MEDICAL BOARD OF CALIFORNIA
Executive Office

MEMBERS OF THE BOARD
Richard Fantozzi, M.D., President
Hedy Chang, Secretary
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.
Barbara Yaroslavsky
Frank V. Zerunyan, J.D.

QUARTERLY BOARD MEETING

November 6-7, 2008

Sheraton Suites
Ovation Room
701 A Street
San Diego, CA 92101
(619) 696-9800

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

AMENDED AGENDA

Thursday, November 6, 2008
11:30 a.m. and 4:00 p.m.

Friday, November 7, 2008
9:00 a.m. to 2:00 p.m.
(or at the conclusion of the Application Review Committee meeting until the conclusion of business)

Thursday, November 6, 2008 11:30 a.m.

1. "Standard of Care" Training – Steve Adler, Supervising Deputy Attorney General

Thursday, November 6, 2008 4:00 p.m.

2. Call to Order / Roll Call

3. Approval of Minutes from the July 25, 2008 meeting

4. Legislation – Ms. Whitney
   A. Status of Regulatory Action
   B. 2008 Legislation and Implementation
   C. 2009 Legislation and Proposals

5. Change in Effective Date of Fee Reduction Regulations – Ms. Scuri and Mr. Schunke

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing and regulatory functions.

6. Discussion on Board Member Administrative Procedure Manual

7. Adjournment

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Friday, November 7, 2008 9:00 a.m.

8. Call to Order / Roll Call

9. Public Comment on Items not on the Agenda

10. Election of Officers

11. President's Report
    A. Executive Committee Update
    B. DCA Summit and Statement

12. Presentation of Physician Humanitarian Award

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

14. Federation of State Medical Boards (FSMB) report – Ms. Chang and Dr. David Watt

15. Peer Review Report Discussion – Ms. Kirchmeyer

16. Enforcement Chief's Report – Ms. Threadgill
    A. Approval of Orders Restoring License Following Satisfactory Completion of Probation, Orders Issuing Public Letter of Reprimand, and Orders for License Surrender During Probation
    B. Enforcement Program Update
    C. Expert Reviewer Survey and Expert Utilization Report Updates

17. Vertical Enforcement Update – Ms. Threadgill and Mr. Ramirez

18. Licensing Chief's Report – Ms. Pellegrini
    A. Licensing Program Update
    B. International Medical School Regulation Revisions
    C. Midwifery Advisory Council Report

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

20. California Physician Corps Program Update – Ms. Yaroslavsky

21. Education Committee Update – Ms. Yarolslavsky

22. Wellness Committee Update – Dr. Duruisseau

23. Physician Assistant Committee Update – Dr. Low

24. Medical Errors Committee Update - Mr. Zerunyan

25. Agenda Items for January 2009 Meeting

26. Adjournment

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting Cheryl Thompson at (916) 263-2389 or sending a written request to Ms. Thompson at the Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815. Requests for further information should be directed to the same address and telephone number.

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

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For additional information call (916) 263-2389.

MEDICAL BOARD OF CALIFORNIA
Executive Office

San Francisco Embassy Suites
250 Gateway Blvd.
South San Francisco, CA

AGENDA ITEM 3

July 25, 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 July 25, 2008 at 9:00 a.m. A quorum was present and notice had been sent to interested parties.

Members Present:
Richard Fantozzi, M.D., President
Steve Alexander
Hedy Chang
John Chin, M.D.
Gary Gitnick, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.
Barbara Yaroslavsky
Frank V. Zerunyan, J.D.

Members Absent:
Cesar Aristeiguieta, M.D.
Shelton Duruisseau, Ph.D.
Ronald H. Wender, M.D.

Staff Present:
Barbara Johnston, Executive Director
Kimberly Kirchmeyer, Deputy Director
Teri Bennett, Supervising Investigator
Fayne Boyd, Manager, Licensing Program
Kathi Burns, Manager, Licensing Program
Candis Cohen, Public Information Officer
Janie Cordray, Research Specialist

Kurt Heppler, Staff Legal Counsel
Armando Melendez, Business Services Office
Kelly Nelson, Legislative Analyst
Debbie Pellegrini, Chief of Licensing
Regina Rao, Business Services Office
Paulette Romero, Associate Analyst
Teresa Schaeffer, Executive Assistant
Kevin Schunke, Regulation Coordinator
Anita Scuri, Senior Legal Counsel, DCA Legal Office
Cheryl Thompson, Executive Assistant
Renee Threadgill, Chief of Enforcement
Linda Whitney, Chief of Legislation

Members of the Audience:

Yvonne Choong, California Medical Association
Frank Cuny, California Citizens for Health Freedom
Karen Ehrlich, Midwifery Advisory Council
Julie D'Angelo Fellmeth, Center for Public Interest Law
Faith Gibson, Midwifery Advisory Council
Jose Guerrero, Office of the Attorney General
Doreathea Johnson, Department of Consumer Affairs
Carrie Lopez, Department of Consumer Affairs
Frank Lucido, M.D., Medical Board Watch
Brett Michelin, California Medical Association
Carlos Ramirez, Office of the Attorney General
Anthony Williams, California Medical Association
Laura Zuniga, Department of Consumer Affairs

Agenda Item 2 Approval of minutes

Steve Alexander made a motion to approve the minutes from the April 25, 2008 meeting with amendments; motion carried.

Agenda Item 3 Public Comments on Items not on agenda

Dr. Frank Lucido, Medical Board Watch, indicated he has developed standards that will satisfy both law enforcement and medical concerns to pave the way for cannabis to become an over-the-counter medicine for individuals over 21 years of age. He directed members to his website for additional information.

Yvette Marquez, a third year neurosurgery resident at USC, requested a hearing or a thorough review of her application for a California medical license. Anita Scuri, Senior Legal Counsel relayed that she and Staff Counsel Kurt Heppler had spoken with Ms. Marquez and her attorney

and advised them that the remedy for her particular situation was to bring her case before the Superior Court since she is asking for an action that the Board has no authority to grant.

Agenda Item 4 President's Report

Dr. Fantozzi publicly recognized the following individuals:

- Teresa Schaeffer for her extensive service to the Board as Barb Johnston's Executive Assistant. Cheryl Thompson was introduced as her replacement.
- Dr. Duruisseau for his leadership on the Wellness Committee. He expressed his pleasure with the committee's progress.
- Ms. Chang for her election to the Board of the Federation of State Medical Boards (FSMB).
- Outgoing Board Members, Dr. Ronald Wender, Dr. Cesar Aristeiguieta, and Steve Alexander, for their commitment and valuable contributions to the Board.

Dr. Fantozzi reported on the following events:

- Dr. Fantozzi and Executive Director Barb Johnston met with Rosario Marin, Secretary of the State and Consumer Services Agency in June 2008 to discuss Medical Board issues, including the Board's process regarding legislation.
- He attended a California Patients Safety Action Coalition (CAPSAC) meeting with staff. CAPSAC's goal is to address medical errors through reporting and analysis and instituting a change in culture within the medical community when adverse events occur.
- A series of meetings have been convened by Regina Evans, Governor's office, regarding the enforcement process timelines.
- Dr. Fantozzi testified at the June 9, 2008 Senate Hearing on three Board sponsored bills and at the June 23, 2008 Senate Business & Professions Hearing on the Board sponsored Wellness Bill. All bills passed out of committee.
- Dr. Fantozzi and Barb Johnston attended the Federation of State Medical Boards meeting in May 2008. He fielded numerous inquiries on diversion and the Board's future plans in this area.

Dr. Fantozzi encouraged members to participate in scheduled Board dinners and luncheons to promote collegial dialog. He thanked Secretary Marin of the State and Consumer Services Agency, Carrie Lopez, Director of the Department of Consumer Affairs, and other DCA staff for joining the Board at the previous evening's dinner event.

Dr. Fantozzi asked members to submit recommendations for speakers for future board meeting presentations.

Dr. Fantozzi assigned Dr. Gitnick and Mr. Zerunyan to a "Guidelines for Licensing" task force to assist staff in preparing a document to use when making determinations on applicants.

Agenda Item 5 Executive Director's Report

A. Budget Overview and Staffing Update

Ms. Johnston directed the members' attention to page 88 of their Board packet for information on the budget. She noted that in the Governor's May Revise, the state sought $6 million from the Medical Board to be loaned to the General Fund which would be paid back without interest in FY 2010 – 2011. The Budget Change Proposals (BCPs) which were previously approved by the Board are currently under review by the Department of Consumer Affairs.

B. Proposed Meeting Dates for 2009

Ms. Johnston directed the members to page 101 of their packets for the proposed Board Meeting dates for 2009. She noted that the July 2009 meeting has been scheduled in Sacramento due to the cost of travel to staff should the state budget not yet be approved. It was m\Yaroslavsky and s\Schipske to approve the 2009 meeting dates; motion carried.

Ms. Johnston described the challenges with the phone system installation resulting from the March 2008 headquarters relocation. The 1-800 Call Center number is still not functioning, but has been optimistically projected to be in place by August. The delay has caused frustration to both staff and consumers.

Ms. Johnston provided an update on staffing. She introduced Deborah Pellegrini as the new Chief of Licensing. Ms. Johnston reported the Medical Board's vacancy rate has decreased as open positions have been filled. Ms. Threadgill has worked diligently to recruit new staff and to assure appropriate training for new Enforcement staff, bringing the vacancy rate from an anticipated 31% down to 6% for sworn enforcement officers.

Ms. Johnston provided an update on Board mandated reports:

- Study of peer review pursuant to B&P Code Section 805.2: The first draft was received on June 1, 2008. The Medical Board requested further development of the draft to meet legislation requirements. The final report is due July 31, 2008.
- Study of medical malpractice insurance for volunteers pursuant to B&P Code Section 2023: The contract was recently finalized and the study will begin August 1, 2008.
- Study of public disclosure pursuant to B&P Code Section 2026: The study, to determine if current laws provide sufficient information about medical doctors to the public, is being conducted by the California Research Bureau; the report is expected in August 2008.

A study of investigator compensation, being conducted by Cooperative Personnel Services (CPS), is in process with the report to be presented at the November 7, 2008 Board Meeting.

Ms. Johnston also commented on the series of meetings that have been convened by Regina Evans from the Governor's office regarding the enforcement process timelines. The Board has worked diligently to cooperate with the Department of Consumer Affairs and the

Governor's Office to provide the requested information. This data and the Medical Board's recommendations will be presented by Ms. Threadgill in her report to the Board.

Agenda Item 6 Department of Consumer Affairs November 2008 Summit

Ms. Carrie Lopez, Director, Department of Consumer Affairs (DCA), invited the Board's participation in the DCA's "Professionals Achieving Consumer Trust Summit" on November 18 – 21, 2008 in Los Angeles. The purpose of the summit is to lay the foundation for further cooperation and future collaboration between board members, consumer advocates, law enforcement and stakeholders in areas that impact consumers and licensees across the state. The summit will include DCA regulatory meetings, training sessions, and panel discussions. Dr. Fantozzi indicated that the Medical Board's meetings are scheduled a year in advance because of logistical and regulatory constraints, making it impractical to combine the previously scheduled November 6-7, 2008 Board and committee meetings with the DCA summit; however, he reported that the Pharmacy Board has invited the Medical Board to co-sponsor a roundtable discussion at the summit on e-prescribing. Dr. Fantozzi asked members to review their schedules and, if available, volunteer to participate in the roundtable discussion; he encouraged all members to participate in the summit event.

Agenda Item 7 Recognition of International Medical School Program

Ms. Pellegrini noted there were three international medical schools seeking recognition from the Board per regulation 1314.1 of Title 16 of the California Code of Regulations. The three medical schools operate alongside the government schools' pre-existing medical education programs. The Board's medical consultants reviewed the applications and recommend approval for all three schools.

A. Medical University of Lublin (English Program) – Lublin, Poland

Harold Simon, M.D., Ph.D., FACP, expert medical education consultant and professor at the UCSD School of Medicine, Division of International Health and Cross-Cultural Medicine, conducted a comprehensive evaluation of the university's Self-Assessment Report and supplemental responses and rendered his opinion that the Medical University of Lublin conforms to the regulations and statutes of the State of California pertaining to the issue of recognition of schools sponsored and under the authority of their national government. Dr. Simon expressed some caution and made additional recommendations with regard to the recognition of the Medical University's English Language program which were included in his report (page 113). Dr. Salomonson and Dr. Low expressed reservations about giving their approval without having Dr. Simon's concerns resolved. Dr. Simon reiterated that the school had met the statutory requirements allowing him to endorse the school's application for recognition at this time; however, if, following a site visit by the Board, insufficient conditions for recognition were identified, it would be appropriate to drop the recognition. With the Board's agreement, Dr.

Fantozzi suggested that Medical Board staff review existing regulations and make recommendations for the future with regard to this issue.

Mr. Alexander made a motion to approve the staff's recommendation to recognize the school, modified with stipulation that a report be returned to the Board within one year, based upon the recommendations that Dr. Simon outlined, and that a further determination be made at that time. Dr. Gitnick pointed out that the school had, indeed, met the requirements, and, therefore, their application should be approved. Dr. Fantozzi stated that the Board had previously voted to begin to review international schools on a re-review process consistent with LCME beginning in the 2008-2009 timeframe. Dr. Gitnick indicated that when the schools receive their approval, they should be notified that they will be re-visited, that the approval is time limited, and that there will be a re-review.

Ms. Scuri, Senior Legal Counsel, recommended that since LCME standards had probably changed in the past 5 years, it would be appropriate for the Board to reevaluate the written regulations and standards for recognizing medical schools, thereby addressing Dr. Simon's concerns and other problem areas. Starting in 2003, schools are required to submit documentation to show that they are in compliance every seven years; for schools that were previously approved, the seven years period started from the time the regulation took effect, hence, those re-evaluations have not yet taken place. She noted that it would be beneficial for the regulations to be modified before these schools began the re-evaluation process so that they would be held to whatever the new standards would be.

Mr. Alexander amended his motion to recommend recognition for the Medical University of Lublin (English Program) with full retroactivity to prior students and graduates; s/Yaroslavsky; the motion carried with Dr. Salomonson abstaining. Dr. Fantozzi asked staff to prepare for discussion of regulatory processes to determine if further meetings regarding changes to regulations are necessary.

B. Poznan University of Medical Sciences (English Program) – Poznan, Poland

Jim Nuovo, M.D., Professor and Associate Dean of Student Affairs and Graduate Medical Education at the UC Davis School of Medicine, agreed with Dr. Simon's assessment that additional vital information would be useful in making an adequate assessment in the recognition of medical schools.

Dr. Nuovo recommended full recognition of the school by the Board. It was m/Alexander, s/Yaroslavsky, c/All to approve the recommendation to grant recognition of the Poznan University of Medical Sciences (English Language) program with full retroactivity to prior students and graduates.

C. Latin American Medical School – Havana, Cuba

Dr. Nuovo recommended full approval of the Latin American Medical School with retroactivity for previous graduates. There was some discussion among members regarding possible

impediments to the Board taking the action to approve given the U.S.'s current relationship with the Cuban government; conducting a site visit was offered as a possible issue, but no other known problems were identified. Congressional representatives have conducted site visits, but Dr. Nuovo was not aware of any site visits done by medical personnel. Dr. Salomonson expressed reservations after having spoken with several Cuban physicians as to the actual facilities at the medical school; she expressed her preference that a site visit be conducted before she voted to approve. Ms. Scuri, Senior Legal Counsel, indicated that the Board does recognize the three governmental Cuban schools and that their graduates are eligible for licensure in California.

It was m/Yaroslavsky, s/Alexander, to approve the recommendation to grant recognition of the Latin American Medical School with full retroactivity to prior students and graduates; the motion carried with Dr. Salomonson and Mr. Zerunyan abstaining.

Agenda Item 8 Presentation on the Victims Compensation Program

Chip Skinner, Deputy Executive Officer of the California Victim Compensation Program (VCP), made a presentation to the Board on the work that VCP does to help pay the bills and expenses of victims of violent crimes. To date, VCP, which is part of the State and Consumer Services Agency, has paid more than $1.7 billion to crime victims, with funding coming from fees paid by offenders. Up to $70,000 in medical expenses are covered by the program, with medical claims comprising the largest percentage of paid claims. The VCP works directly with licensed health care providers to help them obtain compensation for providing their services to victims of violent crime when there is no other source of reimbursement available. Mr. Skinner requested that the Board help spread the word to licensees that the program is available to help. Since the victim, and not the health care provider, must apply to the program, physicians can encourage victims to visit their county's district attorney's office to be put into contact with the VCP. Additional information may be found at www.victimcompensation.ca.gov. The Medical Board's Education Committee would like to partner with VCP to help get the information out about the program, including a possible link on the Medical Board's website.

Agenda Item 9 Revision of Effective Date of Fee Reduction Regulations

Ms. Kimberly Kirchmeyer, Deputy Director, directed members to page 136 of the agenda packet referencing staff's recommendation to modify the proposed regulatory language changing the effective date for the reduction of license fees to July 1, 2009. Ms. Kirchmeyer asked the Board to put forth a motion to delegate authority to the Executive Officer to approve regulations to amend the effective date of fee reduction regulations from November 1, 2008 to July 1, 2009 after a 15-day notice if no negative comments were received. It was m/Yaroslavsky, s/Alexander to delegate the requested authority, as described above, to the Executive Director; the motion carried.

Agenda Item 10 Legislation

A. 2008 Legislation

Ms. Linda Whitney, Chief of Legislation, directed the members' attention to their legislative packet and provided an update on the 2008 legislation, beginning with Board sponsored bills:

- AB 2442 (Nakanishi) - Peer Review Proceedings (to repeal the reporting provisions related to the Diversion Program that sunset July 1, 2008). This bill also includes the proposal to allocate $500,000 from the Medical Board's fund to the Health Professions Education Foundation for the Physician Loan Repayment Program. The bill is currently in Senate Appropriations and will be heard in early August 2008 and is on suspense.
- AB2443 (Nakanishi) - Physician Well Being (codifying the work of the Board's Wellness Committee). The Board received a letter of opposition from the Department of Finance, indicating in its analysis that the bill would cost $100,000 to $200,000, even though the Medical Board has clearly specified it can be accomplished within existing resources.

  Ms. Whitney has met with the Senate Appropriations Staff to explain that any costs are minor and absorbable. There have been no "no" votes all the way through the Assembly and the first Policy Committee on this bill. AB2443 is set for hearing in early August 2008. Ms. Whitney indicated that she would be asking for assistance from Ms. Yaroslavsky and other committee members to make sure the bill gets out of committee.
- AB2444 (Nakanishi) - Public Letter of Reprimand with Educational Programs. This bill has been sent to the Governor for Signature.
- AB2445 (Nakanishi) - Public Letter of Reprimand for Initial Licensing. This bill has been sent to the Governor for Signature.
- SB 1779 - Healing Arts: Omnibus. Although not Board-sponsored, it is an omnibus bill that carries many of the technical changes that the Board has approved. It is on-track to move through the committees and go to the Governor for signature.

The Board authorized an additional legislative fix at the April 25, 2008 Board Meeting related to the certification of medical records upon the first request by the Board. This was deemed not technical and was not incorporated into any bill this year.

Ms. Whitney will begin meetings with various parties in the fall related to the disabled license concept that the Board has approved, along with a concept to develop either a training license or a change in how we deal with the term "doctor" or "M.D." for post-graduates. There was a legislative proposal that might have gone forward; however, Ms. Whitney asked the medical schools to step back from the proposal until the proper parties could be assembled to talk about the issue to ensure that the Board is satisfied with the results, circumventing the possibility of opposing legislation from a medical school.

Ms. Whitney referenced bills that are now dead:

- AB 1436 (Hernandez) -Nurse Practitioners
- AB 1944 (Swanson) - Authorizing District Hospitals to Employ Physicians (which the Board had taken an "Oppose" position on).

SJR 19 (Ridley-Thomas) - Torture: The Board has a "watch" on this bill which is currently on the Assembly floor.

The Board has already taken a position on the following amended bills; the bills have not changed in any way that would require the Board to change its position:

- AB 547 (Ma) - "Cap" on Fees. Support if amended. No action needed.
- AB 2482 (Maze) – Physician Assistants: Continuing Education. Support. No action needed.
- AB2649 (Ma) – Medical Assistants: Authorized Services. Neutral. No action needed.
- AB 2747 (Berg) – End-of-Life Care. Neutral. No action needed.
- AB 2968 (Carter) – Cosmetic Surgery: Physical Examination. Neutral. No action needed.
- AB 2969 (Lieber) – Worker's Compensation: Medical Treatment Utilization Reviews. Support. No action needed.
- SB 797 (Ridley-Thomas) – VE/P Extension. Support. No action needed.
- SB 1294 (Ducheny) – Employed Physicians: Pilot Project Expansion. Neutral. No action needed.
- SB 1379 (Ducheny) – Loan Repayment: Permanent Funding Source. Support. No action needed.
- SB 1394 (Lowenthal) – Lapses of Consciousness: Reports to DMV. Support. No action needed.
- SB 1415 (Kuehl) – Patient Records: Disclosure of Retention Period. Support. No action needed.
- SB 1441 (Ridley-Thomas) – Task Force: Address Standards for Impaired. Support, if amended. No action needed.
- SB 1454 (Ridley-Thomas) – Advertising, OSM, Cosmetic Surgery Standards. Support. No action needed.

AB 214 (Fuentes) Physician Health Program Act of 2008. Although the bill was not included in the agenda packets due to on-going revisions at the time of printing, a copy was provided to members prior to the Board meeting. The bill, sponsored by the California Medical Association (CMA), establishes an oversight body consisting of experts and appointed by the Director of the Department of Public Health. The body would set, review, and revise specific state-wide standards for providing substance abuse and mental illness assessment referral to treatment and the monitoring of physicians in recovery. The provider program would be audited; there would be rules and standards adopted. The cost of the program would be funded by licensing fees, approximately 2.5% of current licensing fees, which is equivalent to the $22 per licensing fee reduction adopted due to the sunset of the Diversion Program.

Anthony Williams, representing the CMA, provided further detail on AB 214. The bill is different from diversion in that it is proactive and focuses on prevention, targeting individuals who are at risk, rather than responding to situations after harm has occurred. Non-profit organizations who meet the requirements and standards set forth by the oversight body would be able to bid to provide monitoring and assessment services to physicians. However, treatment and bodily fluid testing would continue to be paid for by the physicians who are in the program. Dr. Fantozzi asked what would happen if an individual failed to adhere to the program guidelines or standards. Mr. Williams indicated that the program was voluntary and participation was confidential, however, if a physician failed to abide by the rules, regulations, and agreements within the program, then that individual would be determined to be a threat to patient safety and the Medical Board would be notified. As long as the physician abides by the program rules, their confidentiality would be secured.

Dr. Fantozzi stated while the Board supports the proposal in theory, he is requesting that a motion be made to oppose unless amended due to the deficiencies in the current legislative language, specifically with regard to the confidentiality component. Ms. Yaroslavsky urged the Board not to rush to judgment since there are currently other programs available to at-risk physicians. However, Mr. Williams of CMA noted that there is no data on the monitoring or standards of existing programs, and that confidentiality within these programs currently exists.

Public comment was made by Julie D'Angelo Fellmeth, Center for Public Interest Law, voicing her concerns with the bill, specifically in the areas of the governance and supervision of the program, the standards for the program, and the funding of the program. Ms. Yaroslavsky encouraged the CMA to bring all the constituents together to craft a more collaborative solution.

Dr. Gitnick noted, as a public agency, the Board cannot participate in anything that indirectly or directly "hides" information from the public. He stated the CMA's efforts were commendable and urged them to move forward with their legislation, but to do so in a manner independent of the Medical Board.

A motion was made by Mr. Alexander to oppose the legislation unless amended, s/Zerunyan, motion carried. Dr. Fantozzi stated he would appoint a work group to continue to work with Ms. Whitney, CMA, and other various parties to ensure the amended bill addresses the concerns of the Medical Board.

AB 2398 (Nakanishi) Cosmetic Surgery: employment of physicians. The bill has been amended significantly. The only remaining portion is a stronger enforcement authority regarding corporate practice violations related to cosmetic surgery settings. Senior Legal Counsel, Anita Scuri voiced a preference that the bill's language be amended to clarify that corporate practice prohibition still applies. A motion was made to support if amended to reflect Ms. Scuri's concern. It was m/Alexander, s/Yaroslavsky, c/All to support the bill if amended.

AB 2439 (De La Torre) Loan Repayment Program: mandatory fees. Based upon the Board's opposition, the author made the recommended amendment to reduce the mandatory fee from $50 to $25, an equivalent offset to the fee reduction from the sunset of the Diversion Program. The

provision requiring 15% of these funds be directed to applicants who would work in geriatric settings was not removed from the amended bill. A motion was made by Ms. Yaroslavsky to support if amended to delete the 15% requirement; s/Gitnick; motion carried.

AB2543 (Berg) Loan Repayment Program: geriatric workforce. Based on the Board's opposition, the author deleted the requirement that 15% of funds go to applicants in geriatric settings for the loan repayment program. The bill has been re-written to include service in geriatric settings as a factor in the assessment and evaluation of applications, instead of an absolute requirement. Ms. Yaroslavsky made a motion to support the bill; s/Gitnick; motion carried.

AB 2637 (Eng) Dental Auxiliaries. This bill is a re-write of the existing Dental Assistant Law, with the addition of new sections. The section that raised concerns to staff is a new permit that would allow the dental assistant to monitor a patient under sedation only in the presence of the dentist after a considerable amount of training. The American Society of Anesthesiologists has reviewed this provision and has taken a neutral position on the bill. Brett Michelin from CMA noted they have not yet taken a position on the bill. Mr. Alexander made a motion to take a "watch" position on the bill; s/Zerunyan, motion carried.

SB 963 (Ridley-Thomas) Regulatory Boards: Operations. This revised bill would no longer have a provision related to pro-bono work and also takes out provisions related to ex-parte communication reporting as a requirement, setting findings and declarations the responsibility of the Board. However, if the Board were reconstituted, then the list of provisions in the bill would, in fact, apply to the reconstituted Board. The bill also changes the requirement that a report be publicly heard by the Policy Committee; the report may now be accepted by the Committee without a hearing. The sunset date for the Medical Board is changed from 2011 to 2012 in the bill, and the Medical Board's comprehensive report to the Legislature to reconstitute the Board has a new deadline of March 1, 2010. Ms. Yaroslavsky made a motion to take a "watch" position on the bill; the motion was s/Alexander and carried.

Dr. Fantozzi asked the Board Member Procedure Manual, which addresses ex-parte communication, be distributed to all of the members and a copy placed in the back of the room.

Ms. Whitney will be working closely with Ms. Yaroslavsky who has been designated by the Board as the liaison for the Board to the legislature. Ms. Whitney will contact the Board members as needed to write letters, send emails, or make phone calls in support of Board sponsored bills.

SB 1406 (Correa) Optometry. The bill expands the scope of practice for optometrists, allowing them to diagnose and treat diseases of the eye. A motion was made by Ms. Yaroslavsky to oppose the bill unless amended to provide for a permit process similar in design to that which dentists must go through to perform cosmetic surgery; s/Schipske. Brett Michelin clarified the CMA's "oppose unless amended position on the bill". Concerns were expressed about the sufficiency of a permit process. Ms. Yaroslavsky amended her motion to "oppose"; the motion was seconded and carried.

SB 1526 (Perata) Polysomnographic Technologists Registration. The Board had previously taken a "watch" position on this bill, with Dr. Fantozzi working with the sponsor and author's staff to make changes. The bill would require the Board to register polysomnographic technologists who work in sleep centers. The bill was developed due to issues related to scope of practice as it relates to respiratory care and to require fingerprint clearance for the technologists.

The bill is set up to be cost neutral with the registration revenue covering the cost of the administration of the registration program and the individual technologist paying for the fingerprint reports. Ms. Yaroslavsky made a motion that the Board take a "neutral" position on the bill; seconded; motion carried.

C. Status of Regulatory Action

Ms. Whitney directed the Board members to the Status of Pending Regulations matrix on page 139 of their packets. There were no questions.

Agenda Item 11 Discussion of SB 376 Report to the Legislature (District Hospital Employment of Physicians Pilot Program)

Mr. Kevin Schunke, executive staff member, provided an update on SB 376, which authorized the Medical Board to start a pilot program which allows certain qualified district hospitals to employ physicians instead of using the traditional contracting route to bring their services into the hospital. One of the requirements of the bill is that the Medical Board submit a report to the legislature by October 1,

2008. Mr. Schunke referred the members to page 140 of their agenda packets to a draft copy of the report; staff asked for the appointment of one or two Board members to work with them to finalize the report before submission, with these members being authorized to act on behalf of the Board as a whole. Dr. Fantozzi appointed Dr. Duruisseau and Dr. Moran to work with staff on the SB 376 report.

Agenda Item 12 Enforcement Chief's Report

A. Approval of Orders Restoring License Following Satisfactory Completion of Probation, Order Issuing Public Letter of Reprimand, and Order for License Surrender During Probation

Ms. Yaroslavsky made a motion to approve orders restoring license following satisfactory completion of probation; orders issuing Public Letter of Reprimand, and orders for license surrender during probation; s/Schipske, motion carried.

Ms. Renee Threadgill, Chief of Enforcement, publicly acknowledged Enforcement staff present at the meeting.

B. Enforcement Program Update

Ms. Threadgill thanked her staff for their outstanding work in quickly completing background checks to expedite the hiring of investigators. Training for these new investigators has begun. Dr. Fantozzi congratulated and expressed his appreciation to Ms. Threadgill and her staff on reducing the anticipated vacancy rate as reported in the Executive Director's Update. She welcomed Kathi Burns as the new manager of the Discipline Coordination Unit. Ms. Threadgill also announced the promotion of Susan Cady to Staff Manager II, a position that was created as part of the reorganization of the Enforcement Program, responsible for overseeing the management of the Discipline Coordination, Complaint, and Probation Units.

Staff and legal counsel have met to begin review of the model disciplinary guidelines; some suggested revisions have been formulated. Once the revision process is completed, the guidelines will be presented to assigned Board members. Dr. Fantozzi indicated he would assign two Board members to assist staff with the model disciplinary guidelines.

The Investigator Pay and Classification Study has begun and is expected to be completed prior to the November 2008 Board meeting.

C. Expert Reviewer Survey Update

Ms. Threadgill directed members to page 150 of their packets to the results of the Expert Reviewer Survey. The Enforcement Program continues to receive positive feedback from the surveyed medical expert reviewers. The number of experts within each specialty continues to increase, although there are a few specialties that remain low. Mr. Zerunyan suggested questions 12 and 13 on the survey, which refer to the Deputy Attorney General's availability and responsiveness, be reframed to provide a more valid response, reducing the number of "not applicable" responses. Ms. Yaroslavsky asked if there was staff input about the interaction with expert reviewers. In reply, Ms. Threadgill stated that staff investigators are asked to evaluate each expert.

Dr. Low stated several of the Board members had some concerns about the Board's "experts", with some of the reviewers mistakenly believing that being part of the Expert Review Panel provides them with some special position or some insulation from future action against themselves. He expressed his concern over the quality of the experts retained for many of the cases the Board has reviewed, occasionally finding the reviewer was weak and off target, thus creating embarrassment to the Medical Board. Dr. Low would like a better way to select the expert reviewers. Ms. Threadgill indicated staff could look at the criteria and strengthen the minimum requirements for reviewers. She also stated the Board must be cautious about over-utilizing experts so these individuals do not become "hired guns" for the Medical Board. Mr. Carlos Ramirez, Senior Assistant Attorney General, indicated there is a process by which

deputies provide feedback following a hearing with regard to the testifying expert reviewer's qualifications and demeanor on the stand; however, this process does not occur prior to the hearing. Dr. Gitnick raised the related issue of matching the expert reviewer to the case, making sure that the expert selected is the most appropriate, which requires being able to ask the proper question of the expert before they are retained for a particular case.

Agenda Item 13 Vertical Enforcement Update

A. Vertical Enforcement Statistics

Ms. Threadgill distributed a handout detailing investigation and prosecution timeframes from 2005 through the second quarter of 2008 for the Medical Board. Mr. Ramirez distributed information on accusation timeframes for Health Quality Enforcement over the past two and half years.

B. Recommendation to Improve Disciplinary Process Timelines

Ms. Threadgill explained there have been on-going discussions between Enforcement and Mr. Ramirez on ways to decrease the timelines for investigation as well as for the entire enforcement process. Their recommendations and suggestions are noted beginning on page 157 of the agenda packet. With regard to the Office of Administrative Hearings (OAH) and the Attorney General's Office, Ms. Threadgill pointed out she and Mr. Ramirez will continue to meet regularly to reconcile their data. Approval was sought to meet with Ron Diedrich, Director of OAH, to discuss mandatory hearing setting conferences at the beginning of a case to help alleviate some of the disorganization that occurs later when there are scheduling conflicts. Additionally, approval was requested to ask Mr. Diedrich to assign Medical Board cases to the Medical Board impaneled administrative law judges. Dr. Fantozzi asked for a motion to support the staff's recommendations with the qualification that Ms. Threadgill check with OAH for their agreement with the deadline to hear cases within 120 days of receipt of the Request for Hearing. Mr. Zerunyan commended Ms. Threadgill and Mr. Ramirez on their efforts to decrease enforcement timelines and expressed his disappointment that the IT budget does not allow more timely improvements in IT capabilities which would allow increased communication between the Medical Board and the Attorney General's Office. Ms. Johnston stated the obstacle was not money, but rather time in working through the bureaucracy and that staff was also disappointed with the delay. It was m/Chang, s/Yaroslavsky, c/All to support staff recommendations for ways to decrease timeframes in the Medical Board enforcement process.

Agenda Item 14 Licensing Chief's Report

A. Licensing Program Update

Ms. Pellegrini directed the members to the Licensing Report on page 160 of their packets. Last fiscal year, over 6200 applications were received; a little over 4,800 licenses were issued, with over 1,600 issued just in the last quarter.

With the average number of days to issue a license still too long, Ms. Pellegrini's priorities are to analyze the licensing processes and find ways to improve the timeline, while ensuring the licensing program remains customer focused and attentive to the applicant's needs.

With regard to the Information Center, the number of calls increased during the fourth quarter due to the combining of the Licensing Customer Information Center with the Enforcement Call Center. There have been problems with the Call Center telephone system, preventing full functionality. Staff is working diligently to return all calls the same day they are received. An automated phone system should be in place within the next few months which should alleviate the problem. Ms. Yaroslavsky expressed the need for staff to have the proper tools to be able to do their jobs; she wanted to make sure that the Department of Consumer Affairs is aware of the problem and they work with staff to solve the phone issues. Ms. Kirchmeyer shared the Phone Center was supposed to be functional two weeks before the Medical Board moved to their current location on March 14, 2008. The Medical Board staff has been working diligently with DCA, who is aware of the phone problem, and with the vendor (Verizon) to resolve the issues. At this point, the Medical Board was told that the phone system concerns would not be solved until forty-five days from the date the Board signs off on changes. The possibility of securing a new vendor was raised, but would inevitably delay implementation even further.

D. Special Programs Update

Ms. Pellegrini has been working on reinstituting the Special Program site visits and reviewing policy and procedures with the Board's medical consultant, Dr. Nuovo. The first site visit with UC San Diego is scheduled for this Fall.

E. Midwifery Advisory Council Report

Faith Gibson, L.M., Chair of the Midwifery Advisory Council, reported at their June 19, 2008 meeting the Office of Statewide Health Planning and Development (OSHPD) gave the preliminary statistical data from the Licensed Midwife's Annual Report for 2007. Highlights of the report included:

- There are 196 active licensed midwives (LMs) in California in 2007;
- 61% of these LMs returned their annual report;
- 70% of those reported data and services rendered;
- 2061 clients were served by those midwives, delivering 1401 live births, including 104 out of state births (primarily in Nevada).

There was discussion at the meeting on how to improve the data for next year's report. Licensed midwives who did not complete the report will have a flag placed on their records indicating that they cannot renew their licenses. A reminder was sent out by the Board to those who had not submitted their report, asking them to send it in by July 15, 2008. OSHPD is currently consolidating that data.

The next Midwifery Advisory Council is scheduled for October 23, 2008. Dr. Fantozzi asked that the report be distributed to all members when it is completed.

Agenda Item 15 Special Faculty Permit Review Committee Appointment

Ms. Pellegrini reported UC Irvine's Vice Chancellor of Health Affairs has nominated F. Allen Hubbell, M.D. as their new representative for the Special Faculty Permit Review Committee, due to the retirement of Dr. Jeremy Tilles. Ms. Pellegrini asked the Board to approve this nomination. M/Schipske to appoint Dr. Hubbard to the committee, s/Yaroslavsky, motion carried.

Agenda Item 16 California Physician Corps Program Update

Ms. Yaroslavsky reported the Health Professions Education Foundation (HPEF) has been awarded a $2.5 million dollar grant over a period of two years from United Pacific Care; the funds will be used to assist loan repayments for doctors who serve in underserved communities. Dr. Gitnick, Dr. Fantozzi, Executive Director Barb Johnston, and Ms. Yaroslavsky serve as members of the HPEF board. Dr. Fantozzi indicated a strategic plan process would begin in August of 2008 to be completed by the end of the year. An executive director has been appointed and the HPEF board is moving forward in a positive direction.

Agenda Item 17 Education Committee Update

The Education Committee met on July 24, 2008 and heard presentations regarding wellness curriculum from representatives from Kaiser Permanente, Keck School of Medicine at USC and the California Medical Association. Ms. Yaroslavsky expressed her pleasure at the direction of events as they relate to wellness at the school level. The Board will continue to work with these organizations to improve wellness resources for students and physicians. Kevin Schunke of the Medical Board's Executive Office described his work in the development and implementation of outreach programs to assist potential applicants for medical licensure. He routinely represents the Board at new-resident orientation and provides one-on-one assistance at licensing fairs. Mr. Schunke's work helps promote a positive first impression of the Medical Board and provides valuable, practical assistance to applicants. Ms. Yaroslavsky thanked Mr. Schunke for his efforts. The Board's Information Officer, Ms. Candis Cohen, gave a presentation describing the many components of the Board's educational programs, including media outreach, the Board's newsletter and web site (which ranked in the top 10 nationally in 2006 among all State medical Board's web sites by "Public Citizen"), and staff participation in consumer and health-related fairs. As the Education Committee chair, Ms. Yaroslavsky expressed her confidence that the Board has an effective and comprehensive outreach program.

Agenda Item 18 Medical Errors Task Force Update

Mr. Zerunyan asked for a motion to approve the minutes from the April 24, 2008 Medical Errors Task Force meeting. A motion was made to approve, s/Schipske, c/All.

The Task Force heard a presentation from Dr. Elizabeth Banks, California Department of Public Health (CPPH), Licensing and Certification Branch, explaining how CPDH is implementing SB 1301 and SB 1312 (known as the Alquist Legislation) which passed in 2006 requiring additional event reporting from health care facilities and making citations and findings available to the public. Lori Rice, former Medical Board member and member of the 2006 Medications Error Panel established by SCR 49 also spoke, giving an overview of the Panel's work and urging members to engage in more public information activities. Ms. Janie Cordray, Research Specialist for the Medical Board, gave an overview of error initiatives. The Medical Errors Task Force will continue discussion to determine how to best serve as a conduit of information for licensees and consumers. Dr. Salomonson asked if the Task Force might consider being called "Patient Safety" instead of "Medical Errors" to more accurately reflect the broadness of the Task Force's focus and activities.

Agenda Item 19 Physician Assistant Committee Update

Dr. Low stated the Physician Assistant Committee sponsored AB 2482 requiring licensees to complete 50 hours of continuing education from a certified body every two years as a condition of license renewal. This was signed into law by the Governor on July 8, 2008.

AB 3 was a bill that allows physician assistants (PAs) to administer, provide, or issue a drug order for Schedule 2 through 5 controlled substances without advance approval by a supervising physician and surgeon if the PA completes specified educational requirements and if allowed by the supervising physicians.

A strategic planning session has been scheduled for the next Committee meeting; the last strategic plan was adopted in 2004.

The physician assistant license has always been a paper document, but a new plastic license has been created and is currently being piloted; the new plastic card should be rolled out in September.

The delegation of Standardized Procedures Agreement regulations have been filed with the Secretary of State and will take effect in early August 2008. The next meeting of the PA Committee is August 14, 2008.

Agenda Item 20 Wellness Committee Update

Dr. Chin reported the Wellness Committee met on July 24, 2008. Dr. Michael Williams of PRC International delivered a presentation on wellness and prevention at the meeting. The Wellness Committee has developed a page on the Medical Board's website with links to articles and other relevant information; he encouraged the Board members to visit the new webpage. The Committee has been asking malpractice carriers such as NORCAL to help with the goals of the Wellness Committee.

Agenda Item 21 Agenda Items for November 2008 Meeting

The Board has spoken with staff about having Ron Diedrich from the Office of Administrative Hearings come speak to the Board at a future meeting. Dr. Fantozzi repeated his request for members to make suggestions to Barb Johnston for speakers. He indicated he had received a request to have staff look at having presentations from the patient assistance programs and the State Office of Patient Advocates.

Mr. Zerunyan requested an item be added to a future agenda to discuss the public outreach of the Medical Board and how consumers are notified of the existence and function of the Board. Dr. Fantozzi asked staff to agendize the item either at the Education Committee level or at the full Board level, as appropriate.

Action Item 22 Adjournment

There being no further business, it was m/Yaroslavsky, s/Chin, c/All to adjourn the meeting at 12:55 p.m.

_____
Richard Fantozzi, M.D., President

_____
Hedy Chang, Secretary

_____
Barb Johnston, Executive Director

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***
Continuing Education Requirements	At DCA for review	11/2/07	12/07/07	2/1/08	3/17/08	9/9/08		
Disciplinary Guidelines	Filed with Secretary of State; became effective 9/14/08	2/1/08	2/29/08	4/25/08	4/25/08	6/5/08	8/1/08	8/14/08
Fee Reduction to Offset Elimination of Diversion Prog.	Adverse comments received after text was modified in July; to be discussed at Nov mtg.	2/1/08	2/29/08	4/25/08				
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations pending Spring 2009							

* - 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 October 6, 2008
For questions, call (916) 263-2368

LEGISLATIVE PACKET

November 6 – November 7, 2008

San Diego, CA

FULL-BOARD MEETING

November 7, 2008

Medical Board of California
Tracker - Legislative Bill File
10/28/2008

BILL	AUTHOR	TITLE	STATUS	POSITION	VERSION	AMENDED
AB 2439	De La Torre	Loan Repayment Program: mandatory fees	Chapter #640	Support if Amended (ltr)	Amended	8/11/2008
AB 2444	Nakanishi	MBC: PLR with education	Chapter #242	Sponsor/Support (ltr)	Amended	7/1/2008
AB 2445	Nakanishi	MBC: licensing PLR	Chapter #247	Sponsor/Support (ltr)	Amended	6/4/2008
AB 2482	Maze	Physician Assistants: continuing education	Chapter #76	Support (ltr)	Introduced	
AB 2637	Eng	Dental Auxiliaries	Chapter #499	Watch	Amended	8/14/2008
AB 2747	Berg	End-of-Life Care	Chapter #683	Neutral - amends taken	Amended	8/13/2008
SB 797	Ridley-Thomas	VE/P Extension	Chapter #33	Contained VE/P - Support (ltr)	Amended	4/24/2008
SB 963	Ridley-Thomas	Regulatory Boards: Operations	Chapter #385	Watch	Amended	8/22/2008
SB 1379	Ducheny	Loan Repayment: permanent funding source	Chapter #607	Support (ltr)	Amended	8/22/2008
SB 1406	Correa	Optometry	Chapter #352	Oppose	Amended	8/20/2008
SB 1441	Ridley-Thomas	Task Force: address standards for impaired	Chapter #548	Support if amended (ltr)	Amended	8/14/2008
SJR 19	Ridley-Thomas	Health professionals: torture	Chapter #114	Watch	Amended	6/16/2008

* Dead, no bill * **Vetoes** * Veto, policy issue

AB 214

BILL NUMBER: AB 214
VETOED DATE: 09/30/2008

To the Members of the California State Assembly:

I am returning Assembly Bill 214 without my signature.

Physician health programs provide a valuable service and help ensure public safety by encouraging doctors to obtain treatment to overcome substance abuse or manage mental illness. However, separating the operation of such programs from the Medical Board of California is inappropriate. Ideally, diversion programs would always lead to success, but the reality is that not everyone succeeds in recovery. It is critical that the licensing agency be directly involved in monitoring participation in diversion programs to protect patients and enable timely enforcement actions.

Properly designed and administered programs will protect consumers, help doctors overcome their illness; and get more providers back into practice and safely treating patients. Therefore, I invite the author and stakeholder community to engage my Administration on how to design such a program.

For these reasons, I cannot support this bill.

Sincerely,

Arnold Schwarzenegger

AB 547

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 547
Author: Ma
Chapter: **Vetoed**
Subject: "Cap" on Fees
Sponsor: Author
Board Position: Support if amended

DESCRIPTION OF LEGISLATION:

This bill was a result of a fiscal audit by the Bureau of State Audits where it concluded that the Board has excess in its reserve fund and should pursue a reduction to the fee.

This bill would have established a "cap" or "ceiling" on the physician licensing fees instead of a fixed amount as in current law. The initial licensing fee is fixed in law by the Board at no greater than seven hundred ninety dollars ($790). The biennial renewal fee is also fixed in law at no greater than seven hundred ninety dollars ($790).

RECOMMENDATION:

Seek legislation in 2009 to establish a "cap" on the physician licensing fee and allow for a fund reserve between two and six months.

BILL NUMBER: AB 547
VETOED DATE: 09/26/2008

To the Members of the California State Assembly:

I am returning Assembly Bill 547 without my signature.

The historic delay in passing the 2008-2009 State Budget has forced me to prioritize the bills sent to my desk at the end of the year's legislative session. Given the delay, I am only signing bills that are the highest priority for California. This bill does not meet that standard and I cannot sign it at this time.

Sincerely,

Arnold Schwarzenegger

AB 2439

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2439
Author: De La Torre
Chapter: 640
Subject: Loan Repayment Program: Mandatory Fees
Sponsor: Author
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill requires the Medical Board (Board) to asses an additional $25 fee for the issuance and biennial renewal of a physician's license for the purpose of helping to fund the Steven M. Thompson Physician Corps Loan Repayment Program (Program) for the purpose of providing loan repayment awards.

In addition, this bill requires the Program to dedicate a maximum of 15% of this revenue, from physicians fees, to loan assistance for physicians who agree to practice in geriatric care settings or settings that primarily serve adults over the age of 65 or adults with disabilities.

IMPLEMENTATION:

- Article in January 2009 *Newsletter*
- Notify Licensing and cashiering staff
- Notify ISB staff
- Revise forms and publications
- Staff has held meetings regarding the notification to applicants, programs, and schools regarding the start date of January 1, 2009 for this additional fee. The April 2009 renewals (the first renewal notification that is sent after the effective date) will be the first renewal cycle impacted by the mandatory fee. New licensing applicants will be impacted as of January 1, 2009.

Assembly Bill No. 2439

CHAPTER 640

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.

[Approved by Governor September 30, 2008. Filed with Secretary of State September 30, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2439, 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 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. Existing law requires the foundation to use guidelines developed by the Medical Bd. for selection and placement of program applicants, as specified.

This bill would change the fee to $25 and make payment of the fee mandatory for applicants for issuance or renewal of a physician and surgeon's license. The bill would also provide that up to 15% of the funds collected shall 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.

The bill would require the guidelines for the selection and placement of program applicants to include criteria that would give priority consideration to program applicants who agree to practice in geriatric care settings.

Because this bill would provide for the deposit of additional fees in a continuously appropriated fund, it would make an appropriation.

This bill would incorporate an additional change to Section 128553 of the Health and Safety Code proposed by AB 2543 contingent on the prior enactment of that bill.

This bill would make the operation of its provisions contingent upon the enactment of SB 1379 of the 2007–08 Regular Session.

Appropriation: yes.

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

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

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

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

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

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

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

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

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

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

(b) This twenty-five dollar ($25) fee shall be paid at the time of application for initial licensure or biennial renewal. The twenty-five dollar ($25) fee shall be due and payable along with the fee for the initial certificate or biennial renewal.

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

(d) Up to 15 percent of the funds collected pursuant this section shall 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. Priority consideration shall be given to those physicians and surgeons who are trained in, and practice, geriatrics and who can meet the cultural and linguistic needs and demands of diverse populations of older Californians.

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

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

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

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

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

(A) Speak a Medi-Cal threshold language.

(B) Come from an economically disadvantaged background.

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

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

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

(2) Include a process for determining the needs for physician services identified by the practice setting and for ensuring that the practice setting meets the definition specified in subdivision (h) of Section 128552.

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

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

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

(6) Provide priority consideration to applicants who agree to practice in a geriatric care setting and are trained in geriatrics, and who can meet the cultural and linguistic needs and demands of a diverse population of older Californians. On and after January 1, 2009, up to 15 percent of the funds collected pursuant to Section 2436.5 of the Business and Professions Code shall 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.

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

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

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

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

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

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

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

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

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

SEC. 3.5. Section 128553 of the Health and Safety Code is amended to read:

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

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

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

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

(A) Speak a Medi-Cal threshold language.

(B) Come from an economically disadvantaged background.

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

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

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

(2) Include a process for determining the needs for physician services identified by the practice setting and for ensuring that the practice setting meets the definition specified in subdivision (h) of Section 128552.

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

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

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

(6) Provide priority consideration to applicants who agree to practice in a geriatric care setting and are trained in geriatrics, and who can meet the cultural and linguistic needs and demands of a diverse population of older Californians. On and after January 1, 2009, up to 15 percent of the funds

collected pursuant to Section 2436.5 of the Business and Professions Code shall 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.

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

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

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

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

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

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

(f) The office shall adopt a process to reconcile the loan should a physician be unable to complete his or her three-year obligation.

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

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

SEC. 4. Section 3.5 of this bill incorporates amendments to Section 128553 of the Health and Safety Code proposed by both this bill and AB 2543. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2009, (2) each bill amends Section 128553 of the Health and Safety Code, and (3) this bill is enacted after AB 2543, in which case Section 3 of this bill shall not become operative.

SEC. 5. This act shall become operative only if Senate Bill 1379 of the 2007–08 Regular Session is enacted and becomes effective on or before January 1, 2009.

O

AB 2442

BILL NUMBER: AB 2442
VETOED DATE: 09/28/2008

To the Members of the California State Assembly:

I am returning Assembly Bill 2442 without my signature.

This bill is unnecessary. The funds within the Medical Board of California should be used to support ongoing consumer protection activities that are more directly related to the Board's licensure, regulatory and enforcement efforts.

For this reason, I cannot sign this bill.

Sincerely,

Arnold Schwarzenegger

CHAPTER _____

An act to repeal Sections 821.5 and 821.6 of the Business and Professions Code, relating to healing arts, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 2442, Nakanishi. Medicine.

(1) 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 on 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.

This bill would delete these provisions.

(2) Under the Medical Practice Act, the Medical Board of California regulates physicians and surgeons and provides for their licensure. All moneys paid to, and received by, the board are paid into the State Treasury and credited to the Contingent Fund of the Medical Board of California.

Under existing law, the Medically Underserved Account for Physicians is established within the Health Professions Education Fund for purposes of providing funding for the ongoing operations of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified. Funds placed in the account are continuously appropriated for the repayment of loans.

This bill would transfer $500,000 from the Contingent Fund of the Medical Board of California to the Medically Underserved Account for Physicians, a continuously appropriated account, thereby making an appropriation.

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

Appropriation: yes.

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

SECTION 1. Section 821.5 of the Business and Professions Code is repealed.

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

SEC. 3. Notwithstanding Section 2445 of the Business and Professions Code, the amount of five hundred thousand dollars ($500,000) shall be transferred, one time only, from the Contingent Fund of the Medical Board of California to the Medically Underserved Account for Physicians created by Section 128555 of the Health and Safety Code for the Steven M. Thompson Physician Corps Loan Repayment Program.

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure that reporting requirements administered by the diversion program of the Medical Board of California are deleted when that program becomes inoperative, and that the Medically Underserved Account for Physicians receives funding at the earliest possible time, it is necessary that this act take effect immediately.

AB 2443

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2443
Author: Nakanishi
Chapter: **Vetoed**
Subject: MBC: Physician Well-Being
Sponsor: Medical Board of California
Board Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill requires 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. The bill requires that the program be developed within existing resources.

RECOMMENDATION:

- Refer to the Wellness Committee for a recommendation on this legislation.

BILL NUMBER: AB 2443
VETOED DATE: 09/28/2008

To the Members of the California State Assembly:

I am returning Assembly Bill 2443 without my signature.

This bill, while well-intentioned, detracts from the mission and purpose of the Medical Board of California. The Board should be focused on successfully implementing its current licensure, regulatory and enforcement activities before attempting to offer new programs outside its highest priority - protecting the health and safety of consumers.

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

Sincerely,

Arnold Schwarzenegger

CHAPTER _____

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

LEGISLATIVE COUNSEL'S DIGEST

AB 2443, 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 issues concerning physician and surgeon well-being and would require the program to include, among other things, an examination and evaluation of existing wellness education for medical students, postgraduate trainees, and licensed physicians and surgeons and an outreach effort to promote physician and surgeon wellness. The bill would require the program to be developed within existing resources unless otherwise authorized in the annual Budget Act.

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

SECTION 1. Section 2005 is added to the Business and Professions Code, to read:

2005. (a) The board shall establish a program to promote the issues concerning physician and surgeon well-being. This program shall include, but not be limited to, all of the following:

(1) An examination and evaluation of existing wellness education for medical students, postgraduate trainees, and licensed physicians and surgeons.

(2) A series of relevant articles published in the board's newsletter.

(3) A consolidation of resources that promote physician and surgeon wellness.

(4) An examination of incentives to encourage physicians and surgeons to become knowledgeable regarding the issues concerning their well-being.

(5) An outreach effort to promote physician and surgeon wellness.

(b) The program described in subdivision (a) shall be developed within existing resources unless otherwise authorized in the annual Budget Act.

AB 2444

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2444
Author: Nakanishi
Chapter: 242
Subject: MBC: Public Letters of Reprimand with Education
Sponsor: Medical Board of California
Board Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill allows the Medical Board (Board) to include requirements for specific education and training as part of rehabilitation for offenses in public letters of reprimand. The issuance of a public letter of reprimand with education and training would be in lieu of the Board having to file a formal accusation against a physician in order to require the specific education and training as part of a settlement that includes a public reprimand. This will expedite the disciplinary process for both the consumer and the physician and reduce the number of formal accusations filed by Enforcement, it continues to allow for public disclosure of the action. This will further the mission of consumer protection by providing an expedited process for certain cases while maintaining the same level of public disclosure of the discipline and rehabilitation of physicians.

IMPLEMENTATION:

- Article in the January 2009 *Newsletter*
- Notify Enforcement staff
- Develop the process for determining when and which education and training requirements to include.

Assembly Bill No. 2444

CHAPTER 242

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

[Approved by Governor August 1, 2008. Filed with Secretary of State August 1, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2444, 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 a requirement for specified training or education in a public letter of reprimand.

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

SECTION 1. Section 2233 of the Business and Professions Code is amended to read:

2233. The board may, by stipulation or settlement with the affected physician and surgeon, issue a public letter of reprimand after it has conducted an investigation or inspection as provided in this article, rather than filing or prosecuting a formal accusation. The public letter of reprimand may, at the discretion of the board, include a requirement for specified training or education. The affected physician and surgeon shall indicate agreement or nonagreement in writing within 30 days of formal notification by the board of its intention to issue the letter. The board, at its option, may extend the response time. Use of a public reprimand shall be limited to minor violations and shall be issued under guidelines established by regulations of the board. A public letter of reprimand issued pursuant to this section may be disclosed to an inquiring member of the public.

O

AB 2445

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2445
Author: Nakanishi
Chapter: 247
Subject: MBC: Licensing Public Letters of Reprimand
Sponsor: Medical Board of California
Board Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill allows the Medical Board (Board) to issue a public letter of reprimand to applicants who have committed minor violations with regard to unprofessional conduct. This bill requires the Board to publish all public letters of reprimand on the Board's Internet Web site for three years.

Allowing the Board to issue a public letter of reprimand in lieu of probation to applicants who have committed minor violations with regard to unprofessional conduct will benefit the public 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 will be purged from the licensee's record after three years, the same period of time a probationary license is terminated for initial licenses.

IMPLEMENTATION:

- Article in the January 2009 *Newsletter*
- Notify Licensing and Enforcement staff
- Develop process for determining when and which minor violations will apply to the public letter of reprimand option.

Assembly Bill No. 2445

CHAPTER 247

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

[Approved by Governor August 1, 2008. Filed with Secretary of State August 1, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2445, 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 minor violations, as specified, and to concurrently issue a public letter of reprimand, which would be purged 3 years from the date of issuance. The bill would require that the public letter of reprimand be disclosed to an inquiring member of the public and be posted on the board's Internet Web site.

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

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

SECTION 1. Section 2221 of the Business and Professions Code is amended to read:

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

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

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

(3) Continuing medical or psychiatric treatment.
(4) Ongoing participation in a specified rehabilitation program.
(5) Enrollment and successful completion of a clinical training program.
(6) Abstention from the use of alcohol or drugs.
(7) Restrictions against engaging in certain types of medical practice.
(8) Compliance with all provisions of this chapter.
(9) Payment of the cost of probation monitoring.

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

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

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

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

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

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

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

(c) A public letter of reprimand issued pursuant to this section shall be disclosed to an inquiring member of the public and shall be posted on the board's Internet Web site.

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

O

AB 2482

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2482
Author: Maze
Chapter: 76
Subject: Physician Assistants: continuing education
Sponsor: Author
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill permits 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 also gives 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.

IMPLEMENTATION:

- Article in the January 2009 *Newsletter*
- Notify Board staff
- Work with the PAC as requested to implement requirements.

Assembly Bill No. 2482

CHAPTER 76

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

[Approved by Governor July 8, 2008. Filed with Secretary of State July 8, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2482, 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.

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

SECTION 1. Section 3524.5 is added to the Business and Professions Code, to read:

3524.5. The committee may require a licensee to complete continuing education as a condition of license renewal under Section 3523 or 3524. The committee shall not require more than 50 hours of continuing education every two years. The committee shall, as it deems appropriate, accept certification by the National Commission on Certification of Physician Assistants (NCCPA), or another qualified certifying body, as determined by the committee, as evidence of compliance with continuing education requirements.

