduced	Introduced	
AB 2847	Krekorian	Health Care Coverage	Asm. Approps.	03/24/08	
AB 3000	Wolk	Health Care Decisions: life sustaining treatment	Asm. Jud. (4/22)	Introduced	
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ABX1 2	Nunez	Health Care Reform	Asm. Health	11/08/07	
ABX1 6	Nakanishi	Physician Assistants: educational loan program	Introduced	Introduced	
ACR 87	Hayashi	Legislative Task Force on Peripheral Neuroopathy	Asm. Health (4/29)	Introduced	
ACR 112	Soto	Legislative Task Force on Fibromyalgia	Asm. Health (4/29)	04/15/08	

**Medical Board of California
2008 Tracker II - Legislative Bills
4/18/2008**

<u>BILL</u>	<u>AUTHOR</u>	<u>TITLE</u>	<u>STATUS</u>	<u>AMENDED</u>	<u>POSITION</u>
SB 356	Negrete McLeod	List of Reportable Diseases and Conditions	Inactive File	08/20/07	
SB 676	Ridley-Thomas	Health: immunizations	Asm. Approps.-susp	08/20/07	
SB 721	Ashburn	State Agencies: succession plans	Asm. Approps.-susp	Introduced	
SB 731	Oropeza	Massage Therapy	Asm. Approps.-susp	07/09/07	
SB 825	Padilla	Public Health: shaken baby syndrome	Asm. Desk	01/29/08	
SB 840	Kuehl	Single-Payer Health Care Coverage	Asm. Approps.	07/10/07	
SB 963	Ridley-Thomas	Regulatory Boards: Operations	Asm. B&P	06/25/07	
SB 1098	Migden	Medical Marijuana	Sen. Rev. & Tax-susp	03/11/08	
SB 1260	Runner	Health Clinics	Sen. Approps. (4/21)	03/24/08	
SB 1288	Scott	Cal. State Univ.: Doctor of Nursing Practice Degree	Sen. Approps.	Introduced	
SB 1338	Migden	Workers' Comp.: med. treatment: predesignation of phy.	Sen. L&I.R. (4/23)	Introduced	
SB 1402	Corbett	Reporting Requirements	Sen. Approps. (4/28)	04/10/08	
SB 1406	Correa	Optometry	Sen. Approps.	Introduced	
SB 1494	McClintock	State Agency Web Sites: information	Sen. Approps. (4/21)	04/10/08	
SB 1505	Yee	Board of Behavioral Sciences: fees	Sen. B&P (4/28)	04/07/08	
SB 1525	Kuehl	Health Care Coverage: medical necessity determinations	Sen. Approps.	04/10/08	
SB 1633	Kuehl	Dental Services: credit	Sen Approps. (4/28)	Introduced	
SB 1639	Ashburn	Nurse Practitioners	Sen. Rules	Introduced	
SB 1729	Migden	Nursing Home: training	Sen. Approps.	04/08/08	
SB 1769	Perata	Department of Consumer Affairs	Sen. Rules	Introduced	
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SBX1 6	Runner	Hospitals: preventative medical services	Rules	Introduced	
SBX1 9	Runner	Primary Care Clinics	Sec. of Senate	01/10/08	
SBX1 12	Runner	Health Care Cost and Quality Transparency	Rules	01/14/08	
SJR 20	Migden	Medical Marijuana	Sen. Jud.	04/03/08	

**MEDICAL BOARD OF CALIFORNIA
Status of Pending Regulations**

Subject	Current Status	Date Approved by Board	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	On 3/14/08, DCA sent the file to Agency for review	7/28/07	9/7/07	11/2/07	11/2/07	2/8/08		
Continuing Education Requirements	At 2/1/08 hearing, Board modified text. Comment period ended 3/17/08; no adverse comments. Staff completing the file	11/2/07	12/07/07	2/1/08	3/17/08			
Delegation of Services (on behalf of the Physician Assistant Comm)	At DCA for review	11/2/07	12/07/07	2/1/08	2/1/08	3/13/08		
Disciplinary Guidelines	Hearing scheduled 4/25/08	2/1/08	2/29/08	4/1/08				
Fee Reduction to Offset Elimination of Diversion Prog.	Hearing scheduled 4/25/08	2/1/08	2/29/08	4/1/08				
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations pending Spring-Summer 2008							

* - DCA is allowed 30 calendar days for review
 ** - OAL is allowed 30 working days for review
 *** - Regs take effect 30 days after filing with Sec. of State

Prepared by Kevin A. Schunke
 Updated March 25, 2008
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