O

AB 2543

BILL NUMBER: AB 2543
VETOED DATE: 09/28/2008

To the Members of the California State Assembly:

I am returning Assembly Bill 2543 without my signature.

I share the author's concern about the health workforce needs of our state. However, the provisions of this bill place an additional licensing fee on an entire profession to provide specialized loan assistance grants beyond the $10 surcharge they already pay for the Mental Health Service Provider Education Program. Unfortunately, this bill is double-assessing the same profession for similar programs.

I would encourage the stakeholders to consider the loan repayment funds they currently receive though licensure assessments and discuss how those funds can be redirected to address their policy goals.

For these reasons, I am unable to support this bill.

Sincerely,

Arnold Schwarzenegger

AB 2637

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2637
Author: Eng
Chapter: 499
Subject: Dental Auxiliaries
Sponsor: Author
Board Position: Watch

DESCRIPTION OF LEGISLATION:

This bill allows the Dental Board to issue a dental sedation assistant permit to a person who has completed at least 12 months of work experience as a dental assistant and satisfies all other requirements including attending Board approved courses, Basic Life Support, and a written examination. Please refer to page 12 of the attached bill, Sections 13 and 14 (B&P sections 1750.4 and 1750.5).

A dental sedation assistant permit allows the holder to monitor patients undergoing conscious sedation or general anesthesia utilizing data from noninvasive instrumentation such as pulse oximeters and electrocardiograms, capnography, blood pressure, pulse, and respiration rate monitoring devises. Evaluation of the condition of a sedated patient shall remain the responsibility of the dentist or other licensed health care professional authorized to administer conscious sedation or general anesthesia, who shall be at the patient's chairside while conscious sedation or general anesthesia is being administered.

Dental assistants holding a dental sedation assistant permit are also be allowed to add drugs, medications, and fluids to intravenous lines using a syringe, provided that a supervising licensed dentist is present.

IMPLEMENTATION:

- Article in January 2009 *Newsletter*

Assembly Bill No. 2637

CHAPTER 499

An act to amend Sections 1680, 1721.5, 1725, 1741, 1750, 1750.1, 1752.1, 1765, 1771, and 1777 of, to amend and renumber Sections 1753.1, 1754, and 1770 of, to amend, renumber, add, and repeal Sections 1756 and 1757 of, to add Sections 1750.5, 1752.3, 1752.4, and 1753.4 to, to add and repeal Sections 1754.5, 1755, 1756.1, 1756.2, and 1758 of, to repeal Sections 1751.1, 1752, 1752.2, 1752.5, and 1753.5 of, and to repeal and add Sections 1750.2, 1750.3, 1750.4, 1751, 1752.6, and 1753 of, the Business and Professions Code, relating to dentistry.

[Approved by Governor September 28, 2008. Filed with Secretary of State September 28, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2637, Eng. Dental auxiliaries.

Existing law, the Dental Practice Act, provides for the licensure and regulation of dentists by the Dental Board of California and dental auxiliaries by the Committee on Dental Auxiliaries. Existing law, on and after, January 1, 2010, authorizes an unlicensed dental assistant to perform basic supportive dental procedures, as defined, subject to a determination by the supervising licensed dentist that the dental assistant is competent to perform those procedures. Existing law, until January 1, 2011, requires the board to license as a registered dental assistant a person who files an application prior to September 1, 2009, and submits specified written evidence of either graduation from a specified educational program or specified work experience that is satisfactory to the board. Existing law, on and after January 1, 2010, requires the board to license as a registered dental assistant in extended functions a person who submits specified evidence of current licensure as a registered dental assistant or completion of the requirements for licensure, successful completion of a specified extended functions postsecondary program, and board-approved courses in radiation safety, infection control, California dental law, and basic life support, and satisfactory performance on a specified written examination and a clinical or practical examination. Existing law, on and after January 1, 2010, also requires the board to license a person who meets specified requirements as a registered orthodontic assistant, registered surgery assistant, registered restorative assistant, or registered restorative assistant in extended functions.

This bill would repeal those provisions governing registered orthodontic assistants, registered surgery assistants, registered restorative assistants, and registered restorative assistants in extended functions.

The bill would, on and after January 1, 2010, specify the duties that a dental assistant is authorized to perform under the general or direct supervision of a supervising licensed dentist.

The bill would revise and recast the registered dental assistant provisions and would authorize the board to license a person as a registered dental assistant if he or she files an application and submits written evidence, satisfactory to the board, of either (1) graduation from a board-approved educational program in registered dental assisting, or (2) for individuals applying prior to January 1, 2010, satisfactory work experience, as defined, of at least 12 months or, for individuals applying on and after January 1, 2010, satisfactory work experience of at least 15 months, and satisfactory performance on a written and practical examination administered by the committee. The bill would also require that those individuals applying on or after January 1, 2010, pass a written examination in law and ethics and complete board-approved courses in the act, infection control, and basic life support. The bill would, on and after January 1, 2010, impose specific content requirements for the written and practical examinations and would require the board to appoint a registered dental assistant examination committee to assign specific procedures for the practical examination. The bill would, commencing January 1, 2010, specify the duties a registered dental assistant is authorized to perform. The bill would specify that the fee for the written examination in law and ethics shall not exceed the actual cost of the examination.

The bill would, on and after January 1, 2010, modify the requirements for a license as a registered dental assistant in extended functions to include, among other things, completion of a board-approved course in the application of pit and fissure sealants and passage of a written examination and a clinical or practical examination. The bill would specify the duties and procedures a registered dental assistant in extended functions, licensed on or after January 1, 2010, is authorized to perform, as well as those additional procedures that may be performed under the direct supervision of a licensed dentist. The bill would, commencing January 1, 2010, also require applicants for a registered dental assistant in extended functions license to complete a specified examination regarding certain procedures.

The bill would, commencing January 1, 2010, authorize the board to issue an orthodontic assistant permit or a dental sedation assistant permit to a person who files a completed application, including a fee, and provides proof of certain eligibility requirements. The bill would authorize a dental assistant, a registered dental assistant, or a registered dental assistant in extended functions to apply for and maintain an orthodontic assistant permit or a dental sedation assistant permit. The bill would also, commencing January 1, 2010, specify the duties that may be performed by an orthodontic assistant permitholder or a dental sedation assistant permitholder under the direct supervision of a licensed dentist or, with respect to dental sedation assistant permitholders, another specified licensed health care professional. The bill would subject these permitholders to board established continuing education and renewal requirements. The bill would specify that the fee for

these permits shall not exceed $50 and that the fee for the written examination for these permits shall not exceed the actual cost of the examination.

The bill would require the board, commencing January 1, 2010, at least once every 7 years, to review the allowable duties for the various dental auxiliary categories, the supervision level for those categories, and the settings under which those duties may be performed, and to update the regulations as necessary.

The bill would require a dental assisting program or course, a permit program or course, a registered dental assistant program, a registered dental assistant in extended function program, an orthodontic assistant permit course, a dental sedation assistant permit course, and an infection control course to meet various requirements, relating to, among other things, administration, facilities, supervision, curriculum, instruction, equipment, and examinations in order to secure and maintain approval by the board.

Existing law provides that it is a misdemeanor for any person who does not have a license issued by the board to hold himself or herself out as licensed by the board in specified categories of dental practice.

This bill would revise these provisions to make it a misdemeanor for a person to, without a license or permit issued by the board, hold himself or herself out as, among other things, a registered dental assistant, orthodontic assistant permitholder, or dental sedation assistant permitholder. By expanding the scope of an existing crime, the bill would impose a state-mandated local program.

Existing law provides that all fees collected under the Dental Practice Act in connection with the practice of a dental auxiliary are deposited in the State Dental Auxiliary Fund, in the Professions and Vocations Fund.

This bill would abolish the State Dental Auxiliary Fund and would create the State Dental Assistant Fund, to which would be transferred funds in the State Dental Auxiliary Fund related to dental assistants for specific use, and in which would be deposited all funds from the regulation of dental assistants. The bill would make funds in the State Dental Assistant Fund subject to appropriation by the Legislature in the annual Budget Act.

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

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

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

SECTION 1. Section 1680 of the Business and Professions Code is amended to read:

1680. Unprofessional conduct by a person licensed under this chapter is defined as, but is not limited to, any one of the following:

(a) The obtaining of any fee by fraud or misrepresentation.

(b) The employment directly or indirectly of any student or suspended or unlicensed dentist to practice dentistry as defined in this chapter.

(c) The aiding or abetting of any unlicensed person to practice dentistry.

(d) The aiding or abetting of a licensed person to practice dentistry unlawfully.

(e) The committing of any act or acts of sexual abuse, misconduct, or relations with a patient that are substantially related to the practice of dentistry.

(f) The use of any false, assumed, or fictitious name, either as an individual, firm, corporation, or otherwise, or any name other than the name under which he or she is licensed to practice, in advertising or in any other manner indicating that he or she is practicing or will practice dentistry, except that name as is specified in a valid permit issued pursuant to Section 1701.5.

(g) The practice of accepting or receiving any commission or the rebating in any form or manner of fees for professional services, radiograms, prescriptions, or other services or articles supplied to patients.

(h) The making use by the licensee or any agent of the licensee of any advertising statements of a character tending to deceive or mislead the public.

(i) The advertising of either professional superiority or the advertising of performance of professional services in a superior manner. This subdivision shall not prohibit advertising permitted by subdivision (h) of Section 651.

(j) The employing or the making use of solicitors.

(k) The advertising in violation of Section 651.

(*l*) The advertising to guarantee any dental service, or to perform any dental operation painlessly. This subdivision shall not prohibit advertising permitted by Section 651.

(m) The violation of any of the provisions of law regulating the procurement, dispensing, or administration of dangerous drugs, as defined in Chapter 9 (commencing with Section 4000) or controlled substances, as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code.

(n) The violation of any of the provisions of this division.

(o) The permitting of any person to operate dental radiographic equipment who has not met the requirements of Section 1656.

(p) The clearly excessive prescribing or administering of drugs or treatment, or the clearly excessive use of diagnostic procedures, or the clearly excessive use of diagnostic or treatment facilities, as determined by the customary practice and standards of the dental profession.

Any person who violates this subdivision is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) or more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days or more than 180 days, or by both a fine and imprisonment.

(q) The use of threats or harassment against any patient or licensee for providing evidence in any possible or actual disciplinary action, or other

legal action; or the discharge of an employee primarily based on the employee's attempt to comply with the provisions of this chapter or to aid in the compliance.

(r) Suspension or revocation of a license issued, or discipline imposed, by another state or territory on grounds that would be the basis of discipline in this state.

(s) The alteration of a patient's record with intent to deceive.

(t) Unsanitary or unsafe office conditions, as determined by the customary practice and standards of the dental profession.

(u) The abandonment of the patient by the licensee, without written notice to the patient that treatment is to be discontinued and before the patient has ample opportunity to secure the services of another dentist, registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions and provided the health of the patient is not jeopardized.

(v) The willful misrepresentation of facts relating to a disciplinary action to the patients of a disciplined licensee.

(w) Use of fraud in the procurement of any license issued pursuant to this chapter.

(x) Any action or conduct that would have warranted the denial of the license.

(y) The aiding or abetting of a licensed dentist, dental assistant, registered dental assistant, registered dental assistant in extended functions, dental sedation assistant permitholder, orthodontic assistant permitholder, registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions to practice dentistry in a negligent or incompetent manner.

(z) The failure to report to the board in writing within seven days any of the following: (1) the death of his or her patient during the performance of any dental or dental hygiene procedure; (2) the discovery of the death of a patient whose death is related to a dental or dental hygiene procedure performed by him or her; or (3) except for a scheduled hospitalization, the removal to a hospital or emergency center for medical treatment for a period exceeding 24 hours of any patient to whom oral conscious sedation, conscious sedation, or general anesthesia was administered, or any patient as a result of dental or dental hygiene treatment. With the exception of patients to whom oral conscious sedation, conscious sedation, or general anesthesia was administered, removal to a hospital or emergency center that is the normal or expected treatment for the underlying dental condition is not required to be reported. Upon receipt of a report pursuant to this subdivision the board may conduct an inspection of the dental office if the board finds that it is necessary. A dentist shall report to the board all deaths occurring in his or her practice with a copy sent to the Dental Hygiene Committee of California if the death was the result of treatment by a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions. A registered dental hygienist, registered dental hygienist in alternative practice, or registered

dental hygienist in extended functions shall report to the Dental Hygiene Committee of California all deaths occurring as the result of dental hygiene treatment, and a copy of the notification shall be sent to the board.

(aa) Participating in or operating any group advertising and referral services that are in violation of Section 650.2.

(ab) The failure to use a fail-safe machine with an appropriate exhaust system in the administration of nitrous oxide. The board shall, by regulation, define what constitutes a fail-safe machine.

(ac) Engaging in the practice of dentistry with an expired license.

(ad) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of bloodborne infectious diseases from dentist, dental assistant, registered dental assistant, registered dental assistant in extended functions, dental sedation assistant permitholder, orthodontic assistant permitholder, registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions to patient, from patient to patient, and from patient to dentist, dental assistant, registered dental assistant, registered dental assistant in extended functions, dental sedation assistant permitholder, orthodontic assistant permitholder, registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Public Health developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, guidelines, and regulations pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other blood-borne pathogens in health care settings. The board shall review infection control guidelines, if necessary, on an annual basis and proposed changes shall be reviewed by the Dental Hygiene Committee of California to establish a consensus. The committee shall submit any recommended changes to the infection control guidelines for review to establish a consensus. As necessary, the board shall consult with the Medical Board of California, the California Board of Podiatric Medicine, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians, to encourage appropriate consistency in the implementation of this subdivision.

The board shall seek to ensure that all appropriate dental personnel are informed of the responsibility to follow infection control guidelines, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission of bloodborne infectious diseases.

(ae) The utilization by a licensed dentist of any person to perform the functions of any registered dental assistant, registered dental assistant in extended functions, dental sedation assistant permitholder, orthodontic assistant permitholder, registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions

who, at the time of initial employment, does not possess a current, valid license or permit to perform those functions.

(af) The prescribing, dispensing, or furnishing of dangerous drugs or devices, as defined in Section 4022, in violation of Section 2242.1.

SEC. 2. Section 1721.5 of the Business and Professions Code is amended to read:

1721.5. (a) All funds received by the Treasurer pursuant to Section 1725 shall be placed in the State Dental Assistant Fund for the purposes of administering this chapter as it relates to dental assistants, registered dental assistants, registered dental assistants in extended functions, dental sedation assistant permitholders, and orthodontic assistant permitholders. Expenditure of these funds shall be subject to appropriation by the Legislature in the annual Budget Act.

(b) On July 1, 2009, all moneys in the State Dental Auxiliary Fund, other than the moneys described in Section 1945, shall be transferred to the State Dental Assistant Fund. The board's authority to expend those funds, as appropriated in the 2008 Budget Act, shall continue in order to carry out the provisions of this chapter as they related to dental assistants licensed under this chapter for the 2008–09 fiscal year, including the payment of any encumbrances related to dental assistants licensed under this chapter incurred by the State Dental Auxiliary Fund.

SEC. 3. Section 1725 of the Business and Professions Code is amended to read:

1725. The amount of the fees prescribed by this chapter that relate to the licensing and permitting of dental assistants shall be established by board resolution and subject to the following limitations:

(a) The application fee for an original license shall not exceed twenty dollars ($20). On and after January 1, 2010, the application fee for an original license shall not exceed fifty dollars ($50).

(b) The fee for examination for licensure as a registered dental assistant shall not exceed fifty dollars ($50) for the written examination and shall not exceed sixty dollars ($60) for the practical examination.

(c) The fee for application and for the issuance of an orthodontic assistant permit or a dental sedation assistant permit shall not exceed fifty dollars ($50).

(d) The fee for the written examination for an orthodontic assistant permit or a dental sedation assistant permit shall not exceed the actual cost of the examination.

(e) The fee for the written examination in law and ethics for a registered dental assistant shall not exceed the actual cost of the examination.

(f) The fee for examination for licensure as a registered dental assistant in extended functions shall not exceed the actual cost of the examination.

(g) The fee for examination for licensure as a registered dental hygienist shall not exceed the actual cost of the examination.

(h) For third- and fourth-year dental students, the fee for examination for licensure as a registered dental hygienist shall not exceed the actual cost of the examination.

(i) The fee for examination for licensure as a registered dental hygienist in extended functions shall not exceed the actual cost of the examination.

(j) The board shall establish the fee at an amount not to exceed the actual cost for licensure as a registered dental hygienist in alternative practice.

(k) The biennial renewal fee for a registered dental assistant whose license expires on or after January 1, 1991, shall not exceed sixty dollars ($60). On or after January 1, 1992, the board may set the renewal fee for a registered dental assistant license, registered dental assistant in extended functions license, dental sedation assistant permit, or orthodontic assistant permit in an amount not to exceed eighty dollars ($80).

(*l*) The delinquency fee shall not exceed twenty-five dollars ($25) or one-half of the renewal fee, whichever is greater. Any delinquent license or permit may be restored only upon payment of all fees, including the delinquency fee.

(m) The fee for issuance of a duplicate registration, license, permit, or certificate to replace one that is lost or destroyed, or in the event of a name change, shall not exceed twenty-five dollars ($25).

(n) The fee for each curriculum review and site evaluation for educational programs for registered dental assistants that are not accredited by a board-approved agency, or the Chancellor's office of the California Community Colleges shall not exceed one thousand four hundred dollars ($1,400).

(o) The fee for review of each approval application for a course that is not accredited by a board-approved agency, or the Chancellor's office of the California Community Colleges shall not exceed three hundred dollars ($300).

(p) No fees or charges other than those listed in subdivisions (a) to (o), inclusive, above shall be levied by the board in connection with the licensure or permitting of dental assistants, registered dental assistant educational program site evaluations and course evaluations pursuant to this chapter.

(q) Fees fixed by the board pursuant to this section shall not be subject to the approval of the Office of Administrative Law.

(r) Fees collected pursuant to this section shall be deposited in the State Dental Assistant Fund.

SEC. 4. Section 1741 of the Business and Professions Code is amended to read:

1741. As used in this article:

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

(b) "Direct supervision" means supervision of dental procedures based on instructions given by a licensed dentist, who must be physically present in the treatment facility during the performance of those procedures.

(c) "General supervision" means supervision of dental procedures based on instructions given by a licensed dentist but not requiring the physical presence of the supervising dentist during the performance of those procedures.

SEC. 5. Section 1750 of the Business and Professions Code, as amended by Section 6 of Chapter 588 of the Statutes of 2007, is amended to read:

1750. (a) A dental assistant is a person who may perform basic supportive dental procedures as authorized by this article under the supervision of a licensed dentist and who may perform basic supportive procedures as authorized pursuant to subdivision (b) of Section 1751 under the supervision of a registered dental hygienist in alternative practice.

(b) The supervising licensed dentist shall be responsible for determining the competency of the dental assistant to perform allowable functions.

(c) This section shall remain in effect only until January 1, 2010, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2010, deletes or extends that date.

SEC. 6. Section 1750 of the Business and Professions Code, as amended by Section 7 of Chapter 588 of the Statutes of 2007, is amended to read:

1750. (a) A dental assistant is an individual who, without a license, may perform basic supportive dental procedures, as authorized by Section 1750.1 and by regulations adopted by the board, under the supervision of a licensed dentist. "Basic supportive dental procedures" are those procedures that have technically elementary characteristics, are completely reversible, and are unlikely to precipitate potentially hazardous conditions for the patient being treated.

(b) The supervising licensed dentist shall be responsible for determining the competency of the dental assistant to perform the basic supportive dental procedures, as authorized by Section 1750.1.

(c) The employer of a dental assistant shall be responsible for ensuring that the dental assistant who has been in continuous employment for 120 days or more, has already successfully completed, or successfully completes, all of the following within a year of the date of employment:

(1) A board-approved course in the Dental Practice Act.

(2) A board-approved course in infection control.

(3) A course in basic life support offered by an instructor approved by the American Red Cross or the American Heart Association, or any other course approved by the board as equivalent and that provides the student the opportunity to engage in hands-on simulated clinical scenarios.

(d) The employer of a dental assistant shall be responsible for ensuring that the dental assistant maintains certification in basic life support.

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

SEC. 7. Section 1750.1 of the Business and Professions Code is amended to read:

1750.1. (a) A dental assistant may perform the following duties under the general supervision of a supervising licensed dentist:

(1) Extra-oral duties or procedures specified by the supervising licensed dentist, provided that these duties or procedures meet the definition of a basic supportive procedure specified in Section 1750.

(2) Operate dental radiography equipment for the purpose of oral radiography if the dental assistant has complied with the requirements of Section 1656.

(3) Perform intraoral and extraoral photography.

(b) A dental assistant may perform the following duties under the direct supervision of a supervising licensed dentist:

(1) Apply nonaerosol and noncaustic topical agents.

(2) Apply topical fluoride.

(3) Take intraoral impressions for all nonprosthodontic appliances.

(4) Take facebow transfers and bite registrations.

(5) Place and remove rubber dams or other isolation devices.

(6) Place, wedge, and remove matrices for restorative procedures.

(7) Remove post-extraction dressings after inspection of the surgical site by the supervising licensed dentist.

(8) Perform measurements for the purposes of orthodontic treatment.

(9) Cure restorative or orthodontic materials in operative site with a light-curing device.

(10) Examine orthodontic appliances.

(11) Place and remove orthodontic separators.

(12) Remove ligature ties and archwires.

(13) After adjustment by the dentist, examine and seat removable orthodontic appliances and deliver care instructions to the patient.

(14) Remove periodontal dressings.

(15) Remove sutures after inspection of the site by the dentist.

(16) Place patient monitoring sensors.

(17) Monitor patient sedation, limited to reading and transmitting information from the monitor display during the intraoperative phase of surgery for electrocardiogram waveform, carbon dioxide and end tidal carbon dioxide concentrations, respiratory cycle data, continuous noninvasive blood pressure data, or pulse arterial oxygen saturation measurements, for the purpose of interpretation and evaluation by a supervising licensed dentist who shall be at the patient's chairside during this procedure.

(18) Assist in the administration of nitrous oxide when used for analgesia or sedation. A dental assistant shall not start the administration of the gases and shall not adjust the flow of the gases unless instructed to do so by the supervising licensed dentist who shall be present at the patient's chairside during the implementation of these instructions. This paragraph shall not be construed to prevent any person from taking appropriate action in the event of a medical emergency.

(c) Under the supervision of a registered dental hygienist in alternative practice, a dental assistant may perform intraoral retraction and suctioning.

(d) The board may specify additional allowable duties by regulation.

(e) The duties of a dental assistant or a dental assistant holding a permit in orthodontic assisting or in dental sedation do not include any of the following procedures unless specifically allowed by law:

(1) Diagnosis and comprehensive treatment planning.

(2) Placing, finishing, or removing permanent restorations.

(3) Surgery or cutting on hard and soft tissue including, but not limited to, the removal of teeth and the cutting and suturing of soft tissue.

(4) Prescribing medication.

(5) Starting or adjusting local or general anesthesia or oral or parenteral conscious sedation, except for the administration of nitrous oxide and oxygen, whether administered alone or in combination with each other and except as otherwise provided by law.

(f) The duties of a dental assistant are defined in subdivision (a) of Section 1750 and do not include any duty or procedure that only an orthodontic assistant permitholder, dental sedation assistant permitholder, registered dental assistant, registered dental assistant in extended functions, registered dental hygienist, or registered dental hygienist in alternative practice is allowed to perform.

(g) This section shall become operative on January 1, 2010.

SEC. 8. Section 1750.2 of the Business and Professions Code is repealed.

SEC. 9. Section 1750.2 is added to the Business and Professions Code, to read:

1750.2. (a) On and after January 1, 2010, the board may issue an orthodontic assistant permit to a person who files a completed application including a fee and provides evidence, satisfactory to the board, of all of the following eligibility requirements:

(1) Completion of at least 12 months of work experience as a dental assistant.

(2) Successful completion of a board-approved course in the Dental Practice Act and a board-approved, course in infection control.

(3) Successful completion of a course in basic life support offered by an instructor approved by the American Red Cross or the American Heart Association, or any other course approved by the board as equivalent.

(4) Successful completion of a board-approved orthodontic assistant course, which may commence after the completion of six months of work experience as a dental assistant.

(5) Passage of a written examination administered by the board after completion of all of the other requirements of this subdivision. The written examination shall encompass the knowledge, skills, and abilities necessary to competently perform the duties specified in Section 1750.3.

(b) A person who holds an orthodontic assistant permit pursuant to this section shall be subject to the same continuing education requirements for registered dental assistants as established by the board pursuant to Section 1645 and the renewal requirements of Article 6 (commencing with Section 1715).

SEC. 10. Section 1750.3 of the Business and Professions Code is repealed.

SEC. 11. Section 1750.3 is added to the Business and Professions Code, to read:

1750.3. A person holding an orthodontic assistant permit pursuant to Section 1750.2 may perform the following duties under the direct supervision of a licensed dentist:

(a) All duties that a dental assistant is allowed to perform.

(b) Prepare teeth for bonding, and select, preposition, and cure orthodontic brackets after their position has been approved by the supervising licensed dentist.

(c) Remove only orthodontic brackets and attachments with removal of the bonding material by the supervising licensed dentist.

(d) Size, fit, and cement orthodontic bands.

(e) Remove orthodontic bands and remove excess cement from supragingival surfaces of teeth with a hand instrument.

(f) Place and ligate archwires.

(g) Remove excess cement with an ultrasonic scaler from supragingival surfaces of teeth undergoing orthodontic treatment.

(h) Any additional duties that the board may prescribe by regulation.

SEC. 12. Section 1750.4 of the Business and Professions Code is repealed.

SEC. 13. Section 1750.4 is added to the Business and Professions Code, to read:

1750.4. (a) On and after January 1, 2010, the board may issue a dental sedation assistant permit to a person who files a completed application including a fee and provides evidence, satisfactory to the board, of all of the following eligibility requirements:

(1) Completion of at least 12 months of work experience as a dental assistant.

(2) Successful completion of a board-approved course in the Dental Practice Act and a board-approved, course in infection control.

(3) Successful completion of a course in basic life support offered by an instructor approved by the American Red Cross or the American Heart Association, or any other course approved by the board as equivalent.

(4) Successful completion of a board-approved dental sedation assistant course, which may commence after the completion of six months of work experience as a dental assistant.

(5) Passage of a written examination administered by the board after completion of all of the other requirements of this subdivision. The written examination shall encompass the knowledge, skills, and abilities necessary to competently perform the duties specified in Section 1750.5.

(b) A person who holds a permit pursuant to this section shall be subject to the continuing education requirements established by the board pursuant to Section 1645 and the renewal requirements of Article 6 (commencing with Section 1715).

SEC. 14. Section 1750.5 is added to the Business and Professions Code, to read:

1750.5. A person holding a dental sedation assistant permit pursuant to Section 1750.4 may perform the following duties under the direct supervision of a licensed dentist or other licensed health care professional authorized to administer conscious sedation or general anesthesia in the dental office:

(a) All duties that a dental assistant is allowed to perform.

(b) Monitor patients undergoing conscious sedation or general anesthesia utilizing data from noninvasive instrumentation such as pulse oximeters,

electrocardiograms, capnography, blood pressure, pulse, and respiration rate monitoring devices. Evaluation of the condition of a sedated patient shall remain the responsibility of the dentist or other licensed health care professional authorized to administer conscious sedation or general anesthesia, who shall be at the patient's chairside while conscious sedation or general anesthesia is being administered.

(c) Drug identification and draw, limited to identification of appropriate medications, ampule and vial preparation, and withdrawing drugs of correct amount as verified by the supervising licensed dentist.

(d) Add drugs, medications, and fluids to intravenous lines using a syringe, provided that a supervising licensed dentist is present at the patient's chairside, limited to determining patency of intravenous line, selection of injection port, syringe insertion into injection port, occlusion of intravenous line and blood aspiration, line release and injection of drugs for appropriate time interval. The exception to this duty is that the initial dose of a drug or medication shall be administered by the supervising licensed dentist.

(e) Removal of intravenous lines.

(f) Any additional duties that the board may prescribe by regulation.

(g) The duties listed in subdivisions (b) to (e), inclusive, may not be performed in any setting other than a dental office or dental clinic.

SEC. 15. Section 1751 of the Business and Professions Code, as amended by Section 13 of Chapter 588 of the Statutes of 2007, is repealed.

SEC. 16. Section 1751 is added to the Business and Professions Code, to read:

1751. (a) At least once every seven years, the board shall review the allowable duties for dental assistants, registered dental assistants, registered dental assistants in extended functions, dental sedation assistant permitholders, and orthodontic assistant permitholders, the supervision level for these categories, and the settings under which these duties may be performed, and shall update the regulations as necessary to keep them current with the state of the dental practice.

(b) This section shall become operative on January 1, 2010.

SEC. 17. Section 1751.1 of the Business and Professions Code is repealed.

SEC. 18. Section 1752 of the Business and Professions Code, as amended by Section 14 of Chapter 588 of the Statutes of 2007, is repealed.

SEC. 19. Section 1752 of the Business and Professions Code, as amended by Section 15 of Chapter 588 of the Statutes of 2007, is repealed.

SEC. 20. Section 1752.1 of the Business and Professions Code is amended to read:

1752.1. (a) The board may license as a registered dental assistant a person who files an application and submits written evidence, satisfactory to the board, of one of the following eligibility requirements:

(1) Graduation from an educational program in registered dental assisting approved by the board, and satisfactory performance on a written and practical examination administered by the board.

(2) For individuals applying prior to January 1, 2010, evidence of completion of satisfactory work experience of at least 12 months as a dental assistant in California or another state and satisfactory performance on a written and practical examination administered by the board.

(3) For individuals applying on or after January 1, 2010, evidence of completion of satisfactory work experience of at least 15 months as a dental assistant in California or another state and satisfactory performance on a written and practical examination administered by the board.

(b) For purposes of this section, "satisfactory work experience" means performance of the duties specified in Section 1750.1 in a competent manner as determined by the employing dentist, who shall certify to such satisfactory work experience in the application.

(c) The board shall give credit toward the work experience referred to in this section to persons who have graduated from a dental assisting program in a postsecondary institution approved by the Department of Education or in a secondary institution, regional occupational center, or regional occupational program, that are not, however, approved by the board pursuant to subdivision (a). The credit shall equal the total weeks spent in classroom training and internship on a week-for-week basis. The board, in cooperation with the Superintendent of Public Instruction, shall establish the minimum criteria for the curriculum of nonboard-approved programs. Additionally, the board shall notify those programs only if the program's curriculum does not meet established minimum criteria, as established for board-approved registered dental assistant programs, except any requirement that the program be given in a postsecondary institution. Graduates of programs not meeting established minimum criteria shall not qualify for satisfactory work experience as defined by this section.

(d) In addition to the requirements specified in subdivision (a), each applicant for registered dental assistant licensure on or after July 1, 2002, shall provide evidence of having successfully completed board-approved courses in radiation safety and coronal polishing as a condition of licensure. The length and content of the courses shall be governed by applicable board regulations.

(e) In addition to the requirements specified in subdivisions (a) and (d), individuals applying for registered dental assistant licensure on or after January 1, 2010, shall demonstrate satisfactory performance on a written examination in law and ethics administered by the board and shall provide written evidence of successful completion within five years prior to application of all of the following:

(1) A board-approved course in the Dental Practice Act.

(2) A board-approved course in infection control.

(3) A course in basic life support offered by an instructor approved by the American Red Cross or the American Heart Association, or any other course approved by the board as equivalent.

(f) A registered dental assistant may apply for an orthodontic assistant permit or a dental sedation assistant permit, or both, by submitting written evidence of the following:

(1) Successful completion of a board-approved orthodontic assistant or dental sedation assistant course, as applicable.

(2) Passage of a written examination administered by the board that shall encompass the knowledge, skills, and abilities necessary to competently perform the duties of the particular permit.

(g) A registered dental assistant with permits in either orthodontic assisting or dental sedation assisting shall be referred to as an "RDA with orthodontic assistant permit," or "RDA with dental sedation assistant permit," as applicable. These terms shall be used for reference purposes only and do not create additional categories of licensure.

(h) Completion of the continuing education requirements established by the board pursuant to Section 1645 by a registered dental assistant who also holds a permit as an orthodontic assistant or dental sedation assistant shall fulfill the continuing education requirements for the permit or permits.

SEC. 21. Section 1752.2 of the Business and Professions Code is repealed.

SEC. 22. Section 1752.3 is added to the Business and Professions Code, to read:

1752.3. (a) On and after January 1, 2010, the written examination for registered dental assistant licensure required by Section 1752.1 shall comply with Section 139.

(b) On and after January 1, 2010, the practical examination for registered dental assistant licensure required by Section 1752.1 shall consist of three of the procedures described in paragraphs (1) to (4), inclusive. The specific procedures shall be assigned by a registered dental assistant examination committee appointed by the board and shall be graded by examiners appointed by the board. The procedures shall be performed on a fully articulated maxillary and mandibular typodont secured with a bench clamp. Each applicant shall furnish the required materials necessary to complete the examination.

(1) Place a base or liner.

(2) Place, adjust, and finish a direct provisional restoration.

(3) Fabricate and adjust an indirect provisional restoration.

(4) Cement an indirect provisional restoration.

SEC. 23. Section 1752.4 is added to the Business and Professions Code, to read:

1752.4. (a) A registered dental assistant may perform all of the following duties:

(1) All duties that a dental assistant is allowed to perform.

(2) Mouth-mirror inspections of the oral cavity, to include charting of obvious lesions, existing restorations, and missing teeth.

(3) Apply and activate bleaching agents using a nonlaser light-curing device.

(4) Use of automated caries detection devices and materials to gather information for diagnosis by the dentist.

(5) Obtain intraoral images for computer-aided design (CAD), milled restorations.

(6) Pulp vitality testing and recording of findings.
(7) Place bases, liners, and bonding agents.
(8) Chemically prepare teeth for bonding.
(9) Place, adjust, and finish direct provisional restorations.
(10) Fabricate, adjust, cement, and remove indirect provisional restorations, including stainless steel crowns when used as a provisional restoration.
(11) Place post-extraction dressings after inspection of the surgical site by the supervising licensed dentist.
(12) Place periodontal dressings.
(13) Dry endodontically treated canals using absorbent paper points.
(14) Adjust dentures extra-orally.
(15) Remove excess cement from surfaces of teeth with a hand instrument.
(16) Polish coronal surfaces of the teeth.
(17) Place ligature ties and archwires.
(18) Remove orthodontic bands.
(19) All duties that the board may prescribe by regulation.
(b) A registered dental assistant may only perform the following additional duties if he or she has completed a board-approved registered dental assistant educational program in those duties, or if he or she has provided evidence, satisfactory to the board, of having completed a board-approved course in those duties.
(1) Remove excess cement with an ultrasonic scaler from supragingival surfaces of teeth undergoing orthodontic treatment.
(2) The allowable duties of an orthodontic assistant permitholder as specified in Section 1750.3. A registered dental assistant shall not be required to complete further instruction in the duties of placing ligature ties and archwires, removing orthodontic bands, and removing excess cement from tooth surfaces with a hand instrument.
(3) The allowable duties of a dental sedation assistant permitholder as specified in Section 1750.5.
(4) The application of pit and fissure sealants.
(c) Except as provided in Section 1777, the supervising licensed dentist shall be responsible for determining whether each authorized procedure performed by a registered dental assistant should be performed under general or direct supervision.
(d) This section shall become operative on January 1, 2010.
SEC. 24. Section 1752.5 of the Business and Professions Code is repealed.
SEC. 25. Section 1752.6 of the Business and Professions Code is repealed.
SEC. 26. Section 1752.6 is added to the Business and Professions Code, to read:
1752.6. A registered dental assistant licensed on and after January 1, 2010, shall provide evidence of successful completion of a board-approved course in the application of pit and fissure sealants prior to the first expiration of his or her license that requires the completion of continuing education

as a condition of renewal. The license of a registered dental assistant who does not provide evidence of successful completion of that course shall not be renewed until evidence of course completion is provided.

SEC. 27. Section 1753 of the Business and Professions Code is repealed.

SEC. 28. Section 1753 is added to the Business and Professions Code, to read:

1753. (a) On and after January 1, 2010, the board may license as a registered dental assistant in extended functions a person who submits written evidence, satisfactory to the board, of all of the following eligibility requirements:

(1) Current licensure as a registered dental assistant or completion of the requirements for licensure as a registered dental assistant.

(2) Successful completion of a board-approved course in the application of pit and fissure sealants.

(3) Successful completion of either of the following:

(A) An extended functions postsecondary program approved by the board in all of the procedures specified in Section 1753.5.

(B) An extended functions postsecondary program approved by the board to teach the duties that registered dental assistants in extended functions were allowed to perform pursuant to board regulations prior to January 1, 2010, and a course approved by the board in the procedures specified in paragraphs (1), (2), (5), and (7) to (11), inclusive, of subdivision (b) of Section 1753.5.

(4) Passage of a written examination and a clinical or practical examination administered by the board. The board shall designate whether the written examination shall be administered by the board or by the board-approved extended functions program.

(b) A registered dental assistant in extended functions may apply for an orthodontic assistant permit or a dental sedation assistant permit, or both, by providing written evidence of the following:

(1) Successful completion of a board-approved orthodontic assistant or dental sedation assistant course, as applicable.

(2) Passage of a written examination administered by the board that shall encompass the knowledge, skills, and abilities necessary to competently perform the duties of the particular permit.

(c) A registered dental assistant in extended functions with permits in either orthodontic assisting or dental sedation assisting shall be referred to as an "RDAEF with orthodontic assistant permit," or "RDAEF with dental sedation assistant permit," as applicable. These terms shall be used for reference purposes only and do not create additional categories of licensure.

(d) Completion of the continuing education requirements established by the board pursuant to Section 1645 by a registered dental assistant in extended functions who also holds a permit as an orthodontic assistant or dental sedation assistant shall fulfill the continuing education requirement for such permit or permits.

SEC. 29. Section 1753.1 of the Business and Professions Code is amended and renumbered to read:

1753.5. (a) A registered dental assistant in extended functions licensed on or after January 1, 2010, is authorized to perform all duties and procedures that a registered dental assistant is authorized to perform as specified in and limited by Section 1752.4, and those duties that the board may prescribe by regulation.

(b) A registered dental assistant in extended functions licensed on or after January 1, 2010, is authorized to perform the following additional procedures under direct supervision and pursuant to the order, control, and full professional responsibility of a licensed dentist:

(1) Conduct preliminary evaluation of the patient's oral health, including, but not limited to, charting, intraoral and extra-oral evaluation of soft tissue, classifying occlusion, and myofunctional evaluation.

(2) Perform oral health assessments in school-based, community health project settings under the direction of a dentist, registered dental hygienist, or registered dental hygienist in alternative practice.

(3) Cord retraction of gingiva for impression procedures.

(4) Size and fit endodontic master points and accessory points.

(5) Cement endodontic master points and accessory points.

(6) Take final impressions for permanent indirect restorations.

(7) Take final impressions for tooth-borne removable prosthesis.

(8) Polish and contour existing amalgam restorations.

(9) Place, contour, finish, and adjust all direct restorations.

(10) Adjust and cement permanent indirect restorations.

(11) Other procedures authorized by regulations adopted by the board.

(c) All procedures required to be performed under direct supervision shall be checked and approved by the supervising licensed dentist prior to the patient's dismissal from the office.

SEC. 30. Section 1753.4 is added to the Business and Professions Code, to read:

1753.4. On and after January 1, 2010, each applicant for licensure as a registered dental assistant in extended functions shall successfully complete an examination consisting of the procedures described in subdivisions (a) and (b). On and after January 1, 2010, each person who holds a current and active registered dental assistant in extended functions license issued prior to January 1, 2010, who wishes to perform the duties specified in paragraphs (1), (2), (5), and (7) to (11), inclusive, of subdivision (b) of Section 1753.5, shall successfully complete an examination consisting of the procedures described in subdivision (b). The specific procedures shall be assigned by a registered dental assistant in extended functions examination committee appointed by the board and shall be graded by examiners appointed by the board. Each applicant shall furnish the required materials necessary to complete the examination.

(a) Successful completion of the following two procedures on a patient provided by the applicant. The prepared tooth, prior to preparation, shall have had mesial and distal contact. The preparation performed shall have margins at or below the free gingival crest and shall be one of the following:

7/8 crown, 3/4 crown, or full crown, including porcelain fused to metal. Alginate impression materials alone shall not be acceptable:

(1) Cord retraction of gingiva for impression procedures.

(2) Take a final impression for a permanent indirect restoration.

(b) Successful completion of two of the following procedures on a simulated patient head mounted in appropriate position and accommodating an articulated typodont in an enclosed intraoral environment, or mounted on a dental chair in a dental operatory:

(1) Place, condense, and carve an amalgam restoration.

(2) Place and contour a nonmetallic direct restoration.

(3) Polish and contour an existing amalgam restoration.

SEC. 31. Section 1753.5 of the Business and Professions Code is repealed.

SEC. 32. Section 1754 of the Business and Professions Code is amended and renumbered to read:

1752.4. (a) By September 15, 1993, the board, upon recommendation of the board and consistent with this article, standards of good dental practice, and the health and welfare of patients, shall adopt regulations relating to the functions that may be performed by registered dental assistants under direct or general supervision, and the settings within which registered dental assistants may work. At least once every seven years thereafter, the board shall review the allowable duties of registered dental assistants, the supervision level, and settings under which they may be performed, and shall update the regulations as needed to keep them current with the state of the practice.

(b) A registered dental assistant may apply pit and fissure sealants under the general supervision of a licensed dentist, after providing evidence to the board of having completed a board-approved course in that procedure.

(c) This section shall remain in effect only until January 1, 2010, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2010, deletes or extends that date.

SEC. 33. Section 1754.5 is added to the Business and Professions Code, to read:

1754.5. As used in this article, the following definitions shall apply:

(a) "Didactic instruction" means lectures, demonstrations, and other instruction without active participation by students. The approved provider or its designee may provide didactic instruction via electronic media, home study materials, or live lecture methodology if the provider has submitted that content for approval.

(b) "Laboratory instruction" means instruction in which students receive supervised experience performing procedures using study models, mannequins, or other simulation methods. There shall be at least one instructor for every 14 students who are simultaneously engaged in laboratory instruction.

(c) "Preclinical instruction" means instruction in which students receive supervised experience performing procedures on students, faculty, or staff

members. There shall be at least one instructor for every six students who are simultaneously engaged in preclinical instruction.

(d) "Clinical instruction" means instruction in which students receive supervised experience in performing procedures in a clinical setting on patients. Clinical instruction shall only be performed upon successful demonstration and evaluation of preclinical skills. There shall be at least one instructor for every six students who are simultaneously engaged in clinical instruction.

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

SEC. 34. Section 1755 is added to the Business and Professions Code, to read:

1755. (a) (1) The criteria in subdivisions (b) to (h), inclusive, shall be met by a dental assisting program or course and all orthodontic assisting and dental sedation assisting permit programs or courses to secure and maintain approval by the board as provided in this article.

(2) The board may approve, provisionally approve, or deny approval of any program or course.

(3) Program and course records shall be subject to inspection by the board at any time.

(4) The board may withdraw approval at any time that it determines that a program or course does not meet the requirements established in this section or any other requirements of law.

(5) All programs and courses shall be established at the postsecondary educational level or deemed equivalent thereto by the board.

(b) The program or course director shall possess a valid, active, and current license issued by the board. The program or course director shall actively participate in and be responsible for the day-to-day administration of the program or course, including the following requirements:

(1) Maintaining for a period of not less than five years copies of curricula, program outlines, objectives, and grading criteria, and copies of faculty credentials, licenses, and certifications, and individual student records, including those necessary to establish satisfactory completion of the program or course.

(2) Informing the board of any major change to the program or course content, physical facilities, or faculty, within 10 days of the change.

(3) Ensuring that all staff and faculty involved in clinical instruction meet the requirements set forth in this article.

(c) No faculty member shall instruct in any procedure that he or she is not licensed or permitted to perform. Each faculty member shall have been licensed or permitted for a minimum of two years and possess experience in the subject matter he or she is teaching.

(d) A certificate or other evidence of completion shall be issued to each student who successfully completes the program or course and shall include the student's name, the name of the program or course, the total number of

program or course hours, the date of completion, and the signature of the program or course director or his or her designee.

(e) Facilities and class scheduling shall provide each student with sufficient opportunity, with instructor supervision, to develop minimum competency in all duties for which the program or course is approved to instruct.

(1) The location and number of general use equipment and armamentaria shall ensure that each student has the access necessary to develop minimum competency in all of the duties for which the program or course is approved to instruct. The program or course provider may either provide the specified equipment and supplies or require that the student provide them. Nothing in this section shall preclude a dental office that contains the equipment required by this section from serving as a location for laboratory instruction.

(2) The minimum requirement for armamentaria includes infection control materials specified by the Division of Occupational Safety and Health and the regulations of the board, protective eyewear, mask, and gloves for each student and faculty member, and appropriate eye protection for each piece of equipment.

(3) Clinical instruction shall be of sufficient duration to allow the procedures to be performed to clinical proficiency. Operatories shall be sufficient in number to allow a ratio of at least one operatory for every five students who are simultaneously engaged in clinical instruction.

(A) Each operatory shall contain functional equipment, including a power-operated chair for treating patients in a supine position, operator and assistant stools, air-water syringe, adjustable light, oral evacuation equipment, work surface, and adjacent hand-washing sink.

(B) Each operatory shall be of sufficient size to simultaneously accommodate one student, one instructor, and one patient.

(f) The program or course shall establish written clinical and laboratory protocols to ensure adequate asepsis, infection, and hazard control and disposal of hazardous wastes, that comply with the board's regulations and other federal, state, and local requirements. The program or course shall provide these protocols to all students, faculty, and appropriate staff to ensure compliance with these protocols. Adequate space shall be provided for preparing and sterilizing all armamentarium. All reusable armamentarium shall be sterilized and nonreusable items properly disposed.

(g) A written policy on managing emergency situations shall be made available to all students, faculty, and staff. All faculty and staff involved in the direct provision of patient care shall be certified in basic life support procedures, including cardiopulmonary resuscitation. Recertification intervals may not exceed two years. The program or course director shall ensure and document compliance by faculty and staff. A program or course shall not be required to ensure that students complete instruction in basic life support prior to performing procedures on patients.

(h) A detailed program or course outline shall clearly state curriculum subject matter and specific instruction hours in the individual areas of didactic, laboratory, and clinical instruction. General program or course

objectives and specific instructional unit objectives shall be stated in writing, and shall include theoretical aspects of each subject as well as practical application. Objective evaluation criteria shall be used for measuring student progress toward attainment of specific program or course objectives. Students shall be provided with all of the following:

(1) Specific unit objectives and the evaluation criteria that will be used for all aspects of the curriculum including written, practical, and clinical examinations.

(2) Standards of performance that state the minimum number of satisfactory performances that are required for each procedure.

(3) Standards of performance for laboratory, preclinical, and clinical functions, those steps that constitute a critical error and would cause the student to fail the procedure, and a description of each of the grades that may be assessed for each procedure.

(i) (1) If an extramural clinical facility is utilized, students shall, as part of an extramural organized program of instruction, be provided with planned, supervised clinical instruction. Laboratory and preclinical instruction shall be performed under the direct supervision of program or course faculty and shall not be provided in extramural facilities.

(2) The program or course director, or a designated faculty member, shall be responsible for selecting extramural clinical sites and evaluating student competence in performing procedures both before and after the clinical assignment.

(3) The program or course director, or a designated faculty member, shall orient dentists who intend to provide extramural clinical facilities prior to the student assignment. Orientation shall include the objectives of the program or course, the student's preparation for the clinical assignment, and a review of procedures and criteria to be used by the dentist in evaluating the student during the assignment. The program or course faculty and extramural clinic personnel shall use the same objective evaluation criteria.

(4) There shall be a written contract of affiliation with each extramural clinical facility, which shall describe the settings in which the clinical training will be received, and affirm that the dentist and clinic personnel acknowledge the legal scope of duties and infection control requirements, that the clinical facility has the necessary equipment and armamentaria appropriate for the procedures to be performed, and that the equipment and armamentaria are in safe operating condition.

(j) Any additional requirements that the board may prescribe by regulation.

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

SEC. 35. Section 1756 of the Business and Professions Code is amended and renumbered to read:

1753.1. (a) The board may license as a registered dental assistant in extended functions a person who satisfies all of the following eligibility requirements:

(1) Status as a registered dental assistant.

(2) Completion of clinical training approved by the board in a facility affiliated with a dental school under the direct supervision of the dental school faculty.

(3) Satisfactory performance on an examination required by the board.

(b) This section shall remain in effect only until January 1, 2010, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2010, deletes or extends that date.

SEC. 36. Section 1756 is added to the Business and Professions Code, to read:

1756. In addition to the requirements of Section 1755, the following criteria shall be met by a course in infection control, as required in Sections 1750, 1750.2, 1750.4, and 1752.1, to secure and maintain approval by the board:

(a) Adequate provisions for the supervision and operation of the course in infection control shall be made. Notwithstanding Section 1755, faculty shall not be required to be licensed by the board, but faculty shall have experience in the instruction of the infection control regulations and guidelines issued by the board and the Division of Occupational Safety and Health (Cal-DOSH). In addition to the requirements of Section 1755, all faculty responsible for clinical evaluation shall have completed a two-hour methodology course in clinical evaluation.

(b) A course in infection control shall be of sufficient duration for the student to develop minimum competency in all aspects of infection control regulations and guidelines issued by the board and Cal-DOSH, but in no event less than eight hours, including at least four hours of didactic instruction, at least two hours of laboratory or preclinical instruction, and at least two hours of clinical instruction. Preclinical instruction shall utilize instruments, surfaces, and situations where contamination is simulated, without actual contamination, from bloodborne and other pathogens being present.

(c) The minimum requirements for equipment and armamentaria shall include personal protective equipment, FDA-approved sterilizer, ultrasonic unit or instrument processing device, sharps container, selection of instruments, equipment, and armamentaria that are necessary to instruct or demonstrate proper hazardous waste disposal, consistent with Cal-DOSH regulations, local, state, and federal mandates, and all other armamentaria required to instruct or properly demonstrate the subjects described in the course content.

(d) Areas of instruction shall include, at a minimum, the instruction specified in subdivisions (e) and (f).

(e) Didactic instruction shall include, at a minimum, the following as they relate to the infection control regulations of the board and of Cal-DOSH:

(1) Basic dental science and microbiology as they relate to infection control in dentistry.

(2) Legal and ethical aspects of infection control procedures.

(3) Terms and protocols specified in the regulations of the board regarding the minimum standards for infection control.

(4) Principles of modes of disease transmission and prevention.

(5) Principles, techniques, and protocols of hand hygiene, personal protective equipment, surface barriers and disinfection, sterilization, sanitation, and hazardous chemicals associated with infection control.

(6) Principles and protocols of sterilizer monitoring and the proper loading, unloading, storage, and transportation of instruments to work area.

(7) Principles and protocols associated with sharps management.

(8) Principles and protocols of infection control for laboratory areas.

(9) Principles and protocols of waterline maintenance.

(10) Principles and protocols of regulated and nonregulated waste management.

(11) Principles and protocols related to injury and illness prevention, hazard communication, general office safety, exposure control, postexposure requirements, and monitoring systems for radiation safety and sterilization systems.

(f) Preclinical instruction shall include three experiences in the following areas, with one used for a practical examination. Clinical instruction shall include two experiences in the following areas, with one used for a clinical examination:

(1) Apply hand cleansing products and perform hand cleansing techniques and protocols.

(2) Apply, remove, and dispose of patient treatment gloves, utility gloves, overgloves, protective eyewear, masks, and clinical attire.

(3) Apply the appropriate techniques and protocols for the preparation, sterilization, and storage of instruments including, at a minimum, application of personal protective equipment, precleaning, ultrasonic cleaning, rinsing, sterilization wrapping, internal or external process indicators, labeling, sterilization, drying, storage, and delivery to work area.

(4) Preclean and disinfect contaminated operatory surfaces and devices, and properly use, place, and remove surface barriers.

(5) Maintain sterilizer including, at a minimum, proper instrument loading and unloading, operation cycle, spore testing, and handling and disposal of sterilization chemicals.

(6) Apply work practice controls as they relate to the following classification of sharps: anesthetic needles or syringes, orthodontic wires, and broken glass.

(7) Apply infection control protocol for the following laboratory devices: impressions, bite registrations, and prosthetic appliances.

(8) Perform waterline maintenance, including use of water tests and purging of waterlines.

(g) Each student shall pass a written examination that reflects the curriculum content, which may be administered at intervals throughout the course as determined by the course director.

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

SEC. 37. Section 1756.1 is added to the Business and Professions Code, to read:

1756.1. In addition to the requirements of Section 1755, the following criteria shall be met by a orthodontic assistant permit course to secure and maintain approval by the board. The board may approve orthodontic assistant permit courses prior to January 1, 2010, and recognize the completion of orthodontic assistant permit courses by students prior to January 1, 2010, but the board may not issue an orthodontic assistant permit to students graduating from orthodontic assistant permit courses until on or after January 1, 2010.

(a) The course shall be of sufficient duration for the student to develop minimum competence in all of the duties that orthodontic assistant permitholders are authorized to perform, but in no event less than 84 hours, including at least 24 hours of didactic instruction, at least 28 hours of laboratory instruction, and at least 32 hours of clinical instruction.

(b) The minimum requirements for equipment and armamentaria shall include banded or bonded orthodontic typodonts in the ratio of at least one for every four students, bench mount or dental chair mounted mannequin head, curing light, regular typodont with full dentition and soft gingiva in the ratio of at least one for every four students, and a selection of orthodontic instruments and adjunct material for all of the procedures that orthodontic assistant permitholders are authorized to perform.

(c) All faculty responsible for clinical evaluation shall have completed a two-hour methodology course in clinical evaluation prior to conducting clinical evaluations of students.

(d) Areas of instruction shall include, at a minimum, the instruction specified in subdivisions (e) to (j), inclusive. In addition to the requirements of those subdivisions, instruction shall include basic background information on orthodontic practice, including orthodontic treatment review, charting, patient education, and legal and infection control requirements as they apply to orthodontic practice.

(e) The following requirements shall be met for sizing, fitting, cementing, and removing orthodontic bands:

(1) Didactic instruction shall include the following:

(A) Theory of band positioning and tooth movement.

(B) Characteristics of band material including malleability, stiffness, ductility, and work hardening.

(C) Techniques for orthodontic banding and removal, including all of the following:

(i) Armamentaria.

(ii) General principles of fitting and removing bands.

(iii) Normal placement requirements of brackets, tubes, lingual sheaths, lingual cleats, and buttons onto bands.

(iv) Orthodontic cements and adhesive materials: classifications, armamentaria, and mixing technique.

(v) Cementing bands: armamentaria, mixing technique, and band cementation procedures.

(vi) Procedure for removal of bands after cementation.

(2) Laboratory instruction shall include typodont experience in the sizing, fitting, cementing, and removal of four posterior first molar bands a minimum of two times, with the cementing and removal of two first molar bands used as a practical examination.

(3) Clinical instruction shall include the sizing, fitting, cementing, and removal of four posterior first molar bands on at least two patients.

(f) The following requirements shall be met for preparing teeth for bonding:

(1) Didactic instruction shall include the following: chemistry of etching materials and tooth surface preparation, application and time factors, armamentaria, and techniques for tooth etching.

(2) Laboratory instruction shall include typodont experience with etchant application in preparation for subsequent bracket bonding on four anterior and four posterior teeth a minimum of four times each, with one of each of the four times used for a practical examination.

(3) Clinical instruction shall include etchant application in preparation for bracket bonding on anterior and posterior teeth on at least two patients.

(g) The following requirements shall be met for bracket positioning, bond curing, and removal of orthodontic brackets.

(1) Didactic instruction shall include the following:

(A) Characteristics and methods of orthodontic bonding.

(B) Armamentaria.

(C) Types of bracket bonding surfaces.

(D) Bonding material characteristics, application techniques, and curing time factors.

(E) Procedure for direct and indirect bracket bonding.

(F) Procedures for bracket or tube removal.

(2) Laboratory instruction shall include typodont experience with selecting, prepositioning, tooth etching, positioning, curing and removing of four anterior and four posterior brackets a minimum of four times each, with one each of the four times used for a practical examination.

(3) Clinical instruction shall include selecting, adjusting, prepositioning, etching, curing and removal of anterior and posterior brackets on at least two patients.

(h) The following requirements shall be met for archwire placement and ligation:

(1) Didactic instruction shall include the following:

(A) Archwire characteristics.

(B) Armamentaria.

(C) Procedures for placement of archwire previously adjusted by the dentist.

(D) Ligature systems, purpose and types, including elastic, wire, and self-ligating.

(2) Laboratory instruction shall include typodont experience on the following:

(A) The insertion of a preformed maxillary and mandibular archwire a minimum of four times per arch, with one of each of the four times used for a practical examination.

(B) Ligation of maxillary and mandibular archwire using elastic or metal ligatures or self-ligating brackets a minimum of four times per arch, with one of each of the four times used for a practical examination.

(3) Clinical instruction shall include the following:

(A) Insertion of a preformed maxillary and mandibular archwire on at least two patients.

(B) Ligating both preformed maxillary and mandibular archwires using a combination of elastic and metal ligatures or self-ligating brackets on at least two patients for each.

(i) The following requirements shall be met for cement removal with a hand instrument:

(1) Didactic instruction shall include, armamentaria and techniques of cement removal using hand instruments and related materials.

(2) Laboratory instruction shall include typodont experience on the removal of excess cement supragingivally from an orthodontically banded typodont using a hand instrument four times, with one of the four times used for a practical examination.

(3) Clinical instruction shall include removal of excess cement supragingivally from orthodontic bands with a hand instrument on at least two patients.

(j) Instruction for cement removal with an ultrasonic scaler shall be in accordance with the regulations of the board governing courses in the removal of excess cement from teeth under orthodontic treatment with an ultrasonic scaler.

(k) Each student shall pass a written examination that reflects the curriculum content, which may be administered at intervals throughout the course as determined by the course director.

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

SEC. 38. Section 1756.2 is added to the Business and Professions Code, to read:

1756.2. In addition to the requirements of Section 1755, the following criteria shall be met by a dental sedation assistant permit course to secure and maintain approval by the board. The board may approve a dental sedation assistant permit course prior to January 1, 2010, and recognize the completion of these courses by students prior to January 1, 2010, but the board may not issue a dental sedation assistant permit to students graduating from dental sedation assistant permit courses until on or after January 1, 2010. As used in this section, "IV" means "intravenous."

(a) (1) The course director or faculty may, in lieu of a license issued by the board, possess a valid, active, and current license issued in California as a certified registered nurse anesthetist or a physician and surgeon.

(2) All faculty responsible for clinical evaluation shall have completed a two-hour methodology course in clinical evaluation prior to conducting clinical evaluations of students.

(b) The course shall be of a sufficient duration for the student to develop minimum competence in all of the duties that dental sedation assistant permitholders are authorized to perform, but in no event less than 110 hours, including at least 40 hours of didactic instruction, at least 32 hours of combined laboratory and preclinical instruction, and at least 38 hours of clinical instruction.

(c) (1) The following are minimum requirements for equipment and armamentaria: one pulse oximeter for each six students; one automated external defibrillator (AED) or AED trainer; one capnograph or teaching device for monitoring of end tidal CO_2; blood pressure cuff and stethoscope for each six students; one pretracheal stethoscope for each six students; one electrocardiogram machine, one automatic blood pressure/pulse measuring system/machine, and one oxygen delivery system including oxygen tank; one IV start kit for each student; one venous access device kit for each student; IV equipment and supplies for IV infusions including hanging device infusion containers and tubing for each six students; one sharps container for each six students; packaged syringes, needles, needleless devices, practice fluid ampules and vials for each student; stopwatch or timer with second hand for each six students; one heart/lung sounds mannequin or teaching device; tonsillar or pharyngeal suction tip, endotracheal tube forceps, endotracheal tube and appropriate connectors, suction equipment for aspiration of oral and pharyngeal cavities, and laryngoscope in the ratio of at least one for each six students; any other monitoring or emergency equipment that the regulations of the board require for the administration of general anesthesia or conscious sedation; and a selection of instruments and supplemental armamentaria for all of the procedures that dental sedation assistant permitholders are authorized to perform.

(2) Each operatory used for preclinical or clinical training shall contain either a surgery table or a power-operated chair for treating patients in a supine position, an irrigation system or sterile water delivery system as they pertain to the specific practice, and all other equipment and armamentarium required to instruct in the duties that dental sedation assistant permitholders are authorized to perform.

(3) All students, faculty, and staff involved in the direct provision of patient care shall be certified in basic life support procedures, including the use of an automatic electronic defibrillator.

(d) Areas of instruction shall include, at a minimum, the instruction specified in subdivisions (e) to (n), inclusive, as they relate to the duties that dental sedation assistant permitholders are authorized to perform.

(e) General didactic instruction shall include:

(1) Patient evaluation and selection factors through review of medical history, physical assessment, and medical consultation.

(2) Characteristics of anatomy and physiology of the circulatory, cardiovascular, and respiratory systems, and the central and peripheral nervous system.

(3) Characteristics of anxiety management related to the surgical patient, relatives, and escorts, and characteristics of anxiety and pain reduction techniques.

(4) Overview of the classification of drugs used by patients for cardiac disease, respiratory disease, hypertension, diabetes, neurological disorders, and infectious diseases.

(5) Overview of techniques and specific drug groups utilized for sedation and general anesthesia.

(6) Definitions and characteristics of levels of sedation achieved with general anesthesia and sedative agents, including the distinctions between conscious sedation, deep sedation, and general anesthesia.

(7) Overview of patient monitoring during conscious sedation and general anesthesia.

(8) Prevention, recognition, and management of complications.

(9) Obtaining informed consent.

(f) (1) With respect to medical emergencies, didactic instruction shall include an overview of medical emergencies, including, but not limited to, airway obstruction, bronchospasm or asthma, laryngospasm, allergic reactions, syncope, cardiac arrest, cardiac dysrhythmia, seizure disorders, hyperglycemia and hypoglycemia, drug overdose, hyperventilation, acute coronary syndrome including angina and myocardial infarction, hypertension, hypotension, stroke, aspiration of vomitus, and congestive heart failure.

(2) Laboratory instruction shall include the simulation and response to at least the following medical emergencies: airway obstruction, bronchospasm, emesis and aspiration of foreign material under anesthesia, angina pectoris, myocardial infarction, hypotension, hypertension, cardiac arrest, allergic reaction, convulsions, hypoglycemia, syncope, and respiratory depression. Both training mannequins and other students or staff may be used for simulation. Instruction shall include at least two experiences each, one of each of which shall be used for a practical examination.

(g) With respect to sedation and the pediatric patient, didactic instruction shall include the following:

(1) Psychological considerations.

(2) Patient evaluation and selection factors through review of medical history, physical assessment, and medical consultation.

(3) Definitions and characteristics of levels of sedation achieved with general anesthesia and sedative agents, with special emphasis on the distinctions between conscious sedation, deep sedation, and general anesthesia.

(4) Review of respiratory and circulatory physiology and related anatomy, with special emphasis on establishing and maintaining a patent airway.

(5) Overview of pharmacology agents used in contemporary sedation and general anesthesia.

(6) Patient monitoring.

(7) Obtaining informed consent.

(8) Prevention, recognition, and management of complications, including principles of basic life support.

(h) With respect to physically, mentally, and neurologically compromised patients, didactic instruction shall include the following: an overview of characteristics of Alzheimer's disease, autism, cerebral palsy, Down's syndrome, mental retardation, multiple sclerosis, muscular dystrophy, Parkinson's disease, schizophrenia, and stroke.

(i) With respect to health history and patient assessment, didactic instruction shall include, but not be limited to, the recording of the following:

(1) Age, sex, weight, physical status (American Society of Anesthesiologists Classification), medication use, general health, any known or suspected medically compromising conditions, rationale for anesthesia or sedation of the patient, visual examination of the airway, and auscultation of the heart and lungs as medically required.

(2) General anesthesia or conscious sedation records including a time-oriented record with preoperative, multiple intraoperative, and postoperative pulse oximetry and blood pressure and pulse readings, amounts of time of drug administration, length of procedure, complications of anesthesia or sedation, and a statement of the patient's condition at time of discharge.

(j) With respect to monitoring heart sounds with pretracheal/precordial stethoscope and ECG/EKG and use of AED:

(1) Didactic instruction shall include the following:

(A) Characteristics of pretracheal/precordial stethoscope.

(B) Review of anatomy and physiology of circulatory system: heart, blood vessels, and cardiac cycle as it relates to EKG.

(C) Characteristics of rhythm interpretation and waveform analysis basics.

(D) Characteristics of manual intermittent and automatic blood pressure and pulse assessment.

(E) Characteristics and use of an AED.

(F) Procedure for using a pretracheal/precordial stethoscope for monitoring of heart sounds.

(G) Procedure for use and monitoring of the heart with an ECG/EKG machine, including electrode placement, and the adjustment of such equipment.

(H) Procedure for using manual and automatic blood pressure/pulse/respiration measuring system.

(2) Preclinical instruction shall include at least three experiences on another student or staff person for each of the following, one of each of which shall be used for an examination. Clinical instruction shall include at lease three experiences on a patient for each of the following, one of each of which shall be used for a clinical examination:

(A) Assessment of blood pressure and pulse both manually and utilizing an automatic system.

(B) Placement and assessment of an electrocardiogram (ECG/EKG). Instruction shall include the adjustment of such equipment.

(C) Monitoring and assessment of heart sounds with a pretracheal/precordial stethoscope.

(D) Use of an AED or AED trainer.

(k) With respect to monitoring lung/respiratory sounds with pretracheal/precordial stethoscope and monitoring oxygen saturation end tidal CO_2 with pulse oximeter and capnograph:

(1) Didactic instruction shall include the following:

(A) Characteristics of pretracheal/precordial stethoscope, pulse oximeter and capnograph for respiration monitoring.

(B) Review of anatomy and physiology of respiratory system to include the nose, mouth, pharynx, epiglottis, larynx, trachea, bronchi, bronchioles, and alveolus.

(C) Characteristics of respiratory monitoring/lung sounds: mechanism of respiration, composition of respiratory gases, oxygen saturation.

(D) Characteristics of manual and automatic respiration assessment.

(E) Procedure for using a pretracheal/precordial stethoscope for respiration monitoring.

(F) Procedure for using and maintaining pulse oximeter for monitoring oxygen saturation.

(G) Procedure for use and maintenance of capnograph.

(H) Characteristics for monitoring blood and skin color and other related factors.

(I) Procedures and use of an oxygen delivery system.

(J) Characteristics of airway management to include armamentaria and use.

(2) Preclinical and clinical instruction shall include at least three experiences on a student or staff person for each of the following, one of each of which shall be used for an examination. Clinical instruction shall include at least three experiences on a patient for each of the following, one of which shall be used for a clinical examination:

(A) Assessment of respiration rates.

(B) Monitoring and assessment of lung sounds and ventilation with a pretracheal/precordial stethoscope.

(C) Monitoring oxygen saturation with a pulse oximeter.

(D) Use of an oxygen delivery system.

(*l*) With respect to drug identification and draw:

(1) Didactic instruction shall include:

(A) Characteristics of syringes and needles including use, types, gauges, lengths, and components.

(B) Characteristics of drug, medication, and fluid storage units, use, type, components, identification of label including generic and brand names, strength, potential adverse reactions, expiration date, and contraindications.

(C) Characteristics of drug draw including armamentaria, label verification, ampule and vial preparation, and drug withdrawal techniques.

(2) Laboratory instruction shall include at least three experiences in the withdrawal of fluids from a vial or ampule in the amount specified by faculty, one of which shall be for a practical examination.

(3) Clinical instruction shall include at least three experiences in the evaluation of vial or container labels for identification of content, dosage, and strength and in the withdrawal of fluids from a vial or ampule in the amount specified by faculty or the extramural facility dentist.

(m) With respect to adding drugs, medications, and fluids to IV lines:

(1) Didactic instruction shall include:

(A) Characteristics of adding drugs, medications, and fluids to IV lines in the presence of a licensed dentist.

(B) Armamentaria.

(C) Procedures for adding drugs, medications, and fluids, including amount and time intervals.

(D) Procedures for adding drugs, medications, and fluids by IV bolus.

(E) Characteristics of patient observation for signs and symptoms of drug response.

(2) Laboratory instruction shall include at least three experiences of adding fluids to an existing IV line on a venipuncture training arm or in a simulated environment, one of which shall be used for a practical examination.

(3) Clinical instruction shall include at least three experiences adding fluids to existing IV lines on at least three patients in the presence of a licensed dentist.

(n) With respect to the removal of IV lines:

(1) Didactic instruction shall include overview and procedures for the removal of an IV line.

(2) Laboratory instruction shall include at least three experiences on a venipuncture training arm or in a simulated environment for IV removal, one of which shall be used for a practical examination.

(3) Clinical instruction shall include at least three experiences removing IV lines on at least three patients in the presence of a licensed dentist.

(o) Each student shall pass a written examination that reflects the curriculum content, which may be administered at intervals throughout the course as determined by the course director.

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

SEC. 39. Section 1757 of the Business and Professions Code is amended and renumbered to read:

1753.6. (a) Each person who holds a license as a registered dental assistant in extended functions on the operative date of this section may only perform those procedures that a registered dental assistant is allowed to perform as specified in and limited by Section 1752.4, and the procedures specified in paragraphs (1) to (6), inclusive, until he or she provides evidence

of having completed a board-approved course in the additional procedures specified in paragraphs (1), (2), (5), and (7) to (11), inclusive, of subdivision (b) of Section 1753.5, and an examination as specified in Section 1753.4:

(1) Cord retraction of gingiva for impression procedures.

(2) Take final impressions for permanent indirect restorations.

(3) Formulate indirect patterns for endodontic post and core castings.

(4) Fit trial endodontic filling points.

(5) Apply pit and fissure sealants.

(6) Remove excess cement from subgingival tooth surfaces with a hand instrument.

(b) This section shall become operative on January 1, 2010.

SEC. 40. Section 1757 is added to the Business and Professions Code, to read:

1757. (a) A registered dental assistant program shall receive board approval prior to operation.

(1) In order for a registered dental assistant program to secure and maintain approval by the board, it shall meet the requirements of Section 1755 and the following requirements:

(A) Programs approved on or after January 1, 2009, shall meet all of the requirements of this section.

(B) Programs approved prior to January 1, 2009, shall meet all of the requirements of this section except as otherwise specified. Such a program shall continue to be approved only if it has certified to the board no later than April 30, 2009, on a form specified by the board, that it shall, no later than July 1, 2009, comply with all of the requirements of this section in providing instruction in all duties that registered dental assistants will be allowed to perform on and after January 1, 2010. The certification to the board shall contain the date on which the program will begin teaching those duties.

(2) A program shall notify the board in writing if it wishes to increase the maximum student enrollment for which it is approved and shall provide whatever additional documentation the board requires to reapprove the program for the increased enrollment prior to accepting additional students.

(3) The board may at any time conduct a thorough evaluation of an approved educational program's curriculum and facilities to determine whether the program meets the requirements for continued approval.

(4) The board may, in lieu of conducting its own investigation, accept the findings of any commission or accreditation agency approved by the board and adopt those findings as its own.

(b) Programs shall have an advisory committee consisting of an equal number of registered dental assistants and dentists, including at least two registered dental assistants and two dentists, all currently licensed by the board. The advisory committee shall meet at least once each academic year with the program director, faculty, and appropriate institutional personnel to monitor the ongoing quality and performance of the program. Programs that admit students at different phases shall meet at least twice each year.

(c) Adequate provision for the supervision and operation of the program shall be made. In addition to the requirements of Section 1755, the following requirements shall be met:

(1) Each program faculty member shall have successfully completed a board-approved course in the application of pit and fissure sealants.

(2) By January 1, 2010, each faculty member shall have completed a board-approved course in instructional methodology of at least 30 hours, unless he or she holds any one of the following: a postgraduate degree in education, a Ryan Designated Subjects Vocational Education Teaching Credential, a Standard Designated Subjects Teaching Credential, or, a Community College Teaching Credential. Each faculty member employed on or after January 1, 2010, shall complete a course in instructional methodology within six months of employment.

(3) The program director shall have teaching responsibilities that are less than those of a full-time faculty member. He or she shall actively participate in and be responsible for the day-to-day administration of the program including the following:

(A) Participating in budget preparation and fiscal administration, curriculum development and coordination, determination of teaching assignments, supervision and evaluation of faculty, establishment of mission criteria and procedures, design and operation of program facilities, and selection of extramural facilities and coordination of instruction in those facilities.

(B) Holding periodic faculty meetings to provide for subject matter correlation and curriculum evaluation, and coordinating activities of full-time, part-time, and volunteer faculty.

(C) Maintaining for not less than five years' copies of minutes of all advisory committee meetings.

(4) The owner or school administrator shall be responsible for the compliance of the program director with the provisions of this section and Section 1755.

(d) The program shall have sufficient financial resources available to support the program and to comply with this section. If the program or school requires approval by any other governmental agency, that approval shall be obtained prior to application to the board for approval and shall be maintained at all times. The failure to maintain that approval shall result in the automatic withdrawal of board approval of the program.

(e) The program shall be of sufficient duration for the student to develop minimum competence in performing dental assistant and registered dental assistant duties, but in no event less than 800 hours, including at least 275 hours of didactic instruction, at least 260 hours of laboratory instruction, and at least 85 hours of preclinical and clinical instruction conducted in the program's facilities under the direct supervision of program faculty. No more than 20 hours shall be devoted to instruction in clerical, administrative, practice management, or similar duties. A program approved prior to January 1, 2009, shall comply with board regulations with regard to required program hours until the date specified in the written certification from the program

to the board that it will begin teaching the duties that registered dental assistants will be authorized to perform on and after January 1, 2010.

(f) In addition to the requirements of Section 1755 with regard to extramural instruction, no more than 25 percent of the required clinical instruction shall take place in extramural clinical facilities, and no more than 25 percent of extramural clinical instruction shall take place in a speciality dental practice.

(g) Facilities and class scheduling shall provide each student with sufficient opportunity, with instructor supervision, to develop minimum competency in all duties that registered dental assistants are authorized to perform. The following requirements are in addition to those contained in Section 1755:

(1) The following are minimum requirements for equipment and armamentaria during laboratory, preclinical, and clinical sessions as appropriate to each type of session and in ratios specified in Section 1070.2 of Title 16 of the California Code of Regulations: amalgamator, model trimmers, dental rotary equipment, vibrators, light curing devices, functional typodont and bench mounts, functional orthodontically banded typodonts, facebows, automated blood pressure device, EKG machine, pulse oximeters, capnograph or simulated device, sets of hand instruments for each procedure, respiration device, camera for intraoral use, camera for extraoral use, CAD machine or simulated device, caries detection device, and all other equipment and armamentaria required to teach dental assistant and registered dental assistant duties.

(2) One permanently preassembled tray for each procedure shall be provided for reference purposes.

(3) Provision shall be made for reasonable access to current and diverse dental and medical reference texts, current journals, audiovisual materials, and other necessary resources. Library holdings, which may include access through the Internet, shall include materials relating to all subject areas of the program curriculum.

(4) Emergency materials shall include, but not be limited to, an oxygen tank that is readily available and functional. Medical materials for treating patients with life-threatening conditions shall be available for instruction and accessible to the operatories. Facilities that do not treat patients shall maintain a working model of a kit of such emergency materials for instructional purposes.

(h) The curriculum shall be established, reviewed, and amended as necessary to allow for changes in the practice of dentistry and registered dental assisting. Programs that admit students in phases shall provide students with basic instruction prior to participation in any other portion of the program that shall, at a minimum, include tooth anatomy, tooth numbering, general program guidelines and safety precautions, and infection control and sterilization protocols associated with and required for patient treatment. All programs shall provide students with additional instruction in the infection control regulations and guidelines of the board and Cal-DOSH prior to the student's performance of procedures on patients.

(i) (1) A program approved prior to January 1, 2009, shall comply with board regulations with regard to program content until the date specified in the written certification from the program to the board, as specified in subparagraph (B) of paragraph (1) of subdivision (a), after which time the program content shall meet the requirements of paragraph (2).

(2) Programs receiving initial approval on or after January 1, 2009, shall meet all the requirements of Section 1755, and subdivisions (j) and (k) of this section, and shall include the following additional content:

(A) A radiation safety course that meets all of the requirements of the regulations of the board.

(B) A coronal polishing course that meets all of the requirements of the regulations of the board.

(C) A pit and fissure sealant course that meets all of the requirements of the regulations of the board.

(D) A course in basic life support provided by an instructor approved by the American Red Cross or the American Heart Association, or any other course approved by the board as equivalent.

(3) On and after January 1, 2009, a program that desires to provide instruction in the following areas shall apply separately for approval to provide the following courses:

(A) A course in the removal of excess cement with an ultrasonic scaler, which course shall meet the requirements of the regulations of the board.

(B) An orthodontic assistant permit course that shall meet the requirements of Section 1756.1, except that a program shall not be required to obtain separate approval to teach the duties of placing ligature ties and archwires, removing orthodontic bands, and removing excess cement from surfaces of teeth with a hand instrument. Notwithstanding Section 1756.1, an orthodontic assistant permit course provided by a registered dental assistant program, to the students enrolled in such program, shall be no less than 60 hours, including at least 12 hours of didactic instruction, at least 26 hours of preclinical instruction, and at least 22 hours of clinical instruction.

(C) A dental sedation assistant permit course that shall meet the requirements of Section 1756.2.

(j) General didactic instruction shall include, at a minimum, the following:

(1) Principles of general anatomy, physiology, oral embryology, tooth histology, and head-neck anatomy.

(2) Principles of abnormal conditions related to and including oral pathology, orthodontics, periodontics, endodontics, pediatric dentistry, oral surgery, prosthodontics, and esthetic dentistry.

(3) Legal requirements and ethics related to scope of practice, unprofessional conduct, and, patient records and confidentiality.

(4) Principles of infection control and hazardous communication requirements in compliance with the board's regulations and other federal, state, and local requirements.

(5) Principles and federal, state, and local requirements related to pharmacology.

(6) Principles of medical-dental emergencies and first aid management, including symptoms and treatment.

(7) Principles of the treatment planning process including medical health history data collection, patient and staff confidentiality, and charting.

(8) Principles of record classifications including management, storage, and retention protocol for all dental records.

(9) Principles and protocols of special needs patient management.

(10) Principles, protocols, and armamentaria associated with all dental assisting chairside procedures.

(11) Principles, protocols, manipulation, use, and armamentaria for dental materials.

(12) Principles and protocols for oral hygiene preventative methods including, plaque identification, toothbrushing and flossing techniques, and nutrition.

(13) Principles, protocols, armamentaria, and procedures associated with operative and specialty dentistry.

(14) Principles, protocols, armamentaria, and procedures for each duty that dental assistants and registered dental assistants are allowed to perform.

(k) Laboratory and clinical instruction shall be of sufficient duration and content for each student to achieve minimum competence in the performance of each procedure that dental assistant and registered dental assistant is authorized to perform.

(*l*) Each student shall pass a written examination that reflects the curriculum content, which may be administered at intervals throughout the course as determined by the course director.

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

SEC. 41. Section 1758 is added to the Business and Professions Code, to read:

1758. (a) In addition to the requirements of Section 1755, the following criteria shall be met by an educational program for registered dental assistants in extended functions (RDAEF) to secure and maintain approval by the board. A program approved prior to January 1, 2009, shall comply with board regulations with regard to program content until the date specified in a written certification from the program to the board that it will begin teaching the duties that RDAEFs will be allowed to perform beginning January 1, 2010, which may include the instruction of existing RDAEFs in the additional duties specified in Section 1753.6. The certification shall be filed with the board no later than July 1, 2009, and the date on which the program shall comply with the program content specified in this section shall be no later than January 1, 2010.

(1) A program applying for approval to teach all of the duties specified in Section 1753.5 shall comply with all of the requirements of this section. The board may approve RDAEF programs prior to January 1, 2010, and recognize the completion of these approved programs by students prior to

January 1, 2010, but shall not issue a license to students graduating from such programs until on or after January 1, 2010.

(2) A program applying for approval to teach existing RDAEFs the additional duties specified in Section 1753.6 shall comply with all of the requirements of this section, except as follows:

(A) The program shall be no less than 288 hours, including at least 76 hours of didactic instruction, at least 180 hours of laboratory instruction, and at least 32 hours of clinical instruction.

(B) Students shall not be required to complete instruction related to the placement of gingival retraction cord, the taking of final impressions for permanent indirect restorations, or the fitting of master and accessory points.

(b) In order to be admitted to the program, each student shall possess a valid, active, and current license as a registered dental assistant issued by the board and shall provide evidence of successful completion of a board-approved pit and fissure sealant course.

(c) Adequate provision for the supervision and operation of the program shall be made. Notwithstanding the requirements of Section 1755, the program director and each faculty member of an approved RDAEF program shall possess a valid, active, and current license as a dentist or an RDAEF. In addition to the requirements of Section 1755, all faculty members responsible for clinical evaluation shall have completed a six-hour teaching methodology course in clinical evaluation prior to conducting clinical evaluations of students.

(d) The program shall be of sufficient duration for the student to develop minimum competence in all of the duties that RDAEFs are authorized to perform, but in no event less than 380 hours, including at least 100 hours of didactic instruction, at least 200 hours of laboratory instruction, and at least 80 hours of clinical instruction. All instruction shall be provided under the direct supervision of program staff.

(e) The following requirements are in addition to the requirements of Section 1755:

(1) The following are minimum requirements for equipment and armamentaria:

(A) Laboratory facilities with individual seating stations for each student and equipped with air, gas and air, or electric driven rotary instrumentation capability. Each station or operatory shall allow an articulated typodont to be mounted in a simulated head position.

(B) Clinical simulation facilities that provide simulated patient heads mounted in appropriate position and accommodating an articulated typodont in an enclosed intraoral environment, or mounted on a dental chair in a dental operatory. Clinical simulation spaces shall be sufficient to permit one simulation space for each two students at any one time.

(C) Articulated typodonts of both deciduous and permanent dentitions with flexible gingival tissues and with prepared teeth for each procedure to be performed in the laboratory and clinical simulation settings. One of each type of typodont is required for each student.

(D) A selection of restorative instruments and adjunct materials for all procedures that RDAEFs are authorized to perform.

(2) Notwithstanding Section 1755, there shall be at least one operatory for every two students who are simultaneously engaged in clinical instruction.

(f) Areas of instruction shall include, at a minimum, the instruction specified in subdivisions (g) to (m), inclusive. In addition to the requirements of those subdivisions, didactic instruction shall include the following:

(1) The following instruction as it relates to each of the procedures that RDAEFs are authorized to perform: restorative and prosthetic treatment review; charting; patient education; legal requirements; indications and contraindications; problem solving techniques; laboratory, preclinical, and clinical criteria and evaluation; and infection control protocol implementation.

(2) Dental science, including dental and oral anatomy, histology, oral pathology, normal or abnormal anatomical and physiological tooth descriptions, tooth morphology, basic microbiology relating to infection control, and occlusion.

(3) Characteristics and manipulation of dental materials related to each procedure.

(4) Armamentaria for all procedures.

(5) Principles, techniques, criteria, and evaluation for performing each procedure, including implementation of infection control protocols.

(6) Occlusion: the review of articulation of maxillary and mandibular arches in maximum intercuspation.

(7) Tooth isolation and matrix methodology review.

(g) General laboratory instruction shall include:

(1) Rubber dam application for tooth isolation in both maxillary and mandibular arches and for deciduous and permanent dentitions. A minimum of four experiences per arch is required, with two anterior and two posterior applications, with one of the applications used for a practical examination.

(2) Matrix placement for amalgam, and nonmetallic restorative material restorations in both primary and permanent dentitions, with three experiences for each cavity classification and for each material.

(3) Base, liner, and etchant placement on three posterior teeth for each base, liner, or etchant, with one of the three teeth used for a practical examination.

(h) With respect to preliminary evaluation of the patient's oral health, including, but not limited to, charting, intraoral and extraoral evaluation of soft tissue, classifying occlusion, and myofunctional evaluation:

(1) Didactic instruction shall include the following:

(A) Normal anatomical structures: oral cavity proper, vestibule, and lips.

(B) Deviations from normal to hard tissue abnormalities to soft tissue abnormalities.

(C) Overview of classifications of occlusion and myofunction.

(D) Sequence of oral inspection: armamentaria, general patient assessment, review of medical history form, review of dental history form, oral cavity mouth-mirror inspection, and charting existing conditions.

(2) Preclinical instruction shall include performing an oral inspection on at least two other students.

(3) Clinical instruction shall include performing an oral inspection on at least two patients, with one of the two patients used for a clinical examination.

(i) With respect to sizing, fitting, and cementing endodontic master points and accessory points:

(1) Didactic instruction shall include the following:

(A) Review of objectives, canal preparation, filling of root canal space.

(B) Description and goals of filling technique using lateral condensation techniques.

(C) Principles and techniques of fitting, cementing master and accessory points using lateral condensation including, characteristics, manipulation, use of gutta percha and related materials, and criteria for an acceptable master and accessory points technique using lateral condensation.

(2) Laboratory instruction shall include fitting master and cementing cones on extracted teeth or assimilated teeth with canals, with two experiences each on a posterior and anterior tooth.

(j) With respect to gingival retraction, general instruction shall include:

(1) Review of characteristics of tissue management as it relates to gingival retraction with cord and electrosurgery.

(2) Description and goals of cord retraction.

(3) Principles of cord retraction, including characteristics and manipulation of epinephrine, chemical salts classification of cord, characteristics of single versus double cord technique, and techniques and criteria for an acceptable cord retraction technique.

(k) With respect to final impressions for permanent indirect and toothborne restorations:

(1) Didactic instruction shall include the following:

(A) Review of characteristics of impression material and custom.

(B) Description and goals of impression taking for permanent indirect restorations and toothborne prosthesis.

(C) Principles, techniques, criteria, and evaluation of impression taking for permanent indirect restorations and toothborne prosthesis.

(2) Laboratory instruction shall include the following:

(A) Cord retraction and final impressions for permanent indirect restorations, including impression taking of prepared teeth in maxillary and mandibular arches, one time per arch with elastomeric impression materials.

(B) Impressions for toothborne removable prostheses, including taking a total of four impressions on maxillary and mandibular arches with simulated edentulous sites and rest preparations on at least two supporting teeth in each arch.

(3) Clinical instruction shall include taking final impressions on five cord retraction patients, with one used for a clinical examination.

(*l*) With respect to placing, contouring, finishing, and adjusting direct restorations:

(1) Didactic instruction shall include the following:

(A) Review of cavity preparation factors and restorative material.

(B) Review of cavity liner, sedative, and insulating bases.

(C) Characteristics and manipulation of direct filling materials.

(D) Amalgam restoration placement, carving, adjusting and finishing, which includes principles, techniques, criteria and evaluation, and description and goals of amalgam placement, adjusting and finishing in children and adults.

(E) Glass-ionomer restoration placement, carving, adjusting, contouring and finishing, which includes, principles, techniques, criteria and evaluation, and description and goals of glass-ionomer placement and contouring in children and adults.

(F) Composite restoration placement, carving, adjusting, contouring and finishing in all cavity classifications, which includes, principles, techniques, criteria, and evaluation.

(2) Laboratory instruction shall include typodont experience on the following:

(A) Placement of Class I, II, and V amalgam restorations in eight prepared permanent teeth for each classification, and in four deciduous teeth for each classification.

(B) Placement of Class I, II, III, and V composite resin restorations in eight prepared permanent teeth for each classification, and in four deciduous teeth for each classification.

(C) Placement of Class I, II, III, and V glass-ionomer restorations in four prepared permanent teeth for each classification, and in four deciduous teeth for each classification.

(3) Clinical simulation and clinical instruction shall include experience with typodonts mounted in simulated heads on a dental chair or in a simulation laboratory as follows:

(A) Placement of Class I, II, and V amalgam restorations in four prepared permanent teeth for each classification, with one of each classification used for a clinical examination.

(B) Placement of Class I, II, III, and V composite resin restorations in four prepared permanent teeth for each classification, with one of each classification used for a clinical examination.

(C) Placement of Class I, II, III, and V glass-ionomer restorations in four prepared permanent teeth for each classification, with one of each classification used for a clinical examination.

(m) With respect to adjusting and cementing permanent indirect restorations:

(1) Didactic instruction shall include the following:

(A) Review of fixed prosthodontics related to classification and materials for permanent indirect restorations, general crown preparation for permanent indirect restorations, and laboratory fabrication of permanent indirect restorations.

(B) Interocclusal registrations for fixed prosthesis, including principles, techniques, criteria, and evaluation.

(C) Permanent indirect restoration placement, adjustment, and cementation, including principles, techniques, criteria, and evaluation.

(2) Laboratory instruction shall include:

(A) Interocclusal registrations using elastomeric and resin materials. Two experiences with each material are required.

(B) Fitting, adjustment, and cementation of permanent indirect restorations on one anterior and one posterior tooth for each of the following materials, with one of each type used for a practical examination: ceramic, ceramometal, and cast metallic.

(3) Clinical experience for interocclusal registrations shall be performed on four patients who are concurrently having final impressions recorded for permanent indirect restorations, with one experience used for a clinical examination.

(n) Each student shall pass a written examination that reflects the curriculum content, which may be administered at intervals throughout the course as determined by the course director.

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

SEC. 42. Section 1765 of the Business and Professions Code is amended to read:

1765. No person other than a licensed dental hygienist or a licensed dentist may engage in the practice of dental hygiene or perform dental hygiene procedures on patients, including, but not limited to, supragingival and subgingival scaling, dental hygiene assessment, and treatment planning, except for the following persons:

(a) A student enrolled in a dental or a dental hygiene school who is performing procedures as part of the regular curriculum of that program under the supervision of the faculty of that program.

(b) A dental assistant, registered dental assistant, or registered dental assistant in extended functions acting in accordance with the provisions of this chapter.

(c) A registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions licensed in another jurisdiction performing a clinical demonstration for educational purposes.

SEC. 43. Section 1770 of the Business and Professions Code, as amended by Section 25 of Chapter 588 of the Statutes of 2007, is amended and renumbered to read:

1753.7. (a) A licensed dentist may simultaneously utilize in his or her practice no more than two registered dental assistants in extended functions or registered dental hygienists in extended functions licensed pursuant to Sections 1753.1 and 1918.

(b) This section shall remain in effect only until January 1, 2010, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2010, deletes or extends that date.

SEC. 44. Section 1770 of the Business and Professions Code, as amended by Section 26 of Chapter 588 of the Statutes of 2007, is amended and renumbered to read:

1753.7. (a) A licensed dentist may simultaneously utilize in his or her practice no more than three registered dental assistants in extended functions or registered dental hygienists in extended functions licensed pursuant to Section 1753 or 1918.

(b) This section shall become operative on January 1, 2010.

SEC. 45. Section 1771 of the Business and Professions Code is amended to read:

1771. Any person, other than a person who has been issued a license or permit by the board, who holds himself or herself out as a registered dental assistant, orthodontic assistant permitholder, dental sedation assistant permitholder, or registered dental assistant in extended functions, or uses any other term indicating or implying he or she is licensed or permitted by the board as such, is guilty of a misdemeanor.

SEC. 46. Section 1777 of the Business and Professions Code is amended to read:

1777. While employed by or practicing in a primary care clinic or specialty clinic licensed pursuant to Section 1204 of the Health and Safety Code, in a primary care clinic exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role under Section 17000 of the Welfare and Institutions Code, the following shall apply:

(a) A dental assistant, registered dental assistant, or registered dental assistant in extended functions may perform any extraoral duty under the direct supervision of a registered dental hygienist or registered dental hygienist in alternative practice.

(b) A registered dental assistant or a registered dental assistant in extended functions may perform the following procedures under the direct supervision of a registered dental hygienist or a registered dental hygienist in alternative practice, pursuant to subdivision (b) of Section 1763:

(1) Coronal polishing.

(2) Application of topical fluoride.

(3) Application of sealants, after providing evidence to the board of having completed a board-approved course in that procedure.

SEC. 47. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime

within the meaning of Section 6 of Article XIII B of the California Constitution.

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AB 2649

BILL NUMBER: AB 2649
VETOED DATE: 08/01/2008

To the Members of the California State Assembly:

I am returning Assembly Bill 2649 without my signature.

Current law already requires physicians to determine the competency of, and bear responsibility for, the actions of the medical assistants under their supervision. To enact a law that prohibits a specified task on a specified population is both unnecessary and overly restrictive.

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

Sincerely,

Arnold Schwarzenegger

AB 2747

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2747
Author: Berg
Chapter: 683
Subject: End-of-Life Care
Sponsor: Author
Board Position: Neutral

DESCRIPTION OF LEGISLATION:

This bill requires 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. Counseling may include, but not be limited to, discussions about the outcomes on the patient and his or her family, based on the interest of the patient. These discussions may occur over a series of meetings with the health care provider or others who may be providing the counseling based on the patient's needs. 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.

In providing patients with opportunities to receive information, health care providers may utilize information from organizations specializing in end-of-life care that provide information on fact sheets and Internet Web sites.

IMPLEMENTATION:

- Article in January 2009 *Newsletter*
- Notify Enforcement staff
- Update/add to Web site links as appropriate

Assembly Bill No. 2747

CHAPTER 683

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.

[Approved by Governor September 30, 2008. Filed with Secretary of State September 30, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2747, 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 a health care provider, as defined, makes a diagnosis that a patient has a terminal illness, the health care provider shall, upon the patient's request, provide the patient with comprehensive information and counseling regarding legal end-of-life options, as specified, and provide for the referral or transfer of a patient, as provided, if the patient's health care provider does not wish to comply with the patient's request for information on end-of-life options.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) Palliative and hospice care are invaluable resources for terminally ill Californians in need of comfort and support at the end of life.

(b) Palliative care and conventional medical treatment for terminally ill patients should be thoroughly integrated rather than viewed as separate entities.

(c) Even though Californians with a prognosis of six months or less to live are eligible for hospice care, nearly two-thirds of them receive hospice services for less than one month.

(d) Many terminally ill patients benefit from being referred to hospice care earlier, where they receive better pain and symptom management and have an improved quality of life.

(e) Significant information gaps may exist between health care providers and their patients on end-of-life care options potentially leading to delays in, or lack of referrals to, hospice care for terminally ill patients. The sharing of important information regarding specific treatment options in a timely manner by health care providers with terminally ill patients is a key component of quality end-of-life care. Information that is helpful to patients

and their families includes, but is not limited to, the availability of hospice care, the efficacy and potential side effects of continued disease-targeted treatment, and withholding or withdrawal of life-sustaining treatments.

(f) Terminally ill and dying patients rely on their health care providers to give them timely and informative data. Research shows a lack of communication between health care providers and their terminally ill patients can cause problems, including poor availability of, and lack of clarity regarding, advance health care directives and patients' end-of-life care preferences. This lack of information and poor adherence to patient choices can result in "bad deaths" that cause needless physical and psychological suffering to patients and their families.

(g) Those problems are complicated by social issues, such as cultural and religious pressures on the providers, patients, and their family members. A recent survey found that providers that object to certain practices are less likely than others to believe they have an obligation to present all of the options to patients and refer patients to other providers, if necessary.

(h) Every medical school in California is required to include end-of-life care issues in its curriculum and every physician in California is required to complete continuing education courses in end-of-life care.

(i) Palliative care is not a one-size-fits-all approach. Patients have a range of diseases and respond differently to treatment options. A key benefit of palliative care is that it customizes treatment to meet the needs of each individual person.

(j) Informed patient choices will help terminally ill patients and their families cope with one of life's most challenging situations.

SEC. 2. Part 1.8 (commencing with Section 442) is added to Division 1 of the Health and Safety Code, to read:

PART 1.8. END-OF-LIFE CARE

442. For the purposes of this part, the following definitions shall apply:

(a) "Actively dying" means the phase of terminal illness when death is imminent.

(b) "Disease-targeted treatment" means treatment directed at the underlying disease or condition that is intended to alter its natural history or progression, irrespective of whether or not a cure is a possibility.

(c) "Health care provider" means an attending physician and surgeon. It also means a nurse practitioner or physician assistant practicing in accordance with standardized procedures or protocols developed and approved by the supervising physician and surgeon and the nurse practitioner or physician assistant.

(d) "Hospice" means a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and provide

supportive care to the primary caregiver and the family of the hospice patient, and that meets all of the criteria specified in subdivision (b) of Section 1746.

(e) "Palliative care" means medical treatment, interdisciplinary care, or consultation provided to a patient or family members, or both, that has as its primary purpose the prevention of, or relief from, suffering and the enhancement of the quality of life, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life as described in subdivision (b) of Section 1339.31. In some cases, disease-targeted treatment may be used in palliative care.

(f) "Refusal or withdrawal of life-sustaining treatment" means forgoing treatment or medical procedures that replace or support an essential bodily function, including, but not limited to, cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and any other treatment or discontinuing any or all of those treatments after they have been used for a reasonable time.

442.5. When a health care provider makes a diagnosis that a patient has a terminal illness, the health care provider shall, upon the patient's request, provide the patient with comprehensive information and counseling regarding legal end-of-life care options pursuant to this section. When a terminally ill patient is in a health facility, as defined in Section 1250, the health care provider, or medical director of the health facility, if the patient's health care provider is not available, may refer the patient to a hospice provider or private or public agencies and community-based organizations that specialize in end-of-life care case management and consultation to receive comprehensive information and counseling regarding legal end-of-life care options.

(a) If the patient indicates a desire to receive the information and counseling, the comprehensive information shall include, but not be limited to, the following:

(1) Hospice care at home or in a health care setting.

(2) A prognosis with and without the continuation of disease-targeted treatment.

(3) The patient's right to refusal of or withdrawal from life-sustaining treatment.

(4) The patient's right to continue to pursue disease-targeted treatment, with or without concurrent palliative care.

(5) The patient's right to comprehensive pain and symptom management at the end of life, including, but not limited to, adequate pain medication, treatment of nausea, palliative chemotherapy, relief of shortness of breath and fatigue, and other clinical treatments useful when a patient is actively dying.

(6) The patient's right to give individual health care instruction pursuant to Section 4670 of the Probate Code, which provides the means by which a patient may provide written health care instruction, such as an advance health care directive, and the patient's right to appoint a legally recognized health care decisionmaker.

(b) The information described in subdivision (a) may, but is not required to be, in writing. Health care providers may utilize information from organizations specializing in end-of-life care that provide information on factsheets and Internet Web sites to convey the information described in subdivision (a).

(c) Counseling may include, but not be limited to, discussions about the outcomes for the patient and his or her family, based on the interest of the patient. Information and counseling as described in subdivision (a) may occur over a series of meetings with the health care provider or others who may be providing the information and counseling based on the patient's needs.

(d) The information and counseling sessions may include a discussion of treatment options in a manner that the patient and his or her family can easily understand. If the patient requests information on the costs of treatment options, including the availability of insurance and eligibility of the patient for coverage, the patient shall be referred to the appropriate entity for that information.

442.7. If a health care provider does not wish to comply with his or her patient's request for information on end-of-life options, the health care provider shall do both of the following:

(a) Refer or transfer a patient to another health care provider that shall provide the requested information.

(b) Provide the patient with information on procedures to transfer to another health care provider that shall provide the requested information.

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AB 2968

BILL NUMBER: AB 2968
VETOED DATE: 09/28/2008

To the Members of the California State Assembly:

I am returning Assembly Bill 2968 without my signature.

The historic delay in passing the 2008-2009 State Budget has forced me to prioritize the bills sent to my desk at the end of the year's legislative session. Given the delay, I am only signing bills that are the highest priority for California. This bill does not meet that standard and I cannot sign it at this time.

Sincerely,

Arnold Schwarzenegger

AB 2969

BILL NUMBER: AB 2969
VETOED DATE: 09/30/2008

To the Members of the California State Assembly:

I am returning Assembly Bill 2969 without my signature.

This bill would require a physician conducting utilization review in the workers' compensation system to be licensed in California. Such a requirement would be inconsistent with how utilization review is conducted in other areas of medicine in and not in line with best practices nationwide. The proponents of this measure have not demonstrated a need for this disparity in treatment.

Sincerely,

Arnold Schwarzenegger

SB 797

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 797
Author: Ridley-Thomas
Chapter: 33
Subject: VE/P Extension
Sponsor: Author
Board Position: Support MBC Provisions

DESCRIPTION OF LEGISLATION:

This bill carries our extension 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 (Board) and various other boards.

This bill specifies that an investigator is not under the supervision of the deputy attorney general who is simultaneously assigned to a complaint. The bill requires the 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 Health Quality Enforcement Section in the same offices. The bill requires the Board, in consultation with specified agencies, to report and make recommendations to the Governor and the Legislature on this enforcement and prosecution model by July 1, 2009.

IMPLEMENTATION:

- Article in January 2009 *Newsletter*
- Notify stakeholders
- Continue moving forward with Board approved BCP for computer system.
- Continue collecting statistics for July 1, 2009 report, and begin the process to contact with an outside entity to provide an analysis for the legislative report.
- Evaluate office leases as they come up for renewal/expiration to determine co-location opportunities. Also examine video conferencing as an alternative.
- Review, expand, or repeal in 2009 legislation.

Senate Bill No. 797

CHAPTER 33

An act to amend Sections 490, 1616.5, 2006, 2531.75, 2847, 3041.3, 4982, 4989.54, 4990.32, 4992.3, 5552.5, 7028, 7303, 8005, 22258, and 22259 of and to add and repeal Sections 101.2 and 7303.5 of, the Business and Professions Code, and to amend Sections 12529, 12529.5, 12529.6, and 12529.7 of the Government Code, relating to professions and vocations, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor June 23, 2008. Filed with Secretary of State June 23, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

SB 797, Ridley-Thomas. Professions and vocations.

(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 establishes the Dental Board of California, the Speech-Language Pathology and Audiology Board, the Board of Vocational Nursing and Psychiatric Technicians, and the Board of Barbering and Cosmetology in the Department of Consumer Affairs. Existing law authorizes the Dental Board of California and the Speech-Language Pathology and Audiology Board to appoint executive officers, requires the Board of Vocational Nursing and Psychiatric Technicians to select an executive officer, and requires the Board of Barbering and Cosmetology to appoint an executive officer, as specified. Under existing law, the provisions establishing these boards and their authority to appoint or select executive officers will become inoperative on July 1, 2008, and be repealed on January 1, 2009.

This bill would extend the inoperative and repeal dates for the provisions relating to the boards' appointment of executive officers to January 1, 2012. The bill would delete the requirement that the Board of Vocational Nursing and Psychiatric Technicians and the Board of Barbering and Cosmetology appoint or select executive officers, and would instead authorize those boards to do so. The bill, until January 1, 2009, would provide that, if any of these boards becomes inoperative or is repealed, the Governor shall succeed to the authority of that board to appoint an executive officer and the executive

officer of that board shall have the same administrative duties with regard to the bureau replacing the board as it had with regard to the board, and would authorize the Department of Consumer Affairs to create an advisory committee with specified members to advise and direct the executive officer.

(3) 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.

(4) 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 optometrist's education or training for certification, as specified.

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

(5) 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 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 apply specified penalty provisions to a person named on a revoked license and held responsible for the act or omission resulting in the revocation.

(6) 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. 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, and would apply this provision to acts that occurred prior to the effective date of the bill. 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.

(7) 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 for these provisions, making the provisions inoperative and repealing them on January 1, 2012. 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, and would extend the operation of existing crimes provisions, it would impose a state-mandated local program.

(8) 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 and repealing them on January 1, 2012.

(9) 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.

(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.

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

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

SECTION 1. Section 101.2 is added to the Business and Professions Code, to read:

101.2. (a) Notwithstanding paragraph (3) of subdivision (b) of Section 101.1, if the Dental Board of California, the Speech-Language Pathology and Audiology Board, the Board of Vocational Nursing and Psychiatric Technicians, or the Board of Barbering and Cosmetology becomes inoperative or is repealed, both of the following shall apply:

(1) The executive officer of the board shall have the same administrative duties with regard to any bureau replacing the board as he or she had with regard to the board, and shall operate under the direction of the Department of Consumer Affairs.

(2) The Governor shall succeed to the authority of the board to appoint an executive officer pursuant to Section 1616.5, 2531.75, 2847, or 7303.5, respectively.

(b) The Department of Consumer Affairs may create an advisory committee for each bureau described in subdivision (a) to advise and direct the bureau's executive officer. An advisory committee created under this subdivision shall consist of the prior members of the board, and the committee shall be subject to the per diem provisions related to the prior board and to all procedural requirements governing the actions of the prior board.

(c) An advisory committee created pursuant to subdivision (b) shall meet as often as is necessary, as determined by that committee.

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

SEC. 2. Section 490 of the Business and Professions Code is amended to read:

490. (a) In addition to any other action that a board is permitted to take against a licensee, a board may suspend or revoke a license on the ground that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued.

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

(c) A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo contendere. Any action that a board is permitted to take following the establishment of a conviction may be taken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code.

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

SEC. 3. Section 1616.5 of the Business and Professions Code is amended to read:

1616.5. (a) The board, by and with the approval of the director, may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.

(b) This section shall remain in effect only until January 1, 2012, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2012, deletes or extends that date..

SEC. 4. Section 2006 of the Business and Professions Code is amended to read:

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

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

SEC. 5. Section 2531.75 of the Business and Professions Code is amended to read:

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

(b) This section shall remain in effect only until January 1, 2012, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2012, deletes or extends that date.

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

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

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

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

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

(e) This section shall remain in effect only until January 1, 2012, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2012, deletes or extends that date.

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

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

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

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

(2) Completes a preceptorship of no less than 65 hours, during a period of not less than two months nor more than one year, in either an ophthalmologist's office or an optometric clinic. The training received during the preceptorship shall be on the diagnosis, treatment, and management of ocular, systemic disease. The preceptor shall certify completion of the preceptorship. Authorization for the ophthalmologist to serve as a preceptor shall be provided by an accredited school of optometry in California, or by a recognized residency review committee in ophthalmology, and the preceptor shall be licensed as an ophthalmologist in California, board-certified in ophthalmology, and in good standing with the Medical Board of California. The individual serving as the preceptor

shall schedule no more than three optometrist applicants for each of the required 65 hours of the preceptorship program. This paragraph shall not be construed to limit the total number of optometrist applicants for whom an individual may serve as a preceptor, and is intended only to ensure the quality of the preceptorship by requiring that the ophthalmologist preceptor schedule the training so that each applicant optometrist completes each of the 65 hours of the preceptorship while scheduled with no more than two other optometrist applicants.

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

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

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

(6) When any or all of the requirements contained in paragraph (1), (4), or (5) have been satisfied on or after July 1, 1992, and before January 1, 1996, an optometrist shall not be required to fulfill the satisfied requirements in order to obtain certification to use therapeutic pharmaceutical agents. In order for this paragraph to apply to the requirement contained in paragraph (5), the didactic examination that the applicant successfully completed shall meet equivalency standards, as determined by the board.

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

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

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

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

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

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

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

optometrist licensed in California to be certified to use therapeutic pharmaceutical agents.

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

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

(3) The State Board of Optometry shall decide all issues relating to the equivalency of an optometrist's education or training under this subdivision.

SEC. 8. Section 4982 of the Business and Professions Code is amended to read:

4982. The board may deny a license or registration or may suspend or revoke the license or registration of a licensee or registrant if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

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

license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

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

(c) Administering to himself or herself any controlled substance or using of any of the dangerous drugs specified in Section 4022, or of any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license, or the conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this subdivision, or any combination thereof. The board shall deny an application for a registration or license or revoke the license or registration of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing marriage and family therapy services.

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

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

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

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

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

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

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

(k) Engaging in sexual relations with a client, or a former client within two years following termination of therapy, soliciting sexual relations with

a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a marriage and family therapist.

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

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

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

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

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

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

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

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

(t) Permitting a trainee or registered intern under one's supervision or control to perform, or permitting the trainee or registered intern to hold himself or herself out as competent to perform, professional services beyond the trainee's or registered intern's level of education, training, or experience.

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

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

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

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

(y) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(z) Failure to comply with Section 2290.5.

(aa) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

SEC. 9. Section 4989.54 of the Business and Professions Code is amended to read:

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

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

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

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

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

(4) The board may order a license suspended or revoked, or may decline to issue a license when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty or setting aside the verdict of guilty or dismissing the accusation, information, or indictment.

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

(c) Administering to himself or herself a controlled substance or using any of the dangerous drugs specified in Section 4022 or an alcoholic

beverage to the extent, or in a manner, as to be dangerous or injurious to himself or herself or to any other person or to the public or to the extent that the use impairs his or her ability to safely perform the functions authorized by the license.

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

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

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

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

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

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

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

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

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

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

(n) Engaging in sexual relations with a client or a former client within two years following termination of professional services, soliciting sexual relations with a client, or committing an act of sexual abuse or sexual misconduct with a client or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a licensed educational psychologist.

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

(p) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients.

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

(r) Performing, holding himself or herself out as being able to perform, or offering to perform any professional services beyond the scope of the license authorized by this chapter or beyond his or her field or fields of competence as established by his or her education, training, or experience.

(s) Reproducing or describing in public, or in any publication subject to general public distribution, any psychological test or other assessment device the value of which depends in whole or in part on the naivete of the subject in ways that might invalidate the test or device. An educational psychologist shall limit access to the test or device to persons with professional interests who can be expected to safeguard its use.

(t) Aiding or abetting an unlicensed person to engage in conduct requiring a license under this chapter.

(u) When employed by another person or agency, encouraging, either orally or in writing, the employer's or agency's clientele to utilize his or her private practice for further counseling without the approval of the employing agency or administration.

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

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

(x) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(y) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

SEC. 10. Section 4990.32 of the Business and Professions Code is amended to read:

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

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

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

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

(e) If an alleged act or omission involves a minor, the seven-year limitations period provided for by subdivision (a) and the 10-year limitations period provided for by subdivision (d) shall be tolled until the minor reaches the age of majority. However, if the board discovers an alleged act of sexual contact with a minor under Section 261, 286, 288, 288.5, 288a, or 289 of the Penal Code after the limitations periods described in this subdivision have otherwise expired, and there is independent evidence that corroborates the allegation, an accusation shall be filed within three years from the date the board discovers that alleged act.

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

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

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

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

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

SEC. 11. Section 4992.3 of the Business and Professions Code is amended to read:

4992.3. The board may deny a license or a registration, or may suspend or revoke the license or registration of a licensee or registrant if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

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

determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter is a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(w) Failure to comply with Section 2290.5.

(x) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

SEC. 12. Section 5552.5 of the Business and Professions Code is amended to read:

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

SEC. 13. Section 7028 of the Business and Professions Code is amended to read:

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

(b) If a person has been previously convicted of the offense described in this section, unless the provisions of subdivision (c) are applicable, the court shall impose a fine of 20 percent of the price of the contract under which the unlicensed person performed contracting work, or four thousand five hundred dollars ($4,500), whichever is greater, and, unless the sentence prescribed in subdivision (c) is imposed, the person shall be confined in a county jail for not less than 90 days, except in an unusual case where the interests of justice would be served by imposition of a lesser sentence or a fine. If the court imposes only a fine or a jail sentence of less than 90 days for second or subsequent convictions under this section, the court shall state the reasons for its sentencing choice on the record.

(c) A third or subsequent conviction for the offense described in this section is punishable by a fine of not less than four thousand five hundred dollars ($4,500) nor more than the greater amount of either ten thousand dollars ($10,000) or 20 percent of the contract price under which the unlicensed person performed contracting work or by imprisonment in a county jail for not more than one year or less than 90 days, or by both that

fine and imprisonment. The penalty provided by this subdivision is cumulative to the penalties available under all other laws of this state.

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

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

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

SEC. 14. Section 7303 of the Business and Professions Code is amended to read:

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

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

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

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

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

SEC. 15. Section 7303.5 is added to the Business and Professions Code, to read:

7303.5. (a) The board may appoint an executive officer who is exempt from civil service. The executive officer shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter. The appointment of the executive officer is subject to the approval of the director.

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

(c) This section shall become operative on July 1, 2008.

(d) This section shall remain in effect only until January 1, 2012, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2012, deletes or extends that date.

SEC. 16. Section 8005 of the Business and Professions Code is amended to read:

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

This section shall remain in effect only until January 1, 2012, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2012, deletes or extends that date.

SEC. 17. Section 22258 of the Business and Professions Code is amended to read:

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

(1) A person with a current and valid license issued by the California Board of Accountancy.

(2) A person who is an active member of the State Bar of California.

(3) Any trust company or trust business as defined in Chapter 1 (commencing with Section 99) of Division 1 of the Financial Code.

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

(5) A person who is enrolled to practice before the Internal Revenue Service pursuant to Subpart A (commencing with Section 10.1) of Part 10 of Title 31 of the Code of Federal Regulations.

(6) Any employee of any person described in paragraph (1), (2), (3), (4), or (5), while functioning within the scope of that employment.

(7) Any employee of any corporation, partnership, association, or any entity described in subparagraph (B) of paragraph (1) of subdivision (a) of Section 22251.

(b) (1) Except for employees of entities described in paragraph (3) or (4) of subdivision (a), paragraph (6) of subdivision (a) shall apply only if all tax returns prepared by that employee are signed by a person described in paragraph (1), (2), or (5) of subdivision (a).

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

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

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

SEC. 18. Section 22259 of the Business and Professions Code is amended to read:

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

This chapter shall remain in effect only until January 1, 2012, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2012, deletes or extends that date.

SEC. 19. Section 12529 of the Government Code, as amended by Section 90 of Chapter 588 of the Statutes of 2007, is amended to read:

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

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

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

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

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

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

SEC. 20. Section 12529 of the Government Code, as amended by Section 91 of Chapter 588 of the Statutes of 2007, is amended to read:

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

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

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

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

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

SEC. 21. Section 12529.5 of the Government Code, as amended by Section 92 of Chapter 588 of the Statutes of 2007, is amended to read:

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

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

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

(d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, boards, or committees as appropriate in consultation with the senior assistant.

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

SEC. 22. Section 12529.5 of the Government Code, as amended by Section 93 of Chapter 588 of the Statutes of 2007, is amended to read:

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

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to assist the division and the boards in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit of the boards, to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations.

A deputy attorney general of the Health Quality Enforcement Section shall frequently be available on location at each of the working offices at the major investigation centers of the boards, to provide consultation and related services and engage in case review with the boards' investigative, medical advisory, and intake staff. The Senior Assistant Attorney General and deputy attorneys general working at his or her direction shall consult as appropriate with the investigators of the boards, medical advisors, and executive staff in the investigation and prosecution of disciplinary cases.

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

(d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, boards, or committees as appropriate in consultation with the senior assistant.

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

SEC. 23. Section 12529.6 of the Government Code is amended to read:

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

and declares that using a vertical enforcement and prosecution model for those investigations is in the best interests of the people of California.

(b) Notwithstanding any other provision of law, as of January 1, 2006, each complaint that is referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so assigned shall, under the direction but not the supervision of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action.

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

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

(e) It is the intent of the Legislature to enhance the vertical enforcement and prosecution model as set forth in subdivision (a). The Medical Board of California shall do both of the following:

(1) Increase its computer capabilities and compatibilities with the Health Quality Enforcement Section in order to share case information.

(2) Establish and implement a plan to locate its enforcement staff and the staff of the Health Quality Enforcement Section in the same offices, as appropriate, in order to carry out the intent of the vertical enforcement and prosecution model.

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

SEC. 24. Section 12529.7 of the Government Code is amended to read:

12529.7. By July 1, 2009, the Medical Board of California, in consultation with the Department of Justice, the Department of Consumer Affairs, the Department of Finance, and the Department of Personnel Administration, shall report and make recommendations to the Governor and the Legislature on the vertical enforcement and prosecution model created under Section 12529.6.

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

within the meaning of Section 6 of Article XIII B of the California Constitution.

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

To ensure that individuals engaging in certain professions and vocations are adequately regulated in order to protect and safeguard consumers and the public in this state, it is necessary that this act take effect immediately.

O

SB 963

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 963
Author: Ridley-Thomas
Chapter: 385
Subject: Regulatory Boards: operations
Sponsor: Author
Board Position: Watch

DESCRIPTION OF LEGISLATION:

This bill makes various changes to the process of Sunset Review and oversight for various boards under the Department of Consumer Affairs and imposes new requirements regarding report posting. No new requirements for the Board.

IMPLEMENTATION:

- None

Senate Bill No. 963

CHAPTER 385

An act to amend Sections 2920, 2933, 4928, 4934, 4990, 4990.04, 7000.5, 7011, 7810, 7815.5, 8000, 8030.2, 8030.4, 8030.6, 8030.8, 18602, and 18613 of the Business and Professions Code, and to amend and repeal Section 94801.5 of the Education Code, relating to regulatory boards.

[Approved by Governor September 27, 2008. Filed with Secretary of State September 27, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

SB 963, Ridley-Thomas. Department of Consumer Affairs: regulatory boards.

(1) Existing law establishes the Board of Psychology, the Acupuncture Board, the Board of Behavioral Sciences, the Contractors' State License Board, the Board for Geologists and Geophysicists, the Court Reporters Board of California, and the State Athletic Commission. Existing law authorizes or requires those boards to appoint an executive officer. Under existing law, excess funds, as specified, generated by the initial certificate fee collected by the Court Reporters Board of California are used to provide shorthand reporting services for indigent persons, as defined, and are transferred from the Court Reporters' Fund into the Transcript Reimbursement Fund for expenditure for that purpose. Existing law provides that these provisions become inoperative on July 1, 2009, and are repealed on January 1, 2010.

This bill would change the dates on which these provisions are to become inoperative and repealed to January 1, 2011.

(2) Senate Bill 823 of the 2007–08 Regular Session would, among other things, establish the Bureau for Private Postsecondary Education in the Department of Consumer Affairs as a successor agency to the former Bureau for Private Postsecondary and Vocational Education in the Department of Consumer Affairs.

This bill would make the bureau inoperative and repealed on January 1, 2013. The bill would provide that this provision shall become operative only if SB 823 of the 2007–08 Regular Session is also enacted and becomes operative.

(3) This bill would incorporate additional changes to Section 4990 of the Business and Professions Code made by this bill and AB 239 to take effect if both bills are chaptered and this bill is chaptered last.

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

SECTION 1. Section 2920 of the Business and Professions Code is amended to read:

2920. The Board of Psychology shall enforce and administer this chapter. The board shall consist of nine members, four of whom shall be public members.

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

SEC. 2. Section 2933 of the Business and Professions Code is amended to read:

2933. Except as provided by Section 159.5, the board shall employ and shall make available to the board within the limits of the funds received by the board all personnel necessary to carry out this chapter. The board may employ, exempt from the State Civil Service Act, an executive officer to the Board of Psychology. The board shall make all expenditures to carry out this chapter. The board may accept contributions to effectuate the purposes of this chapter.

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

SEC. 3. Section 4928 of the Business and Professions Code is amended to read:

4928. The Acupuncture Board, which consists of seven members, shall enforce and administer this chapter. The appointing powers, as described in Section 4929, may appoint to the board a person who was a member of the prior board prior to the repeal of that board on January 1, 2006.

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

The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473).

SEC. 4. Section 4934 of the Business and Professions Code is amended to read:

4934. (a) The board, by and with the approval of the director, may employ personnel necessary for the administration of this chapter, and the board, by and with the approval of the director, may appoint an executive officer who is exempt from the provisions of the Civil Service Act.

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

SEC. 5. Section 4990 of the Business and Professions Code is amended to read:

4990. (a) There is in the Department of Consumer Affairs, a Board of Behavioral Sciences that consists of 11 members composed as follows:

(1) Two state licensed clinical social workers.

(2) One state licensed educational psychologist.
(3) Two state licensed marriage and family therapists.
(4) Six public members.
(b) Each member, except the six public members, shall have at least two years of experience in his or her profession.
(c) Each member shall reside in the State of California.
(d) The Governor shall appoint four of the public members and the five licensed members with the advice and consent of the Senate. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a public member.
(e) Each member of the board shall be appointed for a term of four years. A member appointed by the Speaker of the Assembly or the Senate Committee on Rules shall hold office until the appointment and qualification of his or her successor or until one year from the expiration date of the term for which he or she was appointed, whichever first occurs. Pursuant to Section 1774 of the Government Code, a member appointed by the Governor shall hold office until the appointment and qualification of his or her successor or until 60 days from the expiration date of the term for which he or she was appointed, whichever first occurs.
(f) A vacancy on the board shall be filled by appointment for the unexpired term by the authority who appointed the member whose membership was vacated.
(g) Not later than the first of June of each calendar year, the board shall elect a chairperson and a vice chairperson from its membership.
(h) Each member of the board shall receive a per diem and reimbursement of expenses as provided in Section 103.
(i) This section shall remain in effect only until January 1, 2011, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2011, deletes or extends that date.
SEC. 5.5. Section 4990 of the Business and Professions Code is amended to read:
4990. (a) There is in the Department of Consumer Affairs, a Board of Behavioral Sciences that consists of the following members:
(1) Two state-licensed clinical social workers.
(2) One state-licensed educational psychologist.
(3) Two state-licensed marriage and family therapists.
(4) After January 1, 2011, one state-licensed alcoholism and drug abuse counselor.
(5) Seven public members.
(b) Each member, except the seven public members, shall have at least two years of experience in his or her profession.
(c) Each member shall reside in the State of California.
(d) The Governor shall appoint five of the public members and the six licensed members with the advice and consent of the Senate. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a public member.

(e) Each member of the board shall be appointed for a term of four years. A member appointed by the Speaker of the Assembly or the Senate Committee on Rules shall hold office until the appointment and qualification of his or her successor or until one year from the expiration date of the term for which he or she was appointed, whichever first occurs. Pursuant to Section 1774 of the Government Code, a member appointed by the Governor shall hold office until the appointment and qualification of his or her successor or until 60 days from the expiration date of the term for which he or she was appointed, whichever first occurs.

(f) A vacancy on the board shall be filled by appointment for the unexpired term by the authority who appointed the member whose membership was vacated.

(g) Not later than the first of June of each calendar year, the board shall elect a chairperson and a vice chairperson from its membership.

(h) Each member of the board shall receive a per diem and reimbursement of expenses as provided in Section 103.

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

SEC. 6. Section 4990.04 of the Business and Professions Code is amended to read:

4990.04. (a) The board shall appoint an executive officer. This position is designated as a confidential position and is exempt from civil service under subdivision (e) of Section 4 of Article VII of the California Constitution.

(b) The executive officer serves at the pleasure of the board.

(c) The executive officer shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.

(d) With the approval of the director, the board shall fix the salary of the executive officer.

(e) The chairperson and executive officer may call meetings of the board and any duly appointed committee at a specified time and place. For purposes of this section, "call meetings" means setting the agenda, time, date, or place for any meeting of the board or any committee.

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

SEC. 7. Section 7000.5 of the Business and Professions Code is amended to read:

7000.5. (a) There is in the Department of Consumer Affairs a Contractors' State License Board, which consists of 15 members.

(b) The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473). However, the review of this board by the department shall be limited to only those unresolved issues identified by the Joint Committee on Boards, Commissions, and Consumer Protection.

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

The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473).

SEC. 8. Section 7011 of the Business and Professions Code is amended to read:

7011. The board, by and with the approval of the director, shall appoint a registrar of contractors and fix his or her compensation.

The registrar shall be the executive officer and secretary of the board and shall carry out all of the administrative duties as provided in this chapter and as delegated to him or her by the board.

For the purpose of administration of this chapter, there may be appointed a deputy registrar, a chief reviewing and hearing officer, and, subject to Section 159.5, other assistants and subordinates as may be necessary.

Appointments shall be made in accordance with the provisions of civil service laws.

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

SEC. 9. Section 7810 of the Business and Professions Code is amended to read:

7810. The Board for Geologists and Geophysicists is within the department and is subject to the jurisdiction of the department. Except as provided in this section, the board shall consist of eight members, five of whom shall be public members, two of whom shall be geologists, and one of whom shall be a geophysicist.

Each member shall hold office until the appointment and qualification of the member's successor or until one year has elapsed from the expiration of the term for which the member was appointed, whichever occurs first. Vacancies occurring prior to the expiration of the term shall be filled by appointment for the remainder of the unexpired term.

Each appointment shall be for a four-year term expiring June 1 of the fourth year following the year in which the previous term expired. No person shall serve as a member of the board for more than two consecutive terms.

The Governor shall appoint three of the public members and the three members qualified as provided in Section 7811. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a public member, and their initial appointment shall be made to fill, respectively, the first and second public member vacancies that occurred on or after January 1, 1983.

At the time the first vacancy is created by the expiration of the term of a public member appointed by the Governor, the board shall be reduced to consist of seven members, four of whom shall be public members, two of whom shall be geologists, and one of whom shall be a geophysicist. Notwithstanding any other provision of law, the term of that member shall not be extended for any reason, except as provided in this section.

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

The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473).

SEC. 10. Section 7815.5 of the Business and Professions Code is amended to read:

7815.5. The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.

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

SEC. 11. Section 8000 of the Business and Professions Code is amended to read:

8000. There is in the Department of Consumer Affairs a Court Reporters Board of California, which consists of five members, three of whom shall be public members and two of whom shall be holders of certificates issued under this chapter who have been actively engaged as shorthand reporters within this state for at least five years immediately preceding their appointment.

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

SEC. 12. Section 8030.2 of the Business and Professions Code is amended to read:

8030.2. (a) To provide shorthand reporting services to low-income litigants in civil cases, who are unable to otherwise afford those services, funds generated by fees received by the board pursuant to subdivision (c) of Section 8031 in excess of funds needed to support the board's operating budget for the fiscal year in which a transfer described below is made shall be used by the board for the purpose of establishing and maintaining a Transcript Reimbursement Fund. The Transcript Reimbursement Fund shall be established by a transfer of funds from the Court Reporters' Fund in the amount of three hundred thousand dollars ($300,000) at the beginning of each fiscal year. Notwithstanding any other provision of this article, a transfer to the Transcript Reimbursement Fund in excess of the fund balance established at the beginning of each fiscal year shall not be made by the board if the transfer will result in the reduction of the balance of the Court Reporters' Fund to an amount less than six months' operating budget.

(b) All moneys held in the Court Reporters' Fund on the effective date of this section in excess of the board's operating budget for the 1996–97 fiscal year shall be used as provided in subdivision (a).

(c) Refunds and unexpended funds that are anticipated to remain in the Transcript Reimbursement Fund at the end of the fiscal year shall be considered by the board in establishing the fee assessment pursuant to

Section 8031 so that the assessment shall maintain the level of funding for the Transcript Reimbursement Fund, as specified in subdivision (a), in the following fiscal year.

(d) The Transcript Reimbursement Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, moneys in the Transcript Reimbursement Fund are continuously appropriated for the purposes of this chapter.

(e) Applicants who have been reimbursed pursuant to this chapter for services provided to litigants and who are awarded court costs or attorneys' fees by judgment or by settlement agreement shall refund the full amount of that reimbursement to the fund within 90 days of receipt of the award or settlement.

(f) Subject to the limitations of this chapter, the board shall maintain the fund at a level that is sufficient to pay all qualified claims. To accomplish this objective, the board shall utilize all refunds, unexpended funds, fees, and any other moneys received by the board.

(g) Notwithstanding Section 16346 of the Government Code, all unencumbered funds remaining in the Transcript Reimbursement Fund as of June 29, 2009, shall be transferred to the Court Reporters' Fund.

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

SEC. 13. Section 8030.4 of the Business and Professions Code is amended to read:

8030.4. As used in this chapter:

(a) "Qualified legal services project" means a nonprofit project incorporated and operated exclusively in California that provides as its primary purpose and function legal services without charge to indigent persons, has a board of directors or advisory board composed of both attorneys and consumers of legal services, and provides for community participation in legal services programming. Legal services projects funded either in whole or in part by the Legal Services Corporation or with Older Americans Act funds are presumed to be qualified legal services projects for the purposes of this chapter.

(b) "Qualified support center" means an incorporated nonprofit legal services center, having an office or offices in California, which office or offices provide legal services or technical assistance without charge to qualified legal services projects and their clients on a multicounty basis in California. Support centers funded either in whole or in part by the Legal Services Corporation or with Older Americans Act funds are presumed to be qualified legal services projects for the purposes of this chapter.

(c) "Other qualified project" means a nonprofit organization formed for charitable or other public purposes, not receiving funds from the Legal Services Corporation or pursuant to the Older Americans Act, which organization or association provides free legal services to indigent persons.

(d) "Pro bono attorney" means any attorney, law firm, or legal corporation, licensed to practice law in this state, that undertakes without

charge to the party, the representation of an indigent person, referred by a qualified legal services project, qualified support center, or other qualified project, in a case not considered to be fee generating as defined in this chapter.

(e) "Applicant" means a qualified legal services project, qualified support center, other qualified project, or pro bono attorney applying to receive funds from the Transcript Reimbursement Fund established by this chapter. The term "applicant" shall not include persons appearing pro se to represent themselves at any stage of the case.

(f) (1) "Indigent person" means any of the following:

(A) A person whose income is 125 percent or less of the current poverty threshold established by the Office of Management and Budget of the United States.

(B) A person who is eligible for supplemental security income.

(C) A person who is eligible for, or receiving, free services under the Older Americans Act or the Developmentally Disabled Assistance Act.

(D) A person whose income is 75 percent or less of the maximum level of income for lower income households as defined in Section 50079.5 of the Health and Safety Code, for purposes of a program that provides legal assistance by an attorney in private practice on a pro bono basis.

(2) For the purposes of this subdivision, the income of a person who is disabled shall be determined after deducting the costs of medical and other disability-related special expenses.

(g) "Fee-generating case" means any case or matter that, if undertaken on behalf of an eligible client by an attorney in private practice, reasonably may be expected to result in payment of a fee for legal services from an award to a client, from public funds, or from an opposing party. A reasonable expectation as to payment of a legal fee exists wherever a client enters into a contingent fee agreement with his or her lawyer. If there is no contingent fee agreement, a case is not considered fee generating if adequate representation is deemed to be unavailable because of the occurrence of any of the following circumstances:

(1) If the applicant has determined that referral is not possible because of any of the following:

(A) The case has been rejected by the local lawyer referral service, or if there is no such service, by two private attorneys who have experience in the subject matter of the case.

(B) Neither the referral service nor any lawyer will consider the case without payment of a consultation fee.

(C) The case is of the type that private attorneys in the area ordinarily do not accept or do not accept without prepayment of a fee.

(D) Emergency circumstances compel immediate action before referral can be made, but the client is advised that, if appropriate and consistent with professional responsibility, referral will be attempted at a later time.

(2) If recovery of damages is not the principal object of the case and a request for damages is merely ancillary to an action for equitable or other nonpecuniary relief or inclusion of a counterclaim requesting damages is

necessary for effective defense or because of applicable rules governing joinder of counterclaims.

(3) If a court appoints an applicant or an employee of an applicant pursuant to a statute or a court rule or practice of equal applicability to all attorneys in the jurisdiction.

(4) In any case involving the rights of a claimant under a public supported benefit program for which entitlement to benefit is based on need.

(h) "Legal Services Corporation" means the Legal Services Corporation established under the Legal Services Corporation Act of 1974, Public Law 93-355, as amended.

(i) "Supplemental security income recipient" means an individual receiving or eligible to receive payments under Title XVI of the Social Security Act, Public Law 92-603, as amended, or payment under Chapter 3 (commencing with Section 12000) of Part 3 of Division 9 of the Welfare and Institutions Code.

(j) "Lawyer referral service" means a lawyer referral program authorized by the State Bar of California pursuant to the rules of professional conduct.

(k) "Older Americans Act" means the Older Americans Act of 1965, Public Law 89-73, as amended.

(*l*) "Rules of professional conduct" means those rules adopted by the State Bar pursuant to Sections 6076 and 6077.

(m) "Certified shorthand reporter" means a shorthand reporter certified pursuant to Article 3 (commencing with Section 8020) performing shorthand reporting services pursuant to Section 8017.

(n) "Case" means a single legal proceeding from its inception, through all levels of hearing, trial, and appeal, until its ultimate conclusion and disposition.

(o) "Developmentally Disabled Assistance Act" means the Developmentally Disabled Assistance and Bill of Rights Act of 1975, (42 U.S.C. Sec. 6001 et seq.) as amended.

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

SEC. 14. Section 8030.6 of the Business and Professions Code is amended to read:

8030.6. The board shall disburse funds from the Transcript Reimbursement Fund for the costs, exclusive of per diem charges by official reporters, of preparing either an original transcript and one copy thereof, or where appropriate, a copy of the transcript, of court or deposition proceedings, or both, incurred as a contractual obligation between the shorthand reporter and the applicant, for litigation conducted in California. If there is no deposition transcript, the board may reimburse the applicant or the certified shorthand reporter designated in the application for per diem costs. The rate of per diem for depositions shall not exceed seventy-five dollars ($75) for a half day, or one hundred twenty-five dollars ($125) for a full day. If a transcript is ordered within one year of the date of the deposition, but subsequent to the per diem having been reimbursed by the

Transcript Reimbursement Fund, the amount of the per diem shall be deducted from the regular customary charges for a transcript. Reimbursement may be obtained through the following procedures:

(a) The applicant or certified shorthand reporter shall promptly submit to the board the certified shorthand reporter's invoice for transcripts together with the appropriate documentation as is required by this chapter.

(b) Except as provided in subdivision (c), the board shall promptly determine if the applicant or the certified shorthand reporter is entitled to reimbursement under this chapter and shall make payment as follows:

(1) Regular customary charges for preparation of original deposition transcripts and one copy thereof, or a copy of the transcripts.

(2) Regular customary charges for expedited deposition transcripts up to a maximum of two thousand five hundred dollars ($2,500) per case.

(3) Regular customary charges for the preparation of original transcripts and one copy thereof, or a copy of transcripts of court proceedings.

(4) Regular customary charges for expedited or daily charges for preparation of original transcripts and one copy thereof or a copy of transcripts of court proceedings.

(5) The charges may not include notary or handling fees. The charges may include actual shipping costs and exhibits, except that the cost of exhibits may not exceed thirty-five cents ($0.35) each or a total of thirty-five dollars ($35) per transcript.

(c) The maximum amount reimbursable by the fund under subdivision (b) may not exceed twenty thousand dollars ($20,000) per case per year.

(d) If entitled, and funds are available, the board shall forthwith disburse the appropriate sum to the applicant or the certified shorthand reporter when documentation as provided in subdivision (d) of Section 8030.8 accompanies the application. A notice shall be sent to the recipient requiring the recipient to file a notice with the court in which the action is pending stating the sum of reimbursement paid pursuant to this section. The notice filed with the court shall also state that if the sum is subsequently included in any award of costs made in the action, that the sum is to be ordered refunded by the applicant to the Transcript Reimbursement Fund whenever the sum is actually recovered as costs. The court may not consider whether payment has been made from the Transcript Reimbursement Fund in determining the appropriateness of any award of costs to the parties. The board shall also forthwith notify the applicant that the reimbursed sum has been paid to the certified shorthand reporter and shall likewise notify the applicant of the duty to refund any of the sum actually recovered as costs in the action.

(e) If not entitled, the board shall forthwith return a copy of the invoice to the applicant and the designated certified shorthand reporter together with a notice stating the grounds for denial.

(f) The board shall complete its actions under this section within 30 days of receipt of the invoice and all required documentation, including a completed application.

(g) Applications for reimbursements from the fund shall be filled on a first-come basis.

(h) Applications for reimbursement that cannot be paid from the fund due to insufficiency of the fund for that fiscal year shall be held over until the next fiscal year to be paid out of the renewed fund. Applications held over shall be given a priority standing in the next fiscal year.

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

SEC. 15. Section 8030.8 of the Business and Professions Code is amended to read:

8030.8. (a) For purposes of this chapter, documentation accompanying an invoice is sufficient to establish entitlement for reimbursement from the Transcript Reimbursement Fund if it is filed with the executive officer on an application form prescribed by the board that is complete in all respects, and that establishes all of the following:

(1) The case name and number and that the litigant or litigants requesting the reimbursement are indigent persons.

(2) The applicant is qualified under the provisions of this chapter.

(3) The case is not a fee-generating case, as defined in Section 8030.4.

(4) The invoice or other documentation shall evidence that the certified shorthand reporter to be reimbursed was, at the time the services were rendered, a duly licensed certified shorthand reporter.

(5) The invoice shall be accompanied by a statement, signed by the applicant, stating that the charges are for transcripts actually provided as indicated on the invoice.

(6) The applicant has acknowledged, in writing, that as a condition of entitlement for reimbursement that the applicant agrees to refund the entire amount disbursed from the Transcript Reimbursement Fund from any costs or attorneys' fees awarded to the applicant by the court or provided for in any settlement agreement in the case.

(7) The certified shorthand reporter's invoice for transcripts shall include separate itemizations of charges claimed, as follows:

(A) Total charges and rates for customary services in preparation of an original transcript and one copy or a copy of the transcript of depositions.

(B) Total charges and rates for expedited deposition transcripts.

(C) Total charges and rates in connection with transcription of court proceedings.

(b) For an applicant claiming to be eligible pursuant to subdivision (a), (b), or (c) of Section 8030.4, a letter from the director of the project or center, certifying that the project or center meets the standards set forth in one of those subdivisions and that the litigant or litigants are indigent persons, is sufficient documentation to establish eligibility.

(c) For an applicant claiming to be eligible pursuant to subdivision (d) of Section 8030.4, a letter certifying that the applicant meets the requirements of that subdivision, that the case is not a fee-generating case, as defined in subdivision (g) of Section 8030.4, and that the litigant or litigants are indigent persons, together with a letter from the director of a project or center defined in subdivision (a), (b), or (c) of Section 8030.4 certifying that the litigant

or litigants had been referred by that project or center to the applicant, is sufficient documentation to establish eligibility.

(d) The applicant may receive reimbursement directly from the board when the applicant has previously paid the certified shorthand reporter for transcripts as provided in Section 8030.6. To receive payment directly, the applicant shall submit, in addition to all other required documentation, an itemized statement signed by the certified shorthand reporter performing the services that describes payment for transcripts in accordance with the requirements of Section 8030.6.

(e) The board may prescribe appropriate forms to be used by applicants and certified shorthand reporters to facilitate these requirements.

(f) This chapter does not restrict the contractual obligation or payment for services, including, but not limited to, billing the applicant directly, during the pendency of the claim.

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

SEC. 16. Section 18602 of the Business and Professions Code is amended to read:

18602. (a) Except as provided in this section, there is in the Department of Consumer Affairs the State Athletic Commission, which consists of seven members. Five members shall be appointed by the Governor, one member shall be appointed by the Senate Rules Committee, and one member shall be appointed by the Speaker of the Assembly.

The members of the commission appointed by the Governor are subject to confirmation by the Senate pursuant to Section 1322 of the Government Code.

No person who is currently licensed, or who was licensed within the last two years, under this chapter may be appointed or reappointed to, or serve on, the commission.

(b) In appointing commissioners under this section, the Governor, the Senate Rules Committee, and the Speaker of the Assembly shall make every effort to ensure that at least four of the members of the commission shall have experience and demonstrate expertise in one of the following areas:

(1) A licensed physician or surgeon having expertise or specializing in neurology, neurosurgery, head trauma, or sports medicine. Sports medicine includes, but is not limited to, physiology, kinesiology, or other aspects of sports medicine.

(2) Financial management.

(3) Public safety.

(4) Past experience in the activity regulated by this chapter, either as a contestant, a referee or official, a promoter, or a venue operator.

(c) Each member of the commission shall be appointed for a term of four years. All terms shall end on January 1. Vacancies occurring prior to the expiration of the term shall be filled by appointment for the unexpired term. No commission member may serve more than two consecutive terms.

(d) Notwithstanding any other provision of this chapter, members first appointed shall be subject to the following terms:

(1) The Governor shall appoint two members for two years, two members for three years, and one member for four years.

(2) The Senate Committee on Rules shall appoint one member for four years.

(3) The Speaker of the Assembly shall appoint one member for four years.

(4) The appointing powers, as described in subdivision (a), may appoint to the commission a person who was a member of the prior commission prior to the repeal of that commission on July 1, 2006.

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

The repeal of this section renders the commission subject to the review required by Division 1.2 (commencing with Section 473).

SEC. 17. Section 18613 of the Business and Professions Code is amended to read:

18613. (a) (1) To assure the continuity and stable transition as the commission is reformed on January 1, 2007, the person serving as the bureau chief on December 31, 2006, shall serve as the executive officer beginning January 1, 2007, for a term through June 30, 2007. On or before June 30, 2007, but not earlier than June 1, 2007, the commission shall determine whether to retain the services of the person who was serving as the bureau chief on December 31, 2006, or to follow the procedure set forth in paragraph (2) of this subdivision to appoint a new executive officer. During the period between January 1, 2007, and June 30, 2007, any inconsistent provisions of this section notwithstanding, the executive officer may be terminated for cause upon the affirmative vote of a majority of the members of the commission.

(2) The commission shall appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the commission and vested in him or her by this chapter. The appointment of the executive officer is subject to the approval of the Director of Consumer Affairs.

(3) The commission may employ in accordance with Section 154 other personnel as may be necessary for the administration of this chapter.

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

SEC. 18. Section 94801.5 of the Education Code, as added by Senate Bill 823 of the 2007–08 Regular Session, is amended to read:

94801.5. (a) There is a Bureau for Private Postsecondary Education in the Department of Consumer Affairs. The bureau has the responsibility for approving and regulating private postsecondary educational institutions and programs.

(b) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.

SEC. 19. Section 5.5 of this bill incorporates amendments to Section 4990 of the Business and Professions Code proposed by both this bill and AB 239. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2009, (2) each bill amends Section 4990 of the Business and Professions Code, and (3) this bill is enacted after AB 239, in which case Section 5 of this bill shall not become operative.

SEC. 20. Section 18 of this bill shall become operative only if Senate Bill 823 of the 2007–08 Regular Session is also enacted, becomes operative, and adds Section 94801.5 to the Education Code.

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SB 1379

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1379
Author: Ducheny
Chapter: 607
Subject: Loan Repayment: permanent funding source
Sponsor: Author
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill prohibits 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 Steven M. Thompson Physician Corps Loan Repayment Program (Program). This bill includes an urgency clause, therefore it takes effect immediately.

This bill redirects the first $1,000,000 of fine revenue from the DMHC's budget to the Program within the Health Professions Education Foundation (HPEF). These funds may only used upon appropriation by the legislature.

Additionally, the DMHC shall immediately make a one-time transfer of $1,000,000 to the Medically Underserved Account for Physicians within the HPEF to be used by the Program. The urgency clause was added to this bill in order to make the funds available at the earliest possible time. These funds are not subject to appropriation.

IMPLEMENTATION:

- Article in January 2009 *Newsletter*, possible expanded article on the program.

Senate Bill No. 1379

CHAPTER 607

An act to amend Sections 1356, 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, and to add Section 12739.05 to the Insurance Code, relating to health care, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor September 30, 2008. Filed with Secretary of State September 30, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1379, Ducheny. Physician and surgeon loan repayment: health care service plans: California Major Risk Medical Insurance Program.

Existing law establishes 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. Existing law establishes the Medically Underserved Account for Physicians within the Health Professions Education Fund for the purpose of funding the loan repayment program and specifies that funds placed in the account are continuously appropriated for those purposes.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), 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. Under existing law, the Managed Risk Medical Insurance Board manages the California Major Risk Medical Insurance Program (MRMIP) to provide major risk medical insurance coverage to eligible persons who have been rejected for health care coverage by at least one private health plan. Existing law creates the Major Risk Medical Insurance Fund, and continuously appropriates the fund to the board for purposes of the program.

This bill would prohibit using the fines and administrative penalties authorized by the Knox-Keene Act to reduce those assessments and would prohibit any refunds or reductions in those assessments in specified

circumstances. The bill would create the Managed Care Administrative Fines and Penalties Fund and would require those fines and administrative penalties to be deposited in that fund. The bill would require, beginning September 1, 2009, and annually thereafter, that the first $1,000,000 deposited in that fund be transferred to the Medically Underserved Account for Physicians to be used, upon appropriation by the Legislature, for the purposes of the loan repayment program and that the remaining moneys deposited in that fund be transferred to the Major Risk Medical Insurance Fund to be used, upon appropriation by the Legislature, for purposes of MRMIP. The bill would specify that those funds are not continuously appropriated. The bill would also require the department to make one-time transfers of $1,000,000 and $10,000,000 in fines and administrative penalties from the Managed Care Fund to the Medically Underserved Account for Physicians within the Health Professions Education Fund and the Major Risk Medical Insurance Fund, respectively, to be used for the purposes of those programs. By depositing these funds into continuously appropriated funds, the bill would thereby make an appropriation.

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

Appropriation: yes.

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

SECTION 1. Section 1341.45 is added to the Health and Safety Code, to read:

1341.45. (a) There is hereby created in the State Treasury the Managed Care Administrative Fines and Penalties Fund.

(b) The fines and administrative penalties collected pursuant to this chapter, on and after the operative date of this section, shall be deposited into the Managed Care Administrative Fines and Penalties Fund.

(c) The fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department, beginning September 1, 2009, and annually thereafter, as follows:

(1) The first one million dollars ($1,000,000) shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) or Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(2) Any amount over the first one million dollars ($1,000,000), including accrued interest, in the fund shall be transferred to the Major Risk Medical Insurance Fund created pursuant to Section 12739 of the Insurance Code and shall, upon appropriation by the Legislature, be used for the Major Risk

Medical Insurance Program for the purposes specified in Section 12739.1 of the Insurance Code.

(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.

SEC. 2. Section 1356 of the Health and Safety Code is amended to read:

1356. (a) Each plan applying for licensure under this chapter shall reimburse the director for the actual cost of processing the application, including overhead, up to an amount not to exceed twenty-five thousand dollars ($25,000). The cost shall be billed not more frequently than monthly and shall be remitted by the applicant to the director within 30 days of the date of billing. The director shall not issue a license to an applicant prior to receiving payment in full from that applicant for all amounts charged pursuant to this subdivision.

(b) (1) In addition to other fees and reimbursements required to be paid under this chapter, each licensed plan shall pay to the director an amount as estimated by the director for the ensuing fiscal year, as a reimbursement of its share of all costs and expenses, including, but not limited to, costs and expenses associated with routine financial examinations, grievances, and complaints including maintaining a toll-free telephone number for consumer grievances and complaints, investigation and enforcement, medical surveys and reports, and overhead reasonably incurred in the administration of this chapter and not otherwise recovered by the director under this chapter or from the Managed Care Fund. The amount may be paid in two equal installments. The first installment shall be paid on or before August 1 of each year, and the second installment shall be paid on or before December 15 of each year.

(2) The amount paid by each plan shall be ten thousand dollars ($10,000) plus an amount up to, but not exceeding, an amount computed in accordance with paragraph (3).

(3) (A) In addition to the amount specified in paragraph (2), all plans, except specialized plans, shall pay 65 percent of the total amount of the department's costs and expenses for the ensuing fiscal year as estimated by the director. The amount per plan shall be calculated on a per enrollee basis as specified in paragraph (4).

(B) In addition to the amount specified in paragraph (2), all specialized plans shall pay 35 percent of the total amount of the department's costs and expenses for the ensuing fiscal year as estimated by the director. The amount per plan shall be calculated on a per enrollee basis as specified in paragraph (4).

(4) The amount paid by each plan shall be for each enrollee enrolled in its plan in this state as of the preceding March 31, and shall be fixed by the director by notice to all licensed plans on or before June 15 of each year. A plan that is unable to report the number of enrollees enrolled in the plan because it does not collect that data, shall provide the director with an estimate of the number of enrollees enrolled in the plan and the method

used for determining the estimate. The director may, upon giving written notice to the plan, revise the estimate if the director determines that the method used for determining the estimate was not reasonable.

(5) In determining the amount assessed, the director shall consider all appropriations from the Managed Care Fund for the support of this chapter and all reimbursements provided for in this chapter.

(c) Each licensed plan shall also pay two thousand dollars ($2,000), plus an amount up to, but not exceeding, forty-eight hundredths of one cent ($0.0048), for each enrollee for the purpose of reimbursing its share of all costs and expenses, including overhead, reasonably anticipated to be incurred by the department in administering Sections 1394.7 and 1394.8 during the current fiscal year. The amount charged shall be remitted within 30 days of the date of billing.

(d) In no case shall the reimbursement, payment, or other fee authorized by this section exceed the cost, including overhead, reasonably incurred in the administration of this chapter.

(e) For the purpose of calculating the assessment under this section, an enrollee who is enrolled in one plan and who receives health care services under arrangements made by another plan or plans, whether pursuant to a contract, agreement, or otherwise, shall be considered to be enrolled in each of the plans.

(f) On and after January 1, 2009, no refunds or reductions of the amounts assessed shall be allowed if any miscalculated assessment is based on a plan's overestimate of enrollment.

SEC. 3. Section 1367.01 of the Health and Safety Code is amended to read:

1367.01. (a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval,

and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

(c) A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the

review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or

modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to

communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

(k) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall include a discussion of compliance with this section as part of its report issued pursuant to that section.

(*l*) This section shall not apply to decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion as set forth in subdivision (a) of Section 1270.

(m) Nothing in this section shall cause a health care service plan to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

SEC. 4. Section 1367.03 of the Health and Safety Code is amended to read:

1367.03. (a) Not later than January 1, 2004, the department shall develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner. In developing these regulations, the department shall develop indicators of timeliness of access to care and, in so doing, shall consider the following as indicators of timeliness of access to care:

(1) Waiting times for appointments with physicians, including primary care and specialty physicians.

(2) Timeliness of care in an episode of illness, including the timeliness of referrals and obtaining other services, if needed.

(3) Waiting time to speak to a physician, registered nurse, or other qualified health professional acting within his or her scope of practice who is trained to screen or triage an enrollee who may need care.

(b) In developing these standards for timeliness of access, the department shall consider the following:

(1) Clinical appropriateness.

(2) The nature of the specialty.

(3) The urgency of care.

(4) The requirements of other provisions of law, including Section 1367.01 governing utilization review, that may affect timeliness of access.

(c) The department may adopt standards other than the time elapsed between the time an enrollee seeks health care and obtains care. If the department chooses a standard other than the time elapsed between the time an enrollee first seeks health care and obtains it, the department shall demonstrate why that standard is more appropriate. In developing these standards, the department shall consider the nature of the plan network.

(d) The department shall review and adopt standards, as needed, concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care, so that consumers have timely access

to care. In so doing, the department shall consider the nature of physician practices, including individual and group practices as well as the nature of the plan network. The department shall also consider various circumstances affecting the delivery of care, including urgent care, care provided on the same day, and requests for specific providers. If the department finds that health care service plans and health care providers have difficulty meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature pursuant to subdivision (i).

(e) In developing standards under subdivision (a), the department shall consider requirements under federal law, requirements under other state programs, standards adopted by other states, nationally recognized accrediting organizations, and professional associations. The department shall further consider the needs of rural areas, specifically those in which health facilities are more than 30 miles apart and any requirements imposed by the State Department of Health Care Services on health care service plans that contract with the State Department of Health Care Services to provide Medi-Cal managed care.

(f) (1) Contracts between health care service plans and health care providers shall assure compliance with the standards developed under this section. These contracts shall require reporting by health care providers to health care service plans and by health care service plans to the department to ensure compliance with the standards.

(2) Health care service plans shall report annually to the department on compliance with the standards in a manner specified by the department. The reported information shall allow consumers to compare the performance of plans and their contracting providers in complying with the standards, as well as changes in the compliance of plans with these standards.

(g) (1) When evaluating compliance with the standards, the department shall focus more upon patterns of noncompliance rather than isolated episodes of noncompliance.

(2) The director may investigate and take enforcement action against plans regarding noncompliance with the requirements of this section. Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director may, by order, assess administrative penalties subject to appropriate notice of, and the opportunity for, a hearing in accordance with Section 1397. The plan may provide to the director, and the director may consider, information regarding the plan's overall compliance with the requirements of this section. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(3) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties

if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:

(A) Repeated failure to act promptly and reasonably to assure timely access to care consistent with this chapter.

(B) Repeated failure to act promptly and reasonably to require contracting providers to assure timely access that the plan is required to perform under this chapter and that have been delegated by the plan to the contracting provider when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(C) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

(4) The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(h) The department shall work with the patient advocate to assure that the quality of care report card incorporates information provided pursuant to subdivision (f) regarding the degree to which health care service plans and health care providers comply with the requirements for timely access to care.

(i) The department shall report to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature on March 1, 2003, and on March 1, 2004, regarding the progress toward the implementation of this section.

(j) Every three years, the department shall review information regarding compliance with the standards developed under this section and shall make recommendations for changes that further protect enrollees.

SEC. 5. Section 1368 of the Health and Safety Code is amended to read:

1368. (a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

(2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.

(3) Provide forms for grievances to be given to subscribers and enrollees who wish to register written grievances. The forms used by plans licensed pursuant to Section 1353 shall be approved by the director in advance as to format.

(4) (A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:

(i) That the grievance has been received.

(ii) The date of receipt.

(iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.

(B) Grievances received by telephone, by facsimile, by e-mail, or online through the plan's Internet Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:

(i) The date of the call.

(ii) The name of the complainant.

(iii) The complainant's member identification number.

(iv) The nature of the grievance.

(v) The nature of the resolution.

(vi) The name of the plan representative who took the call and resolved the grievance.

(5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

(6) Keep in its files all copies of grievances, and the responses thereto, for a period of five years.

(b) (1) (A) After either completing the grievance process described in subdivision (a), or participating in the process for at least 30 days, a subscriber or enrollee may submit the grievance to the department for review. In any case determined by the department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the grievance process or to participate in the process for at least 30 days before submitting a grievance to the department for review.

(B) A grievance may be submitted to the department for review and resolution prior to any arbitration.

(C) Notwithstanding subparagraphs (A) and (B), the department may refer any grievance that does not pertain to compliance with this chapter to the State Department of Health Services, the California Department of

Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity for investigation and resolution.

(2) If the subscriber or enrollee is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the subscriber or enrollee, as appropriate, may submit the grievance to the department as the agent of the subscriber or enrollee. Further, a provider may join with, or otherwise assist, a subscriber or enrollee, or the agent, to submit the grievance to the department. In addition, following submission of the grievance to the department, the subscriber or enrollee, or the agent, may authorize the provider to assist, including advocating on behalf of the subscriber or enrollee. For purposes of this section, a "relative" includes the parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the subscriber or enrollee.

(3) The department shall review the written documents submitted with the subscriber's or the enrollee's request for review, or submitted by the agent on behalf of the subscriber or enrollee. The department may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or who are otherwise assisting or advocating on behalf of the subscriber or enrollee. If after reviewing the record, the department concludes that the grievance, in whole or in part, is eligible for review under the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department shall immediately notify the subscriber or enrollee, or agent, of that option and shall, if requested orally or in writing, assist the subscriber or enrollee in participating in the independent medical review system.

(4) If after reviewing the record of a grievance, the department concludes that a health care service eligible for coverage and payment under a health care service plan contract has been delayed, denied, or modified by a plan, or by one of its contracting providers, in whole or in part due to a determination that the service is not medically necessary, and that determination was not communicated to the enrollee in writing along with a notice of the enrollee's potential right to participate in the independent medical review system, as required by this chapter, the director shall, by order, assess administrative penalties. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(5) The department shall send a written notice of the final disposition of the grievance, and the reasons therefor, to the subscriber or enrollee, the agent, to any provider that has joined with or is otherwise assisting the subscriber or enrollee, and to the plan, within 30 calendar days of receipt of the request for review unless the director, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly

evaluate the relevant grievance. In any case not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department's written notice shall include, at a minimum, the following:

(A) A summary of its findings and the reasons why the department found the plan to be, or not to be, in compliance with any applicable laws, regulations, or orders of the director.

(B) A discussion of the department's contact with any medical provider, or any other independent expert relied on by the department, along with a summary of the views and qualifications of that provider or expert.

(C) If the enrollee's grievance is sustained in whole or in part, information about any corrective action taken.

(6) In any department review of a grievance involving a disputed health care service, as defined in subdivision (b) of Section 1374.30, that is not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), in which the department finds that the plan has delayed, denied, or modified health care services that are medically necessary, based on the specific medical circumstances of the enrollee, and those services are a covered benefit under the terms and conditions of the health care service plan contract, the department's written notice shall do either of the following:

(A) Order the plan to promptly offer and provide those health care services to the enrollee.

(B) Order the plan to promptly reimburse the enrollee for any reasonable costs associated with urgent care or emergency services, or other extraordinary and compelling health care services, when the department finds that the enrollee's decision to secure those services outside of the plan network was reasonable under the circumstances.

The department's order shall be binding on the plan.

(7) Distribution of the written notice shall not be deemed a waiver of any exemption or privilege under existing law, including, but not limited to, Section 6254.5 of the Government Code, for any information in connection with and including the written notice, nor shall any person employed or in any way retained by the department be required to testify as to that information or notice.

(8) The director shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

(9) A subscriber or enrollee, or the agent acting on behalf of a subscriber or enrollee, may also request voluntary mediation with the plan prior to exercising the right to submit a grievance to the department. The use of mediation services shall not preclude the right to submit a grievance to the department upon completion of mediation. In order to initiate mediation, the subscriber or enrollee, or the agent acting on behalf of the subscriber or enrollee, and the plan shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The department shall have

no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

(c) The plan's grievance system shall include a system of aging of grievances that are pending and unresolved for 30 days or more. The plan shall provide a quarterly report to the director of grievances pending and unresolved for 30 or more days with separate categories of grievances for Medicare enrollees and Medi-Cal enrollees. The plan shall include with the report a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more. The plan may include the following statement in the quarterly report that is made available to the public by the director:

"Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues of appeal that are not available to other enrollees. Therefore, grievances pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights."

If requested by a plan, the director shall include this statement in a written report made available to the public and prepared by the director that describes or compares grievances that are pending and unresolved with the plan for 30 days or more. Additionally, the director shall, if requested by a plan, append to that written report a brief explanation, provided in writing by the plan, of the reasons why grievances described in that written report are pending and unresolved for 30 days or more. The director shall not be required to include a statement or append a brief explanation to a written report that the director is required to prepare under this chapter, including Sections 1380 and 1397.5.

(d) Subject to subparagraph (C) of paragraph (1) of subdivision (b), the grievance or resolution procedures authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law.

(e) Nothing in this section shall be construed to allow the submission to the department of any provider grievance under this section. However, as part of a provider's duty to advocate for medically appropriate health care for his or her patients pursuant to Sections 510 and 2056 of the Business and Professions Code, nothing in this subdivision shall be construed to prohibit a provider from contacting and informing the department about any concerns he or she has regarding compliance with or enforcement of this chapter.

SEC. 6. Section 1368.04 of the Health and Safety Code is amended to read:

1368.04. (a) The director shall investigate and take enforcement action against plans regarding grievances reviewed and found by the department to involve noncompliance with the requirements of this chapter, including grievances that have been reviewed pursuant to the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30). Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director shall, by order, assess

administrative penalties subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(b) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:

(1) Repeated failure to act promptly and reasonably to investigate and resolve grievances in accordance with Section 1368.01.

(2) Repeated failure to act promptly and reasonably to resolve grievances when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(c) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

(d) The administrative penalties authorized pursuant to this section shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

SEC. 7. Section 1374.9 of the Health and Safety Code is amended to read:

1374.9. For violations of Section 1374.7, the director may, after appropriate notice and opportunity for hearing, by order, levy administrative penalties as follows:

(a) Any health care service plan that violates Section 1374.7, or that violates any rule or order adopted or issued pursuant to this section, is liable for administrative penalties of not less than two thousand five hundred dollars ($2,500) for each first violation, and of not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000) for each second violation, and of not less than fifteen thousand dollars ($15,000) and not more than one hundred thousand dollars ($100,000) for each subsequent violation.

(b) The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(c) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the director to enforce the provisions of this chapter.

SEC. 8. Section 1374.34 of the Health and Safety Code is amended to read:

1374.34. (a) Upon receiving the decision adopted by the director pursuant to Section 1374.33 that a disputed health care service is medically necessary, the plan shall promptly implement the decision. In the case of reimbursement for services already rendered, the plan shall reimburse the provider or enrollee, whichever applies, within five working days. In the case of services not yet rendered, the plan shall authorize the services within five working days of receipt of the written decision from the director, or sooner if appropriate for the nature of the enrollee's medical condition, and shall inform the enrollee and provider of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of Section 1367.01.

(b) A plan shall not engage in any conduct that has the effect of prolonging the independent review process. The engaging in that conduct or the failure of the plan to promptly implement the decision is a violation of this chapter and, in addition to any other fines, penalties, and other remedies available to the director under this chapter, the plan shall be subject to an administrative penalty of not less than five thousand dollars ($5,000) for each day that the decision is not implemented. The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(c) The director shall require the plan to promptly reimburse the enrollee for any reasonable costs associated with those services when the director finds that the disputed health care services were a covered benefit under the terms and conditions of the health care service plan contract, and the services are found by the independent medical review organization to have been medically necessary pursuant to Section 1374.33, and either the enrollee's decision to secure the services outside of the plan provider network was reasonable under the emergency or urgent medical circumstances, or the health care service plan contract does not require or provide prior authorization before the health care services are provided to the enrollee.

(d) In addition to requiring plan compliance regarding subdivisions (a), (b), and (c) the director shall review individual cases submitted for independent medical review to determine whether any enforcement actions, including penalties, may be appropriate. In particular, where substantial harm, as defined in Section 3428 of the Civil Code, to an enrollee has already occurred because of the decision of a plan, or one of its contracting providers, to delay, deny, or modify covered health care services that an independent medical review determines to be medically necessary pursuant to Section 1374.33, the director shall impose penalties.

(e) Pursuant to Section 1368.04, the director shall perform an annual audit of independent medical review cases for the dual purposes of education and the opportunity to determine if any investigative or enforcement actions should be undertaken by the department, particularly if a plan repeatedly fails to act promptly and reasonably to resolve grievances associated with a delay, denial, or modification of medically necessary health care services when the obligation of the plan to provide those health care services to enrollees or subscribers is reasonably clear.

SEC. 9. Section 1393.6 of the Health and Safety Code is amended to read:

1393.6. For violations of Article 3.1 (commencing with Section 1357) and Article 3.15 (commencing with Section 1357.50), the director may, after appropriate notice and opportunity for hearing, by order levy administrative penalties as follows:

(a) Any person, solicitor, or solicitor firm, other than a health care service plan, who willfully violates any provision of this chapter, or who willfully violates any rule or order adopted or issued pursuant to this chapter, is liable for administrative penalties of not less than two hundred fifty dollars ($250) for each first violation, and of not less than one thousand dollars ($1,000) and not more than two thousand five hundred dollars ($2,500) for each subsequent violation.

(b) Any health care service plan that willfully violates any provision of this chapter, or that willfully violates any rule or order adopted or issued pursuant to this chapter, is liable for administrative penalties of not less than two thousand five hundred dollars ($2,500) for each first violation, and of not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000) for each second violation, and of not less than fifteen thousand dollars ($15,000) and not more than one hundred thousand dollars ($100,000) for each subsequent violation.

(c) The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(d) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the director to enforce the provisions of this chapter.

SEC. 10. Section 128555 of the Health and Safety Code is amended to read:

128555. (a) The Medically Underserved Account for Physicians is hereby established within the Health Professions Education Fund. The primary purpose of this account is to provide funding for the ongoing operations of the Steven M. Thompson Physician Corps Loan Repayment Program provided for under this article. This account also may be used to provide funding for the Physician Volunteer Program provided for under this article.

(b) All moneys in the Medically Underserved Account contained within the Contingent Fund of the Medical Board of California shall be transferred to the Medically Underserved Account for Physicians on July 1, 2006.

(c) Funds in the account shall be used to repay loans as follows per agreements made with physicians:

(1) Funds paid out for loan repayment may have a funding match from foundations or other private sources.

(2) Loan repayments may not exceed one hundred five thousand dollars ($105,000) per individual licensed physician.

(3) Loan repayments may not exceed the amount of the educational loans incurred by the physician participant.

(d) Notwithstanding Section 11105 of the Government Code, effective January 1, 2006, the foundation may seek and receive matching funds from foundations and private sources to be placed in the account. "Matching funds" shall not be construed to be limited to a dollar-for-dollar match of funds.

(e) Funds placed in the account for purposes of this article, including funds received pursuant to subdivision (d), are, notwithstanding Section 13340 of the Government Code, continuously appropriated for the repayment of loans. This subdivision shall not apply to funds placed in the account pursuant to Section 1341.45.

(f) The account shall also be used to pay for the cost of administering the program and for any other purpose authorized by this article. The costs for administration of the program may be up to 5 percent of the total state appropriation for the program and shall be subject to review and approval annually through the state budget process. This limitation shall only apply to the state appropriation for the program.

(g) The office and the foundation shall manage the account established by this section prudently in accordance with the other provisions of law.

SEC. 11. Section 12739.05 is added to the Insurance Code, to read:

12739.05. Notwithstanding Section 12739, funds placed in the Major Risk Medical Insurance Fund pursuant to Section 1341.45 of the Health and Safety Code shall not be continuously appropriated.

SEC. 12. On the effective date of this act, the Department of Managed Health Care shall make the following one-time transfers of fine and administrative penalty moneys from the Managed Care Fund in the following amounts:

(a) One million dollars ($1,000,000) to the Medically Underserved Account for Physicians within the Health Professions Education Fund to be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 of the Health and Safety Code and, notwithstanding Section 128555 of the Health and Safety Code, shall not be used to provide funding for the Physician Volunteer Program.

(b) Ten million dollars ($10,000,000) to the Major Risk Medical Insurance Fund created pursuant to Section 12739 of the Insurance Code to be used for the Major Risk Medical Insurance Program for the purposes specified in Section 12739.1 of the Insurance Code.

SEC. 13. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make available, at the earliest possible time, funds to address the state's pressing need for available health care coverage for individuals who are otherwise uninsurable and to eliminate the current waiting list for the Major Risk Medical Insurance Program, to help carry out the powers

of the Department of Managed Health Care to protect and promote the interests of the public and carry out the intent of the Legislature to promote the delivery and the quality of health and medical care to the public, and for the uninsured who may be prompted to enroll sooner in health care service plans arranging coverage for the Major Risk Medical Insurance Program, it is necessary that this act take effect immediately.

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SB 1394

BILL NUMBER: SB 1394
VETOED DATE: 09/27/2008

To the Members of the California State Senate:

I am returning Senate Bill 1394 without my signature.

This bill would, with few exceptions, eliminate the mandatory requirement that California physicians report to the Department of Motor Vehicles (DMV) every patient whom they diagnose with a condition characterized by lapses of consciousness.

Eliminating mandatory physician reporting would endanger the motoring public. The patient who suffers from a seizure disorder or other severe impairment and continues to operate an automobile is a hazard to himself or herself, as well as to those with whom he or she shares the road.

In vetoing nearly identical legislation in 2005, I noted that it is too great a risk to other motorists to simply eliminate reporting requirements. One of DMV's primary mandates is to ensure that all drivers are competent to safely operate a motor vehicle. The DMV needs physician reports in order to fulfill that mandate.

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

Sincerely,

Arnold Schwarzenegger

SB 1406

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1406
Author: Correa
Chapter: 352
Subject: Optometry
Sponsor: Author
Board Position: Oppose

DESCRIPTION OF LEGISLATION:

This bill allows an optometrist to diagnose and treat diseases of the eye, to prescribe lenses or devices that incorporate a medication or therapy, and to perform nonintraorbital injections. The bill further allows an optometrist who graduated from an accredited school of optometry on or after May 1, 2000, to perform lacrimal irrigation and dilation procedures without additional certification.

This bill requires the Board of Optometry (Board) to appoint a Glaucoma Diagnosis and Treatment Advisory Committee (Committee) for the purpose of establishing requirements for glaucoma certification. The Committee shall recommend an appropriate curriculum for case management of patients diagnosed with glaucoma and an appropriate combined curriculum for didactic instruction in the treatment of glaucoma. The Committee shall consist of six members. Two members shall be optometrists who are certified to treat glaucoma and who are actively managing glaucoma patients in full-time practice; one member shall be an optometrist who is currently active in educating optometry students in glaucoma; one member shall be a physician who is both board-certified in ophthalmology with a specialty or subspecialty in glaucoma and currently active in educating ophthalmology students in glaucoma; two members shall be physicians who are board-certified in ophthalmology who treat glaucoma patients. The Committee shall submit its report to the Department of Consumer Affairs, Office of Examination Resources (Office), by April 1, 2009. The Office shall present its findings to the Board by July 1, 2009, and the Board shall adopt the findings by January 1, 2010.

IMPLEMENTATION:

- Article in January 2009 *Newsletter*
- Notify enforcement staff regarding expanded scope of practice for optometrists
- Track submission on report and findings to report back to MBC

Senate Bill No. 1406

CHAPTER 352

An act to amend Sections 3041 and 3152 of, and to add and repeal Section 3041.10 of, the Business and Professions Code, relating to optometry.

[Approved by Governor September 26, 2008. Filed with Secretary of State September 26, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1406, Correa. Optometry.

Existing law, the Optometry Practice Act, creates the State Board of Optometry, which licenses optometrists and regulates their practice. The act defines the practice of optometry as including the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system. The act also prescribes certain eye or eye appendage conditions which an optometrist who is certified to use therapeutic pharmaceutical agents may diagnose and treat, as specified and subject to certain limitations, and requires additional certification for the performance of primary open-angle glaucoma and lacrimal irrigation and dilation procedures, respectively.

This bill would revise and recast those provisions to further allow an optometrist who is certified to use therapeutic pharmaceutical agents to, among others, treat glaucoma, as defined, under specified certification standards, order X-rays necessary for the diagnosis of conditions or diseases of the eye or adnexa, perform venipuncture for testing patients suspected of having diabetes, administer oral fluorescein to patients suspected of having diabetic retinopathy, prescribe lenses or devices that incorporate a medication or therapy the optometrist is certified to prescribe or provide, and use specified instruments within the central 3 millimeters of the cornea. The bill would further allow an optometrist who graduated from an accredited school of optometry on or after May 1, 2000, to perform lacrimal irrigation and dilation procedures without additional certification. The bill would also make other changes with regard to the circumstances under which an ophthalmologist or an appropriate physician and surgeon is required to be consulted with, or patients referred to, and to certain age requirements related to treatment or diagnosis, as specified. The bill would further make a conforming change to a related provision.

Until January 1, 2010, this bill would also provide for a Glaucoma Diagnosis and Treatment Advisory Committee to consist of 6 members appointed by the State Board of Optometry for purposes of establishing certain requirements for glaucoma certification. The bill would require the committee to submit its final recommendations to the Office of Examination

Resources of the Department of Consumer Affairs by April 1, 2009, would require the office to present its findings and any modifications thereof to the board by July 1, 2009, and require the board to adopt the office's findings by January 1, 2010.

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

SECTION 1. Section 3041 of the Business and Professions Code is amended to read:

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

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

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

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

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

(5) The use of topical pharmaceutical agents for the purpose of the examination of the human eye or eyes for any disease or pathological condition.

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

(A) Through medical treatment, infections of the anterior segment and adnexa, excluding the lacrimal gland, the lacrimal drainage system, and the sclera in patients under 12 years of age.

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

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

consult with an ophthalmologist or appropriate physician and surgeon if a patient has a recurrent case of peripheral corneal inflammatory keratitis within one year of the initial occurrence.

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

(E) Corneal surface disease and dry eyes.

(F) Ocular pain, nonsurgical in cause except when comanaged with the treating physician and surgeon, associated with conditions optometrists are authorized to treat.

(G) Pursuant to subdivision (f), glaucoma in patients over 18 years of age, as described in subdivision (j).

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

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

(1) Pharmaceutical agents as described in paragraph (5) of subdivision (a), as well as topical miotics.

(2) Topical lubricants.

(3) Antiallergy agents. In using topical steroid medication for the treatment of ocular allergies, an optometrist shall consult with an ophthalmologist if the patient's condition worsens 21 days after diagnosis.

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

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

(B) Peripheral corneal inflammatory keratitis, excluding Moorens and Terriens diseases, an optometrist shall consult with an ophthalmologist or appropriate physician and surgeon if the patient's condition worsens 72 hours after diagnosis.

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

(5) Topical antibiotic agents.

(6) Topical hyperosmotics.

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

(A) The optometrist shall refer the patient to an ophthalmologist if requested by the patient or if angle closure glaucoma develops.

(B) If the glaucoma patient also has diabetes, the optometrist shall consult with the physician treating the patient's diabetes in developing the glaucoma treatment plan and shall inform the physician in writing of any changes in the patient's glaucoma medication.

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

(9) Oral antihistamines.

(10) Prescription oral nonsteroidal antiinflammatory agents.

(11) Oral antibiotics for medical treatment of ocular disease.

(A) If the patient has been diagnosed with a central corneal ulcer and the central corneal ulcer has not improved 48 hours after diagnosis, the optometrist shall refer the patient to an ophthalmologist.

(B) If the patient has been diagnosed with preseptal cellulitis or dacryocystitis and the condition has not improved 48 hours after diagnosis, the optometrist shall refer the patient to an ophthalmologist.

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

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

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

(13) Oral analgesics that are not controlled substances.

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

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

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

(1) Corneal scraping with cultures.

(2) Debridement of corneal epithelia.

(3) Mechanical epilation.

(4) Venipuncture for testing patients suspected of having diabetes.

(5) Suture removal, with prior consultation with the treating physician and surgeon.

(6) Treatment or removal of sebaceous cysts by expression.

(7) Administration of oral fluorescein to patients suspected as having diabetic retinopathy.

(8) Use of an auto-injector to counter anaphylaxis.

(9) Ordering of smears, cultures, sensitivities, complete blood count, mycobacterial culture, acid fast stain, urinalysis, and X-rays necessary for the diagnosis of conditions or diseases of the eye or adnexa. An optometrist may order other types of images subject to prior consultation with an ophthalmologist or appropriate physician and surgeon.

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

(11) The prescription of therapeutic contact lenses, including lenses or devices that incorporate a medication or therapy the optometrist is certified to prescribe or provide.

(12) Removal of foreign bodies from the cornea, eyelid, and conjunctiva with any appropriate instrument other than a scalpel or needle. Corneal foreign bodies shall be nonperforating, be no deeper than the midstroma, and require no surgical repair upon removal.

(13) For patients over 12 years of age, lacrimal irrigation and dilation, excluding probing of the nasal lacrimal tract. The board shall certify any optometrist who graduated from an accredited school of optometry before May 1, 2000, to perform this procedure after submitting proof of satisfactory completion of 10 procedures under the supervision of an ophthalmologist as confirmed by the ophthalmologist. Any optometrist who graduated from an accredited school of optometry on or after May 1, 2000, shall be exempt from the certification requirement contained in this paragraph.

(f) The board shall grant a certificate to an optometrist certified pursuant to Section 3041.3 for the treatment of glaucoma, as described in subdivision (j), in patients over 18 years of age after the optometrist meets the following applicable requirements:

(1) For licensees who graduated from an accredited school of optometry on or after May 1, 2008, submission of proof of graduation from that institution.

(2) For licensees who were certified to treat glaucoma under this section prior to January 1, 2009, submission of proof of completion of that certification program.

(3) For licensees who have substantially completed the certification requirements pursuant to this section in effect between January 1, 2001, and December 31, 2008, submission of proof of completion of those requirements on or before December 31, 2009. "Substantially completed" means both of the following:

(A) Satisfactory completion of a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma.

(B) Treatment of 50 glaucoma patients with a collaborating ophthalmologist for a period of two years for each patient that will conclude on or before December 31, 2009.

(4) For licensees who completed a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma, submission of proof of satisfactory completion of the case management requirements for certification established by the board pursuant to Section 3014.10.

(5) For licensees who graduated from an accredited school of optometry on or before May 1, 2008, and not described in paragraph (2), (3), or (4), submission of proof of satisfactory completion of the requirements for certification established by the board pursuant to Section 3014.10.

(g) Other than for prescription ophthalmic devices described in subdivision (b) of Section 2541, any dispensing of a therapeutic pharmaceutical agent by an optometrist shall be without charge.

(h) The practice of optometry does not include performing surgery. "Surgery" means any procedure in which human tissue is cut, altered, or otherwise infiltrated by mechanical or laser means. "Surgery" does not include those procedures specified in subdivision (e). Nothing in this section shall limit an optometrist's authority to utilize diagnostic laser and ultrasound technology within his or her scope of practice.

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

(j) For purposes of this chapter, "glaucoma" means either of the following:

(1) All primary open-angle glaucoma.

(2) Exfoliation and pigmentary glaucoma.

(k) In an emergency, an optometrist shall stabilize, if possible, and immediately refer any patient who has an acute attack of angle closure to an ophthalmologist.

SEC. 2. Section 3041.10 is added to the Business and Professions Code, to read:

3041.10. (a) The Legislature hereby finds and declares that it is necessary to ensure that the public is adequately protected during the transition to full certification for all licensed optometrists who desire to treat and manage glaucoma patients.

(b) The board shall appoint a Glaucoma Diagnosis and Treatment Advisory Committee as soon as practicable after January 1, 2009. The committee shall consist of six members currently licensed and in active practice in their professions in California, with the following qualifications:

(1) Two members shall be optometrists who were certified by the board to treat glaucoma pursuant to the provisions of subdivision (f) of Section 3041, as that provision read on January 1, 2001, and who are actively managing glaucoma patients in full-time practice.

(2) One member shall be a glaucoma-certified optometrist currently active in educating optometric students in glaucoma.

(3) One member shall be a physician and surgeon board-certified in ophthalmology with a specialty or subspecialty in glaucoma who is currently active in educating optometric students in glaucoma.

(4) Two members shall be physicians and surgeons board-certified in ophthalmology who treat glaucoma patients.

(c) The board shall appoint the members of the committee from a list provided by the following organizations:

(1) For the optometrists' appointments, the California Optometric Association.

(2) For the physician and surgeons' appointments, the California Medical Association and the California Academy of Eye Physicians and Surgeons.

(d) The committee shall establish requirements for glaucoma certification, as authorized by Section 3041, by recommending both of the following:

(1) An appropriate curriculum for case management of patients diagnosed with glaucoma for applicants for certification described in paragraph (4) of subdivision (f) of Section 3041.

(2) An appropriate combined curriculum of didactic instruction in the diagnostic, pharmacological, and other treatment and management of glaucoma, and case management of patients diagnosed with glaucoma, for certification described in paragraph (5) of subdivision (f) of Section 3041.

In developing its findings, the committee shall presume that licensees who apply for glaucoma certification and who graduated from an accredited school of optometry on or after May 1, 2008, possess sufficient didactic and case management training in the treatment and management of patients diagnosed with glaucoma to be certified. After reviewing training programs for representative graduates, the committee in its discretion may recommend additional glaucoma training to the Office of Examination Resources pursuant to subdivision (f) to be completed before a license renewal application from any licensee described in this subdivision is approved.

(e) The committee shall meet at such times and places as determined by the board and shall not meet initially until all six members are appointed. Committee meetings shall be public and a quorum shall consist of four members in attendance at any properly noticed meeting.

(f) (1) The committee shall submit its final recommendations to the Office of Examination Resources of the department on or before April 1, 2009. The office shall examine the committee's recommended curriculum requirements to determine whether they will do the following:

(A) Adequately protect glaucoma patients.

(B) Ensure that defined applicant optometrists will be certified to treat glaucoma on an appropriate and timely basis.

(C) Be consistent with the department's and board's examination validation for licensure and occupational analyses policies adopted pursuant to subdivision (b) of Section 139.

(2) The office shall present its findings and any modifications necessary to meet the requirements of paragraph (1) to the board on or before July 1,

2009. The board shall adopt the findings of the office and shall implement certification requirements pursuant to this section on or before January 1, 2010.

(g) This section shall remain in effect only until January 1, 2010, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2010, deletes or extends that date.

SEC. 3. Section 3152 of the Business and Professions Code is amended to read:

3152. The amount of fees and penalties prescribed by this chapter shall be established by the board in amounts not greater than those specified in the following schedule:

(a) The fee for applicants applying for a license shall not exceed two hundred seventy-five dollars ($275).

(b) The fee for renewal of an optometric license shall not exceed five hundred dollars ($500).

(c) The annual fee for the renewal of a branch office license shall not exceed seventy-five dollars ($75).

(d) The fee for a branch office license shall not exceed seventy-five dollars ($75).

(e) The penalty for failure to pay the annual fee for renewal of a branch office license shall not exceed twenty-five dollars ($25).

(f) The fee for issuance of a license or upon change of name authorized by law of a person holding a license under this chapter shall not exceed twenty-five dollars ($25).

(g) The delinquency fee for renewal of an optometric license shall not exceed fifty dollars ($50).

(h) The application fee for a certificate to treat lacrimal irrigation and dilation shall not exceed fifty dollars ($50).

(i) The application fee for a certificate to treat glaucoma shall not exceed fifty dollars ($50).

(j) The fee for approval of a continuing education course shall not exceed one hundred dollars ($100).

(k) The fee for issuance of a statement of licensure shall not exceed forty dollars ($40).

(*l*) The fee for biennial renewal of a statement of licensure shall not exceed forty dollars ($40).

(m) The delinquency fee for renewal of a statement of licensure shall not exceed twenty dollars ($20).

(n) The application fee for a fictitious name permit shall not exceed fifty dollars ($50).

(o) The renewal fee for a fictitious name permit shall not exceed fifty dollars ($50).

(p) The delinquency fee for renewal of a fictitious name permit shall not exceed twenty-five dollars ($25).

O

SB 1415

BILL NUMBER: SB 1415
VETOED DATE: 09/30/2008

To the Members of the California State Senate:

I am returning Senate Bill 1415 without my signature.

The historic delay in passing the 2008-2009 State Budget has forced me to prioritize the bills sent to my desk at the end of the year's legislative session. Given the delay, I am only signing bills that are the highest priority for California. This bill does not meet that standard and I cannot sign it at this time.

Sincerely,

Arnold Schwarzenegger

SB 1441

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1441
Author: Ridley-Thomas
Chapter: 548
Subject: Task Force: address standards for impaired
Sponsor: Author
Board Position: Support if amended

DESCRIPTION OF LEGISLATION:

This bill establishes the Substance Abuse Coordination Committee (SACC) within the Department of Consumer Affairs (DCA) which will be comprised of the executive officers of the department's healing arts licensing boards. The bill requires the committee to formulate, no later than January 1, 2010, uniform and specific standards in specified areas that each healing arts board would be required to use in dealing with substance-abusing licensees whether or not the board chooses to have a formal diversion program.

IMPLEMENTATION:

- Article in January 2009 *Newsletter*
- Participate in Department held meetings as required.

Senate Bill No. 1441

CHAPTER 548

An act to amend Sections 1695.1, 1695.5, 1695.6, 1697, 1698, 2361, 2365, 2366, 2367, 2369, 2663, 2665, 2666, 2770.1, 2770.7, 2770.8, 2770.11, 2770.12, 3501, 3534.1, 3534.3, 3534.4, 3534.9, and 4371 of, and 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.

[Approved by Governor September 28, 2008. Filed with Secretary of State September 28, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1441, Ridley-Thomas. Healing arts practitioners: substance abuse.

Existing law requires various healing arts licensing boards, including the Dental Board of California, the Board of Registered Nursing, the Physical Therapy Board of California, the Physician Assistant Committee, the Osteopathic Medical Board of California, and the California State Board of Pharmacy to establish and administer diversion or recovery programs or diversion evaluation committees for the rehabilitation of healing arts practitioners whose competency is impaired due to the abuse of drugs or alcohol, and gives the diversion evaluation committees certain duties related to termination of a licensee from the diversion program and reporting termination, designing treatment programs, denying participation in the program, reviewing activities and performance of contractors, determining completion of the program, and purging and destroying records, as specified. Existing law requires the California State Board of Pharmacy to contract with one or more qualified contractors to administer the pharmacists recovery program and requires the board to review the pharmacists recovery program on a quarterly basis, as specified.

This bill would establish in the Department of Consumer Affairs the Substance Abuse Coordination Committee, which would be comprised of the executive officers of the department's healing arts licensing boards, as specified, and a designee of the State Department of Alcohol Drug Programs. The bill would require the committee to formulate, by January 1, 2010, uniform and specific standards in specified areas that each healing arts board would be required to use in dealing with substance-abusing licensees. The bill would specify that the program managers of the diversion programs for the Dental Board of California, the Board of Registered Nursing, the Physical Therapy Board of California, the Physician Assistant Committee, and the Osteopathic Medical Board of California, as designated by the executive officers of those entities, are responsible for certain duties, including, as specified, duties related to termination of a licensee from the diversion program, the review and evaluation of recommendations of the committee,

approving the designs of treatment programs, denying participation in the program, reviewing activities and performance of contractors, and determining completion of the program. The bill would also provide that diversion evaluation committees created by any of the specified boards or committees operate under the direction of the program manager of the diversion program, and would require those diversion evaluation committees to make certain recommendations. The bill would require the executive officer of the California State Board of Pharmacy to designate a program manager of the pharmacists recovery program, and would require the program manager to review the pharmacists recovery program quarterly and to work with the contractors, as specified. The bill would set forth provisions regarding entry of a registered nurse into the diversion program and the investigation and discipline of registered nurses who are in, or have been in, the diversion program, and would require registered nurses in the diversion program to sign an agreement of understanding regarding withdrawal or termination from the program, as specified.

The bill would specify that the diversion program responsibilities imposed on licensing boards under these provisions shall be considered current operating expenses of those boards.

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

SECTION 1. The Legislature hereby finds and declares all of the following:

(a) Substance abuse is an increasing problem in the health care professions, where the impairment of a health care practitioner for even one moment can mean irreparable harm to a patient.

(b) Several health care licensing boards have "diversion programs" designed to identify substance-abusing licensees, direct them to treatment and monitoring, and return them to practice in a manner that will not endanger the public health and safety.

(c) Substance abuse monitoring programs, particularly for health care professionals, must operate with the highest level of integrity and consistency. Patient protection is paramount.

(d) The diversion program of the Medical Board of California, created in 1981, has been subject to five external performance audits in its 27-year history and has failed all five audits, which uniformly concluded that the program has inadequately monitored substance-abusing physicians and has failed to promptly terminate from the program, and appropriately refer for discipline, physicians who do not comply with the terms and conditions of the program, thus placing patients at risk of harm.

(e) The medical board's diversion program has failed to protect patients from substance-abusing physicians, and the medical board has properly decided to cease administering the program effective June 30, 2008.

(f) The administration of diversion programs created at other health care boards has been contracted to a series of private vendors, and none of those

vendors has ever been subject to a performance audit, such that it is not possible to determine whether those programs are effective in monitoring substance-abusing licensees and assisting them to recover from their addiction in the long term.

(g) Various health care licensing boards have inconsistent or nonexistent standards that guide the way they deal with substance-abusing licensees.

(h) Patients would be better protected from substance-abusing licensees if their regulatory boards agreed to and enforced consistent and uniform standards and best practices in dealing with substance-abusing licensees.

SEC. 2. It is the intent of the Legislature that:

(a) Pursuant to Section 156.1 of the Business and Professions Code and Section 8546.7 of the Government Code, that the Department of Consumer Affairs conduct a thorough audit of the effectiveness, efficiency, and overall performance of the vendor chosen by the department to manage diversion programs for substance-abusing licensees of health care licensing boards created in the Business and Professions Code, and make recommendations regarding the continuation of the programs and any changes or reforms required to ensure that individuals participating in the programs are appropriately monitored, and the public is protected from health care practitioners who are impaired due to alcohol or drug abuse or mental or physical illness.

(b) The audit shall identify, by type of board licensee, the percentage of self-referred participants, board-referred participants, and board-ordered participants. The audit shall describe in detail the diversion services provided by the vendor, including all aspects of bodily fluids testing, including, but not limited to, frequency of testing, randomnicity, method of notice to participants, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, such as whether the collection process is observed by the collector, location of testing, and average timeframe from the date of the test to the date the result of the test becomes available; group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by program participants; standards used in determining whether inpatient or outpatient treatment is necessary; and, if applicable, worksite monitoring requirements and standards. The audit shall review the timeliness of diversion services provided by the vendor; the thoroughness of documentation of treatment, aftercare, and monitoring services received by participants; and the thoroughness of documentation of the effectiveness of the treatment and aftercare services received by participants. In determining the effectiveness and efficiency of the vendor, the audit shall evaluate the vendor's approval process for providers or contractors that provide diversion services, including specimen collectors, group meeting facilitators, and worksite monitors; the vendor's disapproval of providers or contractors that fail to provide effective or timely diversion services; and the vendor's promptness in notifying the boards when a participant fails to comply with the terms of his or her

diversion contract or the rules of the board's program. The audit shall also recommend whether the vendor should be more closely monitored by the department, including whether the vendor should provide the department with periodic reports demonstrating the timeliness and thoroughness of documentation of noncompliance with diversion program contracts and regarding its approval and disapproval of providers and contractors that provide diversion services.

(c) The vendor and its staff shall cooperate with the department and shall provide data, information, and case files as requested by the department to perform all of his or her duties. The provision of confidential data, information, and case files from health care-related boards and the vendor to the department shall not constitute a waiver of any exemption from disclosure or discovery or of any confidentiality protection or privilege otherwise provided by law that is applicable to the data, information, or case files. It is the Legislature's intent that the audit be completed by June 30, 2010, and on subsequent years thereafter as determined by the department.

SEC. 3. Article 3.6 (commencing with Section 315) is added to Chapter 4 of Division 1 of the Business and Professions Code, to read:

Article 3.6. Uniform Standards Regarding Substance-Abusing Healing Arts Licensees

315. (a) For the purpose of determining uniform standards that will be used by healing arts boards in dealing with substance-abusing licensees, there is established in the Department of Consumer Affairs the Substance Abuse Coordination Committee. The committee shall be comprised of the executive officers of the department's healing arts boards established pursuant to Division 2 (commencing with Section 500), the State Board of Chiropractic Examiners, the Osteopathic Medical Board of California, and a designee of the State Department of Alcohol and Drug Programs. The Director of Consumer Affairs shall chair the committee and may invite individuals or stakeholders who have particular expertise in the area of substance abuse to advise the committee.

(b) The committee shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Division 3 of Title 2 of the Government Code).

(c) By January 1, 2010, the committee shall formulate uniform and specific standards in each of the following areas that each healing arts board shall use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program:

(1) Specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee.

(2) Specific requirements for the temporary removal of the licensee from practice, in order to enable the licensee to undergo the clinical diagnostic

evaluation described in subdivision (a) and any treatment recommended by the evaluator described in subdivision (a) and approved by the board, and specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.

(3) Specific requirements that govern the ability of the licensing board to communicate with the licensee's employer about the licensee's status and condition.

(4) Standards governing all aspects of required testing, including, but not limited to, frequency of testing, randomnicity, method of notice to the licensee, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

(5) Standards governing all aspects of group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by licensees.

(6) Standards used in determining whether inpatient, outpatient, or other type of treatment is necessary.

(7) Worksite monitoring requirements and standards, including, but not limited to, required qualifications of worksite monitors, required methods of monitoring by worksite monitors, and required reporting by worksite monitors.

(8) Procedures to be followed when a licensee tests positive for a banned substance.

(9) Procedures to be followed when a licensee is confirmed to have ingested a banned substance.

(10) Specific consequences for major violations and minor violations. In particular, the committee shall consider the use of a "deferred prosecution" stipulation similar to the stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency unless or until the licensee commits a major violation, in which case it is revived and the license is surrendered.

(11) Criteria that a licensee must meet in order to petition for return to practice on a full-time basis.

(12) Criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license.

(13) If a board uses a private-sector vendor that provides diversion services, standards for immediate reporting by the vendor to the board of any and all noncompliance with any term of the diversion contract or probation; standards for the vendor's approval process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors;

standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services; and standards for a licensee's termination from the program and referral to enforcement.

(14) If a board uses a private-sector vendor that provides diversion services, the extent to which licensee participation in that program shall be kept confidential from the public.

(15) If a board uses a private-sector vendor that provides diversion services, a schedule for external independent audits of the vendor's performance in adhering to the standards adopted by the committee.

(16) Measurable criteria and standards to determine whether each board's method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.

SEC. 4. Section 1695.1 of the Business and Professions Code is amended to read:

1695.1. As used in this article:

(a) "Board" means the Board of Dental Examiners of California.

(b) "Committee" means a diversion evaluation committee created by this article.

(c) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

SEC. 5. Section 1695.5 of the Business and Professions Code is amended to read:

1695.5. (a) The board shall establish criteria for the acceptance, denial, or termination of licentiates in a diversion program. Unless ordered by the board as a condition of licentiate disciplinary probation, only those licentiates who have voluntarily requested diversion treatment and supervision by a committee shall participate in a diversion program.

(b) A licentiate who is not the subject of a current investigation may self-refer to the diversion program on a confidential basis, except as provided in subdivision (f).

(c) A licentiate under current investigation by the board may also request entry into the diversion program by contacting the board's Diversion Program Manager. The Diversion Program Manager may refer the licentiate requesting participation in the program to a diversion evaluation committee for evaluation of eligibility. Prior to authorizing a licentiate to enter into the diversion program, the Diversion Program Manager may require the licentiate, while under current investigation for any violations of the Dental Practice Act or other violations, to execute a statement of understanding that states that the licentiate understands that his or her violations of the Dental Practice Act or other statutes that would otherwise be the basis for discipline, may still be investigated and the subject of disciplinary action.

(d) If the reasons for a current investigation of a licentiate are based primarily on the self-administration of any controlled substance or dangerous drugs or alcohol under Section 1681 of the Business and Professions Code,

or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drugs for self-administration that does not involve actual, direct harm to the public, the board shall close the investigation without further action if the licentiate is accepted into the board's diversion program and successfully completes the requirements of the program. If the licentiate withdraws or is terminated from the program by a diversion evaluation committee, and the termination is approved by the program manager, the investigation shall be reopened and disciplinary action imposed, if warranted, as determined by the board.

(e) Neither acceptance nor participation in the diversion program shall preclude the board from investigating or continuing to investigate, or taking disciplinary action or continuing to take disciplinary action against, any licentiate for any unprofessional conduct committed before, during, or after participation in the diversion program.

(f) All licentiates shall sign an agreement of understanding that the withdrawal or termination from the diversion program at a time when a diversion evaluation committee determines the licentiate presents a threat to the public's health and safety shall result in the utilization by the board of diversion treatment records in disciplinary or criminal proceedings.

(g) Any licentiate terminated from the diversion program for failure to comply with program requirements is subject to disciplinary action by the board for acts committed before, during, and after participation in the diversion program. A licentiate who has been under investigation by the board and has been terminated from the diversion program by a diversion evaluation committee shall be reported by the diversion evaluation committee to the board.

SEC. 6. Section 1695.6 of the Business and Professions Code is amended to read:

1695.6. A committee created under this article operates under the direction of the program manager. The program manager has the primary responsibility to review and evaluate recommendations of the committee. Each committee shall have the following duties and responsibilities:

(a) To evaluate those licentiates who request to participate in the diversion program according to the guidelines prescribed by the board and to make recommendations. In making the recommendations, a committee shall consider the recommendations of any licentiates designated by the board to serve as consultants on the admission of the licentiate to the diversion program.

(b) To review and designate those treatment facilities to which licentiates in a diversion program may be referred.

(c) To receive and review information concerning a licentiate participating in the program.

(d) To consider in the case of each licentiate participating in a program whether he or she may with safety continue or resume the practice of dentistry.

(e) To perform such other related duties, under the direction of the board or program manager, as the board may by regulation require.

SEC. 7. Section 1697 of the Business and Professions Code is amended to read:

1697. Each licentiate who requests participation in a diversion program shall agree to cooperate with the treatment program designed by the committee and approved by the program manager and to bear all costs related to the program, unless the cost is waived by the board. Any failure to comply with the provisions of a treatment program may result in termination of the licentiate's participation in a program.

SEC. 8. Section 1698 of the Business and Professions Code is amended to read:

1698. (a) After the committee and the program manager in their discretion have determined that a licentiate has been rehabilitated and the diversion program is completed, the committee shall purge and destroy all records pertaining to the licentiate's participation in a diversion program.

(b) Except as authorized by subdivision (f) of Section 1695.5, all board and committee records and records of proceedings pertaining to the treatment of a licentiate in a program shall be kept confidential and are not subject to discovery or subpoena.

SEC. 9. Section 2361 of the Business and Professions Code is amended to read:

2361. As used in this article:

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

(b) "Diversion program" means a treatment program created by this article for osteopathic physicians and surgeons whose competency may be threatened or diminished due to abuse of drugs or alcohol.

(c) "Committee" means a diversion evaluation committee created by this article.

(d) "Participant" means a California licensed osteopathic physician and surgeon.

(e) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

SEC. 10. Section 2365 of the Business and Professions Code is amended to read:

2365. (a) The board shall establish criteria for the acceptance, denial, or termination of participants in the diversion program. Unless ordered by the board as a condition of disciplinary probation, only those participants who have voluntarily requested diversion treatment and supervision by a committee shall participate in the diversion program.

(b) A participant who is not the subject of a current investigation may self-refer to the diversion program on a confidential basis, except as provided in subdivision (f).

(c) A participant under current investigation by the board may also request entry into the diversion program by contacting the board's Diversion Program Manager. The Diversion Program Manager may refer the participant requesting participation in the program to a diversion evaluation committee for evaluation of eligibility. Prior to authorizing a licentiate to enter into the

diversion program, the Diversion Program Manager may require the licentiate, while under current investigation for any violations of the Medical Practice Act or other violations, to execute a statement of understanding that states that the licentiate understands that his or her violations of the Medical Practice Act or other statutes that would otherwise be the basis for discipline may still be investigated and the subject of disciplinary action.

(d) If the reasons for a current investigation of a participant are based primarily on the self-administration of any controlled substance or dangerous drugs or alcohol under Section 2239, or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drugs for self-administration that does not involve actual, direct harm to the public, the board may close the investigation without further action if the licentiate is accepted into the board's diversion program and successfully completes the requirements of the program. If the participant withdraws or is terminated from the program by a diversion evaluation committee, and the termination is approved by the program manager, the investigation may be reopened and disciplinary action imposed, if warranted, as determined by the board.

(e) Neither acceptance nor participation in the diversion program shall preclude the board from investigating or continuing to investigate, or taking disciplinary action or continuing to take disciplinary action against, any participant for any unprofessional conduct committed before, during, or after participation in the diversion program.

(f) All participants shall sign an agreement of understanding that the withdrawal or termination from the diversion program at a time when a diversion evaluation committee determines the licentiate presents a threat to the public's health and safety shall result in the utilization by the board of diversion treatment records in disciplinary or criminal proceedings.

(g) Any participant terminated from the diversion program for failure to comply with program requirements is subject to disciplinary action by the board for acts committed before, during, and after participation in the diversion program. A participant who has been under investigation by the board and has been terminated from the diversion program by a diversion evaluation committee shall be reported by the diversion evaluation committee to the board.

SEC. 11. Section 2366 of the Business and Professions Code is amended to read:

2366. A committee created under this article operates under the direction of the diversion program manager. The program manager has the primary responsibility to review and evaluate recommendations of the committee. Each committee shall have the following duties and responsibilities:

(a) To evaluate those licensees who request participation in the program according to the guidelines prescribed by the board, and to make recommendations.

(b) To review and designate those treatment facilities and services to which a participant in the program may be referred.

(c) To receive and review information concerning participants in the program.

(d) To consider whether each participant in the treatment program may safely continue or resume the practice of medicine.

(e) To prepare quarterly reports to be submitted to the board, which include, but are not limited to, information concerning the number of cases accepted, denied, or terminated with compliance or noncompliance and a cost analysis of the program.

(f) To promote the program to the public and within the profession, including providing all current licentiates with written information concerning the program.

(g) To perform such other related duties, under the direction of the board or the program manager, as the board may by regulation require.

SEC. 12. Section 2367 of the Business and Professions Code is amended to read:

2367. (a) Each licensee who requests participation in a treatment program shall agree to cooperate with the treatment program designed by the committee and approved by the program manager. The committee shall inform each participant in the program of the procedures followed, the rights and responsibilities of the participant, and the possible results of noncompliance with the program. Any failure to comply with the treatment program may result in termination of participation.

(b) Participation in a program under this article shall not be a defense to any disciplinary action which may be taken by the board. Further, no provision of this article shall preclude the board from commencing disciplinary action against a licensee who is terminated from a program established pursuant to this article.

SEC. 13. Section 2369 of the Business and Professions Code is amended to read:

2369. (a) After the committee and the program manager, in their discretion, have determined that a participant has been rehabilitated and the program is completed, the committee shall purge and destroy all records pertaining to the participation in a treatment program.

(b) Except as authorized by subdivision (f) of Section 2365, all board and committee records and records of proceedings pertaining to the treatment of a participant in a program shall be confidential and are not subject to discovery or subpoena except in the case of discovery or subpoena in any criminal proceeding.

SEC. 14. Section 2663 of the Business and Professions Code is amended to read:

2663. The board shall establish and administer a diversion program for the rehabilitation of physical therapists and physical therapist assistants whose competency is impaired due to the abuse of drugs or alcohol. The board may contract with any other state agency or a private organization to perform its duties under this article. The board may establish one or more diversion evaluation committees to assist it in carrying out its duties under this article. Any diversion evaluation committee established by the board shall operate under the direction of the diversion program manager, as designated by the executive officer of the board. The program manager has

the primary responsibility to review and evaluate recommendations of the committee.

SEC. 15. Section 2665 of the Business and Professions Code is amended to read:

2665. Each diversion evaluation committee has the following duties and responsibilities:

(a) To evaluate physical therapists and physical therapist assistants who request participation in the program and to make recommendations. In making recommendations, the committee shall consider any recommendations from professional consultants on the admission of applicants to the diversion program.

(b) To review and designation of treatment facilities to which physical therapists and physical therapist assistants in the diversion program may be referred.

(c) To receive and review information concerning physical therapists and physical therapist assistants participating in the program.

(d) Calling meetings as necessary to consider the requests of physical therapists and physical therapist assistants to participate in the diversion program, to consider reports regarding participants in the program, and to consider any other matters referred to it by the board.

(e) To consider whether each participant in the diversion program may with safety continue or resume the practice of physical therapy.

(f) To set forth in writing the terms and conditions of the diversion agreement that is approved by the program manager for each physical therapist and physical therapist assistant participating in the program, including treatment, supervision, and monitoring requirements.

(g) Holding a general meeting at least twice a year, which shall be open and public, to evaluate the diversion program's progress, to prepare reports to be submitted to the board, and to suggest proposals for changes in the diversion program.

(h) For the purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, any member of a diversion evaluation committee shall be considered a public employee. No board or diversion evaluation committee member, contractor, or agent thereof, shall be liable for any civil damage because of acts or omissions which may occur while acting in good faith in a program established pursuant to this article.

SEC. 16. Section 2666 of the Business and Professions Code is amended to read:

2666. (a) Criteria for acceptance into the diversion program shall include all of the following:

(1) The applicant shall be licensed as a physical therapist or approved as a physical therapist assistant by the board and shall be a resident of California.

(2) The applicant shall be found to abuse dangerous drugs or alcoholic beverages in a manner which may affect his or her ability to practice physical therapy safely or competently.

(3) The applicant shall have voluntarily requested admission to the program or shall be accepted into the program in accordance with terms and conditions resulting from a disciplinary action.

(4) The applicant shall agree to undertake any medical or psychiatric examination ordered to evaluate the applicant for participation in the program.

(5) The applicant shall cooperate with the program by providing medical information, disclosure authorizations, and releases of liability as may be necessary for participation in the program.

(6) The applicant shall agree in writing to cooperate with all elements of the treatment program designed for him or her.

Any applicant may be denied participation in the program if the board, the program manager, or a diversion evaluation committee determines that the applicant will not substantially benefit from participation in the program or that the applicant's participation in the program creates too great a risk to the public health, safety, or welfare.

(b) A participant may be terminated from the program for any of the following reasons:

(1) The participant has successfully completed the treatment program.

(2) The participant has failed to comply with the treatment program designated for him or her.

(3) The participant fails to meet any of the criteria set forth in subdivision (a) or (c).

(4) It is determined that the participant has not substantially benefited from participation in the program or that his or her continued participation in the program creates too great a risk to the public health, safety, or welfare. Whenever an applicant is denied participation in the program or a participant is terminated from the program for any reason other than the successful completion of the program, and it is determined that the continued practice of physical therapy by that individual creates too great a risk to the public health, safety, and welfare, that fact shall be reported to the executive officer of the board and all documents and information pertaining to and supporting that conclusion shall be provided to the executive officer. The matter may be referred for investigation and disciplinary action by the board. Each physical therapist or physical therapy assistant who requests participation in a diversion program shall agree to cooperate with the recovery program designed for him or her. Any failure to comply with that program may result in termination of participation in the program.

The diversion evaluation committee shall inform each participant in the program of the procedures followed in the program, of the rights and responsibilities of a physical therapist or physical therapist assistant in the program, and the possible results of noncompliance with the program.

(c) In addition to the criteria and causes set forth in subdivision (a), the board may set forth in its regulations additional criteria for admission to the program or causes for termination from the program.

SEC. 17. Section 2770.1 of the Business and Professions Code is amended to read:

2770.1. As used in this article:

(a) "Board" means the Board of Registered Nursing.

(b) "Committee" means a diversion evaluation committee created by this article.

(c) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

SEC. 18. Section 2770.7 of the Business and Professions Code is amended to read:

2770.7. (a) The board shall establish criteria for the acceptance, denial, or termination of registered nurses in the diversion program. Only those registered nurses who have voluntarily requested to participate in the diversion program shall participate in the program.

(b) A registered nurse under current investigation by the board may request entry into the diversion program by contacting the board. Prior to authorizing a registered nurse to enter into the diversion program, the board may require the registered nurse under current investigation for any violations of this chapter or any other provision of this code to execute a statement of understanding that states that the registered nurse understands that his or her violations that would otherwise be the basis for discipline may still be investigated and may be the subject of disciplinary action.

(c) If the reasons for a current investigation of a registered nurse are based primarily on the self-administration of any controlled substance or dangerous drug or alcohol under Section 2762, or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drug for self-administration that does not involve actual, direct harm to the public, the board shall close the investigation without further action if the registered nurse is accepted into the board's diversion program and successfully completes the requirements of the program. If the registered nurse withdraws or is terminated from the program by a diversion evaluation committee, and the termination is approved by the program manager, the investigation shall be reopened and disciplinary action imposed, if warranted, as determined by the board.

(d) Neither acceptance nor participation in the diversion program shall preclude the board from investigating or continuing to investigate, or taking disciplinary action or continuing to take disciplinary action against, any registered nurse for any unprofessional conduct committed before, during, or after participation in the diversion program.

(e) All registered nurses shall sign an agreement of understanding that the withdrawal or termination from the diversion program at a time when the program manager or diversion evaluation committee determines the licentiate presents a threat to the public's health and safety shall result in the utilization by the board of diversion treatment records in disciplinary or criminal proceedings.

(f) Any registered nurse terminated from the diversion program for failure to comply with program requirements is subject to disciplinary action by the board for acts committed before, during, and after participation in the

diversion program. A registered nurse who has been under investigation by the board and has been terminated from the diversion program by a diversion evaluation committee shall be reported by the diversion evaluation committee to the board.

SEC. 19. Section 2770.8 of the Business and Professions Code is amended to read:

2770.8. A committee created under this article operates under the direction of the diversion program manager. The program manager has the primary responsibility to review and evaluate recommendations of the committee. Each committee shall have the following duties and responsibilities:

(a) To evaluate those registered nurses who request participation in the program according to the guidelines prescribed by the board, and to make recommendations.

(b) To review and designate those treatment services to which registered nurses in a diversion program may be referred.

(c) To receive and review information concerning a registered nurse participating in the program.

(d) To consider in the case of each registered nurse participating in a program whether he or she may with safety continue or resume the practice of nursing.

(e) To call meetings as necessary to consider the requests of registered nurses to participate in a diversion program, and to consider reports regarding registered nurses participating in a program.

(f) To make recommendations to the program manager regarding the terms and conditions of the diversion agreement for each registered nurse participating in the program, including treatment, supervision, and monitoring requirements.

SEC. 20. Section 2770.11 of the Business and Professions Code is amended to read:

2770.11. (a) Each registered nurse who requests participation in a diversion program shall agree to cooperate with the rehabilitation program designed by the committee and approved by the program manager. Any failure to comply with the provisions of a rehabilitation program may result in termination of the registered nurse's participation in a program. The name and license number of a registered nurse who is terminated for any reason, other than successful completion, shall be reported to the board's enforcement program.

(b) If the program manager determines that a registered nurse, who is denied admission into the program or terminated from the program, presents a threat to the public or his or her own health and safety, the program manager shall report the name and license number, along with a copy of all diversion records for that registered nurse, to the board's enforcement program. The board may use any of the records it receives under this subdivision in any disciplinary proceeding.

SEC. 21. Section 2770.12 of the Business and Professions Code is amended to read:

2770.12. (a) After the committee and the program manager in their discretion have determined that a registered nurse has successfully completed the diversion program, all records pertaining to the registered nurse's participation in the diversion program shall be purged.

(b) All board and committee records and records of a proceeding pertaining to the participation of a registered nurse in the diversion program shall be kept confidential and are not subject to discovery or subpoena, except as specified in subdivision (b) of Section 2770.11 and subdivision (c).

(c) A registered nurse shall be deemed to have waived any rights granted by any laws and regulations relating to confidentiality of the diversion program, if he or she does any of the following:

(1) Presents information relating to any aspect of the diversion program during any stage of the disciplinary process subsequent to the filing of an accusation, statement of issues, or petition to compel an examination pursuant to Article 12.5 (commencing with Section 820) of Chapter 1. The waiver shall be limited to information necessary to verify or refute any information disclosed by the registered nurse.

(2) Files a lawsuit against the board relating to any aspect of the diversion program.

(3) Claims in defense to a disciplinary action, based on a complaint that led to the registered nurse's participation in the diversion program, that he or she was prejudiced by the length of time that passed between the alleged violation and the filing of the accusation. The waiver shall be limited to information necessary to document the length of time the registered nurse participated in the diversion program.

SEC. 22. Section 3501 of the Business and Professions Code is amended to read:

3501. As used in this chapter:

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

(b) "Approved program" means a program for the education of physician assistants that has been formally approved by the committee.

(c) "Trainee" means a person who is currently enrolled in an approved program.

(d) "Physician assistant" means a person who meets the requirements of this chapter and is licensed by the committee.

(e) "Supervising physician" means a physician and surgeon licensed by the board or by the Osteopathic Medical Board of California who supervises one or more physician assistants, who possesses a current valid license to practice medicine, and who is not currently on disciplinary probation for improper use of a physician assistant.

(f) "Supervision" means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant.

(g) "Committee" or "examining committee" means the Physician Assistant Committee.

(h) "Regulations" means the rules and regulations as contained in Chapter 13.8 (commencing with Section 1399.500) of Title 16 of the California Code of Regulations.

(i) "Routine visual screening" means uninvasive nonpharmacological simple testing for visual acuity, visual field defects, color blindness, and depth perception.

(j) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

SEC. 23. Section 3534.1 of the Business and Professions Code is amended to read:

3534.1. The examining committee shall establish and administer a diversion program for the rehabilitation of physician assistants whose competency is impaired due to the abuse of drugs or alcohol. The examining committee may contract with any other state agency or a private organization to perform its duties under this article. The examining committee may establish one or more diversion evaluation committees to assist it in carrying out its duties under this article. As used in this article, "committee" means a diversion evaluation committee. A committee created under this article operates under the direction of the diversion program manager, as designated by the executive officer of the examining committee. The program manager has the primary responsibility to review and evaluate recommendations of the committee.

SEC. 23. Section 3534.3 of the Business and Professions Code is amended to read:

3534.3. Each committee has the following duties and responsibilities:

(a) To evaluate physician assistants who request participation in the program and to make recommendations to the program manager. In making recommendations, a committee shall consider any recommendations from professional consultants on the admission of applicants to the diversion program.

(b) To review and designate treatment facilities to which physician assistants in the diversion program may be referred, and to make recommendations to the program manager.

(c) The receipt and review of information concerning physician assistants participating in the program.

(d) To call meetings as necessary to consider the requests of physician assistants to participate in the diversion program, to consider reports regarding participants in the program, and to consider any other matters referred to it by the examining committee.

(e) To consider whether each participant in the diversion program may with safety continue or resume the practice of medicine.

(f) To set forth in writing the terms and conditions of the diversion agreement that is approved by the program manager for each physician assistant participating in the program, including treatment, supervision, and monitoring requirements.

(g) To hold a general meeting at least twice a year, which shall be open and public, to evaluate the diversion program's progress, to prepare reports to be submitted to the examining committee, and to suggest proposals for changes in the diversion program.

(h) For the purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, any member of a committee shall be considered a public employee. No examining committee or committee member, contractor, or agent thereof, shall be liable for any civil damage because of acts or omissions which may occur while acting in good faith in a program established pursuant to this article.

SEC. 24. Section 3534.4 of the Business and Professions Code is amended to read:

3534.4. Criteria for acceptance into the diversion program shall include all of the following: (a) the applicant shall be licensed as a physician assistant by the examining committee and shall be a resident of California; (b) the applicant shall be found to abuse dangerous drugs or alcoholic beverages in a manner which may affect his or her ability to practice medicine safely or competently; (c) the applicant shall have voluntarily requested admission to the program or shall be accepted into the program in accordance with terms and conditions resulting from a disciplinary action; (d) the applicant shall agree to undertake any medical or psychiatric examination ordered to evaluate the applicant for participation in the program; (e) the applicant shall cooperate with the program by providing medical information, disclosure authorizations, and releases of liability as may be necessary for participation in the program; and (f) the applicant shall agree in writing to cooperate with all elements of the treatment program designed for him or her.

An applicant may be denied participation in the program if the examining committee, the program manager, or a committee determines that the applicant will not substantially benefit from participation in the program or that the applicant's participation in the program creates too great a risk to the public health, safety, or welfare.

SEC. 25. Section 3534.9 of the Business and Professions Code is amended to read:

3534.9. If the examining committee contracts with any other entity to carry out this section, the executive officer of the examining committee or the program manager shall review the activities and performance of the contractor on a biennial basis. As part of this review, the examining committee shall review files of participants in the program. However, the names of participants who entered the program voluntarily shall remain confidential, except when the review reveals misdiagnosis, case mismanagement, or noncompliance by the participant.

SEC. 26. Section 4371 of the Business and Professions Code is amended to read:

4371. (a) The executive officer of the board shall designate a program manager of the pharmacists recovery program. The program manager shall have background experience in dealing with substance abuse issues.

(b) The program manager shall review the pharmacists recovery program on a quarterly basis. As part of this evaluation, the program manager shall review files of all participants in the pharmacists recovery program.

(c) The program manager shall work with the contractor administering the pharmacists recovery program to evaluate participants in the program according to established guidelines and to develop treatment contracts and evaluate participant progress in the program.

SEC. 27. The responsibilities imposed on a licensing board by this act shall be considered a current operating expense of that board, and shall be paid from the fund generally designated to provide operating expenses for that board, subject to the appropriation provisions applicable to that fund.

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SB 1526

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1526
Author: Perata
Chapter: **Vetoed**
Subject: Polysomnographic Technologists
Sponsor: Author
Board Position: Neutral

DESCRIPTION OF LEGISLATION:

This bill would have required the Medical Board (Board) to adopt regulations by July 1, 2010, 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.

RECOMMENDATION:

- Staff to work with legal counsel and sponsor of bill to clarify the Board's role in any new legislation regarding polysomnographic registration.

BILL NUMBER: SB 1526
VETOED DATE: 09/27/2008

To the Members of the California State Senate:

I am returning Senate Bill 1526 without my signature.

The historic delay in passing the 2008-2009 State Budget has forced me to prioritize the bills sent to my desk at the end of the year's legislative session. Given the delay, I am only signing bills that are the highest priority for California. This bill does not meet that standard and I cannot sign it at this time.

Sincerely,

Arnold Schwarzenegger

SB 1779

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1779
Author: Senate Business and Professions Committee
Chapter: **Vetoed**
Subject: Healing Arts: Omnibus
Sponsor: Author/Various Boards
Board Position: Support MBC Provisions

DESCRIPTION OF LEGISLATION:

This bill was the vehicle by which omnibus legislation has been carried by the Senate Business and Professions Committee. Some provisions, although non-substantive, impact statutes governing the Medical Practices Act.

This bill proposed 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 (only these sections of the bill are attached):

- 801.01 – Clarifying whether or not malpractice actions have to be in California to be reported.

- 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 among all licensing pathways.
  - Technical changes.

- 2168.4 – Making the renewal requirements for the special faculty permit the same as those for the physician's certificate renewal.

- 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.

- 2221 – Making the process by which an applicant's probationary certificate can be modified or terminated consistent with the process that a probationary certificate is modified or terminated through enforcement

- 2307 – Specify that recommendations can come from physicians licensed in <u>any</u> state; and technical changes.

- 2335 – Re-amending section from AB 253 (2007), the Board's restructuring bill, due to subsequent section amendments in a bill that was signed afterward. This section was included in a bill that was signed after ours, which did not include the amendments we were requesting.

<u>RECOMMENDATION</u>:

1. Authorize staff to seek legislation for the same clean up provisions and additions that staff develops.

2. Add repeal of Business and Professions Code section 821.5 and 821.6 to omnibus sections.

BILL NUMBER: SB 1779
VETOED DATE: 09/27/2008

To the Members of the California State Senate:

I am returning Senate Bill 1779 without my signature.

The historic delay in passing the 2008-2009 State Budget has forced me to prioritize the bills sent to my desk at the end of the year's legislative session. Given the delay, I am only signing bills that are the highest priority for California. This bill does not meet that standard and I cannot sign it at this time.

Sincerely,

Arnold Schwarzenegger

CHAPTER _____

An act to amend Sections 27, 101, 128.5, 144, 146, 149, 683, 733, 800, 801, 801.01, 803, 2089.5, 2096, 2102, 2107, 2135, 2168.4, 2175, 2221, 2307, 2335, 2486, 2488, 2570.5, 2570.6, 2570.7, 2760.1, 3503, 3517, 3518, 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, 4161, 4174, 4231, 4301, 4305, 4329, 4330, 4857, 4980.03, 4980.30, 4980.43, 4982, 4989.54, 4992.3, 4996.2, 4996.17, 4996.18, 4996.23, 5801, 6534, 6536, 6561, 7616, 7629, 8740, and 8746 of, to amend and renumber Section 2570.185 of, to add Sections 2169, 2570.36, 4036.5, 4980.04, 4990.09, 5515.5, and 9855.1.5 to, and to repeal Sections 2172, 2173, 2174, 4981, 4994.1, 4996.20, 4996.21, and 6761 of, the Business and Professions Code, to amend Section 8659 of the Government Code, to amend Sections 8778.5, 11150, and 11165 of the Health and Safety Code, and to amend Section 14132.100 of the Welfare and Institutions Code, relating to professions and vocations, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 1779, Committee on Business, Professions and Economic Development. Professions and vocations.

(1) Existing law provides for the licensure and regulation of various professions and vocations by boards and bureaus within the Department of Consumer Affairs.

Existing law requires certain boards and bureaus to disclose on the Internet information on licensees.

This bill would require the Cemetery and Funeral Bureau to disclose on the Internet information on specified licensees.

(2) Under existing law, if, upon investigation, a specified state regulatory agency has probable cause to believe that a person is advertising in a telephone directory with respect to the offering or performance of services, without being properly licensed by or registered with that agency, the agency is authorized to issue a specified citation.

This bill would add the Physical Therapy Board of California to those authorized agencies.

all parties thereto or within 30 days after service of the arbitration award on the parties.

(c) Every insurer providing professional liability insurance to a dentist licensed pursuant to Chapter 4 (commencing with Section 1600) shall send a complete report to the Dental Board of California as to any settlement or arbitration award over ten thousand dollars ($10,000) of a claim or action for damages for death or personal injury caused by that person's negligence, error, or omission in practice, or rendering of unauthorized professional services. The report shall be sent within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto or within 30 days after service of the arbitration award on the parties.

(d) Every insurer providing liability insurance to a veterinarian licensed pursuant to Chapter 11 (commencing with Section 4800) shall send a complete report to the Veterinary Medical Board of any settlement or arbitration award over ten thousand dollars ($10,000) of a claim or action for damages for death or injury caused by that person's negligence, error, or omission in practice, or rendering of unauthorized professional service. The report shall be sent within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto or within 30 days after service of the arbitration award on the parties.

(e) The insurer shall notify the claimant, or if the claimant is represented by counsel, the insurer shall notify the claimant's attorney, that the report required by subdivision (a), (b), or (c) has been sent to the agency. If the attorney has not received this notice within 45 days after the settlement was reduced to writing and signed by all of the parties, the arbitration award was served on the parties, or the date of entry of the civil judgment, the attorney shall make the report to the agency.

(f) Notwithstanding any other provision of law, no insurer shall enter into a settlement without the written consent of the insured, except that this prohibition shall not void any settlement entered into without that written consent. The requirement of written consent shall only be waived by both the insured and the insurer. This section shall only apply to a settlement on a policy of insurance executed or renewed on or after January 1, 1971.

* SEC. 11. Section 801.01 of the Business and Professions Code is amended to read:

801.01. (a) A complete report shall be sent to the Medical Board of California, the Osteopathic Medical Board, or the California Board of Podiatric Medicine, with respect to a licensee of the board as to the following:

(1) A settlement over thirty thousand dollars ($30,000) or arbitration award of any amount or a civil judgment of any amount, whether or not vacated by a settlement after entry of the judgment, that was not reversed on appeal, of a claim or action for damages for death or personal injury caused by the licensee's alleged negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services.

(2) A settlement over thirty thousand dollars ($30,000) if it is based on the licensee's alleged negligence, error, or omission in practice in California, or by the licensee's rendering of unauthorized professional services, and a party to the settlement is a corporation, medical group, partnership, or other corporate entity in which the licensee has an ownership interest or that employs or contracts with the licensee.

(b) The report shall be sent by the following:

(1) The insurer providing professional liability insurance to the licensee.

(2) The licensee, or his or her counsel, if the licensee does not possess professional liability insurance.

(3) A state or local governmental agency that self-insures the licensee.

(c) The entity, person, or licensee obligated to report pursuant to subdivision (b) shall send the complete report if the judgment, settlement agreement, or arbitration award is entered against or paid by the employer of the licensee and not entered against or paid by the licensee. "Employer," as used in this paragraph, means a professional corporation, a group practice, a health care facility or clinic licensed or exempt from licensure under the Health and Safety Code, a licensed health care service plan, a medical care foundation, an educational institution, a professional institution, a professional school or college, a general law corporation, a public entity, or a nonprofit organization that employs, retains, or contracts with a licensee referred to in this section. Nothing in this paragraph shall be construed to authorize the employment of, or contracting with, any licensee in violation of Section 2400.

(d) The report shall be sent to the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine, as appropriate, within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto, within 30 days after service of the arbitration award on the parties, or within 30 days after the date of entry of the civil judgment.

(e) If an insurer is required under subdivision (b) to send the report, the insurer shall notify the claimant, or if the claimant is represented by counsel, the claimant's counsel, that the insurer has sent the report to the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine. If the claimant, or his or her counsel, has not received this notice within 45 days after the settlement was reduced to writing and signed by all of the parties or the arbitration award was served on the parties or the date of entry of the civil judgment, the claimant or the claimant's counsel shall make the report to the appropriate board.

(f) If the licensee or his or her counsel is required under subdivision (b) to send the report, the licensee or his or her counsel shall send a copy of the report to the claimant or to his or her counsel if he or she is represented by counsel. If the claimant or his or her counsel has not received a copy of the report within 45 days after the settlement was reduced to writing and signed by all of the parties or the arbitration award was served on the parties or the date of entry of the civil judgment, the claimant or the claimant's counsel shall make the report to the appropriate board.

(g) Failure of the licensee or claimant, or counsel representing the licensee or claimant, to comply with subdivision (f) is a public offense punishable by a fine of not less than fifty dollars ($50) and not more than five hundred dollars ($500). A knowing and intentional failure to comply with subdivision (f) or a conspiracy or collusion not to comply with subdivision (f), or to hinder or impede any other person in the compliance, is a public offense punishable by a fine of not less than five thousand dollars ($5,000) and not more than fifty thousand dollars ($50,000).

(h) (1) The Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine may develop a prescribed form for the report.

(2) The report shall be deemed complete only if it includes the following information:

(A) The name and last known business and residential addresses of every plaintiff or claimant involved in the matter, whether or not the person received an award under the settlement, arbitration, or judgment.

(B) The name and last known business and residential address of every physician and surgeon or doctor of podiatric medicine who was alleged to have acted improperly, whether or not that person was a named defendant in the action and whether or not that person was required to pay any damages pursuant to the settlement, arbitration award, or judgment.

(C) The name, address, and principal place of business of every insurer providing professional liability insurance to any person described in subparagraph (B), and the insured's policy number.

(D) The name of the court in which the action or any part of the action was filed, and the date of filing and case number of each action.

(E) A brief description or summary of the facts of each claim, charge, or allegation, including the date of occurrence.

(F) The name and last known business address of each attorney who represented a party in the settlement, arbitration, or civil action, including the name of the client he or she represented.

(G) The amount of the judgment and the date of its entry; the amount of the arbitration award, the date of its service on the parties, and a copy of the award document; or the amount of the settlement and the date it was reduced to writing and signed by all parties. If an otherwise reportable settlement is entered into after a reportable judgment or arbitration award is issued, the report shall include both the settlement and the judgment or award.

(H) The specialty or subspecialty of the physician and surgeon or the doctor of podiatric medicine who was the subject of the claim or action.

(I) Any other information the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine may, by regulation, require.

(3) Every professional liability insurer, self-insured governmental agency, or licensee or his or her counsel that makes a report under this section and has received a copy of any written or electronic patient medical or hospital records prepared by the

treating physician and surgeon or podiatrist, or the staff of the treating physician and surgeon, podiatrist, or hospital, describing the medical condition, history, care, or treatment of the person whose death or injury is the subject of the report, or a copy of any deposition in the matter that discusses the care, treatment, or medical condition of the person, shall include with the report, copies of the records and depositions, subject to reasonable costs to be paid by the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine. If confidentiality is required by court order and, as a result, the reporter is unable to provide the records and depositions, documentation to that effect shall accompany the original report. The applicable board may, upon prior notification of the parties to the action, petition the appropriate court for modification of any protective order to permit disclosure to the board. A professional liability insurer, self-insured governmental agency, or licensee or his or her counsel shall maintain the records and depositions referred to in this paragraph for at least one year from the date of filing of the report required by this section.

(i) If the board, within 60 days of its receipt of a report filed under this section, notifies a person named in the report, that person shall maintain for the period of three years from the date of filing of the report any records he or she has as to the matter in question and shall make those records available upon request to the board to which the report was sent.

(j) Notwithstanding any other provision of law, no insurer shall enter into a settlement without the written consent of the insured, except that this prohibition shall not void any settlement entered into without that written consent. The requirement of written consent shall only be waived by both the insured and the insurer.

SEC. 12. Section 803 of the Business and Professions Code is amended to read:

803. (a) Except as provided in subdivision (b), within 10 days after a judgment by a court of this state that a person who holds a license, certificate, or other similar authority from the Board of Behavioral Sciences or from an agency mentioned in subdivision (a) of Section 800 (except a person licensed pursuant to Chapter 3 (commencing with Section 1200)) has committed a crime, or is liable for any death or personal injury resulting in a judgment for an amount in excess of thirty thousand dollars ($30,000) caused

by his or her negligence, error or omission in practice, or his or her rendering unauthorized professional services, the clerk of the court that rendered the judgment shall report that fact to the agency that issued the license, certificate, or other similar authority.

(b) For purposes of a physician and surgeon, osteopathic physician and surgeon, or doctor of podiatric medicine, who is liable for any death or personal injury resulting in a judgment of any amount caused by his or her negligence, error or omission in practice, or his or her rendering unauthorized professional services, the clerk of the court that rendered the judgment shall report that fact to the agency that issued the license.

SEC. 13. Section 2089.5 of the Business and Professions Code is amended to read:

2089.5. (a) Clinical instruction in the subjects listed in subdivision (b) of Section 2089 shall meet the requirements of this section and shall be considered adequate if the requirements of subdivision (a) of Section 2089 and the requirements of this section are satisfied.

(b) Instruction in the clinical courses shall total a minimum of 72 weeks in length.

(c) Instruction in the core clinical courses of surgery, medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry shall total a minimum of 40 weeks in length with a minimum of eight weeks instruction in surgery, eight weeks in medicine, six weeks in pediatrics, six weeks in obstetrics and gynecology, a minimum of four weeks in family medicine, and four weeks in psychiatry.

(d) Of the instruction required by subdivision (b), including all of the instruction required by subdivision (c), 54 weeks shall be performed in a hospital that sponsors the instruction and shall meet one of the following:

(1) Is a formal part of the medical school or school of osteopathic medicine.

(2) Has a residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada (RCPSC), in family practice or in the clinical area of the instruction for which credit is being sought.

(3) Is formally affiliated with an approved medical school or school of osteopathic medicine located in the United States or

Canada. If the affiliation is limited in nature, credit shall be given only in the subject areas covered by the affiliation agreement.

(4) Is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada.

(e) If the institution, specified in subdivision (d), is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada, it shall meet the following:

(1) The formal affiliation shall be documented by a written contract detailing the relationship between the medical school, or a school of osteopathic medicine, and hospital and the responsibilities of each.

(2) The school and hospital shall provide to the board a description of the clinical program. The description shall be in sufficient detail to enable the board to determine whether or not the program provides students an adequate medical education. The board shall approve the program if it determines that the program provides an adequate medical education. If the board does not approve the program, it shall provide its reasons for disapproval to the school and hospital in writing specifying its findings about each aspect of the program that it considers to be deficient and the changes required to obtain approval.

(3) The hospital, if located in the United States, shall be accredited by the Joint Commission on Accreditation of Hospitals, and if located in another country, shall be accredited in accordance with the law of that country.

(4) The clinical instruction shall be supervised by a full-time director of medical education, and the head of the department for each core clinical course shall hold a full-time faculty appointment of the medical school or school of osteopathic medicine and shall be board certified or eligible, or have an equivalent credential in that specialty area appropriate to the country in which the hospital is located.

(5) The clinical instruction shall be conducted pursuant to a written program of instruction provided by the school.

(6) The school shall supervise the implementation of the program on a regular basis, documenting the level and extent of its supervision.

(7) The hospital-based faculty shall evaluate each student on a regular basis and shall document the completion of each aspect of the program for each student.

(8) The hospital shall ensure a minimum daily census adequate to meet the instructional needs of the number of students enrolled in each course area of clinical instruction, but not less than 15 patients in each course area of clinical instruction.

(9) The board, in reviewing the application of a foreign medical graduate, may require the applicant to submit a description of the clinical program, if the board has not previously approved the program, and may require the applicant to submit documentation to demonstrate that the applicant's clinical training met the requirements of this subdivision.

(10) The medical school or school of osteopathic medicine shall bear the reasonable cost of any site inspection by the board or its agents necessary to determine whether the clinical program offered is in compliance with this subdivision.

SEC. 14. Section 2096 of the Business and Professions Code is amended to read:

2096. In addition to other requirements of this chapter, before a physician's and surgeon's license may be issued, each applicant, including an applicant applying pursuant to Article 5 (commencing with Section 2100), shall show by evidence satisfactory to the board that he or she has satisfactorily completed at least one year of postgraduate training, which includes at least four months of general medicine, in a postgraduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or Royal College of Physicians and Surgeons of Canada (RCPSC).

The amendments made to this section at the 1987 portion of the 1987–88 session of the Legislature shall not apply to applicants who completed their one year of postgraduate training on or before July 1, 1990.

SEC. 15. Section 2102 of the Business and Professions Code is amended to read:

2102. Any applicant whose professional instruction was acquired in a country other than the United States or Canada shall provide evidence satisfactory to the board of compliance with the following requirements to be issued a physician's and surgeon's certificate:

(a) Completion in a medical school or schools of a resident course of professional instruction equivalent to that required by Section 2089 and issuance to the applicant of a document acceptable to the board that shows final and successful completion of the course. However, nothing in this section shall be construed to require the board to evaluate for equivalency any coursework obtained at a medical school disapproved by the board pursuant to this section.

(b) Certification by the Educational Commission for Foreign Medical Graduates, or its equivalent, as determined by the board. This subdivision shall apply to all applicants who are subject to this section and who have not taken and passed the written examination specified in subdivision (d) prior to June 1, 1986.

(c) Satisfactory completion of the postgraduate training required under Section 2096. An applicant shall be required to have substantially completed the professional instruction required in subdivision (a) and shall be required to make application to the board and have passed steps 1 and 2 of the written examination relating to biomedical and clinical sciences prior to commencing any postgraduate training in this state. In its discretion, the board may authorize an applicant who is deficient in any education or clinical instruction required by Sections 2089 and 2089.5 to make up any deficiencies as a part of his or her postgraduate training program, but that remedial training shall be in addition to the postgraduate training required for licensure.

(d) Pass the written examination as provided under Article 9 (commencing with Section 2170). An applicant shall be required to meet the requirements specified in subdivision (b) prior to being admitted to the written examination required by this subdivision.

Nothing in this section prohibits the board from disapproving any foreign medical school or from denying an application if, in the opinion of the board, the professional instruction provided by the medical school or the instruction received by the applicant is not equivalent to that required in Article 4 (commencing with Section 2080).

SEC. 16. Section 2107 of the Business and Professions Code is amended to read:

2107. (a) The Legislature intends that the board shall have the authority to substitute postgraduate education and training to remedy deficiencies in an applicant's medical school education

and training. The Legislature further intends that applicants who substantially completed their clinical training shall be granted that substitute credit if their postgraduate education took place in an accredited program.

(b) To meet the requirements for licensure set forth in Sections 2089 and 2089.5, the board may require an applicant under this article to successfully complete additional education and training. In determining the content and duration of the required additional education and training, the board shall consider the applicant's medical education and performance on standardized national examinations, and may substitute approved postgraduate training in lieu of specified undergraduate requirements. Postgraduate training substituted for undergraduate training shall be in addition to the postgraduate training required by Sections 2102 and 2103.

SEC. 17. Section 2135 of the Business and Professions Code is amended to read:

2135. The board shall issue a physician and surgeon's certificate to an applicant who meets all of the following requirements:

(a) The applicant holds an unlimited license as a physician and surgeon in another state or states, or in a Canadian province or Canadian provinces, which was issued upon:

(1) Successful completion of a resident course of professional instruction leading to a degree of medical doctor equivalent to that specified in Section 2089. However, nothing in this section shall be construed to require the board to evaluate for equivalency any coursework obtained at a medical school disapproved by the board pursuant to Article 4 (commencing with Section 2080).

(2) Taking and passing a written examination that is recognized by the board to be equivalent in content to that administered in California.

(b) The applicant has held an unrestricted license to practice medicine, in a state or states, in a Canadian province or Canadian provinces, or as a member of the active military, United States Public Health Services, or other federal program, for a period of at least four years. Any time spent by the applicant in an approved postgraduate training program or clinical fellowship acceptable to the board shall not be included in the calculation of this four-year period.

(c) The board determines that no disciplinary action has been taken against the applicant by any medical licensing authority and that the applicant has not been the subject of adverse judgments or settlements resulting from the practice of medicine that the board determines constitutes evidence of a pattern of negligence or incompetence.

(d) The applicant (1) has satisfactorily completed at least one year of approved postgraduate training and is certified by a specialty board approved by the American Board of Medical Specialties or approved by the board pursuant to subdivision (h) of Section 651; (2) has satisfactorily completed at least two years of approved postgraduate training; or (3) has satisfactorily completed at least one year of approved postgraduate training and takes and passes the clinical competency written examination.

(e) The applicant has not committed any acts or crimes constituting grounds for denial of a certificate under Division 1.5 (commencing with Section 475) or Article 12 (commencing with Section 2220).

(f) Any application received from an applicant who has held an unrestricted license to practice medicine, in a state or states, or Canadian province or Canadian provinces, or as a member of the active military, United States Public Health Services, or other federal program for four or more years shall be reviewed and processed pursuant to this section. Any time spent by the applicant in an approved postgraduate training program or clinical fellowship acceptable to the board shall not be included in the calculation of this four-year period. This subdivision does not apply to applications that may be reviewed and processed pursuant to Section 2151.

SEC. 18. Section 2168.4 of the Business and Professions Code is amended to read:

2168.4. (a) A special faculty permit expires and becomes invalid at midnight on the last day of the permitholder's birth month during the second year of a two-year term, if not renewed.

(b) A person who holds a special faculty permit shall show at the time of license renewal that he or she continues to meet the eligibility criteria set forth in Section 2168.1. After the first renewal of a special faculty permit, the permitholder shall not be required to hold a full-time faculty position, and may instead be employed

part-time in a position that otherwise meets the requirements set forth in paragraph (1) of subdivision (a) of Section 2168.1.

(c) A person who holds a special faculty permit shall show at the time of license renewal that he or she meets the continuing medical education requirements of Article 10 (commencing with Section 2190).

(d) In addition to the requirements set forth above, a special faculty permit shall be renewed in accordance with Article 19 (commencing with Section 2420) in the same manner as a physician's and surgeon's certificate.

(e) Those fees applicable to a physician's and surgeon's certificate shall also apply to a special faculty permit and shall be paid into the State Treasury and credited to the Contingent Fund of the Medical Board of California.

SEC. 19. Section 2169 is added to the Business and Professions Code, to read:

2169. A person who holds a special faculty permit shall meet the continuing medical education requirements set forth in Article 10 (commencing with Section 2190).

SEC. 20. Section 2172 of the Business and Professions Code is repealed.

SEC. 21. Section 2173 of the Business and Professions Code is repealed.

SEC. 22. Section 2174 of the Business and Professions Code is repealed.

SEC. 23. Section 2175 of the Business and Professions Code is amended to read:

2175. State examination records shall be kept on file by the board until June 1, 2069. Examinees shall be known and designated by number only, and the name attached to the number shall be kept secret until the examinee is sent notification of the results of the examinations.

SEC. 24. Section 2221 of the Business and Professions Code is amended to read:

2221. (a) The board may deny a physician's and surgeon's certificate to an applicant guilty of unprofessional conduct or of any cause that would subject a licensee to revocation or suspension of his or her license; or, the board in its sole discretion, may issue a probationary physician's and surgeon's certificate to an applicant

subject to terms and conditions, including, but not limited to, any of the following conditions of probation:

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

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

(3) Continuing medical or psychiatric treatment.

(4) Ongoing participation in a specified rehabilitation program.

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

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

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

(8) Compliance with all provisions of this chapter.

(9) Payment of the cost of probation monitoring.

(b) The board may modify or terminate the terms and conditions imposed on the probationary certificate upon receipt of a petition from the licensee. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board.

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

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

SEC. 24.5. Section 2221 of the Business and Professions Code is amended to read:

2221. (a) The board may deny a physician's and surgeon's certificate to an applicant guilty of unprofessional conduct or of any cause that would subject a licensee to revocation or suspension

of his or her license; or, the board in its sole discretion, may issue a probationary physician's and surgeon's certificate to an applicant subject to terms and conditions, including, but not limited to, any of the following conditions of probation:

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

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

(3) Continuing medical or psychiatric treatment.

(4) Ongoing participation in a specified rehabilitation program.

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

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

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

(8) Compliance with all provisions of this chapter.

(9) Payment of the cost of probation monitoring.

(b) The board may modify or terminate the terms and conditions imposed on the probationary certificate upon receipt of a petition from the licensee. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board.

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

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

SEC. 25. Section 2307 of the Business and Professions Code is amended to read:

2307. (a) A person whose certificate has been surrendered while under investigation or while charges are pending or whose certificate has been revoked or suspended or placed on probation, may petition the board for reinstatement or modification of penalty, including modification or termination of probation.

(b) The person may file the petition after a period of not less than the following minimum periods have elapsed from the effective date of the surrender of the certificate or the decision ordering that disciplinary action:

(1) At least three years for reinstatement of a license surrendered or revoked for unprofessional conduct, except that the board may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

(2) At least two years for early termination of probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a license surrendered or revoked for mental or physical illness, or termination of probation of less than three years.

(c) The petition shall state any facts as may be required by the board. The petition shall be accompanied by at least two verified recommendations from physicians and surgeons licensed in any state who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

(d) The petition may be heard by a panel of the board. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board or the California Board of Podiatric Medicine, as applicable, which shall be acted upon in accordance with Section 2335.

(e) The panel of the board or the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the certificate was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the administrative law judge designated in Section 11371 of the Government Code finds necessary.

(f) The administrative law judge designated in Section 11371 of the Government Code reinstating a certificate or modifying a penalty may recommend the imposition of any terms and conditions deemed necessary.

(g) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the person. The board may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

(h) This section is applicable to and may be carried out with regard to licensees of the California Board of Podiatric Medicine. In lieu of two verified recommendations from physicians and surgeons, the petition shall be accompanied by at least two verified recommendations from doctors of podiatric medicine licensed in any state who have personal knowledge of the activities of the petitioner since the date the disciplinary penalty was imposed.

(i) Nothing in this section shall be deemed to alter Sections 822 and 823.

SEC. 26. Section 2335 of the Business and Professions Code is amended to read:

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

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

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

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

except to the extent those findings of fact are controverted by new evidence.

(2) The board's staff or the staff of the California Board of Podiatric Medicine shall poll the members of the board or panel or of the California Board of Podiatric Medicine by written mail ballot concerning the proposed decision. The mail ballot shall be sent within 10 calendar days of receipt of the proposed decision, and shall poll each member on whether the member votes to approve the decision, to approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of additional evidence, to defer final decision pending discussion of the case by the panel or board as a whole, or to nonadopt the decision. No party to the proceeding, including employees of the agency that filed the accusation, and no person who has a direct or indirect interest in the outcome of the proceeding or who presided at a previous stage of the decision, may communicate directly or indirectly, upon the merits of a contested matter while the proceeding is pending, with any member of the panel or board, without notice and opportunity for all parties to participate in the communication. The votes of a majority of the board or of the panel, and a majority of the California Board of Podiatric Medicine, are required to approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of further evidence, or to nonadopt the decision. The votes of two members of the panel or board are required to defer final decision pending discussion of the case by the panel or board as a whole. If there is a vote by the specified number to defer final decision pending discussion of the case by the panel or board as a whole, provision shall be made for that discussion before the 100-day period specified in paragraph (3) expires, but in no event shall that 100-day period be extended.

(3) If a majority of the board or of the panel, or a majority of the California Board of Podiatric Medicine vote to do so, the board or the panel or the California Board of Podiatric Medicine shall issue an order of nonadoption of a proposed decision within 100 calendar days of the date it is received by the board. If the board or the panel or the California Board of Podiatric Medicine does not refer the case back to the administrative law judge for the taking of additional evidence or issue an order of nonadoption within 100 days, the decision shall be final and subject to review

under Section 2337. Members of the board or of any panel or of the California Board of Podiatric Medicine who review a proposed decision or other matter and vote by mail as provided in paragraph (2) shall return their votes by mail to the board within 30 days from receipt of the proposed decision or other matter.

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

(5) A vote of a majority of the board or of a panel, or a majority of the California Board of Podiatric Medicine, are required to increase the penalty from that contained in the proposed administrative law judge's decision. No member of the board or panel or of the California Board of Podiatric Medicine may vote to increase the penalty except after reading the entire record and personally hearing any additional oral argument and evidence presented to the panel or board.

SEC. 27. Section 2486 of the Business and Professions Code is amended to read:

2486. The Medical Board of California shall issue, upon the recommendation of the board, a certificate to practice podiatric medicine if the applicant has submitted directly to the board from the credentialing organizations verification that he or she meets all of the following requirements:

(a) The applicant has graduated from an approved school or college of podiatric medicine and meets the requirements of Section 2483.

(b) The applicant, within the past 10 years, has passed parts I, II, and III of the examination administered by the National Board of Podiatric Medical Examiners of the United States or has passed a written examination that is recognized by the board to be the equivalent in content to the examination administered by the National Board of Podiatric Medical Examiners of the United States.

(c) The applicant has satisfactorily completed the postgraduate training required by Section 2484.

(d) The applicant has passed within the past 10 years any oral and practical examination that may be required of all applicants by the board to ascertain clinical competence.

SJR 19

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SJR 19
Author: Ridley-Thomas
Chapter: 114
Subject: Health professionals: torture
Sponsor: American Friends Services Committee
Board Position: Watch

DESCRIPTION OF LEGISLATION:

This resolution states that California-licensed health professionals are prohibited from participating in the use of specified condemned techniques regarding interrogations.

The resolution requires the Board to notify its licensees via newsletter, e-mail, Web site, or other notification processes about their professional obligations under international law. The Board is also required to notify licensees that those who participate in coercive or "enhanced" interrogation, torture, or other forms of cruel, inhuman, or degrading treatment or punishment may one day be subject to prosecution.

IMPLEMENTATION:

- Article in January 2009 *Newsletter*
- Update Board Web site with bill information
- Update other publications as appropriate

Senate Joint Resolution No. 19

RESOLUTION CHAPTER 114

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

[Filed with Secretary of State August 18, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

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

This measure would request all relevant California agencies to notify California-licensed health professionals about their professional obligations under international law relating to torture and the treatment of detainees, as specified, and to also notify those professionals that those who participate in coercive or enhanced interrogation, torture, or other forms of cruel, inhuman, or degrading treatment or punishment may be subject to prosecution. The measure would request that those health professionals report abusive interrogation practices to the appropriate authorities, as specified. In addition, the measure would request the United States Department of Defense and the Central Intelligence Agency to remove all California-licensed health professionals from participating in prisoner and detainee interrogations, as specified.

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

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

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

WHEREAS, In honor of the birthday of Dr. Martin Luther King, Jr., a broad coalition of medical, human rights, and legal organizations are petitioning the State of California to warn its medical licensees of the legal prohibitions against torture and the risks of prosecution, and are demanding

that the United States government remove California-licensed health professionals from coercive interrogation and torture of detainees; and

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

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

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

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

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

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

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

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

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

WHEREAS, AMA policy also states that "[t]orture refers to the deliberate, systematic or wanton administration of cruel, inhumane and degrading treatments or punishments during imprisonment or detainment. Physicians

must oppose and must not participate in torture for any reason .... Physicians should help provide support for victims of torture and, whenever possible, strive to change the situation in which torture is practiced or the potential for torture is great"; and

WHEREAS, Section 2340 of Title 18 of the United States Code defines the term "torture" as an act committed by a person acting under the color of law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody or physical control. That section further defines the term "severe mental pain or suffering" as the prolonged mental harm caused by or resulting from: (A) the intentional infliction or threatened infliction of severe physical pain or suffering; (B) the administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt profoundly the senses or the personality; (C) the threat of imminent death; or (D) the threat that another person will imminently be subjected to death, severe physical pain or suffering, or the administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the senses or personality; and

WHEREAS, In May 2006, the American Psychiatric Association stated that psychiatrists should not "participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere," and that "psychiatrists should not participate in, or otherwise assist or facilitate, the commission of torture of any person. Psychiatrists who become aware that torture has occurred, is occurring, or has been planned must report it promptly to a person or persons in a position to take corrective action"; and

WHEREAS, In August 2006, the American Psychological Association stated that "psychologists shall not knowingly participate in any procedure in which torture or other forms of cruel, inhuman, or degrading treatment or cruel, inhuman, or degrading punishment is used or threatened" and that "should torture or other cruel, inhuman, or degrading treatment or cruel, inhuman, or degrading punishment evolve during a procedure where a psychologist is present, the psychologist shall attempt to intervene to stop such behavior, and failing that exit the procedure"; and

WHEREAS, In June 2005, the House of Delegates of the American Nurses Association issued a resolution stating all of the following: "prisoners and detainees have the right to health care and humane treatment"; "registered nurses shall not voluntarily participate in any deliberate infliction of physical or mental suffering"; "registered nurses who have knowledge of ill-treatment of any individuals including detainees and prisoners must take appropriate action to safeguard the rights of that individual"; "the American Nurses Association shall condemn interrogation procedures that are harmful to mental and physical health"; "the American Nurses Association shall advocate for nondiscriminatory access to health care for wounded military and paramilitary personnel and prisoners of war"; and "the American Nurses

Association shall counsel and support nurses who speak out about acts of torture and abuse"; and

WHEREAS, The California Nurses Association clearly states that "the social contract between registered nurses and society is based upon a code of ethics that is grounded in the basic ethical principles of respect for human rights and dignity, the non-infliction of harm, and because these principles command that registered nurses protect or preserve life, avoid doing harm, advocate in the exclusive interest of their patients, and create a fiduciary relationship of trust and loyalty with recipients of their care"; and

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

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

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

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

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

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

WHEREAS, Medical and psychological studies and clinical experience show that these abuses can cause severe or serious mental pain and suffering

in their victims, and therefore may violate the "torture" and "cruel and inhuman treatment" provisions of CAT and the United States War Crimes Act, as amended by the Military Commissions Act of 2006; and

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

WHEREAS, Waterboarding is a crime under the United States War Crimes Act and Chapter 113C (commencing with Section 2340) of Title 18 of the United States Code, is a crime against humanity under international human rights law, is a war crime under humanitarian laws, and is prohibited by the United States Army Field Manual. United States district courts, state courts, including, but not limited to, the Mississippi Supreme Court, and United States military tribunals have convicted defendants of criminal acts in waterboarding cases; and

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

Resolved by the Senate and the Assembly of the State of California, jointly, That California-licensed health professionals are absolutely prohibited from knowingly planning, designing, participating in, or assisting in the use of condemned techniques at any time and may not enlist others to employ these techniques to circumvent that prohibition; and be it further

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

Resolved, That the Legislature hereby requests all relevant California agencies to notify health professionals licensed in California that those who participate in coercive or "enhanced" interrogation, torture, as defined by CAT, or other forms of cruel, inhuman, or degrading treatment or punishment may one day be subject to prosecution; and be it further

RESOLVED, That the Legislature hereby requests that when California licensed health professionals have reason to believe that interrogations are coercive or "enhanced" or involve torture or cruel, inhuman, or degrading

treatment or punishment, they shall report their observations to the appropriate authorities, and if the authorities are aware of those abusive interrogation practices, but have not intervened, then those health professionals are ethically obligated to report those practices to independent authorities that have the power to investigate and adjudicate those allegations; and be it further

Resolved, That in view of the ethical obligations of health professionals, the record of abusive interrogation practices, and the Legislature's interest in protecting California-licensed health professionals, the Legislature hereby requests the United States Department of Defense and the Central Intelligence Agency to remove all California-licensed health professionals from participating in any way in prisoner and detainee interrogations that are coercive or "enhanced" or that involve torture or cruel, inhuman, or degrading treatment or punishment, as defined by the Geneva Conventions, CAT, relevant jurisprudence regarding CAT, and related human rights documents and treaties; and be it further

Resolved, That no law, regulation, order, or exceptional circumstance, whether induced by state of war or threat of war, internal political instability, or any other public emergency, may be invoked as justification for torture or cruel, inhuman, or degrading treatment or punishment; and be it further

Resolved, However, that California-licensed health professionals continue to provide appropriate health care if called upon to deal with a victim of the conduct and torture described in this resolution; and be it further

Resolved, That the Secretary of the Senate transmit copies of this resolution to the United States Department of Defense, the Central Intelligence Agency, and all relevant California agencies, including, but not limited to, the Board of Behavioral Sciences, the Dental Board of California, the Medical Board of California, the Osteopathic Medical Board of California, the Bureau of Naturopathic Medicine, the California State Board of Pharmacy, the Physician Assistant Committee of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Vocational Nursing and Psychiatric Technicians, the Board of Psychology, and the Board of Registered Nursing.

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Tracker II

Medical Board of California
2008 Tracker II - Legislative Bills
10/28/2008

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 54	Dymally	Health Care Coverage: acupuncture	Vetoed	03/03/08
AB 55	Laird	Referral Fee: technology and services	Chapter #290	07/03/08
AB 638	Bass	Physician Assistants: educational loan program	Chapter #628	07/02/08
AB 865	Davis	State Agencies: live customer service agents	Vetoed	06/24/08
AB 1203	Salas	Health Care Service Plans: noncontracting hospitals	Chapter #603	08/21/08
Ab 1574	Plescia	Surgical Clinics: licensure	Vetoed	07/02/08
AB 1922	Hernandez	Healing Arts Practitioners: peer review	Chapter #25	05/14/08
AB 2111	Smyth	Physical Therapy: regulation	Chapter #301	06/23/08
AB 2120	Galgiani	Medical Telemedicine	Chapter #260	05/15/08
AB 2210	Price	Dentistry: emergency services	Chapter #449	07/02/08
AB 2423	Bass	Professions and Vocations: Licensure	Chapter #675	08/19/08
AB 2697	Huffman	Hospitals: emergency medical services	Vetoed	08/06/08
AB 2702	Nunez	Maddy Emerg. Med. Serv. Fund: phys. reimburs.: LA county	Chapter #288	08/06/08
AB 2794	Blakeslee	Diagnostic Imaging Services	Chapter #469	06/19/08
AB 3000	Wolk	Health Care Decisions: life sustaining treatment	Chapter #266	07/02/08
ACR 87	Hayashi	Legislative Task Force on Peripheral Neuroopathy	Chapter #153	06/19/08
ACR 112	Soto	Legislative Task Force on Fibromyalgia	Chapter #154	06/25/08
SB 356	Negrete McLeod	List of Reportable Diseases and Conditions	Vetoed	08/14/08
SB 731	Oropeza	Massage Therapy	Chapter #384	08/08/08
SB 840	Kuehl	Single-Payer Health Care Coverage	Vetoed	08/11/08
SB 1184	Kuehl	Public Health	Chapter #347	07/03/08
SB 1260	Runner	Health Clinics	Chatper # 396	06/18/08
SB 1307	Ridley-Thomas	Pharmacy: pedigree	Chapter #713	08/14/08
SB 1338	Migden	Workers' Comp.: med. treatment: predesignation of phy.	Vetoed	04/30/08
SB 1402	Corbett	Reporting Requirements	Vetoed	06/11/08
SB 1505	Yee	Board of Behavioral Sciences: fees	Vetoed	08/05/08
SB 1633	Kuehl	Dental Services: credit	Vetoed	06/18/08
SB 1634	Steinberg	Health Care Coverage: cleft palates	Vetoed	08/13/08
SB 1729	Migden	Nursing Home: training	Chapter #550	08/13/08

Legislative Proposals

2009 MEDICAL BOARD LEGISLATIVE PROPOSALS

From 2008

1. Wellness Committee codified in statute.

   This proposal was placed in AB 2443 and that bill was vetoed. This issue will go to the Wellness Committee for discussion then to the full board with a recommendation.

   Recommendation: Refer to Wellness Committee and await its recommendation.

2. $500,000 to HPEF for the Physician Loan Repayment Program.

   This proposal was placed in AB 2442, an urgency bill, so the program could obtain funding in 2008 and issue loans in that year. This bill was vetoed. If the board was to pursue this proposal the money could not be available in 2008, the purpose of the original proposal. Permanent funding has been obtain through two other sources to fund loans in 2009 and beyond.

   Recommendation: Do not pursue this proposal.

3. Repeal the reporting sections related to peer reports coming to the diversion program administrator (B&P 821.5 and 821.6).

   This proposal was placed in AB 2442 and the bill was vetoed.

   Recommendation: Direct staff to include the repeal of these sections in an omnibus bill.

4. Set a "cap" or "ceiling" on the initial/renewal fee, allowing the board to set the fee in regulation, and allow the board to have between two and six months funding in its reserve.

   The "cap" was placed by Assembly Member Ma in AB 547, but the bill was vetoed. It did not contain the range in the reserve fund.

   Recommendation: Direct staff to pursue the cap and expanded reserve.

5. Omnibus.

   All of our proposals for clean up were placed in the Omnibus bill, SB 1779, and that bill was vetoed.

   Recommendation: Direct staff to include all of the SB 1779 provisions in the 2009 omnibus bill. This would include B&P sections from #3 above.

2009 Proposals that have been Approved by the Board

6. Certified Medical Records.

   The board approved this proposal at its April 2008 meeting, but it was substantive, thus could not go into omnibus legislation for 2008. Medical records provided by a physician, clinic or hospital in the course of reviewing a complaint are not certified. If the case goes to investigation, then the records must be obtained again as certified records. This proposal would reduce the time for investigating complaints and eliminate duplication of work.

7. Develop an Initial Limited License.

   There are applicants who wish to be licensed in California who are able to practice safely with a limited license. The board does not have the authority to issue an initial limited license. This proposal will address that concern and may assist in addressing some access to care issues facing patients in California.

8. Use of "M.D." by residents.

   There has been concern raised that residents are physicians but are not allowed the use of "M.D." which confuses the patients. Some teaching hospitals have suggested a resident license or training license. Rather than create a new category of licensees, the Board approved the examination of revising the codes regarding the use of the term "M.D."

2009 Proposals that Have Not been Approved by the Board

9. Sunset Review - Extension of the Board.

   The board (members) is set to sunset (become inoperative) July 1, 2010 and the statutes are repealed January 1, 2011. SB 963 had the extension of the board for another year while the legislature and administration determined how the sunset review process was to be reformed.

   This bill, as passed, did not include the extension of the Medical Board. The Senate B&P Committee may include a one year extension in its bill for 2009, but this has not been confirmed as the V/E-P program is set to sunset too.

   Recommendation: Direct staff to work with committee staff to determine how to proceed.

10. Vertical Enforcement/Prosecution - Sunset of Pilot.

    This pilot is set to sunset (become inoperative) on July 1, 2010 and is repealed January 1, 2011 (see SB 797, page 20). The new evaluation report is due July 1, 2009.

    Recommendation: Direct staff to incorporate the report findings and recommendations into legislation, as/if appropriate, after the report is issued.

11. Require reporting, at time of renewal, of any criminal, civil or disciplinary action.

This proposal would require a physician, at time of renewal and under penalty of perjury, to report any criminal (felony or misdemeanor convictions), civil (settlements over $30,000, judgments, arbitration awards) or B&P 805 events. This will enable the board to obtain this information in a secondary manner since there is evidence that primary sources are not reporting all the information that should be reported to the board.

Recommendation: Direct staff to seek legislative authority of gather this information from each physician at time of renewal.

12. Require all physicians who have an active license and have not submitted fingerprints to the board to do so by January 1, 2012.

This proposal will allow the board to obtain and maintain a record of arrests of licensed physicians in California. This is currently done for all physicians since 1986 upon application to become licensed in California. There is a "gap" in the information for those licensed prior to 1986. Some of those physicians should submit information to the board regarding convictions, but do not. Those physicians licensed prior to 1986 have not been fingerprinted, therefore the Board may not be aware the physician has been arrested and convicted. In these situations, the board must rely on the physician notifying the board after a conviction.

A review of records shows that 45,000 licensees need to be fingerprinted. The cost is $51 to each licensee. The cost to the board is approximately $ $108,000.

Should the board proceed with this proposal, legislation should allow for this to be completed concurrently with the next renewal of the license. This would allow for a even work flow, but would take two years to complete the process.

Recommendation: Direct staff to seek legislation to require all active physicians to be fingerprinted by their next renewal date.

13. B&P 801.01 Reporting Revisions.

This section of law continues to be confusing to reporting entities. Some have asked for changes and clarification to understand exactly what is required.

Recommendation: Direct staff to continue to work with the legal staff and develop language that will clarify to the reporting entities what and when information must be submitted to the board.

Proposals that may come from the Administration that MBC may wish to co-sponsor.

14. Licensing/Accreditation of Outpatient Surgery Settings

A legal decision was made in the case of Capen v. Shewry that created an issue between licensing and accreditation of outpatient surgery settings. The Court's opinion stated that physician owned and operated surgical clinics are to be regulated by the Medical Board, when general anesthesia is used, and surgical clinics operated by non-physicians are to be regulated by the Department of Public Health. The problem with that opinion is that the board does not have the authority to regulate clinics, it has the authority to approve accrediting agencies who verify compliance with standards. CDPH has stopped issuing licenses to these clinics, stating it does not have the authority to do so based upon the Court opinion. The Administration tried to sponsor legislation in 2008 to fix this issue, but was unsuccessful. We believe interested parties will work with the Administration in the 2009 legislative session in an attempt to resolve this issue.

Recommendation: Direct staff to work with the Administration and interested parties to resolve this issue. Appoint a board member who has experience working in these settings to work with staff on this issue.

15. Extension of MBC members on the Health Professions Education Foundation.

When the board sponsored legislation to establish the California Physician Corps Program (Loan Repayment and Volunteer Programs) within the Health Professions Education Foundation, two members from the board were placed on the Foundation's board. This provision sunsets (is repealed) January 1, 2011 (the date coincides with the sunset of the Medical Board members). An evaluation of the program is due January 1, 2010. The board could wait until that evaluation and support the findings that might include the extension of the MBC members on the board or it could request the extension in its own sunset bill.

Recommendation: Direct staff to work with the HPEF (as required in law) on the evaluation and support the bill in 2010.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: September 22, 2008
DEPARTMENT: Executive Office
SUBJECT: Proposed Regulations – Reduction in License Fees to Offset Loss of Diversion Program
STAFF CONTACT: Kevin A. Schunke

REQUESTED ACTION:
Vote to adopt the modifications to the Board's proposed regulatory language, as approved at the July 2008 Board meeting.

STAFF RECOMMENDATION:
To allow for the timely and most-prudent implementation of the reduction of the initial and renewal licensing fees through the regulatory process in an amount commensurate with the decrease in spending authority due to the discontinuation of the Board's Diversion Program, staff recommends the Board move forward with language approved at the July 2008 meeting. (See attached language)

EXECUTIVE SUMMARY:
Section 2435.2 of the Business and Professions Code states that the Board shall reduce license and renewal fees if the Diversion Program is eliminated. At the April 24, 2008, Board meeting, a hearing was held on the proposed regulations to implement this law under the assumption that there would be no urgency legislation to extend the program. However, the time needed for staff to finalize the file and move it forward through the approval process was not adequately estimated.

Assuming the file were to be submitted to the Office of Administrative Law by January 1, 2009 and approved by February 1, 2009, this would allow for the four-month window needed to format changes for the printing and mailing of renewal notices. Further, for accounting purposes, it seems logical that the fee reduction take effect at the beginning of Fiscal Year 09-10, instead of the last month or two of the previous fiscal year. Therefore, at the July 2008 meeting, the Board voted to modify the effective date to be July 1, 2009. If no adverse comments had been received, then the Executive Officer was authorized to adopt and move the file forward.

In an effort to work cooperatively with various interested parties considering legislation to extend the program or use that funding, staff did not strive to aggressively move this file forward promptly. Throughout the legislative session, the parties were actively seeking alternatives to the Board's Diversion Program, which was being sunsetted; the loss of that program was the statutory impetus for this rulemaking. Current law states that, while the fees should be reduced due to the elimination of a Diversion Program, the board "shall not make the reductions . . . if a [new] diversion program is established by statute and requires the board to fund it in whole or in part from licensure fees." With the uncertainly of whether a legislative bill would be successful in securing a new alternative program, and the added uncertainty of what the funding source of such a program might be, staff continued working this rulemaking, but with a concerted effort to have it ready for final submission only at the end of the Legislative session.

During the 15-day public comment period for the modified language, which closed on August 15, 2008, CMA submitted comments (see attached). In summary, CMA contends that the Board was not moving quickly enough to reduce the licensing and renewal fees in view of the elimination of the diversion program. CMA posits that the elimination of the diversion program took effect on July 1, 2008 and any money collected thereafter violates the law. Thus, this then equals an unfair revenue gain for the Board, money which should rightfully belong to licensees.

However, it must be noted that Business and Professions Code Section 2435.2 (the law requiring the reduction in fees if the diversion program is sunsetted) did not include any timeframe during which the fees must be reduced. The law, therefore, must have contemplated the need for a formal rulemaking process, which is well-known to take many months; this is particularly true in light of the fact that the Board could not have known whether or not the original diversion program would actually sunset or another program created in its place, to be funded in whole or in part by the Board's fees. Lastly, the governing statute did not provide for a "penalty" for the failure to promptly reduce the fee.

All monies collected by the Board are deposited into the Board's Contingent Fund. With passage of the 2008-09 budget, the Contingent Fund is left with a balance of 4.3 months of operating expenses.

Since this rulemaking is scheduled to be effective on July 1, 2009, and the argument has been made the Board should have acted sooner, the Board could seek to refund $22 to each of the approximate 55,000 physicians who paid a license or renewal fee during FY 08-09. This would cover those persons who paid fees after the date the law became effective and before the effective date of the fee reduction. This would represent about $1.2 million and still would leave a balance in the Contingent Fund for about 4.0 months of operating expenses. (See attached fund condition document)

The process for issuing such a plethora of refunds has not been previously addressed by any of the DCA regulatory boards. DCA is working with the State Controller's Office to identify the most cost-efficient and least labor-intensive process. It is not known if the Board's data can be downloaded into a program which would expedite payment. At present, the only way to accomplish this task would involve preparing 4,500 "refund schedule" forms, and having each form processed individually, a very cumbersome process. The postage for mailing the refunds would be in excess of $23,000, and the administrative costs to accomplish this task would be high.

FISCAL CONSIDERATIONS:
Adoption of the modified rulemaking language, as approved at the July 2008 meeting, is a cost-neutral proposal.

If the Board were to move forward with either of the alternatives listed below (refunding $22 to each of the approximate 55,000 physicians who paid a license or renewal fee during FY 08-09), this would represent about $1.2 million. Additionally, the estimated administrative costs of authorizing, issuing, and mailing 55,000 checks would be high.

PREVIOUS MBC AND/OR COMMITTEE ACTION:
A hearing was held at the April 2008 Board meeting to discuss this rulemaking; the Board voted to adopt regulations which would reduce the fee by $22 beginning November 1, 2008. At the July 2008 meeting, the Board voted to modify the effective date to July 1, 2009.

ALTERNATIVES:
1. The Board could vote to amend the current rulemaking to include language to refund $22 to each of the approximate 55,000 physicians who paid a license or renewal fee during FY 08-09. The danger of doing this, however, is that if there are any adverse comments to the modified text, then the entire rulemaking would have to be on the agenda at the Board meeting scheduled for the end of January, 2009, potentially compromising the timely completion of the entire file.

Government Code Section 11346.6 provides that a rulemaking must be finalized and submitted to the Office of Administrative Law (OAL) within one year from the date the first hearing was noticed, which in the case of

this rulemaking, was February 29, 2007. An exception is provided for DCA Boards, which must submit the finalized file to the Director of DCA within that one year period and the Director may, at his/her discretion, offer a brief extension so that DCA can review and take action on the file.

2. The Board could vote to amend the current rulemaking to include language that would make the effective date of the regulations earlier than July 1, 2009. The timeframe problems outlined in Alternative 1 would also be problematic for this option. If the Board approved the amendment, there would have to be a 15-day comment period for the new language. If no adverse comments were received, and if the Board agreed, the Executive Director could finalize the rulemaking package and submit it to DCA for approval. It would be difficult to put an exact date as the effective date because DCA would have to review the package and then submit it to OAL for approval. Once the package was approved by OAL, the regulations do not become effective for 30 days. The staff would have to estimate the time for all reviewers and hope that the date staff chooses does not occur prior to final filing by the Secretary of State.

Also, as stated at previous meetings, renewal notices are sent out 100-120 days prior to the expiration date. This would not allow necessary staff time to change the renewal fee on the renewal application. Although separate notices could be mailed to physicians indicating the fee had changed, the DCA cashiering unit processes renewals in a batch processing using the renewal form. They could not cashier physicians and surgeons renewals during this time. All renewals would have to be processed through the Medical Board, which would cause an overwhelming workload and would lead to renewals not being processed timely.

3. The concept of a $22 refund could move forward in a separate rulemaking. If the Board were to vote and direct staff to set such a proposal for hearing, the hearing could be held at the January 2009 Board meeting. If the rulemaking were to move forward without adverse comments, the language might become effective by the end of 2009 and refunds could be issued during the first half of 2010. By that time, the issue of an expedited refund process may be resolved and the administrative costs reduced to a minor impact, plus the $23,000 postage.

RECOMMENDATIONS:
The Board should follow the staff recommendation of voting to adopt the modifications to the Board's proposed regulatory language, as approved at the July 2008 Board meeting. This action should be taken, as legal counsel believes the fees can not be reduced by administrative action alone; only a rulemaking can accomplish this. There are no drawbacks to this action.

Staff does not recommend Alternatives 1 or 2. Any further delays to the current rulemaking risks a timely completion of the file, potentially delaying submittal of the rulemaking to OAL by the statutory deadline. In addition, if Alternative 2 was chosen, it could lead to renewals not being processed timely.
Staff does not offer a recommendation on Alternative 3. While many licensees would appreciate a refund of $22, to individuals, that amount probably is not of great benefit to most. And it must be noted that the administrative costs of authorizing, issuing, and mailing 55,000 checks could be high.

Medical Board of California
Specific Language of Proposed Regulations

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

MODIFIED TEXT: Additions to the originally proposed language are shown by double underline for new text and deletions to the originally proposed language are shown by a strikeout and single underline.

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~~ July 1, 2009.

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~~ July 1, 2009 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.

California Medical Association
Physicians dedicated to the health of Californians

August 14, 2008

Kevin A. Schunke
Medical Board of California
2005 Evergreen St, Suite 1200
Sacramento, CA 95815

Subject: Comment letter on Fee Reduction to Offset Elimination of Diversion Program

Dear Mr. Schunke:

The California Medical Association (CMA) respectfully submits the following comments for consideration related to the recent modification to existing regulations to reduce the physician license fee from $805.00 to $783.00. The modification changes the effective date of the fee reduction from November 1, 2008 to July 1, 2009. The comments are in response to the solicitation for comments in a notice of proposed rulemaking posted on July 30, 2008 containing proposed regulation §1351.5 and 1352 (the "Proposed Regulations").

California Medical Association is an advocacy organization that represents more than 34,000 California physicians. Dedicated to the health of Californians, CMA is active in the legal, legislative, reimbursement and regulatory areas on behalf of California physicians and their patients.

I. Background

At its July 27, 2007 board meeting, the Medical Board of California (MBC) voted to allow the Diversion Program to sunset on 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. At the April 24, 2008 MBC board meeting, a public hearing was held on the proposed regulations to implement Section 2435.2 and amend those sections which set forth the initial license fee and the biennial renewal fee. The proposed regulations reduced the initial and renewal licensing fees for physicians and surgeons from $805 to $783 for licenses and permits expiring on or after November 1, 2008. The MBC voted to adopt the regulation to amend 1351.5 and 1352 of Title 16 to reduce the initial license fee and renewal fee. These regulations will hereinafter be referred to as "Existing Regulations."

At the July 25, 2008 MBC board meeting, the MBC voted to adopt modifications to the existing regulations that changed the effective date of the fee reduction from November 1, 2008 to July 1, 2009. These proposed changes will hereinafter be referred to as "Proposed Regulations."

II. CMA's Comments

CMA's concerns regarding the existing and proposed regulations are that the Proposed Regulations violate state law. Upon elimination of the diversion program, the MBC must either reduce license fees to equal the board's cost of operating the diversion program or direct funding to a similar program if established by law. Provisions for the termination of the MBC Diversion Program are clearly stated in Section 2435.2 of the Business and Professions Code as follows:

> (a) Notwithstanding any other provision of law, if Article 14 (commencing with Section 2340) becomes inoperative or the diversion program described in that article is discontinued, the board shall reduce the amount of the following fees:
> (1) The initial license fee, as described in subdivision (c) of Section 2435.
> (2) The biennial renewal fee, as described in subdivision (d) of Section 2435.
> (3) An increase in the fees established pursuant to subdivision (e) of Section 2435.
> (b) The amount of the reductions made pursuant to subdivision (a) shall equal the board's cost of operating the diversion program.
> (c) The board shall not make the reductions described in subdivision (a) if a diversion program is established by statute and requires the board to fund it in whole or in part from licensure fees.

The MBC is in violation of the California Business and Professions Code as follows:

1. Violation of Section 2453.2(a) – The initial license fee and biennial renewal fee have not been reduced to reflect the discontinuation of the diversion program.

   Pursuant to Business and Professions Code Sections 2340 et seq., the MBC Diversion Program is inoperative effective July 1, 2008. Under existing regulations, the MBC will continue to collect physician and surgeon licensing fees—that include the $22 surcharge for the diversion program—until November 1, 2008. Under the proposed regulations, the MBC Diversion Program will continue to collect physician and surgeon licensing fees—that include the $22 surcharge for the diversion program—until July 1, 2009. The Proposed Regulations clearly violate Section 2453.2(a) of the Business and Professions Code.

2. Violation of Section 2453.2(b) – Reductions have not been made which equal the board's cost of operating the diversion program.

   Under the proposed regulations, the licensing fee reduction of $22 will be implemented on July 1, 2009. However, due to the delay in implementation, the board's savings from discontinuing operating the diversion program will be more than the its reduction

revenue, resulting in a net revenue gain for the MBC. The licensing fee reductions will be smaller than what is required to equal the board's cost.

3. Violation of Business and Professions Code Section 2453.2(c) – The MBC has not met the conditions which would allow it to avoid reducing licensing fees.

   Section 2435.2 (c) of the Business and Professions Code provides that the MBC shall not make reductions if a diversion program is established by statute and requires the board to fund it in whole or in part from licensure fees. Under current law, no other diversion program has been established to replace the MBC diversion program, so the MBC is in violation of state law by not immediately reducing the licensing fee.

4. Violation of Business and Professions Code Section 2435(h) – The MBC will exceed its maximum reserve if it continues to collect higher licensing fees through July 1, 2009.

   Section 2435(h) of the Business and Professions Code states:

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

   We estimate that by not reducing the licensing fee to reflect the discontinuation of the diversion program, the MBC will exceed its maximum reserve in the Contingent Fund by at least $1.2 million by July 1, 2009. To our knowledge, the MBC has not submitted any budget change proposals to expend the surplus diversion funds in fiscal year 2008-2009.

III. Conclusion

In conclusion, the CMA believes that the Proposed Regulations constitute multiple violations of California state law, including failure to immediately reduce licensing fees to reflect the discontinuation of the diversion program and exceeding the maximum revenue reserve for the Contingent Fund of the Medical Board of California. For these reasons, we urge the MBC to withdraw these proposed regulations and discontinue their efforts to delay the implementation of the licensing fee reduction.

Sincerely,

Yvonne Choong
Associate Director, Center for Medical and Regulatory Policy
California Medical Association
1201 J Street, Suite 200
Sacramento, CA 95814

Cc: Don Moulds, CMA Vice-President, Center for Medical and Regulatory Policy
Francisco Silva. CMA Legal Counsel

0758 - Medical Board
Analysis of Fund Condition
(Dollars in Thousands)

		Actual 2007-08	2008-09	2009-10	2010-11	2011-12
BEGINNING BALANCE		$ 18,467	$ 23,866	$ 19,325	$ 19,793	$ 20,750
Prior Year Adjustment		$ 152	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 18,619	$ 23,866	$ 19,325	$ 19,793	$ 20,750
REVENUES AND TRANSFERS						
Revenues:						
125600	Other regulatory fees	$ 354	$ 383	$ 387	$ 387	$ 387
125700	Other regulatory licenses and permits	$ 5,596	$ 5,745	$ 5,737	$ 5,737	$ 5,737
125800	Renewal fees	$ 44,917	$ 44,459	$ 44,866	$ 45,264	$ 45,670
125900	Delinquent fees	$ 102	$ 102	$ 100	$ 100	$ 100
141200	Sales of documents	$ -	$ -	$ -	$ -	$ -
142500	Miscellaneous services to the public	$ 20	$ 20	$ 20	$ 20	$ 20
150300	Income from surplus money investments	$ 1,079	$ 1,163	$ 900	$ 945	$ 827
160400	Sale of fixed assets	$ -	$ -	$ -	$ -	$ -
161000	Escheat of unclaimed checks and warrants	$ 22	$ -	$ -	$ -	$ -
161400	Miscellaneous revenues	$ 1	$ 5	$ 5	$ 5	$ 5
164300	Penalty assessments - Probation Monitoring	$ -	$ 900	$ 900	$ 900	$ 900
Totals, Revenues		$ 52,091	$ 52,777	$ 52,915	$ 53,358	$ 53,646
Transfers:						
Loan:						
General Fund Loan per May Revise			$ (6,000)			
	Totals, Revenues and Transfers	$ 52,091	$ 46,777	$ 52,915	$ 53,358	$ 53,646
	Totals, Resources	$ 70,710	$ 70,643	$ 72,240	$ 73,151	$ 74,396
EXPENDITURES						
Disbursements:						
0840 State Controller (State Operations)		$ 39	$ 36	$ -	$ -	$ -
Budget Act of 2007						
1110 Program Expenditures (State Operations) - Galley 3		$ 46,805	$ 51,282	$ 51,282	$ 51,282	$ 51,282
	2009-10 BCPs: Program					
	Enforcement Staff			$ -	$ -	$ 1,191
	Probation Staff -(Via redirection)			$ -	$ -	$ -
	MBC CRIMS Project			$ -	$ -	$ 2,531
	2009-10 BCPs: Divisions					
	DCA - Public Affiars			$ 128	$ 101	$ 101
	DCA - AISD (Incl. OIS)			$ 185	$ 166	$ 166
BL 08-18 price increase				$ 852	$ 852	$ 852
Total Disbursements		$ 46,844	$ 51,318	$ 52,447	$ 52,401	$ 56,123
FUND BALANCE						
Reserve for economic uncertainties		$ 23,866	$ 19,325	$ 19,793	$ 20,750	$ 18,273
Months in Reserve		5.6	4.4	4.5	4.4	4.0

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2008-09 AND BEYOND.

B. INTEREST ON FUND ESTIMATED AT 5%.

State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

Board Member Administrative Procedure Manual

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Revised 11/08

Chapter 1. Introduction

Overview

The Medical Board of California (MBC) was created by the California Legislature in 1876. Today the MBC is one of the boards, bureaus, commissions, and committees within the Department of Consumer Affairs (DCA), part of the State and Consumer Services Agency under the aegis of the Governor. The Department is responsible for consumer protection and representation through the regulation of certain licensed professions and the provision of consumer services. While the DCA provides oversight in various areas including, but not limited to, budget change proposals, regulations, and contracts, and also provides support services, MBC has policy autonomy and sets its own policies procedures, and initiates its own regulations. (See Business and Professions Code sections 108, 109(a), and 2018.)

The MBC is presently comprised of 15 Members. By law, seven are public Members, and eight are physicians. The Senate Rules Committee and the Speaker of the Assembly each appoint one public member. Board Members may serve two full four-year terms. Board Members fill non-salaried positions, and are paid $100 per day for each meeting day and are reimbursed travel expenses.

This procedure manual is provided to Board Members as a ready reference of important laws, regulations, and Board policies, to guide the actions of Board Members and ensure Board effectiveness and efficiency.

Due notice of each meeting and the time and place thereof shall be given each member in the manner provided by law.

Definitions

B&P	Business and Professions Code
SAM	State Administrative Manual
President	Where the term "President" is used in this manual, it includes "his or her designee"

General Rules of Conduct

Board Members shall not speak to interested parties (such as vendors, lobbyists, legislators, or other governmental entities) on behalf of the Board or act for the Board without proper authorization.

Board Members shall maintain the confidentiality of confidential documents and information.

Board Members shall commit time, actively participate in Board activities, and prepare for Board meetings, which includes reading Board packets and all required legal documents.

Board Members shall respect and recognize the equal role and responsibilities of all Board Members, whether public or licensee.

Board Members shall act fairly and in a nonpartisan, impartial, and unbiased manner.

Board Members shall treat all applicants and licensees in a fair and impartial manner.

Board Members' actions shall uphold the Board's primary mission – protection of the public.

Board Members shall not use their positions on the Board for political, personal, familial, or financial gain.

Chapter 2. Board Meeting Procedures

Frequency of Meetings
(B&P Code sections 2013, 2014)

The Board shall meet at least once each calendar quarter in various parts of the state for the purpose of transacting such business as may properly come before it.

Special meetings of the Board may be held at such times as the Board deems necessary.

Four Members of a panel of the Board shall constitute a quorum for the transaction of business at any meeting of the panel.

Eight Members shall constitute a quorum for the transaction of business at any Board meeting.

Due notice of each meeting and the time and place thereof shall be given each member in the manner provided by the law.

Board Member Attendance at Board Meetings
(B&P Code sections 106, 2011)

Board Members shall attend each meeting of the Board. If a member is unable to attend, he or she must contact the Board President and ask to be excused from the meeting for a specific reason. The Governor has the power to remove from office any member appointed by him for continued neglect of duties, which may include unexcused absences from meetings.

Board Members shall attend the entire meeting and allow sufficient time to conduct all Board business at each meeting.

Public Attendance at Board Meetings
(Government Code section 11120 et. seq.)

Meetings are subject to all provisions of the Bagley-Keene Open Meetings Act. This act governs meetings of state regulatory boards and meetings of committees of those boards where the committee consists of more than two Members. It specifies meeting notice and agenda requirements and prohibits discussing or taking action on matters not included on the agenda.

If the agenda contains matters which are appropriate for closed session, the agenda must cite the particular statutory section and subdivision authorizing the closed session.

Quorum
(B&P Code section 2013)

Eight of the Members of the Board constitute a quorum of the Board for the transaction of business. The concurrence of a majority of those Members of the Board present and voting at a duly noticed meeting at which a quorum is present shall be necessary to constitute an act or decision of the Board.

Agenda Items
(Board Policy)

Any Board Member may submit items for a meeting agenda to the Executive Director not fewer than 30 days prior to the meeting with the approval of the Board President or Chair of the Committee.

Notice of Meetings
(Government Code section 11120 et seq.)

In accordance with the Open Meetings Act, meeting notices (including agendas for Board, Committee, or Panel meetings) shall be sent to persons on the Board's mailing list at least 10 calendar days in advance. The notice shall include the name, work address, and work telephone number of a staff person who can provide further information prior to the meeting.

Notice of Meetings to be Posted on the Internet
(Government Code section 11125 et seq.)

Notice shall be given and also made available on the Internet at least 10 days in advance of the meeting and shall include the name, address, and telephone number of any person who can provide further information prior to the meeting, but need not include a list of witnesses expected to appear at the meeting. The written notice shall additionally include the address of the Internet site where notices required by this article are made available.

Record of Meetings
(B&P Code section 2017)

The Board and each Committee or Panel shall keep an official record of all their proceedings. The minutes are a summary, not a transcript, of each Board or Committee meeting. They shall be prepared by staff and submitted to Members for review before the next meeting. Minutes shall be approved at the next scheduled meeting of the Board, Committee, or Panel. When approved, the minutes shall serve as the official record of the meeting.

Tape Recording
(Board Policy)

The meeting may be tape-recorded if determined necessary for staff purposes. Tape recordings will be disposed of upon approval of the minutes in accordance with record retention schedules.

Meeting Rules
(Board Policy)

The Board will use Robert's Rules of Order, to the extent that it does not conflict with state law (e.g. Bagley-Keene Open Meeting Act), as a guide when conducting its meetings.

Public Comment
(Board Policy)

Due to the need for the Board to maintain fairness and neutrality when performing their adjudicative function, the Board shall not receive any substantive information from a member of the public regarding any matter that is currently under or subject to investigation or involves a pending criminal or administrative action.

1. If, during a Board meeting, a person attempts to provide the Board with substantive information regarding matters that are currently under or subject to investigation or involve a pending administrative or criminal action, the person shall be advised that the Board cannot properly consider or hear such substantive information, and the person shall be instructed to refrain from making such comments.

2. If, during a Board meeting, a person wishes to address the Board concerning alleged errors of procedure or protocol or staff misconduct, involving matters that are currently under or subject to investigation or involve a pending administrative or criminal action, the Board will address the matter as follows:

   a. Where the allegation involves errors of procedure or protocol, the Board may designate either its Executive Director or a Board employee to review whether the proper procedure or protocol was followed and to report back to the Board.
   b. Where the allegation involves significant staff misconduct, the Board may designate one of its Members to review the allegation and to report back to the Board.

3. The Board may deny a person the right to address the Board and have the person removed if such person becomes disruptive at the Board meeting.

(Government Code section 11120 et seq.)

4. Persons wishing to address the Board or a Committee of the Board shall complete a speaker request slip. At the discretion of the Board President or Chair of the Committee, speakers may be limited in the amount of time to present to give adequate time to everyone who wants to speak. In the event the number of people wishing to address the Board exceeds the allotted time, the Board President or Chair of the Committee may limit each speaker to a statement of his/her name, organization, and whether they support or do not support the proposed action

Chapter 3. Travel & Salary Policies & Procedures

Travel Approval
(DCA Memorandum 96-01)

The Board President's approval is required for all Board Members for travel, except for travel to regularly scheduled Board and Committee meetings to which the Board Member is assigned.

Travel Arrangements
(Board Policy)

Board Members should make their own travel arrangements through Giselle's Travel but are encouraged to coordinate with the Executive Director's Executive Assistant on lodging accommodations.

Out-of-State Travel
(SAM section 700 et seq.)

For out-of-state travel, Board Members will be reimbursed for actual lodging expenses, supported by vouchers, and will be reimbursed for meal and supplemental expenses. Out-of-state travel for all persons representing the State of California is controlled by and must be approved by the Governor's Office.

Travel Claims
(SAM section 700 et seq. and DCA Memorandum 96-01)

Rules governing reimbursement of travel expenses for Board Members are the same as for management-level state staff. All expenses shall be claimed on the appropriate travel expense claim forms. The Executive Director's Executive Assistant maintains these forms and completes them as needed. Board Members should submit their travel expense forms immediately after returning from a trip and no later than two weeks following the trip.

For the expenses to be reimbursed, Board Members shall follow the procedures contained in DCA Departmental Memoranda, which are periodically disseminated by the Executive Director and are provided to Board Members.

Salary Per Diem
(B&P Code section 103)

Compensation in the form of salary per diem and reimbursement of travel and other related expenses for Board Members is regulated by B&P Code Section 103.

In relevant part, this section provides for the payment of salary per diem for Board Members "for each day actually spent in the discharge of official duties," and provides that the Board Member "shall be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties."

Accordingly, the following general guidelines shall be adhered to in the payment of salary per diem or reimbursement for travel:

1. No salary per diem or reimbursement for travel-related expenses shall be paid to Board Members, except for attendance at an official Board, Committee, or Panel meeting, unless a substantial official service is performed by the Board Member. Attendance at gatherings, events, hearings, conferences, or meetings other than official Board, Committee, or Panel meetings, in which a substantial official service is performed, shall be approved in advance by the Board President. The Executive Director shall be notified of the event and approval shall be obtained from the Board President prior to Board Member's attendance.
2. The term "day actually spent in the discharge of official duties" shall mean such time as is expended from the commencement of a Board, Committee, or Panel meeting to the conclusion of that meeting. Where it is necessary for a Board Member to leave a meeting early, the Board President shall determine if the member has provided a substantial service during the meeting and, if so, shall authorize payment of salary per diem and reimbursement for travel-related expenses.

For Board-specified work, Board Members will be compensated for actual time spent performing work authorized by the Board President. That work includes, but is not limited to, authorized attendance at other gatherings, events, meetings, hearings, or conferences. It includes preparation time for Board, Committee, or Panel meetings.

Chapter 4. Selection of Officers & Committees

Officers of the Board
(B&P Code Section 2012)

The Board shall select a President, Vice President, and Secretary from its Members.

Election of Officers
(Board Policy)

The Board shall elect the officers at the last meeting of the calendar year. Officers shall serve a term of one year beginning the next calendar year. All officers may be elected on one motion or ballot as a slate of officers unless more than one Board Member is running per office. An officer may be re-elected and serve for more than one term.

Panel Members
(B&P Code section 2008)

A Panel of the Board shall at no time be composed of less than four Members and the number of public Members assigned shall not exceed the number of licensed physician and surgeon Members assigned to the Panel. The Board President shall not be a member of any Panel. The Board usually is comprised of two panels, however, if there is an insufficient number of Members, there may only be one Panel.

Election of Panel Members
(B&P Code section 2008)

Each Panel shall annually, at the first meeting of the calendar year, elect a Chair and a Vice Chair.

Officer Vacancies
(Board Policy)

If an office becomes vacant during the year, an election shall be held at the next meeting. If the office of the President becomes vacant, the Vice President shall assume the office of the President. Elected officers then shall serve the remainder of the term.

Committee Appointments
(Board Policy)

The Board President shall establish Committees, whether standing or special, as he or she deems necessary. The composition of the Committees and the appointment of the Members shall be determined by the Board President in consultation with the Vice President, Secretary, and the Executive Director. Committees may include the appointment of non-Board Members.

Attendance at Committee Meetings
(Government Code section 11120 et seq.)

If a Board Member wishes to attend a meeting of a Committee of which he or she is not a member, that Board Member should notify the Committee chair and staff. Board Members who are not Members of the Committee that is meeting cannot vote during the Committee meeting and may participate only as observers if a majority of the Board is present at a Committee meeting.

Chapter 5. Board Administration & Staff

Board Administration
(DCA Reference Manual)

Board Members should be concerned primarily with formulating decisions on Board policies rather than decisions concerning the means for carrying out a specific course of action. It is inappropriate for Board Members to become involved in the details of program delivery. Strategies for the day-to-day management of programs and staff shall be the responsibility of the Executive Director. Board Members should not interfere with day-to-day operations, which are under the authority of the Executive Director.

Strategic Planning

The Board will conduct periodic strategic planning sessions.

Executive Director Evaluation
(Board Policy)

Board Members shall evaluate the performance of the Executive Director on an annual basis.

Board Staff
(DCA Reference Manual)

Employees of the Board, with the exception of the Executive Director, are civil service employees. Their employment, pay, benefits, discipline, termination, and conditions of employment are governed by a myriad of civil service laws and regulations and often by collective bargaining labor agreements. Because of this complexity, it is most appropriate that the Board delegate all authority and responsibility for management of the civil service staff to the Executive Director. Board Members shall not intervene or become involved in specific day-to-day personnel transactions.

Business Cards

Business cards will be provided to each Board Member with the Board's name, address, telephone and fax number, and Web site address.

Chapter 6. Other Policies & Procedures

Board Member Disciplinary Actions
(Board Policy)

A member may be censured by the Board if, after a hearing before the Board, the Board determines that the member has acted in an inappropriate manner.

The President of the Board shall sit as chair of the hearing unless the censure involves the President's own actions, in which case the Vice President of the Board shall sit as President. In accordance with the Open Meeting Act, the censure hearing shall be conducted in open session.

Removal of Board Members
(B&P Code sections 106 & 2011)

The Governor has the power to remove from office, at any time, any member of any Board appointed by him or her for continued neglect of duties required by law or for incompetence or unprofessional or dishonorable conduct.

Resignation of Board Members
(Government Code section 1750)

In the event that it becomes necessary for a Board Member to resign, a letter shall be sent to the appropriate appointing authority (Governor, Senate Rules Committee, or Speaker of the Assembly) with the effective date of the resignation. Written notification is required by state law. A copy of this letter also shall be sent to the director of the Department, the Board President, and the Executive Director.

Conflict of Interest
(Government Code section 87100)

No Board Member may make, participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest. Any Board Member who has a financial interest shall disqualify himself or herself from making or attempting to use his or her official position to influence the decision. Any Board Member who feels he or she is entering into a situation where there is a potential for a conflict of interest should immediately consult the Executive Director or the Board's legal counsel.

Board Members should refrain from attempting to influence staff regarding applications for licensure or potential disciplinary matters.

Gifts from Candidates
(Board Policy)

Gifts of any kind to Board Members from candidates for licensure with the Board shall not be permitted.

Request for Records Access
(Board Policy)

No Board Member may access the file of a licensee or candidate without the Executive Director's knowledge and approval of the conditions of access. Records or copies of records shall not be removed from the MBC's office.

Ex Parte Communications
(Government Code section 11430.10 et seq.)

The Government Code contains provisions prohibiting *ex parte* communications. An "*ex parte*" communication is a communication to the decision-maker made by one party to an enforcement action without participation by the other party. While there are specified exceptions to the general prohibition, the key provision is found in subdivision (a) of section 11430.10, which states:

> *"While the proceeding is pending, there shall be no communication, direct or indirect, regarding any issue in the proceeding to the presiding officer from an employee or representative or if an agency that is a party or from an interested person outside the agency, without notice and an opportunity for all parties to participate in the communication."*

Occasionally, an applicant who is being formally denied licensure, or a licensee against whom a disciplinary action is being taken, will attempt to directly contact Board Members.

If the communication is written, the member should read only enough to determine the nature of the communication. Once he or she realizes it is from a person against whom an action is pending, he or she should reseal the documents and send them to the Executive Director.

If a Board Member receives a telephone call from an applicant or licensee against whom an action is pending, he or she should immediately tell the person they cannot speak to him or her about the matter. If the person insists on discussing the case, he or she should be told that the Board Member will be required to recuse himself or herself from any participation in the matter. Therefore, continued discussion is of no benefit to the applicant or licensee.

If a Board Member believes that he or she has received an unlawful *ex parte* communication, he or she should contact the Board's assigned attorney or Executive Director.

Board Member Training Requirements

Upon initial appointment, Board Members will be given an overview of Board operations, policies, and procedures by Board Executive Staff.

(B&P Code section 453)

Every newly appointed Board Member shall, within one year of assuming office, complete a training and orientation program offered by the Department of Consumer Affairs. This is in addition to the Board orientation given by Board staff. This is a one-time training requirement.

(Government Code section 11146)

All Board Members are required to file an annual Form 700 statement of economic interest. Members must also complete an orientation course on the relevant ethics statutes and regulations that govern the official conduct of state officials. The Government Code requires completion of this ethics orientation within the first six months of appointment and completion of a refresher every two years thereafter.

(Government Code section 12950.1)

AB 1825 (Chapter 933, Statutes of 2004, Reyes) requires supervisors, including Board Members, to complete two hours of sexual harassment prevention training by January 1, 2006, and every two years thereafter.

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 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	1,796,000	33,478,000	4,077,000	2,113,000	1,037,000	2,696,000	1,647,000	46,844,000 *
Positions Authorized	8.8	147.6	44.5	15.0	14.0	16.0	19.0	264.9
FY 08/09								
$ Budgeted	2,064,000	37,083,000	4,702,000	2,336,000		3,198,000	1,899,000	51,282,000
$ Spent thru 8/31*	139,000	5,184,000	504,000	207,000		276,000	190,000	6,500,000 *
Positions Authorized	8.8	146.6	45.5	15.0		16.0	20.0	251.9

* net expenditures (includes unscheduled reimbursements)

10/2/2008
Budget Overview by Program.xls

0758 - Medical Board
Analysis of Fund Condition
(Dollars in Thousands)

		Actual 2007-08	2008-09	2009-10	2010-11	2011-12
BEGINNING BALANCE		$ 18,467	$ 23,866	$ 19,325	$ 19,793	$ 20,750
Prior Year Adjustment		$ 152	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 18,619	$ 23,866	$ 19,325	$ 19,793	$ 20,750
REVENUES AND TRANSFERS						
Revenues:						
125600	Other regulatory fees	$ 354	$ 383	$ 387	$ 387	$ 387
125700	Other regulatory licenses and permits	$ 5,596	$ 5,745	$ 5,737	$ 5,737	$ 5,737
125800	Renewal fees	$ 44,917	$ 44,459	$ 44,866	$ 45,264	$ 45,670
125900	Delinquent fees	$ 102	$ 102	$ 100	$ 100	$ 100
141200	Sales of documents	$ -	$ -	$ -	$ -	$ -
142500	Miscellaneous services to the public	$ 20	$ 20	$ 20	$ 20	$ 20
150300	Income from surplus money investments	$ 1,079	$ 1,163	$ 900	$ 945	$ 827
160400	Sale of fixed assets	$ -	$ -	$ -	$ -	$ -
161000	Escheat of unclaimed checks and warrants	$ 22	$ -	$ -	$ -	$ -
161400	Miscellaneous revenues	$ 1	$ 5	$ 5	$ 5	$ 5
164300	Penalty assessments - Probation Monitoring	$ -	$ 900	$ 900	$ 900	$ 900
Totals, Revenues		$ 52,091	$ 52,777	$ 52,915	$ 53,358	$ 53,646
Transfers:						
Loan:						
General Fund Loan per May Revise			$ (6,000)			
	Totals, Revenues and Transfers	$ 52,091	$ 46,777	$ 52,915	$ 53,358	$ 53,646
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	MBC CRIMS Project			$ -	$ -	$ 2,531
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	DCA - AISD (Incl. OIS)			$ 185	$ 166	$ 166
BL 08-18 price increase				$ 852	$ 852	$ 852
Total Disbursements		$ 46,844	$ 51,318	$ 52,447	$ 52,401	$ 56,123
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Reserve for economic uncertainties		$ 23,866	$ 19,325	$ 19,793	$ 20,750	$ 18,273
Months in Reserve		5.6	4.4	4.5	4.4	4.0

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2008-09 AND BEYOND.

B. INTEREST ON FUND ESTIMATED AT 5%.

Medical Board of California

FY 08/09
Budget Expenditure Report
(As of August 31, 2008)
(16.7% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	14,940,934	2,267,287	15.2	12,673,647
Board Members	31,500	0	0.0	31,500
Phy Fitness Incentive Pay	29,623	0	0.0	29,623
Temp Help	1,144,410	140,832	12.3	1,003,578
Overtime	12,143	26,248	216.2	(14,105)
Staff Benefits	6,223,391	851,260	13.7	5,372,131
Salary Savings	(807,251)			(807,251)
TOTALS, PERS SERVICES	21,574,750	3,285,627	15.2	18,289,123
OPERATING EXP & EQUIP				
General Expense	628,730	225	0.0	628,505
Fingerprint Reports	372,859	0	0.0	372,859
Printing	873,205	56,608	6.5	816,597
Communications	577,350	0	0.0	577,350
Postage	464,500	11,021	2.4	453,479
Insurance	38,414	0	0.0	38,414
Travel In-State	369,921	0	0.0	369,921
Travel Out-of-State	1,700	0	0.0	1,700
Training	62,072	764	1.2	61,308
Facilities Operation (Rent)	2,528,431	1,112,266	44.0	1,416,165
Consult/Prof Services	925,994	138,825	15.0	787,169
Departmental Prorata	4,149,368	0	0.0	4,149,368
Consolidated Data Ctr (Teale)	605,228	41,826	6.9	563,402
Data Processing	111,810	3,348	3.0	108,462
Central Admin Svcs (Statewide Prorata)	2,323,914	0	0.0	2,323,914
Attorney General Services	12,419,270	1,961,701	15.8	10,457,569
Office of Administrative Hearings	1,731,603	137,118	7.9	1,594,485
Court Reporter Services	175,000	0	0.0	175,000
Evidence/Witness	1,771,718	0	0.0	1,771,718
Major Equipment	185,000	0	0.0	185,000
Minor Equipment	207,000	0	0.0	207,000
Vehicle Operation/Other Items	245,163	10,750	4.4	234,413
TOTALS, OE&E	30,768,250	3,474,452	11.3	27,293,798
TOTALS, EXPENDITURES	52,343,000	6,760,079	12.9	45,582,921
Scheduled Reimbursements	(384,000)	(48,190)	12.5	(335,810)
Distributed Costs	(677,000)	(75,136)	11.1	(601,864)
NET TOTAL, EXPENDITURES	51,282,000	6,636,753	12.9	44,645,247
Unscheduled Reimbursements		(136,602)		
		6,500,151		

Budget Expenditure Report.xls
Date: September 23, 2008

Medical Board of California
Board Members' Expense Report
July 1, 2008 - August 31, 2008

	*Per Diem**			*Travel Expenses**	*Total July-Aug*	***Total FYTD***
	JULY	AUG	TOTAL			
Mr. Alexander	700	0	700	940.80	1,640.80	1,640.80
Dr. Aristeiguieta	0	0	0	0.00	0.00	0.00
Ms. Chang	0	0	0	0.00	0.00	0.00
Dr. Chin	200	0	200	335.25	535.25	535.25
Dr. Duruisseau	400	0	400	0.00	400.00	400.00
Dr. Fantozzi	700	800	1,500	1,925.85	3,425.85	3,425.85
Dr. Gitnick	0	0	0	0.00	0.00	0.00
Dr. Low	0	0	0	0.00	0.00	0.00
Dr. Moran	0	0	0	0.00	0.00	0.00
Dr. Salomonson	400	0	400	751.84	1,151.84	1,151.84
Ms. Schipske		0	0	0.00	0.00	0.00
Dr. Wender	0	0	0	0.00	0.00	0.00
Ms. Yaroslavsky	0	0	0	0.00	0.00	0.00
Mr. Zerunyan	800	600	1,400	859.54	2,259.54	2,259.54
BOARD TOTAL	3,200	1,400	4,600	4,813.28	9,413.28	**9,413.28**

*includes claims paid/submitted through September 19, 2008

Board Members Expense Report.xls
Date: September 23, 2008

ENFORCEMENT/PROBATION RECEIPTS
MONTHLY PROFILE: JULY 2006 - AUGUST 2008

	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
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	3,307	15,221	6,086	13,493	134,177
Criminal Cost Recovery	0	0	0	0	0	2,975	0	0	50,000	0	0	12	52,987
Probation Monitoring	31,949	49,534	24,134	32,231	119,692	140,590	247,147	220,081	27,151	62,498	39,786	46,564	1,041,357
Exam	3,545	4,227	1,248	1,820	1,209	300	905	2,055	2,265	6,530	1,080	325	25,509
Cite/Fine	1,200	9,100	6,250	4,800	13,440	1,850	1,700	3,500	14,900	5,731	6,200	3,150	71,821
MONTHLY TOTAL	51,768	75,586	45,483	49,688	141,445	152,147	263,852	241,583	97,623	89,980	53,152	63,544	1,325,851
FYTD TOTAL	51,768	127,354	172,837	222,525	363,970	516,117	779,969	1,021,552	1,119,175	1,209,155	1,262,307	1,325,851	

	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	FYTD Total
Invest Cost Recovery	18,069	1,850											19,919
Criminal Cost Recovery	0	5,694											5,694
Probation Monitoring	56,999	17,107											74,106
Exam	825	75											900
Cite/Fine	3,050	3,200											6,250
MONTHLY TOTAL	78,943	27,926	0	0	0	0	0	0	0	0	0	0	106,869
FYTD TOTAL	78,943	106,869	106,869	106,869	106,869	106,869	106,869	106,869	106,869	106,869	106,869	106,869	

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MEDICAL BOARD OF CALIFORNIA
EXECUTIVE PROGRAM
BUDGET REPORT
JULY 1, 2008 - AUGUST 31, 2008

	FY 08/09 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	670,553	105,615	current
Staff Benefits	279,013	30,672	current
TOTAL PERSONAL SERVICES	949,566	136,287	
OPERATING EXPENSE & EQUIPMENT			
General Expense 1/	70,500	0	2
Printing	340,000	2,508	1-2
Communications	27,851	0	2
Postage	206,670	0	2
Travel In-State	102,000	0	2
Travel Out-of-State	800	0	2
Training	7,500	0	2
Facilities Operations 2/	72,000	0	2
Consultant & Professional Services	24,000	624	1-2
Departmental Services 3/	166,805	0	current
Other Items of Expense	0	0	2
Data Processing	2,500	0	2
Central Administrative Services 4/	93,421	0	current
Minor Equipment	0	0	2
TOTAL OPERATING EXPENSES & EQUIPMENT	1,114,047	3,132	
TOTAL BUDGET/EXPENDITURES	**2,063,613**	**139,419**	

See footnotes on next page

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1/ costs for employee relocation, miscellaneous office supplies, freight and drayage, General Services administration overhead (charges levied by the Department of General Services for purchase orders, contracts, traffic management, fleet administration, and confidential destruction; charges levied by the State Controller's Office for the processing of disability insurance claims, late payroll document costs; by EDD for unemployment insurance and by DPA Admininstration; charges levied by any other state agency for services provided not under contract), meetings and conferences, library purchases and subscriptions, photography, and office equipment rental, maintenance and repairs.

2/ rent, security, maintenance, facility planning, waste removal, purchase of building supplies and materials.

3/ Department of Consumer Affairs prorata assessments for support of the following:

a/ Public Affairs Division
b/ Consumer and Community Relations Division
c/ Administrative & Information Services Division
d/ Division of Investigation Special Operations Unit

4/ Charges for support of the State Personnel Board, Department of Finance, State Controller, State Treasurer, Legislature, Governor's Office, etc.

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MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2008 - AUGUST 31, 2008

	FY 08/09 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	9,883,500	1,505,622	current
Staff Benefits	3,887,414	522,747	current
TOTAL PERSONAL SERVICES	13,770,914	2,028,369	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	156,804	0	2
Printing	360,705	34,465	1-2
Communications	329,433	0	2
Postage	101,806	11,021	1-2
Insurance	31,713	0	current
Travel In-State	150,000	0	2
Travel Out-of-State	900	0	current
Training	22,886	0	2
Facililties Operations	1,622,789	1,073,981	current
Consultant/Professional Services	300,000	43,263	1-2
Departmental Services	3,000,823	0	current
Data Processing	12,000	3,348	1-2
Central Administrative Services	1,680,654	0	current
Attorney General 1/	12,229,270	1,940,992	current
OAH	1,731,603	137,118	current
Evidence/Witness Fees	1,702,150	0	2
Court Reporter Services	175,000	0	2
Major Equipment	140,000	0	2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	76	10,750	1-2
Vehicle Operations	197,587	0	2
Minor Equipment	0	0	2
TOTAL OPERATING EXPENSES & EQUIPMENT	23,946,199	3,254,938	
DISTRIBUTED COSTS	(633,666)	(75,136)	
TOTAL BUDGET/EXPENDITURES	**37,083,447**	**5,208,171**	
Unscheduled Reimbursements		(24,527)	
		5,183,644	

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MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 08/09
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

		Number of Hours	Rate	Amount
July	Attorney Services	6,320.00	158.00	998,560.00
	Paralegal Services	320.25	101.00	32,345.25
	Auditor/Analyst Services	108.75	63.00	6,851.25
	Special Agent Services	14.00	120.00	1,680.00
	Cost of Suit			
				1,039,436.50
August	Attorney Services	5,536.75	158.00	874,806.50
	Paralegal Services	216.50	101.00	21,866.50
	Auditor/Analyst Services	77.50	63.00	4,882.50
	Cost of Suit			
				901,555.50
September	Attorney Services		158.00	0.00
	Paralegal Services		101.00	0.00
	Auditor/Analyst Services		63.00	0.00
	Cost of Suit			
				0.00
October	Attorney Services		158.00	0.00
	Paralegal Services		101.00	0.00
	Auditor/Analyst Services		63.00	0.00
	Special Agent Services		110.00	0.00
	Cost of Suit			
				0.00
November	Attorney Services		158.00	0.00
	Paralegal Services		101.00	0.00
	Auditor/Analyst		63.00	0.00
	Special Agent Services		110.00	0.00
	Cost of Suit			
				0.00
December	Attorney Services		158.00	0.00
	Paralegal Services		101.00	0.00
	Auditor/Analyst		63.00	0.00
	Cost of Suit			
				0.00
			08/09 FYTD Total =	**1,940,992.00**
			08/09 FY Budget =	**12,229,270.00**

Revised 9/18/08

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2008 - AUGUST 31, 2008

	FY 08/09 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,991,604	338,701	current
Staff Benefits	868,136	126,372	current
TOTAL PERSONAL SERVICES	2,859,740	465,073	
OPERATING EXPENSES & EQUIPMENT			
General Expense	44,460	0	1-2
Fingerprint Reports*	368,659	0	2
Printing	120,000	7,841	1-2
Communications	78,193	0	2
Postage	137,447	0	2
Travel In-State	35,000	0	2
Training	4,000	764	1-2
Facilities Operation	200,000	0	2
Consult/Professional Services	474,994	94,939	current
Departmental Services	380,497	0	current
Data Processing	500	0	2
Central Administrative Services	213,103	0	current
Attorney General	190,000	20,709	current
Evidence/Witness Fees	5,000	0	2
TOTAL OPERATING EXPENSES & EQUIPMENT	2,251,853	124,253	
SCHEDULED REIMBURSEMENTS	(384,000)	(48,190)	
DISTRIBUTED COSTS	(25,087)	0	
TOTAL BUDGET/EXPENDITURES	**4,702,506**	**541,136**	
Unscheduled Reimbursements		(37,154)	
		503,982	

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

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MEDICAL BOARD OF CALIFORNIA
ADMINISTRATIVE SERVICES PROGRAM
BUDGET REPORT
JULY 1, 2008 - AUGUST 31, 2008

	FY 08/09 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	799,503	142,760	current
Staff Benefits	345,007	53,204	current
TOTAL PERSONAL SERVICES	1,144,510	195,964	
OPERATING EXPENSE & EQUIPMENT			
General Expense	292,266	225	1-2
Printing	30,000	4,811	1-2
Communications	85,204	0	2
Postage	10,131	0	2
Travel In-State	18,000	0	2
Training	3,000	0	2
Facilities Operations	442,642	5,628	1-2
Consultant & Professional Services	27,000	0	2
Departmental Services	188,796	0	current
Data Processing	2,500	0	2
Central Administrative Services	105,738	0	current
Vehicle Operations/Insurance/Other	2,760	0	2
Major Equipment	0	0	2
Minor Equipment	0	0	2
TOTAL OPERATING EXPENSES & EQUIPMENT	1,208,037	10,664	
DISTRIBUTED COSTS	(16,985)	0	
TOTAL BUDGET/EXPENDITURES	**2,335,562**	**206,628**	

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MEDICAL BOARD OF CALIFORNIA
INFORMATION SYSTEMS PROGRAM
BUDGET REPORT
JULY 1, 2008 - AUGUST 31, 2008

	FY 08/09 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,036,779	174,663	current
Staff Benefits	451,902	57,655	current
TOTAL PERSONAL SERVICES	1,488,681	232,318	
OPERATING EXPENSE & EQUIPMENT			
General Expense	38,400	0	2
Printing	15,000	1,808	2
Communications	22,779	0	2
Postage	5,255	0	2
Travel In-State	19,921	0	2
Training	20,186	0	2
Facililties Operations	150,000	0	2
Consultant/Professional Services	100,000	0	2
Departmental Services	258,921	0	current
Consolidated Data Centers (Teale)	605,228	41,826	current
Data Processing	93,810	0	2
Central Administrative Services	145,012	0	current
Major Equipment	29,000	0	2
Minor Equipment	207,000	0	2
TOTAL OPERATING EXPENSES & EQUIPMENT	1,710,512	43,634	
DISTRIBUTED COSTS	(1,262)	0	
TOTAL BUDGET/EXPENDITURES	**3,197,931**	**275,952**	

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MEDICAL BOARD OF CALIFORNIA
PROBATION MONITORING
BUDGET REPORT
JULY 1, 2008 - AUGUST 31, 2008

	FY 08/09 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	969,418	167,006	current
Staff Benefits	391,921	60,610	current
TOTAL PERSONAL SERVICES	1,361,339	227,616	
OPERATING EXPENSES & EQUIPMENT			
General Expense/Fingerprint Reports	30,500	0	2
Printing	7,500	5,174	1-2
Communications	33,890	0	2
Postage	3,191	0	2
Insurance	6,441	0	current
Travel In-State	45,000	0	2
Training	4,500	0	2
Facilities Operation	41,000	32,657	current
Departmental Services	153,527	0	current
Data Processing	500	0	2
Central/Administrative Services	85,985	0	current
Evidence/Witness Fees	64,568	0	2
Major Equipment	16,000	0	2
Vehicle Operations/Other Items	45,000	0	2
Minor Equipment	0,000	0	2
TOTAL OPERATING EXPENSES & EQUIPMENT	537,602	37,831	
TOTAL BUDGET/EXPENDITURES	**1,898,941**	**265,447**	
Unscheduled Reimbursements*		(74,921)	
		190,526	

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*no authority to spend

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10/2/2008

State of California
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, Ca 95815
www.mbc.ca.gov

Memorandum

Date: October 22, 2008

To: Members

From: Kimberly Kirchmeyer

Subject: July 31, 2008 Report on Peer Review in California

SB 231 (Figueroa; Chap. 674, Stats. of 2005) amended Business and Professions Code section 805.2, requiring the Medical Board of California (Board) to contract with an independent entity to perform a comprehensive study of the peer review process. The study was to include, but not be limited to, evaluating the process, describing the steps of the decision makers, determining compliance with reporting laws, evaluating the resources and time used, reviewing the hearing process, and making recommendations to enhance the peer review process including necessary legislative changes. As you may remember, the original legislation was amended to add confidentiality requirements and for the information being provided and immunity to the individuals who provided information to the entity. The study was to be completed by July 31, 2008.

The Board executed a contract with Lumetra to perform the required peer review study. On July 31, 2008, Lumetra released the attached report. Lumetra used several methods to obtain information from peer review groups, peer reviewed physicians, individuals involved in the peer review, attomeys involved in peer review, the Board, and others involved in the process. After analysis of the information required, Lumetra found the following:

- There is excessive variation in the policies of peer review bodies, e.g. the events that start peer review, the peer review process, decision making, etc.
- Peer review bodies have poor tracking systems. They found the tracking by peer review bodies was either non-existent or not consistent and therefore did not ensure appropriate action was being followed up.
- There is a potential for biased and ineffective reviews in the process. The report stated the reviews are usually done by medical staff that work together and it would be impossible to provide unbiased, objective and confidential reviews.
- The peer review process is lengthy and lacks transparency. The report stated that it could be years before a report pursuant to Business and Professions Code section 805 is filed because of the lengthy hearing process. The report stated that neither the peer review entity employees nor the public is able to receive information regarding peer review, except in certain situations. Additionally, the report pointed out the Board is limited in the information that can be provided to the public regarding peer review and the Board's process to take action is lengthy.

- Peer review entities avoid following the "spirit" of Business and Professions Code section 805. According to the report, entities may pressure a physician to resign for reasons other than "medical disciplinary cause or reason", may suspend for less than 14 days (which is not reportable), or offer physicians an extension on educational sessions or other remedial opportunities that would not cause a report to be filed with the Board.

- There may be groups of physicians who are never peer reviewed. Because some of the medical groups/clinics may not be required to perform peer review, their physicians, if they remain in the facility for their lifetime, may never be reviewed.

- Costs of the peer review process, including the hearing process, are prohibitive and therefore are avoided if at all possible.

- It is claimed that Business and Professions Code sections 805 and 809 are unclear as to when a report must be submitted to the Board. Most entities believe that an 809 hearing should be completed before reporting the action. (Business and Professions Code section 805 is clear that when an entity takes certain actions a report must be filed within 15 days. If there is confusion, it is because under some circumstances action is taken before the physician is given a hearing. Business and Profession Code section 809.5 grants entities the authority to take action immediately if there is an eminent threat to patient safety. While the physician still has the right to a hearing, under those circumstances a report would be filed before the hearing.)

The report concluded with several recommendations, based upon the information they obtained. Some of those recommendations were:

- Redesign the peer review process and create an independent review organization. The entities would still provide first level screening of a physician, but an unbiased independent peer review organization would perform the investigation of any physician whose action appeared to not meet the standard of care. This independent organization would make a recommendation to the entity regarding filing an 805 report and what action is recommended for the physician.

- Improve transparency for the public. The recommendation included having the Board post any action recommended by the independent organization on its Web site.

- Revise the role of the Board in the review process, including giving the responsibility of the 809 hearing to the Board.

- Promote education of all entities regarding 805 reporting.

- Clarify Business and Profession Code section 805 and 809.

- Identify funding sources due to the changes being recommended, which would increase costs to the Board.

Most, if not all, of the recommendations would require legislation. This report was submitted to the legislature for their review. According to the Senate Business and Professions Committee a special hearing may be held within the next couple months to discuss this report and its recommendations. The Board may wish to appoint a physician Member (or physician consultant) who is or has been involved in peer review to represent the Board at this hearing.

Lumetra

Brighter insights. Better healthcare.

Comprehensive Study of Peer Review in California: Final Report

July 31, 2008

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This report was prepared by Lumetra under contract with the Medical Board of California (MBC).

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Quality Safety Efficiency Integrity

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All study participants and entities

Funding: Medical Board of California

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Executive Summary

In October 2005, Governor Arnold Schwarzenegger signed into law California Senate Bill 231 (Figueroa), which, among other things, amended the California Business and Professions Code 800, including Section 805.2.

Section 805.2 provided for a comprehensive study of the physician peer review process, as conducted by peer review bodies. Another equally important component of this study was to evaluate the continuing validity of Section 805 and Sections 809 to 809.8, inclusively, and their relevance to the conduct of peer review in California, since they play such a critical role in ensuring quality medical care.

Lumetra, a non-profit healthcare consulting organization with 24 years of experience in California, was selected as the independent entity to conduct this peer review study, which was to be completed by July 31, 2008. The study, designed around the requirements of the 805.2 legislation, focused on four entities involved in peer review activities: 1) Licensed healthcare facilities/clinics, 2) Healthcare service plans, 3) Professional societies, and 4) Medical groups. The research was quantitative and qualitative, cross-sectional, retrospective, and descriptive. Multiple data collection methods were employed, including document review, surveys, focus groups, key informant interviews, and onsite visits.

The study generated controversy and anxiety among the four entities, particularly hospitals. Their concerns ranged from the time and expense to provide documents for review to reluctance in releasing legally protected information for "fear" of discovery. Lumetra was able to respond to and overcome these barriers and produce statistically valid findings from the data that were collected from study participants.

This report presents these findings, which enabled us to draw several conclusions about the state of peer review in California and make sound recommendations to improve the current system.

Findings

The complete findings are presented in Chapter IV: Results. One finding that was apparent is that the present peer review system is broken for various reasons and is in need of a major fix, if the process is to truly serve the citizens of California. This report cites the inconsistencies in the way entities conduct peer review, select and apply criteria (e.g., implicit vs. explicit review), and interpret the law regarding 805 reporting and 809 hearings.

These variations can result in physicians continuing to provide substandard care (at times for years) impacting the protection of the public. We also found that, although entities make a sincere effort to conduct peer review, it rarely leads to actual 805 or 809 actions, perhaps due to the confusion over when to file a report. And there is evidence that entities do not understand what should trigger a peer review, 805, or 821.5 reporting. Additionally, the costs in time and money associated with 805 reporting are high and may influence an entity's desire to actively pursue a case against a physician and choose a less expensive alternative (e.g., resignation, remediation, etc.).

This study also examined the role of the Medical Board of California (MBC) and assessed its effectiveness in the regulation of the practice of medicine in California. We found the MBC procedures for the complaint and enforcement process and the rules for public disclosure to be complex and multi-layered. The MBC is sometimes viewed as only intermittently responding to 805

reports (particularly focusing on those events that result in patient harm), unacceptably delaying the response, and failing to report public information. While the MBC obviously has earnest intentions about protecting the public's health, its bureaucracy and current mode of operation may create barriers. And in all fairness to the MBC, it is somewhat hampered by current laws and legislation.

Recommendations

The study findings led to recommendations that are logical, practical and, most importantly, achievable. They also address the relevant study requirements specified in the 805.2 legislation. The complete list of recommendations appears in Chapter V.

One major recommendation is to re-design the peer review process, including establishing a separate, independent peer review organization that has no vested interest in the review outcome, except the protection of the public. Each of the four entities would still provide the first level quality/safety screening of the physician practice, but the independent agency would assume the responsibility for making decisions about any actions toward the physician, including 805 or 821.5 reporting. The establishment of an unbiased third party would eliminate the inconsistencies, variations, and conflicts of interest that confront and baffle entities that perform peer review. The MBC would continue to investigate all 805 reports and make determinations about any license actions.

Less dramatic but equally important recommendations involve correcting the transparency issue (e.g., through improved public disclosure), emphasizing credentialing and re-credentialing as a means to identify and further investigate potential physician practice problems, and promoting education to better inform physician and entities about peer review and 805 and 809 reporting criteria. We recommend that the codes be clarified, especially as they relate to the timing of when to report an 805. We also offer suggestions on ways to fund these recommendations that would not involve increasing taxes or diverting State funds.

Finally, we emphasize the importance of pilot studies and program evaluation in implementing any system change and recommend that any change be phased in over time to allow adjustments by the affected systems and entities.

Lumetra appreciates the opportunity to have a major role in trying to measure, evaluate, and improve peer review in California.

Chapter I: Introduction

In October 2005, Governor Arnold Schwarzenegger signed into law California Senate Bill 231 (Figueroa), which, among other statutory changes, amended the California Business & Professions Code 800, including Section 805.2.

Briefly, it is the intent of 805.2 "to provide for a comprehensive study of the peer review process, as it is conducted by peer review bodies," by an independent firm selected by the Medical Board of California (MBC). A primary goal of the study is to "evaluate the continuing validity of Section 805 and Sections 809 and 809.8, inclusive, and their relevance to the conduct of peer review in California." The due date for the written report of this study was extended to July 31, 2008 (from the original due date of July 31, 2007).

This Report details the findings of the Peer Review Study for the Medical Board of California and the California State Legislature. It encompasses the 10 required components of the Study, as dictated by Section 805.2.

Table 1.1 lists the ten required components for the Comprehensive Study of Peer Review (Peer Review Study) and the mechanisms used by Lumetra to satisfy each component.

Table 1.1: Comprehensive Study of Peer Review Report Components

Comprehensive Study of Peer Review Components[1]	Mechanism Used by Lumetra
1) A comprehensive description of the various steps of and decision makers in the peer review process as it is conducted by peer review bodies throughout the State, including the role of other related committees of acute care health facilities and clinics involved in the peer review process.	Entity documents, surveys, site visits
(2) A survey of peer review cases to determine the incidence of peer review by peer review bodies, and whether they are complying with the reporting requirement in Section 805.	Entity documents and site visits
(3) A description and evaluation of the roles and performance of various State agencies, including the State Department of Health Services and occupational licensing agencies that regulate healing arts professionals, in receiving, reviewing, investigating, and disclosing peer review actions, and in sanctioning peer review bodies for failure to comply with Section 805.	MBC site visit and data analysis
(4) An assessment of the cost of peer review to licentiates and the facilities which employ them.	Survey and focus groups
(5) An assessment of the time consumed by the average peer review proceeding, including the hearing provided pursuant to Section 809.2, and a description of any difficulties encountered by either licentiates or facilities in assembling peer review bodies or panels to participate in peer review decision-making.	Survey and focus groups
(6) An assessment of the need to amend Section 805 and Sections 809 to 809.8, inclusive, to ensure that they continue to be relevant to the actual conduct of peer review as described in paragraph (1), and to evaluate whether the current reporting requirement is yielding timely and accurate information to aid	Survey, focus groups, and key informant interviews

Comprehensive Study of Peer Review Components[1]	Mechanism Used by Lumetra
licensing boards in their responsibility to regulate and discipline healing arts practitioners when necessary, and to assure that peer review bodies function in the best interest of patient care.	
(7) Recommendations of additional mechanisms to stimulate the appropriate reporting of peer review actions under Section 805.	Survey, focus groups, and key informant interview
(8) Recommendations regarding the Section 809 hearing process to improve its overall effectiveness and efficiency.	Survey, focus groups, and key informant interview
(9) An assessment of the role of medical professionals, using professionals who are experts and are actively practicing medicine in this State, to review and investigate for the protection of consumers, allegations of substandard practice or professional misconduct.	Surveys, key informant interviews, and MBC visit and data analysis
(10) An assessment of the process to identify and retain a medical professional with sufficient expertise to review allegations of substandard practice or professional misconduct by a physician and surgeon, if the peer review process is discontinued.	Surveys, key informant interviews, and MBC visit and data analysis

Following a competitive review process, the MBC selected Lumetra as the independent firm to conduct the Peer Review Study.

As an independent healthcare consulting firm with nearly 24 years of experience in healthcare program evaluation and peer review analysis in California, Lumetra understands well the nuances and political landscape of California's variety of healthcare entities, including hospitals, clinics, health plans, medical groups, and professional entities and societies - the key targets of this study.

Section 2220.1 provided for the appointment of an independent enforcement monitor, charged with evaluating "the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board's enforcement program and operations and the improvement of the overall efficiency of the board's disciplinary system."

In November 2005, the MBC and the legislature received the final report from the Enforcement Monitor[2, 3]. Two of the findings, listed below, are related to the work of this study, because they describe limitations of the MBC.

> "…5**. Many of MBC's most important detection mechanisms are failing it.** Despite the extensive "mandatory reporting scheme" set forth in Business and Professions Code section 800 et seq., <u>the Medical Board is not receiving information to which it is statutorily entitled</u> (underlining added for emphasis) about civil judgments, settlements, and arbitration awards against physicians, criminal convictions against physicians, or hospital disciplinary (peer review) actions against physicians as required by law - information that enables MBC to detect possible physician wrongdoing, investigate, and take disciplinary action as appropriate.
>
> Further, physicians themselves routinely conceal information about their own misconduct from the Board through the insertion of **"**<u>regulatory gag clauses</u>**"** (underlining added for emphasis) — provisions that prohibit an injured plaintiff from complaining to or cooperating with the Medical Board — into civil malpractice settlement agreements….

6. **The Medical Board's public disclosure policy is insufficient.** The Board's complex public disclosure statutes and regulations — which have evolved in patchwork-quilt style over the past decade — do not allow the Board to disclose sufficient information about physician conduct and history (underlining added for emphasis) to enable patients to make informed decisions about their physicians (p. ES-5)…"[3].

The Legislature took steps to address the recommendations in the final Fellmeth and Papageorge report, including closing the gag clause loophole[3]. However, it is not clear that the MBC is even now receiving information "to which it is statutorily entitled," nor is it clear that the MBC is able to "disclose sufficient information about physician conduct and history" to protect the public.

In preparing this report, we note the following exclusion and limitation to this study. The Peer Review Study excludes Allied Health Licensing Programs (AHLP). The MBC serves not only physicians and surgeons, but also several "allied health licensing programs" that regulate non-physician healthcare practitioners.

In recent years, most AHLPs have successfully sought legislation creating discipline-specific boards. However, some of them still contract for the use of components of MBC's enforcement program to varying degrees. Because the intent of SB 231 (Figueroa) was to assess the physician and surgeon peer review programs, we have generally excluded peer review of AHLP. Additionally, the AHLP reviews constitute only a small proportion of overall MBC workload.

A limitation of this report was the reluctance of many of the entities, particularly hospitals, to provide access to documents (specifically peer review committee minutes) needed to estimate the efficacy and efficiency of peer review.

Although the legislation (and subsequently the law) states that any documents provided to the independent entity are not "discoverable," several entity staff members reported that hospital attorneys had advised clients to not provide peer review committee minutes because of California Evidence Code 1157. Therefore, verification of hospital compliance with policies and bylaws was difficult.

In some cases, the entities **only** communicated with Lumetra through attorneys. In spite of these obstacles, Lumetra reviewed documents from 68 entities (excluding site visits) from the four entity types and was able to estimate the overall efficacy of medical peer review process in the State.

This report is organized as follows:

- Chapter I is an introduction.
- Chapter II provides the background and significance of the study.
- Chapter III discusses the study methodology and details each study component and mechanism used to collect data for each component.
- Chapter IV presents the study results.
- Chapter V provides conclusions and recommendations based on the findings.

Chapter II: Background and Significance

Introduction

In order to understand the complexity and challenge of Sections 805, 821, and 809, and their requirements, Chapter II provides a background of the MBC, an overview of medical peer review, a historical perspective which has significantly influenced the peer review process, and the relevant codes and regulations that govern the practice of medicine in California today.

Medical Board of California

The Medical Board of California (MBC) is a State government agency, which licenses and disciplines medical doctors. In 2007, the MBC regulated 124,056 physicians, 96,299 of whom resided in California. The MBC receives no funding or support from the State's general fund, rather it is funded entirely by physician licensing, renewal, and application fees; as such, it is characterized as a "special-fund agency." The California Business and Professions Code, Section 2001.1, defines the highest priority of the Medical Board as:

> "Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount"[4].

The Board provides two principal types of services to consumers: 1) public-record information about California-licensed physicians and 2) investigation of complaints against physicians[4].

The Board does not regulate health plans or insurance companies. The Department of Managed Healthcare (http://www.dmhc.ca.gov/default.aspx), in the Business, Transportation and Housing Agency, regulates California health plans, and the Department of Insurance (http://www.insurance.ca.gov/) regulates insurance companies in the Executive Branch of State government[5].

Although physicians are closely associated with hospitals and clinics, those facilities are regulated by other agencies. The California Department of Public Health (CDPH) (http://www.cdph.ca.gov/Pages/default.aspx), within the California Health and Human Services Agency (CHHS) (http://www.chhs.ca.gov/Pages/default.aspx), regulates hospitals and clinics. However, the California Department of Healthcare Services (DHCS) (http://www.dhcs.ca.gov/Pages/default.aspx) contracts for Medi-Cal and other services and, therefore, has some regulatory relationship with primary and rural health (which includes come clinics and hospitals), and long term care.

The MBC is semi-autonomous in that its members make final licensing and enforcement decisions (subject to judicial review). MBC was composed of two autonomous divisions - the Division of Licensing (DOL) and the Division of Medical Quality (DMQ). These two divisions were abolished, effective January 1, 2008, by AB 253.

Now, the Board as a whole manages the business that was formerly managed by the two divisions. The Board focuses on the licensure of physicians and the regulation of several non-physician healthcare professions, oversees a large enforcement staff, and adopts final decisions in disciplinary matters against licensees[3, 6].

Overview of Medical Peer Review

In academia, scholars use peer review as a way to subject their work to criticism by discipline-specific experts. It serves to help normalize high standards and expectations and prevents unwarranted conclusions or interpretation in research. The notion of medical peer review is similar, that is to review and critique the work of a colleague in order to maintain high standards of medical care. It has been defined as:

> "a process where selected members of the medical or other professional staff review the basic qualifications (credentials), medical outcomes and professional conduct of other physicians or licensed professional members and staff applicants, to determine whether the professional may practice or continue to practice in the hospital or other clinical setting and, if so, to determine the parameters of their practice" (p. 1)[7].

There is a long history of the relationship between hospitals and physicians related to patient quality and safety. Prior to 1846, hospitals were essentially almshouses for the poor that gradually became a place to care for the sick. With the advent of anesthesia in 1846 by Morton, the emphasis on sanitation by Nightingale in the Crimea in 1854, and Lister's work in antiseptics in 1867, hospitals began to become safer for surgical patients[8]. During the late 19th century, the hospital medical staff members could generally be categorized as:

1. Consulting physicians who had no regular duties
2. Resident or house physicians who supervised treatment
3. Residents or house physicians in training who carried out treatments
4. Dispensary physicians who saw outpatients

Hospitals paid none of these doctors for their work. The physicians provided their services without pay in order to train, have access to surgical suites, gain prestige, and add patients to their private practices. A small elite group of physicians held hospital appointments (privileges), and physicians outside that elite group resented the "unjust" control exerted by a "ring of monopolists" (p. 166)[8].

Generally, the American College of Surgeons is credited with beginning medical peer review in 1918[9] or 1919[8] as part of its Hospital Standardization Program. The medical staff members of hospitals were required to be "competent reputable physicians abide by formal bylaws, and hold monthly meetings and reviews of clinical experiences" (p. 107)[8].

However, Glaser wrote in 1963, "…Granting or withdrawing hospitalization privileges [in other countries] cannot be used to regulate professional and personal behavior; in fact, this use of hospitalization privileges makes America one of the few countries with any controls over the quality of private practice" (p. 54)[10].

In contrast, Starr opined that it was never clear that withdrawing hospital privileges was effective at raising quality of private practice, but there was no doubt that it was used to exclude undesirables[8]. He maintained that it was used to exclude black doctors and "anyone else who threatened to rock the boat" (p. 168)[8]. So, from the beginning of modern medical care in the US, physicians, surgeons, and hospitals were mutually dependent, physicians were generally not paid for their work in the hospital, and granting or withholding hospital privileges was used to try to ensure quality care, but was also thought to be used for "political" reasons, such as excluding "undesirables."

It is not surprising that the question of whether peer review and restriction of hospital privileges are used to exclude "undesirables" remains. The phrases "sham peer review" or "peer review injustice" refer to the use of the peer review process to eliminate "mavericks, whistleblowers, rivals, and nonconformists" (p. 1)[11].

These issues are often raised by physicians who have had negative experiences with peer review. Others in the medical-legal community claim that this is just "sour grapes" from people who deserved disciplinary action. However, there are such a growing number of concerns raised about peer review injustice, that it has become more difficult to ignore the complaints.

The Association of American Physicians and Surgeons has a Web page listing numerous opinion pieces, presentations, news reports, and court causes related to sham peer review[12]. A physician from that organization opines that the sham process "begins in the minds of those who set out to destroy a targeted physician" (p. 3)[13].

Others use stronger language to describe sham peer review in medicine calling it "workplace mobbing" and allege that it is used to rid an entity of a troublemaker or to rid an "insider" physician of a competitor[14]. This is reiterated in a publication describing the peer review process as "misused, ineffective, and corrupt"[11].

The literature mentions two general types of peer review: implicit and explicit. Implicit peer review relies on expert judgment and is typically performed by a physician. Explicit peer review, frequently used by nurses, involves applying a specific set of criteria[15].

Evidence of reliability of the methods is mixed. A report comparing the two methods found many discrepancies in findings. In the discordant cases, physicians tended to find quality problems unavoidable, there was no adverse outcome, or they were present on admission[16]. Another report found unstructured implicit review was not a reliable method for determining error and measuring compliance with standards[17]. However structured implicit review tended to be moderately reliable and certainly more reliable than unstructured implicit review[15, 18, 19].

Peer review in the U.S. is closely related to the credentialing and re-credentialing of providers, the method used to restrict or allow hospital privileges, and it continues to be linked with disciplinary action in the form of allowing or withdrawal of hospital privileges[7]. Although there was a movement by hospitals in the 1980s and 1990s to focus on systems analyses rather than individual blame to control error, the difficulty of changing systems provided a barrier to this notion. Therefore, individual blame continues to be a large part of error management in hospitals.

In medical-care-providing entities, quality, risk, or error management customarily begins in one of several ways:

1. A complaint
2. As the result of a routine quality screening study
3. A sentinel or egregious event
4. An unexpected adverse outcome or other triggers

The issue/case then goes before one or more peer review bodies. There may be one of several results of the peer review investigation within the entity that affects the physician:

1. Nothing
2. Mandatory education or training
3. Monitoring or proctoring procedures and practices
4. Mandatory behavior counseling or some variant
5. Change/restriction in privileges
6. Summary suspension or termination.

Some of these results require reporting to state or national agencies and may have an impact on the physician's livelihood and ability to work. But whether the result is positive or negative for the physician, the peer review process is a significant part of the investigation and any discipline that occurs. Because of the link between peer review and disciplinary action, physician generally are apprehensive about the process of peer review, whether as a recipient or as a reviewer.

If the event that triggered the peer review investigation meets the criteria for reporting to a state medical board, disciplinary action by the medical board may occur. A number of studies have reported characteristics of physicians who have been disciplined by medical boards, including being male[20-23], not being board certified[20-22, 24], not being white[21], being a foreign medical graduate[21, 22], and increasing age[22, 25].

Specialties that tend to be disciplined more frequently include anesthesia, psychiatry, internal medicine/family practice, obstetrics and gynecology, and emergency medicine[21-24, 26]. Interestingly, lower patient-provider communication scores were associated with higher numbers of retained complaints made to regulatory authorities[27].

The complaints were both communication-related complaints and quality-of-care complaints. Also, lower scores on traditional written examinations that tested clinical decision-making at the end of medical school were also associated with higher numbers of communication and quality of care complaints[27]. Among other findings, these studies provide support for the notion that foreign medical graduates and non-whites are disciplined more frequently than U.S.-trained graduates and whites.

One of the most difficult issues facing entities is working with a physician who is incompetent, disabled, disruptive, or impaired[28, 29]. Leape has suggested categorizing "problem doctors" as psychopathic, impaired, demonstrating declining competency, or demonstrating behavioral problems[28]. These categories are not mutually exclusive, and one type of issue frequently is related to another.

The most common reasons for disciplinary actions taken by medical boards against physicians are impairment related to drugs or alcohol, negligence or incompetence, and drug-related charges/inappropriate prescribing practices[20, 24]. The issue of incompetence, dyscompetence[30], or underperformance are often addressed first by recommending or requiring continuing medical education (CME) or skill training and monitoring or proctoring[31, 32]. However, it has not been demonstrated that CME or skill training is effective in changing practice behavior of physicians[25]. There is evidence that some physicians who are incompetent have some type of cognitive impairment that accounts for the poor performance. This cognitive or neuropsychological impairment has been found more frequently in the elderly physician[33, 34].

An even more difficult issue facing entities is managing the physician with cognitive difficulty, alcohol or drug impairment, or disruptive behavior. The latter is typically defined as the use of profane or

disrespectful language, demeaning behavior, throwing instruments, and anger outbursts, among others[28]. Entities typically ignore these behavior problems for extended periods of time and may not manage them at all[28].

Some state medical boards have developed diversion programs that seek to monitor physicians with drug or alcohol problems rather than discipline them. The programs became popular in the 1980s with California creating the first such program in 1980[35]. Initially, evidence indicated that this program was successful in encouraging the treatment of physicians[36]. However, the California Medical Board recently voted to terminate the program effective 2008 after multiple audits determined that the program did not protect patients[37].

Malpractice litigation increased between 1840 and 1850[38]. If a medical error led to patient injury, the patient had the option of suing the physician for malpractice. Previous to that time period, medical doctors had advertised flamboyant successes and made exaggerated claims of cures. Additionally, there were few regulatory statutes or professional standards of medical practice and education[38]. The public became unwilling to tolerate unfavorable medical outcomes. Other issues were involved, but also during this time, the relationship between doctors and lawyers deteriorated and remains tenuous today.

Malpractice litigation also encouraged and continues to encourage holding individual providers accountable for poor outcomes and perpetuates the blaming of an individual rather than considering systematic problems as the cause. Risks of malpractice litigation include being a surgeon and having a higher number of patient complaints and increased patient volume[39]. Interestingly, the majority of technical errors in surgery were associated with experienced surgeons. These errors occurred in routine operations and involved patient-related complexity[40].

Errors and the threat of malpractice take a toll on physicians as well as on patients. There is evidence that some specialty physicians reduce the number of high-risk procedures they perform in order to control their risk of malpractice litigation. Some neurosurgeons in Florida are reported to have reduced the volume of brain surgeries they perform, and patients have had to travel longer distances to obtain care[41].

Physicians report increased anxiety, sleep loss, job dissatisfaction, and harm to their reputation following serious errors[42, 43, 44]. In 1975, California legislators passed the Medical Injury Compensation Reform Act of 1975 (MICRA)[45], codified in the California Civil Code Section 3333.2. Medicine and hospital trade entities hailed this legislation as the action that kept doctors' offices opened and increased patient access to healthcare. Others note that malpractice litigation has declined in California since the legislation was passed and that the $250,000 limit on "pain and suffering" has not been altered since 1975.

Disclosure of errors to patients and reporting of errors are topics that often leave physicians conflicted. Generally, physicians want to be transparent but are fearful of litigation, embarrassed, or unsure of the best way to disclose[42, 46, 47]. Some reports provide evidence that disclosure of errors to patients is associated with a reduced likelihood in the patient changing physicians, increased patient satisfaction, trust, and a positive emotional response. However, there was mixed evidence about whether the patient was likely to seek legal advice[48, 49]. Another report found that disclosure was not associated with reduced litigation volume or cost[50].

Today, hospitals typically do not "employ" most physicians, although there are exceptions (i.e., contracted anesthesiologists, ED physicians, and hospitalists). Rather, the relationship of mutual

benefit between physician and hospital persists as it has in the past. There is no "employer-physician" relationship, and physicians perform work at the hospital, such as participating in peer review, usually without compensation in exchange for the privilege of admitting patients. Additionally, there are few recognized employee-employer safeguards in the hospital-physician relationship, other than those provided in the medical staff bylaws or those that can be won in litigation[51].

Because the physician needs a place for acutely ill patients and the hospital needs patients, the relationship is generally smooth. However, when there are potential quality issues, there are several liability "landmines": 1) anti-trust issues; 2) due process issues; and 3) ethical dilemma issues[51]. Although legal protection exists, there is the potential that a reviewed physician, whose privileges have been terminated, might litigate alleging that the peer review (or reviewer) was used to eliminate competition[52]. This type of litigation generally fails, as long as the decision was made in good faith[51].

Another potential litigation issue is the allegation of the denial of the protection of due process. Because of a number of successful lawsuits related to due process, such as Potvin v. Metropolitan Life Insurance Company[53], hospitals feel compelled to err on the side of caution and increase the number of protections for the physician[51]. In that case the California Supreme Court held that a managed care entity cannot terminate one of its panel physicians unless it accords that physician a fair hearing with basic due process protections[53].

Another issue of concern is that of the ethical dilemma. When reporting an error or reporting a colleague, the individual will weigh the consequences of the actions that might be taken:

- Potential improvement of patient care quality and safety and knowledge that you are doing the right thing, versus,
- Potential for anti-trust or due process violation litigation and potentially creating a rift among the medical staff group that may lead to tension, a loss of referrals, and/or a decrease in peer cooperation (such as emergency coverage for your patients)[51].

As discussed previously in regard to disclosure, physicians are generally moral individuals who try to do the right thing, but the negative consequences of reporting are significant and will undoubtedly be weighed by thoughtful, intelligent people.

805 Reporting – A Historical Perspective

In 2001, the California legislature added Section 805.2 to the Business and Professions Code requiring the MBC to contract with the Institute of Medical Quality, a subsidiary of the California Medical Association, to engage in a comprehensive study of the way in which peer review was actually conducted in California at that time, and to compare the process with the reporting language in section 805. The study report was to be completed by November 1, 2002, which was later extended to November 1, 2003[54].

When the study was not performed due to budget shortfalls, SB231 (2005) amended 805.2 to require MBC to contract with an independent entity to conduct the 2001-mandated study by July 31, 2007. The 2007 deadline was later extended to July 31, 2008[3].

The specific language and requirements of the study of peer review is documented in Table 1.1. The peer review process, as defined in the legislation, is essential to maintaining safe, quality medical care for California citizens. However, the peer review process is obscure[55], and it is not clear that the MBC receives reports as required by law.

Based on absolute numbers, 805 reporting has varied over time and, based on number of reports adjusted for population of citizens or population of physicians, the number has declined (see Figures 2.1, 2.2, 2.3, and 2.4). This decline is not an isolated event to California. The January 1995 Newsletter of the California Medical Board stated, “Over the past year, we have noted deterioration in the cooperation required between hospitals and the Board in protecting consumer/patient safety. We have experienced incomplete reports, and on some occasions, excuses for not reporting at all[56].

The Federation of State Medical Boards reported a decline in reports of disciplinary actions against physicians by medical boards in the U.S. beginning in 2005 and continuing through 2006 and 2007[57, 58]. Baldwin et al reported a low and declining level of hospital privileges action reporting to the National Practitioner Data Bank between 1991 and 1995[59]. The Office of the Inspector General reported that as of September 30, 1998, only about 67 percent of U.S. hospitals had made a report[60], and issued another report in 2001 warning that the database was underused[61].

Historical events in the State and nation likely influenced the number of 805 reports submitted to the MBC (see Figure 2.1). In the mid-1990s, managed care penetration increased substantially in California with the objective of controlling costs[62, 63]. Hospitals instituted dramatic staffing reductions.

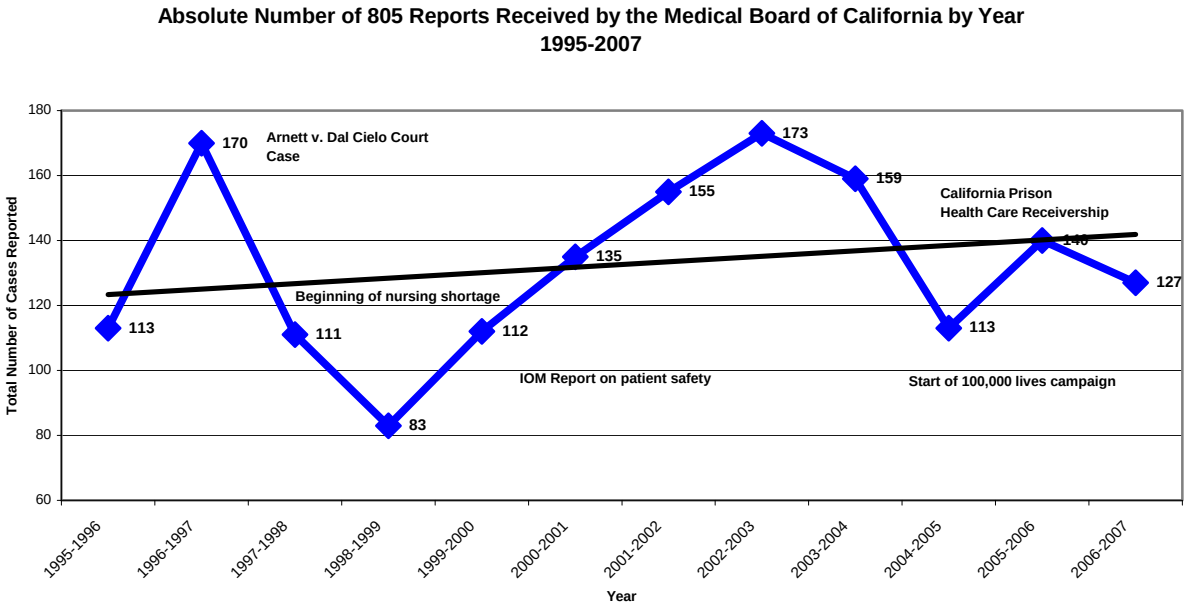
In 1996, the California Supreme Court clarified that a subpoena of peer review records by the Medical Board did not constitute “discovery” in the legal sense[64] and the Board had the right to enforce its subpoena for such records. This may have affected responses to 805 reporting and likely made entities more cautious and more reluctant to provide any information, other than what was specifically subpoenaed.

In 1997, the federal government passed the Balanced Budget Act[65], which put more financial pressure on hospitals and health plans to curb costs. The latest and very substantial nursing shortage started in hospitals in California in 1998[66, 67], and in 1999 California passed the first mandated hospital nurse to patient ratios legislation in the United States[68, 69]. This added more financial pressure on hospitals.

In 2000, the Institute of Medicine published To Err is Human[43], which generated publicity and interest in medical errors, particularly in hospitals. Even though the wording is "medical errors," it should be remembered that physicians are not responsible for all “medical” errors in hospitals. Many medical errors are related to the complex and chaotic systems in U.S. hospitals. (Note: This report will address complaints, errors, and events directly related to physician medical practice, not to system errors in the study entities.)

Figure 2.1 graphs the absolute number of 805 reports and includes major historical events that occurred over the 12-year period between 1995 and 2007. The added trend line indicates that the number of 805 reports increased during those years.

Figure 2.1: Absolute Number of 805 Reports Received by the Medical Board of California by Year, 1995-2007



However, if you adjust the number of 805 reports received by the MBC for the number of MDs licensed by the State (see Figure 2.2), the number of MDs licensed and living in California (see Figure 2.3), or the number people living in California (see Figure 2.4), the trend lines show a downward direction.

Figure 2.2: Number of 805 Reports per 1000 MDs Living Both In and Out of California by Year, 1995-2007

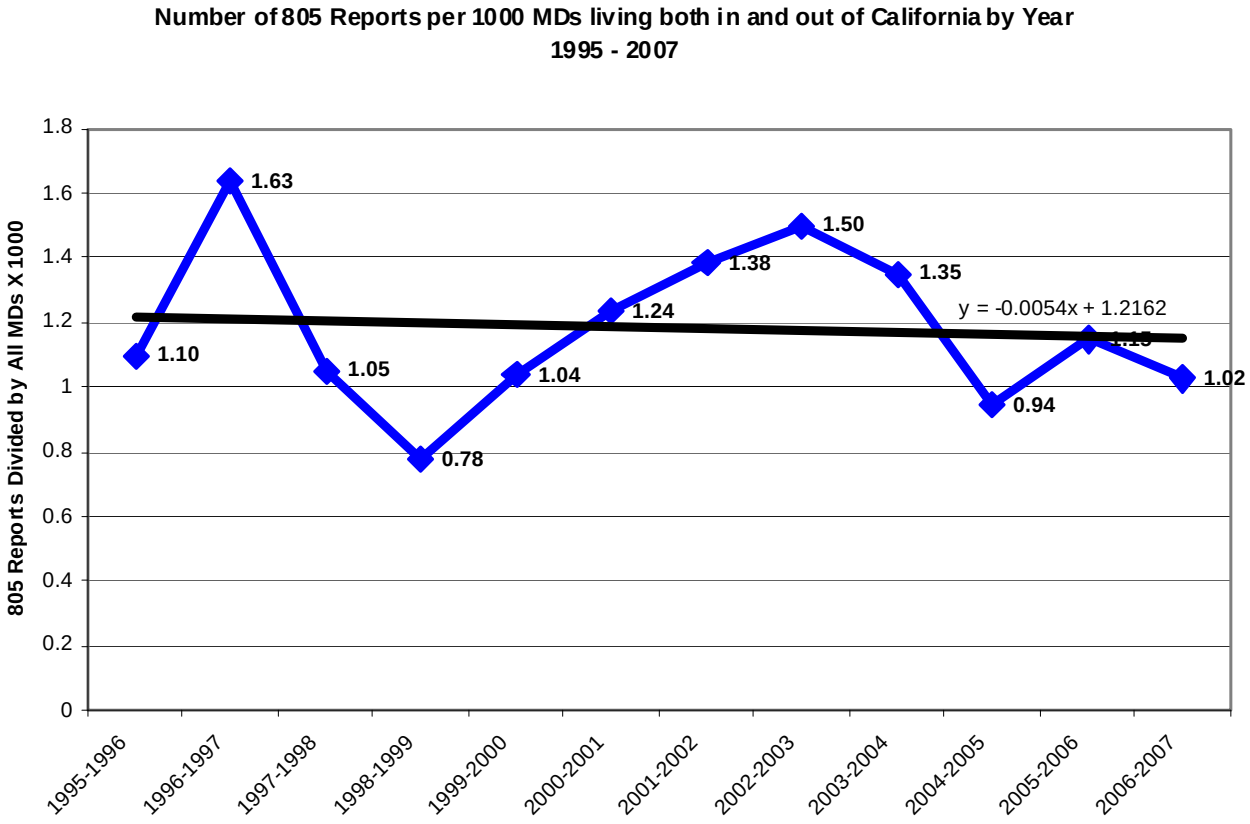


Figure 2.3: Number of 805 Reports per 1000 MDs Living in California by Year, 1995-2007

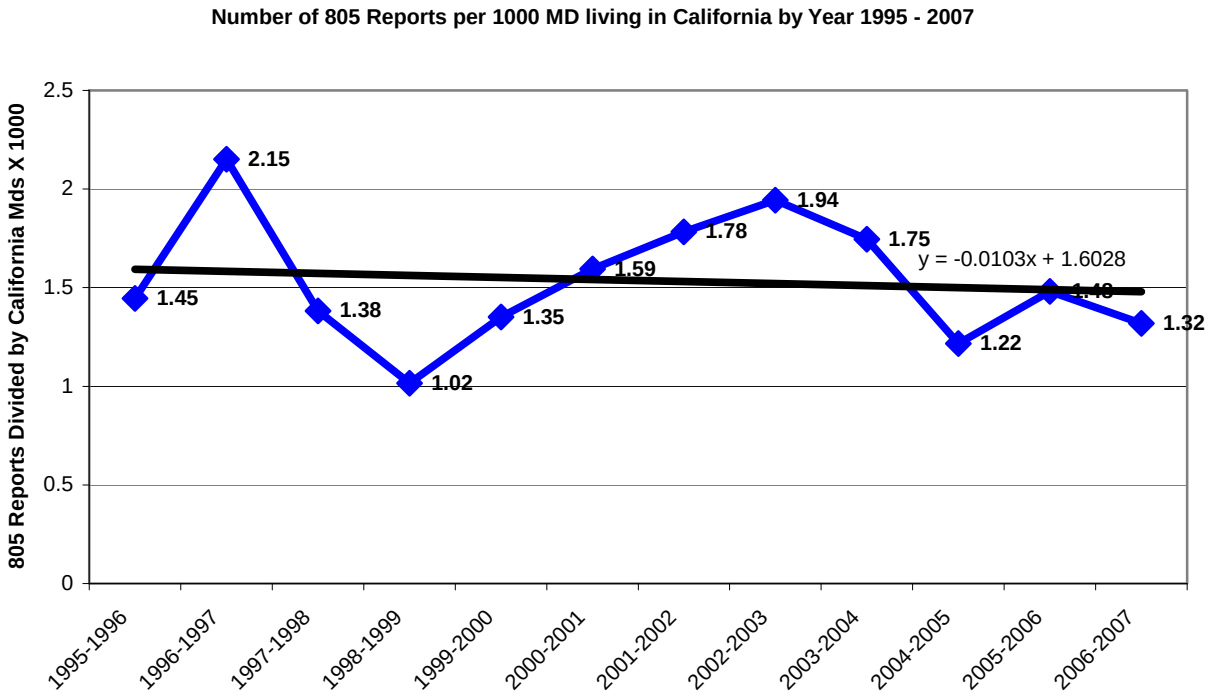
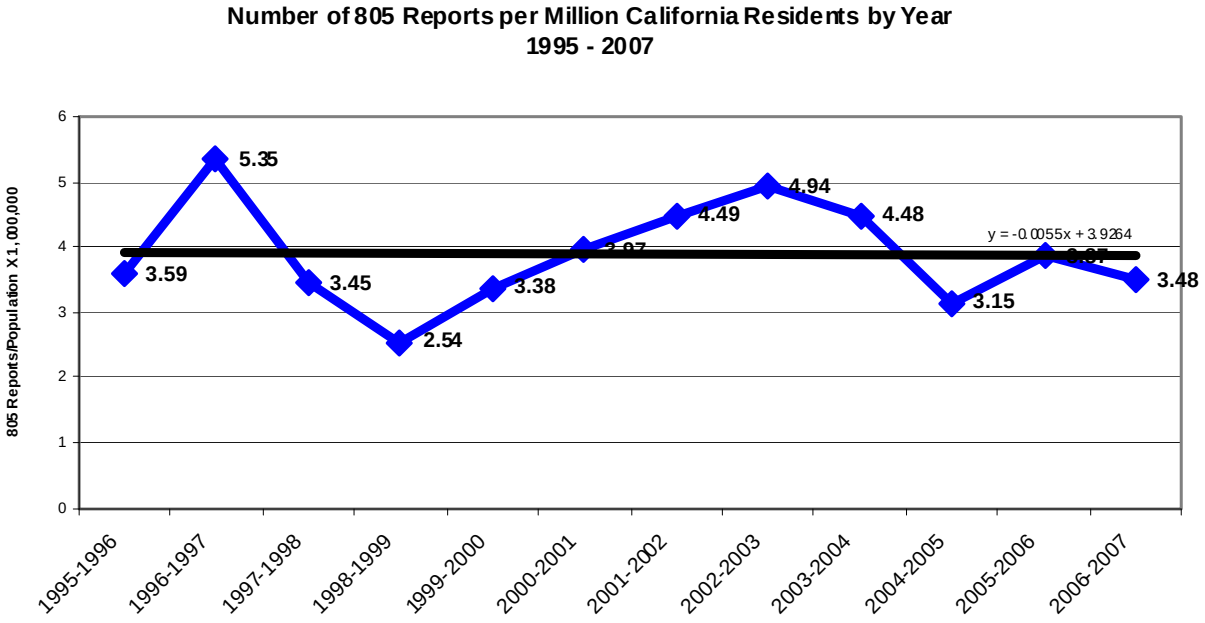


Figure 2.4: Number of 805 Reports per Million California Residents by Year, 1995-2007



These historical events likely influenced the California legislators to become interested in evaluating the mechanisms, such as peer review, used to assess medical care in the State. In this matter, the California Legislature was prescient. In 2005, the Federation of State Medical Boards announced

that reports of disciplinary actions against physicians by U.S. state and territory medical boards had declined in 2005 for the first time in eight years and declined again by 4.6% between 2006 and 2007[57, 58]. The time for this evaluation of peer review is entirely appropriate.

The Challenge and Future of Peer Review

In the years since 1918, the provision of medical care has evolved into a multi-national industry that includes numerous ancillary providers, mid-level providers, administrators, insurers, federal and state laws, attorneys, and others. Some of the questions raised during the early 19th century are still being raised today:

1. Should physicians be paid for work such as peer review in the hospital?
2. Are peer review and discipline using the withdrawal of hospital privileges effective in ensuring quality care?
3. Are peer review and exclusion from hospital privileges done for "political" reasons?

Some entities and states have proposed or tried new ways to determine quality and safety in medical care. Since 1987, the Massachusetts Medical Board has required all hospitals, physicians, and clinics to report adverse events through the Patient Care Assessment (PCA) program. All unexpected deaths and major complications must be reported quarterly through this confidential program, which is protected from legal discovery. A somewhat unique advantage of the Massachusetts Medical Board is that it has extensive authority over physician practice and healthcare facilities in the areas of quality, safety, and error prevention[70].

The Texas State Board of Medical Examiners uses an investigations process that includes the informal show compliance (ISC). The ISC is a mechanism that allows the physician to show that he or she has not violated the medical practice act. The physician can provide written documents and/or make a personal appearance and is encouraged to engage the assistance of an attorney. This process is not recorded and the rules of evidence do not apply, but it allows the board to provide recommendations to the physician and attempt to reach an agreement informally[71].

Other entities have suggested using independent review entities and adjusting for patient risk[72], providing confidential ongoing feedback[73], establishing or designating independent federal oversight through Patient Safety Organizations (PSO) in the U.S. Department of Health and Human Services[74], and using centralized supervision or regulation, practice guidelines, information technologies, and continuous quality improvement activities[75].

The literature seems to indicate that professionals are questioning whether peer review should continue to be the primary way that medical quality and safety are estimated. Some have even questioned whether there is still any place for medical peer review in determining quality and safety of medical care[11, 15]. There is evidence that with structured implicit review, physician-reviewers are less likely to record poor quality in surgical patients presenting with an acute illness[19], and discussion between physician reviewers does not improve the reliability of peer review hospital quality[76]. Other evidence indicates that developing an enhanced peer assessment using trained peer assessors in one-on-one interactions is a promising method of changing physician behavior[77]. Other suggested strategies include using:

1. Performance assessment rather than peer review[78].
2. Multi-source feedback to assess physician competencies[79].

3. Specialty certification status to measure quality[80].
4. Administrative data for some types of complications[81].
5. Standardized patients (actors trained to present certain symptoms to train and evaluate practitioners) to evaluate decision making[82].
6. Clinical vignettes to measure quality of physician practice[83].

However, California codes require the use of peer review in healthcare entities as one of the processes for determining safe and effective medical care, and they are used in defining who is required to report medical events to the licensing board (see Table 2.6).

Codes and Regulations

The codes that govern the practice of medicine in California are extensive and complex, but it is necessary to have a basic comprehension of these statutes in order to understand the process of medical peer review and event reporting and the challenges they present in conducting this study. In order to explicate the complexity of the laws, we provide a partial list of codes and regulations in the following tables.

Many of the laws (codes) related to medical practice in California are contained in various sections of the **Business and Professions Code** (B&P) (see Table 2.1)[84, 85].

Table 2.1: Select California Business and Professions Code

Topic	Section
General Provisions	Section 500
Physician Advertising	Section 651
Medical Malpractice Reporting	Section 801
Medical Practice Act Internet Information on Doctors License Required and Exemptions	Section 2000 Section 2027 Section 2050
Medical Assistants	Section 2069
Physician and Surgeon Licensing Information Requirements for Licensure Foreign Medical Graduates	Section 2080 Section 2080 Section 2100
Continuing Medical Education Outpatient Surgery Settings Enforcement Unprofessional Conduct Prescribing/Dispensing Reinstatement of License/Modification of Probation Diversion Evaluation Committee Medical Corporations Renewal of Licenses	Section 2190 Section 2215 Section 2220 Section 2234 Section 2241 Section 2307 Section 2340 Section 2400 Section 2420
Alternative Practices and Treatments	Section 2500
Licensed Midwives	Section 2505
Research Psychoanalysts	Section 2529

There are other State regulations, codes, sections of codes, and case law that dictate the highly complex business and practice of the science and art of medicine (see Table 2.2 and Table 2.3). We reference these laws in this report because they are relevant to the study. For example, letters from study respondents (see Appendix III: Hospital Related Documents) highlight the fact that entity attorneys made numerous references to Evidence Code 1157 and the Lanterman-Petris-Short Act as reasons for not providing peer review minutes for the study.

Two more examples of relevant law to this study are the Dal Cielo case, which was described by participants as a turning point in the relationship between the MBC and hospitals, and the Patrick case which relates to the issue of peer review and the issue of antitrust liability. The other laws listed are related to the issue of quality of care.

Table 2.2: Other California Laws and Cases Relevant to Peer Review

Regulations, Codes, Case Law	Relevance to Medical Practice
Arnett v. Dal Cielo; CA Supreme Court 1996[64]	The Court ruled that an investigative subpoena issued by the Medical Board of California as part of its inquiry into the conduct of a physician with an apparent drug problem is not "discovery" within the meaning of Evidence Code 1157
CA B&P Code 2027[86], 805.5 and 803.1[1]	Definition of what is publicly disclosed by the MBC
CA B&P Code 2056[86]	Protects against retaliation for physicians who advocate for medically appropriate healthcare for their patients
CA B&P Code 2222.07[87]	Elimination of the "Gag Clause" in malpractice suits
CA Code of Regulations Title 22[88]	Governs many aspects of hospitals and hospital care
CA Code of Regulations Title 28, Division 1, Chapter 1 (Sections 1300.41-1300.826)[89]	Detailed regulations under which healthcare plans must operate
CA Evidence Code Section 1157[55]	Provides that the records of a hospital peer review committee are not subject to discovery
CA Health & Safety Code Section 1278.5 (aka Whistleblower Protection for Healthcare Workers)	Protects patients, nurses, members of the medical staff, and other healthcare workers if they report suspected unsafe patient care and conditions
CA Health & Safety Code Section 1340-1345 (aka. Knox-Keene Healthcare Service Plan Act of 1975)[45]	The set of laws that regulate health maintenance entities (HMOs) in CA
CA Welfare & Institutions Code Section 5000 (aka Lanterman-Petris-Short Act of 1972)[90]	To guarantee and protect public safety; to safeguard individual rights through judicial review, specifically mentally disordered persons and persons impaired by chronic alcoholism
Patrick v Burget and the Healthcare Quality Improvement Act of 1986; U.S. Supreme Court, 1988[91]	The Court ruled that the state action doctrine (Parker v Brown)[92] does not protect Oregon physicians from federal antitrust liability for their activities on hospital peer review committees

*partial list

There are other laws governing the medical profession and entities that provide medical and health care, which try to ensure quality and safety of patients. Multiple persons and entities are required to report events to the MBC using different mechanisms. Additionally, consumers can file complaints directly to the Medical Board.

Table 2.3: Select California Codes Defining Who Must Report and What Gets Reported Related to Medical Practice*

B&P Code Sections	Who Reports and What is Reportable
801.1[1]	Physician self-reporting of settlements, judgments, or arbitration awards
802.1[1]	Physician self-reporting of indictment for felony or conviction of misdemeanor or felony
802.5[1]	Coroner report evidence of negligence or incompetence related to death
803[1]	Court clerks reporting of physician criminal actions
805[1]	**Peer Review body reporting of issues related to changes in entity privileges for medical cause or reason**
805 (j)[1]	No person shall incur any civil or criminal liability as the result of making any report required by this section
809.2[1]	Physician is entitled to fair hearing
820-828[93]	Peer Review Body reporting of physical or mental illness or substance abuse
2021[86]	Physician self-reporting of change of address within 30 days after each change
2220-2319[87]	MBC Enforcement; Definitions of reasons for discipline and unprofessional conduct; gross negligence and incompetence
2240[87]	Physician self-reporting of deaths while performing procedures outside hospital; ED transfers

*partial list

Two closely related federal laws also are related to medical event reporting and the goals of patient care quality and safety:

1. The Sherman Anti-Trust Act[52, 94]

2. Healthcare Quality Improvement Act (HCQIA) of 1986[95]
    a. National Practitioner Data Bank (NPDB)
    b. Healthcare Integrity and Protection Data Bank (HIPDB)

The Sherman Anti-Trust Act is important because physician practices are typically for-profit business entities and are subject to laws relevant to tax-paying entities, specifically laws about anti-competitive practices. Confusion can occur because hospitals and some health plans are nonprofit entities (non tax-paying). Thus the anti-trust act becomes particularly important when physician competitors are required to participate in peer review of each other.

The HCQIA created two databanks: 1) the National Practitioner Data Bank (NPDB) to which certain entities are required to report events related to medical practice; and 2) the Healthcare Integrity and Protection Data Bank to be used as part of credentialing and peer review. The HCQIA also provided immunity, given restrictions, from damages by peer review participants[7]. However, a case taken to the U.S. Supreme Court in 1988, Patrick v Burget[91] (see Table 2.2), provided further legal guidance.

The Court held that Oregon physicians are not protected by the federal antitrust exemption known as the state action doctrine[92] for their activities on hospital peer review committees[96]. If the peer review process conforms to the standards of the HCQIA and is done in good faith, there are state and federal protections[96, 97], and some authorities maintain that it is difficult to win an antitrust case that challenges peer review of individual competence[98]. Other authorities view the immunity from liability provided by the laws as a way to hide from consequences of bad faith peer review[99]. This controversy continues today.

An essential part of the process of measuring patient quality and safety is medical peer review and event ("805") reporting. Although the terms "peer review" or "peer review body" have been misused by various entity committees (Quality, Risk, Utilization, small "p" peer review versus large "P" peer review), the California code language seems clear about what is a reportable event (see Table 2.4) and what the law defines as a peer review body (see Table 2.6).

Rather than inserting the statute language, the following tables highlight various events in the 805 process. The Business and Professions Code specifies what is to be reported and which entities are to report under Section 805 (see Tables 2.4 to 2.6 and 2.7). Definitions of terms and reporting times are also specified in the code (see Tables 2.4, 2.5, and 2.6).

Table 2.4: What is "805" Reportable (California Business & Professions Code 805)[1]

805 (b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed healthcare facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date of any of the following that occur as a result of an action of a peer review body:

What is "805" Reportable (California Business & Professions Code 805) [1]
(1) A licentiate's application for staff privileges or membership is denied or rejected for **a medical disciplinary cause or reason;**
(2) A licentiate's membership, staff privileges, or employment is terminated or revoked for **a medical disciplinary cause or reason;**
(3) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for **a medical disciplinary cause or reason;**
805 (c)…Any of the following occur after notice of either an impending investigation or the denial or rejection of the application for **a medical disciplinary cause or reason:**
(1) Resignation or leave of absence from membership, staff, or employment. (2) The withdrawal or abandonment of a licentiate's application for staff privileges or membership. (3) The request for renewal of those privileges or membership is withdrawn or abandoned.
805 (e) An 805 report shall also be filed within 15 days following **the imposition of summary suspension** of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.

Table 2.5: Relevant Definitions (California Business & Professions Code 805)[1]

Relevant Definitions (California Business & Professions Code 805)[1]
805 (a) (2)"Licentiate" means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, or dentist. "Licentiate" also includes a person authorized to practice medicine pursuant to Section 2113 (see Table 2.1).
(4) "Staff privileges" means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.
(5) "Denial or termination of staff privileges, membership, or employment" includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.
(6) "Medical disciplinary cause or reason" means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

Table 2.6: Peer Review Bodies Defined - Who Reports (CA Business & Professions Code 805) [1]

"Peer review body" includes:

Peer Review Bodies Defined - Who Reports (CA Business & Professions Code 805) [1]
805 (a) (1) (A) A medical or professional staff of any healthcare facility or clinic licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code or of a facility certified to participate in the federal Medicare Program as an ambulatory surgical center.
(B) A healthcare service plan registered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that contracts with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code.
(C) Any medical, psychological, marriage and family therapy, social work, dental, or podiatric professional society having as members at least 25 percent of the eligible licentiates in the area in which it functions (which must include at least one county), which is not organized for profit and which has been determined to be exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code.
(D) A committee organized by any entity consisting of or employing more than 25 licentiates of the same class, that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity.

Table 2.7: Entities that Report through California 805 Mechanism*

B&P Code 805 & Codes Referenced in B&P Code 805	B&P Code Excerpts
Business & Professions Code 805[1]	Any facility **certified** to participate in the federal Medicare Program as an ambulatory surgical center
Business & Professions Code 805[1]	A committee organized by any entity consisting of or employing **more than 25 licentiates** of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity
Health and Safety Code 1200[100]; 1250-1264[101]	Licensed healthcare facilities or clinics; definition of licensed healthcare facilities or clinics; 1204 defines clinics eligible for licensure; 1250 defines as "health facility" means any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer, ...
Health and Safety Code 1340[45]	**Certified** healthcare service plan; Definition of certified healthcare service plan; KKA 1345(f)(1), (f) "Healthcare service plan" or "specialized healthcare service plan" means either of the following: (1) Any person who undertakes to arrange for the provision of healthcare services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees (but there are several exemptions).
Health and Safety Code 1370; 1370.1[1]	Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs.
Insurance Code 10133 (aka. Knox-Keene Healthcare Service Plan Act of 1975)[45]	A disability insurer that contracts with licentiates (providers) to provide services at **alternative rates of payment**
Revenue and Taxation Code 23701 tax exempt[102]	Any medical, psychological, marriage and family therapy, social work, dental, or podiatric professional society having as members **at least 25 percent** of the eligible licentiates in the area
Welfare and Institutions Code 14087.95[103]	**Exempts** counties in this category from Health and Safety Code 1340

*partial list

The Business and Professions code specifies the procedure for a “fair hearing” (see Table 2.8) related to 805 reporting. The sections that follow 809.2 in the code further detail the procedures to be followed.

Table 2.8: The 809 Hearing (California Business & Profession Section 809.2[104])

If a licentiate timely requests a hearing concerning a final proposed action for which a report is required to be filed under Section 805, the following shall apply:

B & P Section 809.2
(a) The hearing shall be held, as determined by the peer review body, before a trier of fact, which shall be an arbitrator or arbitrators selected by a process mutually acceptable to the licentiate and the peer review body, or before a panel of unbiased individuals who shall gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, fact finder, or initial decision maker in the same matter, and which shall include, where feasible, an individual practicing the same specialty as the licentiate.
(b) If a hearing officer is selected to preside at a hearing held before a panel, the hearing officer shall gain no direct financial benefit from the outcome, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.
(c) The licentiate shall have the right to a reasonable opportunity to voir dire the panel members and any hearing officer, and the right to challenge the impartiality of any member or hearing officer. Challenges to the impartiality of any member or hearing officer shall be ruled on by the presiding officer, who shall be the hearing officer if one has been selected.
(d) The licentiate shall have the right to inspect and copy at the licentiate's expense any documentary information relevant to the charges which the peer review body has in its possession or under its control, as soon as practicable after the receipt of the licentiate's request for a hearing. The peer review body shall have the right to inspect and copy at the peer review body's expense any documentary information relevant to the charges which the licentiate has in his or her possession or control as soon as practicable after receipt of the peer review body's request. The failure by either party to provide access to this information at least 30 days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable licentiates, other than the licentiate under review. The arbitrator or presiding officer shall consider and rule upon any request for access to information, and may impose any safeguards the protection of the peer review process and justice requires.
(e) When ruling upon requests for access to information and determining the relevancy thereof, the arbitrator or presiding officer shall, among other factors, consider the following: (1) Whether the information sought may be introduced to support or defend the charges. (2) The exculpatory or inculpatory nature of the information sought, if any. (3) The burden imposed on the party in possession of the information sought, if access is granted. (4) Any previous requests for access to information submitted or resisted by the parties to the same proceeding.
(f) At the request of either side, the parties shall exchange lists of witnesses expected to testify and copies of all documents expected to be introduced at the hearing. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least 10 days before the commencement of the hearing shall constitute good cause for a continuance.
(g) Continuances shall be granted upon agreement of the parties or by the arbitrator or presiding officer on a showing of good cause.
(h) A hearing under this section shall be commenced within 60 days after receipt of the request for hearing, and the peer review process shall be completed within a reasonable time, after a licentiate receives notice of a final proposed action or an immediate suspension or restriction of clinical privileges, unless the arbitrator or presiding officer issues a written decision finding that the licentiate failed to comply with subdivisions (d) and (e) in a timely manner, or consented to the delay.

The Business and Professions code also defines what is meant by an 821.5 report and how impaired physicians are to be reported (see Table 2.9).

Table 2.9: The Impaired Physician (California Business & Profession Section 821.5[105])

B & P Section 821.5
821.5. (a) A peer review body, as defined in Section 805, that reviews physicians and surgeons, shall, within 15 days of initiating a formal investigation of a physician and surgeon's ability to practice medicine safely based upon information indicating that the physician and surgeon may be suffering from a disabling mental or physical condition that poses a threat to patient care, report to the diversion program of the Medical Board the name of the physician and surgeon under investigation and the general nature of the investigation. A peer review body that has made a report to the diversion program under this section shall also notify the diversion program when it has completed or closed an investigation.
(b) The diversion program administrator, upon receipt of a report pursuant to subdivision (a), shall contact the peer review body that made the report within 60 days in order to determine the status of the peer review body's investigation. The diversion program administrator shall contact the peer review body periodically thereafter to monitor the progress of the investigation. At any time, if the diversion program administrator determines that the progress of the investigation is not adequate to protect the public, the diversion program administrator shall notify the chief of enforcement of the Division of Medical Quality of the Medical Board of California, who shall promptly conduct an investigation of the matter. Concurrently with notifying the chief of enforcement, the diversion program administrator shall notify the reporting peer review body and the chief executive officer or an equivalent officer of the hospital of its decision to refer the case for investigation by the chief of enforcement.
(c) For purposes of this section "formal investigation" means an investigation ordered by the peer review body's medical executive committee or its equivalent, based upon information indicating that the physician and surgeon may be suffering from a disabling mental or physical condition that poses a threat to patient care. "Formal investigation" does not include the usual activities of the well-being or assistance committee or the usual quality assessment and improvement activities undertaken by the medical staff of a health facility in compliance with the licensing and certification requirements for health facilities set forth in Title 22 of the California Code of Regulations, or preliminary deliberations or inquiries of the executive committee to determine whether to order a formal investigation. For purposes of this section, "usual activities" of the well-being or assistance committee are activities to assist medical staff members who may be impaired by chemical dependency or mental illness to obtain necessary evaluation and rehabilitation services that do not result in referral to the medical executive committee.
(d) Information received by the diversion program pursuant to this section shall be governed by, and shall be deemed confidential to the same extent as program records under, Section 2355. The records shall not be further disclosed by the diversion program, except as provided in subdivision (b).

B & P Section 821.5
(e) Upon receipt of notice from a peer review body that an investigation has been closed and that the peer review body has determined that there is no need for further action to protect the public, the diversion program shall purge and destroy all records in its possession pertaining to the investigation unless the diversion program administrator has referred the matter to the chief of enforcement pursuant to subdivision (b).
(f) A peer review body that has made a report under subdivision (a) shall not be deemed to have waived the protections of Section 1157 of the Evidence Code. It is not the intent of the Legislature in enacting this subdivision to affect pending litigation concerning Section 1157 or to create any new confidentiality protection except as specified in subdivision (d). "Pending litigation" shall include Arnett v. Dal Cielo (No. S048308), pending before the California Supreme Court.
(g) The report required by this section shall be submitted on a short form developed by the board. The board shall develop the short form, the contents of which shall reflect the requirements of this section, within 30 days of the effective date of this section. The board shall not require the filing of any report until the short form is made available by the board.
(h) This section shall become operative on January 1, 1997, unless the regulations required to be adopted pursuant to Section 821.6 are adopted prior to that date, in which case this section shall become operative on the effective date of the regulations.

Table 2.10: Public Disclosure - (California Business & Profession Section 2027)

The Business and Professions code defines what the Medical Board can report to the public, what can be reported to entities and agencies, and how long the information is to remain public (see Table 2.10).

B & P Section 2027[106]
2027. (a) On or after July 1, 2001, the board shall post on the Internet the following information in its possession, custody, or control regarding licensed physicians and surgeons: (1) With regard to the status of the license, whether or not the licensee is in good standing, subject to a temporary restraining order (TRO), subject to an interim suspension order (ISO), or subject to any of the enforcement actions set forth in Section 803.1. (2) With regard to prior discipline, whether or not the licensee has been subject to discipline by the board or by the board of another state or jurisdiction, as described in Section 803.1. (3) Any felony convictions reported to the board after January 3, 1991. (4) All current accusations filed by the Attorney General, including those accusations that are on appeal. For purposes of this paragraph, "current accusation" shall mean an accusation that has not been dismissed, withdrawn, or settled, and has not been finally decided upon by an administrative law judge and the Medical Board of California unless an appeal of that decision is pending. (5) Any malpractice judgment or arbitration award reported to the board after January 1, 1993. (6) Any hospital disciplinary actions that resulted in the termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason. (7) Any misdemeanor conviction that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed. (8) Appropriate disclaimers and explanatory statements to accompany the above information, including an explanation of what types of information are not disclosed. These disclaimers and statements shall be developed by the board and shall be adopted by regulation. (9) Any information required to be disclosed pursuant to Section 803.1.
(b) (1) From January 1, 2003, the information described in paragraphs (1) (other than whether or not the licensee is in good standing), (2), (4), (5), (7), and (9) of subdivision (a) shall remain posted for a period of 10 years from the date the board obtains possession, custody, or control of the information, and after the end of that period shall be removed from being posted on the board's Internet Web site. Information in the possession, custody, or control of the board prior to January 1, 2003, shall be posted for a period of 10 years from January 1, 2003. Settlement information shall be posted as described in paragraph (2) of subdivision (b) of Section 803.1. (2) The information described in paragraphs (3) and (6) of subdivision (a) shall not be removed from being posted on the board's Internet Web site. Notwithstanding the provisions of this paragraph, if a licensee's hospital staff privileges are restored and the licensee notifies the board of the restoration, the information pertaining to the termination or revocation of those privileges, as described in paragraph (6) of subdivision (a), shall remain posted for a period of 10 years from the restoration date of the privileges, and at the end of that period shall be removed from being posted on the board's Internet Web site.
(c) The board shall provide links to other Web sites on the Internet that provide information on board certifications that meet the requirements of subdivision (b) of Section 651. The board may provide links to other Web sites on the Internet that provide information on healthcare service plans, health insurers, hospitals, or other facilities. The board may also provide links to any other sites that would provide information on the affiliations of licensed physicians and surgeons.

Summary

The Medical Board of California is charged with protecting the public in regards to medical practice and is responsible for tracking and enforcing the laws that govern medical practice. As the laws and healthcare have increased in complexity, so has the work of the Medical Board. It has become more difficult to ensure that entities are adhering to all the laws and that the laws do not conflict with each other.

Required by law, medical peer review by entities is one of the key mechanisms to monitor patient quality and safety. But peer review as a quality and safety process is being called into question. Professionals have begun to wonder if the "old" way of peer review is sufficient or even necessary any longer. This chapter has provided an overview of some of the history and positive and negative aspects of peer review. Additionally, it has provided alternate strategies used by other states and other entities to monitor quality and safety.

California laws governing medical practice are numerous and complex. Because of this complexity, most hospitals and many physician groups and health plans employ or contract with an attorney or attorneys. The intent of all of these laws has been to protect the public and improve patient care quality and safety. Unfortunately, they have not always worked as intended.

Previous to this study, there has been little empirical evidence on which to base a decision to change the current peer review system. This Peer Review Study is an effort to analyze empirical data to ascertain whether peer review can continue to be relevant in assessing medical care. Chapter III will detail the methodology used in this study to determine whether medical peer review is still appropriate for ensuring patient safety and quality in California medical care entities.

Chapter III: Methodology

Introduction

In this chapter, we provide a detailed explanation of the study methodology in the following format.

Research design includes:

- Study type
- Population
- Sample selection
- Sample size estimates
- Independence of study personnel
- Measurement instruments
- Data collection
- Data analyses

Additionally, we cover criticisms of the study uncovered during the study and the methods used to mitigate them.

Research Design

Study Type

The design of this study is both quantitative and qualitative; it is cross-sectional, retrospective, and descriptive. Since the topic has not been extensively studied in the past, we used multiple data collection methods, including document review, survey, focus groups, site visits, and key informant interviews. All these methods, described in detail later in this chapter, cover the questions required in the 805.2 legislation (see Table 1.1) but in different ways and in different formats. We examined peer review from as many perspectives as possible.

Population

The legislation specified the population for the study. Specifically, Section 805.2 states, "peer review bodies throughout the State, including the role of other related committees of acute care health facilities and clinics involved in the peer review process."[1] We produced a population frame based on the definitions of the eligible entities, as specified in the legislation (see Tables 2.6 and 3.1). We used multiple sources to identify the population of each entity type (see Table 3.1).

Table 3.1: Population Count and Data Source for Study Entities

Entity Type	Population	Sources
Hospitals	366	Office of Statewide Health Planning and Development (OSHPD) 2005[107]
Healthcare plans	51	The California Department of Managed Care 2007[108, 109], California Association of Health Plans[110], Medicare database of health plans
Professional societies	9	Web sites of the state and national professional entities
Medical groups/clinics	123	OSHPD[107], Cattaneo and Stroud Databases and Reports[111], the California Office of the Patient Advocate[112], Medicare database of medical groups

Professional societies are defined in the legislation (see Table 2.6), but we had difficulty estimating a comprehensive population. The legislation lists a number of professions in addition to medicine, so we included those professional entities in our sample. Since the MBC focuses specifically on monitoring the practice of medical doctors and podiatrists, we also included professional entities related to medicine and podiatry.

We defined healthcare facilities as short-term general/general acute care (GAC) hospitals; we defined healthcare plans as full-service medical plans versus dental plans, behavioral health or other system or disease-specific plans. We included both licensed/certified and unlicensed healthcare plans, and we sampled medical groups and clinics that are both licensed/certified and unlicensed/not certified.

We encountered several barriers in obtaining comprehensive lists of health plans, clinics, and medical groups. A list of licensed health plans is available from the Department of Managed Care, but a list of unlicensed health plans is not. We were able to identify some unlicensed health plans using a proprietary Medicare database but were unable to determine why some health plans are not required to be licensed.

Certain primary care and specialty clinics are licensed or certified and lists are available from OSHPD; some clinics are certified by the federal government (e.g., VA and Indian Health). However, there are many clinics that are neither certified nor licensed. Again, we were unable to determine the reasons for why some clinics are neither licensed nor certified by the State. No separate list of "medical groups" exists. Some medical groups can be found in the list of health plans. Others are found in the list of clinics; and some others are found in a proprietary Medicare database.

Another barrier in identifying the population was that health plans and medical groups frequently have multiple aliases (e.g., also-known-as or aka) and doing-business-as (dba) names. Health plans also have multiple names and use different names for various programs within the company, such as the Medicare-specific program, a psychiatric/behavioral health program, or others. An additional complicating factor was that management service organizations (MSO) frequently manage multiple medical groups or clinics and perform various services for them, including peer review. The MSOs may also have other management business, such as a health plan or hospital, or own a health plan or hospital, in addition to managing clinics or medical groups.

The Cattaneo and Stroud Databases maintained jointly by Cattaneo and Stroud and the Pacific Business Group on Health were extremely helpful, as were the reports they produced that were

funded by the California Healthcare Foundation[111]. Therefore, our population is based on the most accurate information available, as well as on the setting-specific parameters mentioned previously. The next section of this chapter details our sampling selection method.

Sample Selection

After establishing the populations, we used the SAS survey select procedure to generate the sample. Following our initial selection, we discovered that a number of the health plans and medical groups were closed and others were duplicates because of dba and aka names. At this point, we discovered the Cattaneo and Stroud databases[111] and were able to obtain the multiple names of medical groups, along with their correct addresses. We searched health plan Web sites to identify the multiple names and multiple program names that were in use, as well as addresses and other contact information. We corrected the populations and again selected our sample. We searched for California chapters of national professional associations for the professions listed in the legislation. There were nine professional societies that were selected to participate.

The selected sample produces an accurate representation of the population of hospitals, health plans, and medical groups in California because 1) the sample adheres to the assumptions in the proportions from a finite population sampling methodology, and 2) we over-sampled both health plans and medical groups by 25% to ensure an adequate number. In the hospital sample, two had changed designation to long-term care (LTC), so we replaced them with matches from their strata. The hospitals were over-sampled by 10% so the sample size remained robust. After the cleaning and replacements, our total sample was n=245 (see Table 3.2).

Table 3.2: Population and Final Sample for Entities

Entity type	Population	Final Sample	% of Population
Hospitals	366	132	36.1%
Healthcare plans	51	28	54.9%
Professional societies	9	9	100.0%
Medical groups/clinics	123	76	61.8%
Total	**549**	**245**	**46.5%**

This final sample was used for Phase I (Document review) and Phase II (Online survey) of the study. Phases III (Site visits) and V (Validation) participants were a 5% sub-sample drawn randomly from within the initial sample (see Table 3.3). Phase IV (Focus groups and Key informant interviews) used invited participants who met certain criteria listed in the proposal: representatives from the four entities, attorneys involved in peer review, physicians who had been reviewed and were reviewers, malpractice company representatives, and patient advocates.

Table 3.3: Sample Counts for Entities by Study Phase

Entity Type	Phase I Document Review	Phase II Survey	Phase III Site Visit	Phase IV Focus Groups*	Phase V Validation (Parts 1 & 2)
Hospitals	132	132	6	*	5/6
Healthcare plans	28	28	1	*	1/1
Professional societies	9	9	0	*	1/0
Medical groups/clinics	76	76	3	*	1/3
Total	**245**	**245**	**10**	*	**8/10**

*Focus group participants and key informant interviewees were invited based on the proposal criteria. These data will be described in Chapter IV.

Sample Size Estimates

Hospitals

We conducted a stratified random selection based on 366 short-term general hospitals in the 14 Health Services Agencies (HSAs) of California[113]. We additionally ensured that the sample was representative of the hospital population in number of staffed beds, rural/urban mix, teaching/non-teaching mix, type of control/ownership, and major hospital systems in California. These variables have previously been shown to have a relationship with hospital patient outcomes and also describe the variability in California medical care delivery. We over-sampled by 10% and selected 132 hospitals.

The sample size was estimated using proportions from a finite population with a bound of .05 (i.e., the sample size is > 5% of the population), a confidence of 95% (i.e., we can be 95% certain that the population parameters are within the confidence intervals), and a predicted population proportion of .50 (i.e., we assume the maximum allowable variance [50%] in the population and use the most conservative [largest] sample [in the language of the social sciences; this produces adequate statistical power to find an effect if an effect is present]).

Table 3.4 provides comparisons of percentages and absolute numbers of the population frames versus sample estimates for each of the strata. The percentages are similar, so we are confident our selection method provides a representative sample of the hospitals in California.

Table 3.4: Comparisons of Hospital Sample Stratified to Population

		Population (n=366)		Sample (n=132)	
Variable	**Level**	**N**	**% of 366**	**n**	**% of 132**
Region	Northern Cal.	31	8.5%	7	5.3%
	Golden Empire	18	4.9%	7	5.3%
	West Bay	14	3.8%	5	3.8%
	North Bay	20	5.5%	7	5.3%
	East Bay	20	5.5%	7	5.3%
	N. San Joaquin	21	5.7%	8	6.1%
	Santa Clara	12	3.3%	5	3.8%
	Mid Coast	11	3.0%	4	3.0%
	Central	30	8.2%	10	7.6%
	Santa Barbara	12	3.3%	5	3.8%
	LA	91	24.9%	36	27.3%
	Inland Empire	33	9.0%	12	9.1%
	Orange County	31	8.5%	11	8.3%
	San Diego/Imperial	22	6.0%	8	6.1%
Bed No.	<120	143	39.1%	53	40.2%
	120-249	128	35.0%	47	35.6%
	250-499	81	22.1%	24	18.2%
	500+	14	3.8%	8	6.1%
Rural/Non	Rural	66	18.0%	22	16.7%
	Non Rural	300	82.0%	110	83.3%
Teach/Non	Teaching	26	7.1%	9	6.8%
	Non Teach	340	92.9%	123	93.2%
Profit/Non	City/County/State	26	7.1%	9	6.8%
	District	46	12.6%	12	9.1%
	Investor	93	25.4%	37	28.0%
	Non Profit	201	54.9%	74	56.1%
System/ Non	CHW	28	7.7%	11	8.3%
	Kaiser	28	7.7%	8	6.1%
	Tenet	20	5.5%	14	10.6%
	Sutter	21	5.7%	10	7.6%
	HCA	5	1.4%	1	0.8%
	Adventist	14	3.8%	4	3.0%
	Non/Other	250	68.3%	84	63.6%

Notes:
Sample frame 2005 Financial Data from OSHPD – Short term general hospitals only.
Simple random selection stratified by HSA.

Health Plans

The sampling method for health plans was a stratified random selection based on strata for HSA (region) and rural versus non-rural. The sampling size was estimated using proportions from a finite population with a bound of .075 (i.e., the sample size is > 7.5% of the population), a confidence of 95% (i.e., we can be 95% certain that the population parameters are within the confidence interval), and a predicted population proportion of .50 (i.e., we assume the maximum allowable variance [50%] in the population and use the most conservative [largest] sample [in the language of the social sciences, this produces adequate statistical power to find an effect if an effect is present]).

Table 3.5 provides comparisons of percentages and absolute numbers of the population frames versus sample estimates for each of the strata. The percentages are similar, so we are confident our selection method provides a representative sample of the health plans in California. We over-sampled by 25% and selected 28 health plans.

Table 3.5: Comparison of Health Plan Sample Stratified to Population

		Population (N=51)		Sample (n=28)	
Variable	**Level**	**N**	**% of 51**	**n**	**% of 28**
Region	01 – Northern California	0	0.0%	0	0.0%
	02 - Golden Empire	3	5.9%	1	3.6%
	03 - West Bay	1	2.0%	1	3.6%
	04 - North Bay	5	9.8%	4	14.3%
	05 - East Bay	8	15.7%	4	14.3%
	06 - North San Joaquin	1	2.0%	0	0.0%
	07 - Santa Clara	3	5.9%	1	3.6%
	08 – Mid Coast	0	0.0%	0	0.0%
	09 - Central	2	3.9%	1	3.6%
	10 - Santa Barbara/ Ventura	2	3.9%	1	3.6%
	11 - Los Angeles County	16	31.4%	11	39.3%
	12 - Inland Counties	1	2.0%	1	3.6%
	13 - Orange County	6	11.8%	2	7.1%
	14 - San Diego/ Imperial	3	5.9%	1	3.6%
Rural/Non	Rural	0	0.0%	0	0.0%
	Non	51	100.0%	28	100.0%

Notes:
Matched health plan address county location to assigned 14 OSHPD regions.
Matched health plan address county location with assigned Rural vs. Urban location based on the 2005 CMS MSA crosswalk.

Medical Groups/Clinics

The sampling method for medical groups was a stratified random selection based on strata for HSA (region), number of physicians in the medical group/clinic, and rural versus non-rural. The sampling size was estimated using proportions from a finite population with a bound of .075 (i.e., the sample size is > 7.5% of the population), a confidence of 95% (i.e., we can be 95% certain that the population parameters are within the confidence interval), and predicted population proportion of .50 (i.e., we assume the maximum allowable variance [50%] in the population and use the most conservative [largest] sample [in the language of the social sciences; this produces adequate statistical power to find an effect if an effect is present]).

Table 3.6 provides comparisons of percentages and absolute numbers of the population frames versus sample estimates for each of the strata. The percentages are similar, so we are confident our selection method provides a representative sample of the medical groups/clinics in California. We over-sampled by 25% and selected 76 medical groups.

Table 3.6: Comparison Medical Group/Clinics Sample Stratified to Population

		Population (N=123)		Sample (n=76)	
Variable	**Level**	**N**	**% of 123**	**n**	**% of 76**
Region	01 – Northern California	2	1.6%	2	2.6%
	02 - Golden Empire	5	4.1%	3	3.9%
	03 - West Bay	5	4.1%	3	3.9%
	04 - North Bay	5	4.1%	2	2.6%
	05 - East Bay	6	4.9%	4	5.3%
	06 - North San Joaquin	4	3.3%	2	2.6%
	07 - Santa Clara	5	4.1%	3	3.9%
	08 – Mid Coast	3	2.4%	2	2.6%
	09 - Central	4	3.3%	2	2.6%
	10 - Santa Barbara/ Ventura	4	3.3%	2	2.6%
	11 - Los Angeles County	41	33.3%	26	34.2%
	12 - Inland Counties	18	14.6%	12	15.8%
	13 - Orange County	10	8.1%	5	6.6%
	14 - San Diego/ Imperial	11	8.9%	8	10.5%
No. of Physicians	1-100	12	9.8%	9	11.8%
	100-500	48	39.0%	31	40.8%
	501+	16	13.0%	7	9.2%
	Unknown	47	38.2%	29	38.2%
Rural/Non	Rural	3	2.4%	3	3.9%
	Non Rural	120	97.6%	73	96.1%

Notes:
Sample frame 2006 California Office of the Patient Advocate (from www.opa.gov site) – Healthcare Quality Report Card Directory and original file sent from OPA contact.

Matched medical group administrative address county location with assigned Rural vs. Urban location based on the 2005 CMS MSA crosswalk.

Two individual primary care clinics were included in the sample for representation.

Professional Societies

We were unable to locate a comprehensive list of professional societies in California. We selected the California chapters of national professional associations/societies representing all the professions listed in the legislation. Additionally, we contacted the California Association of Neurological Surgeons, because they were listed as having filed an 805 in the past, and the California Association of Physician Groups, because they represent physician groups. We contacted a total of nine professional associations/societies and report on the entire population (N=9) rather than a sample.

Independence of Study Personnel

The Legislature and the MBC required that the healthcare consulting firm and the scientists performing the study remained independent of any of the numerous individuals and entities with a vested interest in the peer review process. We maintained this independence in various ways. When we received unsolicited telephone calls and e-mails from entities and individuals asking us questions about the study or offering to assist us with the study or to redesign the methods, we used the following strategies to handle these inquiries:

1. Answered specific questions about the legislation that authorized the study and method.
2. Referred the person to the legislation.
3. Set up a Web site with details and frequently asked questions about the study and referred people to the Web site.
4. Encouraged the person to send messages to the e-mail box listed on the Web site.
5. Encouraged the person to write letters with comments to us.

We consistently informed everyone that the messages and letters would be reviewed near the end of the study and incorporated them in the report or the appendices. Study personnel referred callers or e-mails to Lumetra personnel not involved in the study to allow callers to express their opinions.

In determining the population frame and sample estimates, making decisions, managing refusals, and answering questions and criticisms, we used accepted scientific standards and rigorous methodology in the study. We kept track of all telephone calls and responses, e-mails and responses, and faxes, confirmations, and responses. We responded promptly to participant questions and requests and were flexible in extending deadlines for study phases when possible, while still maintaining the project timeline. We followed up on all calls, e-mails and faxes to ensure the entity an opportunity to participate in the study and maintained the confidentiality of all participants. However, we were required by contract to disclose those entities that declined, did not return contacts, or failed to participate.

We notified these entities that their lack of participation would be noted in the final report. We solicited facts, opinions, and perceptions and attempted to objectively and fairly represent divergent views in this report.

Measurement Instruments

Data were collected using multiple methods to investigate processes of medical peer review, the fair hearing process, and physician physical or mental impairment within the 805 and 821 processes. Phase I of the study was a mailed letter that requested documents from all the sampled entities, including policies, procedures, bylaws, and committee minutes. Phase II of the study was an online structured short-answer survey to staff in specified roles within each participant entity. The survey was designed to specifically address questions raised by the legislation. The survey questions were designed to be analyzed separately, so no psychometric testing was needed.

The survey was piloted twice with internal Lumetra respondents, including physicians, non-physician administrative staff, registered nurses, and statistical analysts. Based on input from these pilot participants, questions were edited for clarity and to make analyses more quantitative.

We created six versions of the survey. Each version was directed to individuals with different peer review roles related within the entities. The peer review committee chair and the non-physician support staff member received the full survey, while people in other positions received a shorter version with questions relevant to their role in the process.

Phase III consisted of site visits to 10 entities as part of the validation process. We created a sub-sample of 5% of the initial sample for site visits to compare documents, minutes, and interviews during an onsite review. Phase IV included focus groups, key informant interviews, and telephone conversations with people with a vested interest in peer review (representatives from the four entities, attorneys involved in peer review, physicians who had been reviewed and were reviewers, malpractice company representatives, and patient advocates). Phase V was the second part of the validation process using a different 5% sub-sample of the initial sample comparing survey results with documents and structured implicit patient record review by physician reviewers.

Data Collection

We followed up with entities by e-mail, telephone, or fax. If they did not respond within four weeks, we made two more attempts to contact them. After three attempts, the entities were listed as "no response" (see Appendix VI: Organizations that Declined or Made No Comment). A number of entities inquired about a penalty if they did not participate, and we cited the legislation as saying, "The independent entity for the study had no authority over them." However, the MBC directed that we list the names of those entities that did not participate in the final report.

Contacts between Lumetra study staff and each entity were maintained by e-mail, telephone, and/or fax with a primary contact (typically a medical staff support person) designated by the CEO or Chief of Medical Staff. In Phase I of the study, we requested all policies, procedures, bylaws, or other documents that described the entities' peer review process. We asked for five years of minutes from any committee whose function was peer review, particularly the decision-making committee such as the Medical Executive Committee (see Appendix I: Study Results and Appendix IV: Structured Review Forms).

In Phase II of the study, we requested that the primary contact forward our request for survey completion to the appropriate individuals within the entity, including peer review committee chairs, reviewing physicians, reviewed physicians, attorneys who represented the entity, attorneys who represented reviewed physicians, and non-physician support staff. We also solicited survey completion by direct mail to physicians who had been reported through the 805 mechanism in the year 2007. As noted earlier, not everyone received the complete survey because not all the questions were relevant to each role (see Appendix II: Survey and Focus Group Questions).

In Phase III of the study, we selected 10 sites from our site visit sample to compare onsite peer review minutes and policies with the documents submitted. The study reviewer spent a day at each site checking documents, including policies and minutes, as well as discussing the entity's processes with the contact person (see Appendix IV: Structured Review Forms). We also made two site visits to the MBC to ask questions and collect data and information (see Appendices I and IV)

In Phase IV, we conducted two telephone focus groups and several key informant interviews between March 15 and April 14, 2008. There were five to seven invited participants in each focus group, with each group of participants representing different roles, including patient safety advocates, attorneys for entities and physicians, health plan executives, medical group executives, and representatives from malpractice companies.

Key informant interviews included patient safety advocates, malpractice companies, health plan executives, and attorneys. One important concern that was raised in the interviews was the possibility of physicians in solo or small practices without hospital privileges never being peer reviewed.

We invited these types of participants based on our contacts with participant entities and their roles in national, state, and local entities (see Appendix II: Survey and Focus Group Questions). In Phase V (Validation) of the study, we performed several activities to allow us to validate the results of the study, including structured implicit patient record reviews by the study medical director (see Appendix IV: Structured Review Forms), comparison of documents with survey results (see Appendix IV), multiple reviewers of all documents and minutes to check reliability, and a review of all data collected and analyzed.

A Web page linked to the Lumetra Web site was created to give an overview of the study, including the specific legislation. The Web page also included frequently asked questions and an e-mail box for anyone who wished to provide feedback about the study. Lumetra staff in a department separate from the study staff monitored the e-mail box, and the e-mails were only examined in the data analysis phase of the study. Appendices I, II, and V contains all study data collection instruments, including the initial document request letter, document review form, minutes review form, all versions of the online survey, MBC visit questions and document review form, focus group/key informant interview questions, and validation request.

Data Analyses

Because of the numerous ways in which data were collected, the issue of unit of analysis for the study was a concern. Peer review is performed at the entity level, so that is our unit of interest. For analyses of the documents and minutes, we aggregated data results to the level of the entity. The data collected via the online survey were not identifiable by individual and are aggregated to the entity type or the respondents' role in the peer review process.

Because of the way some of the survey questions were phrased, we analyzed them by response rather than by role or entity type. The focus group and key informant interview data are analyzed in the context of the role of the participants in relationship to the type of entity or to their role in relationship to peer review. The site visits and other validation methods are analyzed in terms of entity type.

Data analyses encompassed multiple methods beginning with descriptive information of central tendency of the sample. For Phase I, documents were reviewed using a structured format (see Appendix IV: Structured Review Forms); responses were aggregated and quantified using descriptive statistics. The structured format allowed for analyses of comments related to the policies, procedures, and other documents.

Those data are described using qualitative descriptions. Short answer responses from document reviews, surveys, and site visits, focus group/ key informant responses, and structured implicit

review were qualitatively analyzed using 1) an analysis of words (word repetitions, key terms, and key words in contexts); and 2) a careful reading of blocks of texts to identify themes[114].

For Phase II, survey responses were analyzed using measures of central tendency, including mean, median, and mode, measures of proportion, including frequencies and percentages, and measures of variation, including range and standard deviation. We also investigated correlations and means comparisons. Many of the survey questions allowed respondents to provide comments. These comments are described qualitatively in the results section, and the actual comments appear in Appendix IX: Comments About Study.

For Phase III (Site Visits), data were analyzed using content analysis of the structured reviews (see Appendix IV: Structured Review Forms) and by quantifying data as possible. In Phase IV, focus groups and key informant interviews were also analyzed using content analysis based on the broad questions that were asked (see Appendix II: Survey and Focus Group Questions). Phase V (Validation) data were analyzed descriptively using the comparisons (survey responses and documents) and structured implicit chart review (reviewing actions taken by the entity).

Study Criticisms

Through several sources, we heard about criticism of the study while it was in progress. Below, we describe the types of criticism/concern of which we are aware and list underneath the methods (responses) we used to counter or mitigate any negative effects.

1. Lumetra's ability to maintain independence during the study
   a. Lumetra has no vested interest in the results of the study.
   b. The sampling method was random, blinded to the researchers, and generated by computer.
   c. A Web site was created to explain the study and allowed people to submit comments.
   d. A department separate from the study researchers monitored the site and only provided the comments to the researchers at the end of the study.

2. Funding for Lumetra to conduct this study (i.e., to "do it right")
   Although both money and time were limited, we made use of both by setting deadlines and moving through the study requirements in a consistent manner.

3. Study presumption that there is failure in the 805 reporting method
   a. Although there appears to be a small number of 805 reports per California population, one of the purposes of the study was to investigate the issue of appropriate reporting.
   b. As an independent contractor, Lumetra was in the position of being objective about the data and did not form premature assumptions.

4. Information about cases not reported and reasons why to be used against physician or hospital
   a. In order to understand whether appropriate 805 reporting is being done, it is necessary to understand decisions that are made <u>not</u> to report an event.
   b. The legislation guaranteed that the information would not be used against a hospital or a physician.

5. The burden of and expense of study requests (e.g., five years' worth of cases too many to send to Lumetra).
   a. The entities' policies dictate the number of cases reviewed and the peer review committee minutes format.
   b. Entities with the least electronic record capability were the most significantly impacted.

   c. We asked for the minimum data to answer the study questions; we also extended numerous deadlines for entities in all phases of the study.

6. Document requests in violation of Evidence Code 1157
   B&P 805.2 made clear that the documents provided to the study team would not be "discoverable."

7. MBC requirement to provide a list of entities that declined or did not participate
   Lists of entities that declined or did not participate are in Appendix VI: Organizations that Declined or Made No Comment, of this final report, as required by MBC.

8. Superficial and biased survey questions would produce sensational results but no meaningful data (see Appendices II and IV)
   a. The survey was one method of allowing a large number of individuals to have input into the study.
   b. The questions attempted to uncover complex and difficult issues.
   c. Individuals were invited to add comments or write e-mails or letters to Lumetra to provide additional information and for inclusion in the study.
   d. Many did provide additional comments, and they are included in Appendix IX: Comments About Study.

9. Awkward wording of survey questions (see Appendices II and IV)
   a. The questions were reviewed numerous times before the survey went online to try to insure they were clear and concise.
   b. The content of the legislation is complex and questions and absolute answers were difficult to construct.
   c. The wording of some of the questions is a limitation of this part of the study.
   d. We also offered all participants the option of writing comments and letters.

10. Closed hospitals surveyed by Lumetra
    a. Requests were sent to one hospital that had closed between the creation of the database and the beginning of the study; two others had converted from a general acute care hospital to long term care; a third error in our data led to a letter meant for a health plan being sent to one of their older closed hospitals.
    b. We corrected all these errors in our data.

11. People not notified about the survey
    a. Each entity had a primary contact person.
    b. The online survey Web link was forwarded to the contact person.
    c. We contacted physicians who had been the subject of an 805 report and invited them to complete a survey.
    d. All the people who had emailed or called were encouraged to comment through our study Web site or direct mail surveys.

12. The necessity of asking whether MDs are paid or not for peer review
    One of the study requirements is to estimate the cost of peer review.

13. The inclusions of questions suggesting that an elite group controls hospital privileges and uses peer review for political reasons, such as the elimination of competitors, ethnic minorities, persons for whom English is a second language, and females
    a. These questions were required by the legislation.
    b. Some individuals were offended that these questions were asked.
       Other individuals were grateful that these questions were asked.

14. The term “peer review process” not defined by law, and Lumetra staff refusal to elaborate on the law (some entities say “little peer review” and others, “big peer review”)
    a. The term peer review is used to mean many things.
    b. This study was designed to study medical peer review performed by medical doctors.

15. Lumetra inability to define peer review body or clarify more specifically what documents would be required
    a. The study team used the definitions in the law to try to clarify terms.
    b. The team attempted to be explicit about what was required (five years of minutes from peer review committees).

16. Study request for information protected by the Lantermann-Petris-Short Act
    a. The team did not ask for protected mental health information, rather we asked for the process of dealing with physicians who are impaired.
    b. We also asked that neither patients nor physicians be identified to us.

17. Lack of a representative sample with only 10 site visits conducted
    a. The primary way the study was designed to answer questions was through a review of policies, procedures, bylaws, and committee minutes.
    b. The initial proposal did not call for site visits; however, we added them because some entities were reluctant to provide peer review committee minutes.
    c. The sampling strategy was presented earlier in the chapter and demonstrates that our sample is representative.

18. Only few events were found that should have, but did not, trigger an 805 report
    a. Generally, we found that entities followed the letter of the law as they understand it.
    b. We contacted organizations that had questionable events and suggested they review the specific issue we found.

19. Creation of peer review policies by entities after requested by Lumetra
    Based on the documents reviewed and telephone and e-mail communication with the entities’ staff members, we did not find evidence to support this concern.

Summary

This chapter has provided detail about the research study design, measurement instruments, data collection, and data analyses. The study is retrospective, cross-sectional, and descriptive. The sampling method was stratified random selection. Data collection methods included document review, survey, site visits, focus group/key informant interviews, and study validation. We are confident that our sample is representative of healthcare entities in California based on the rigorous sampling and comparison of respondents and non-respondents.

From the study onset, there was resistance and anxiety from entities that were included in the sample. Although we attempted to alleviate the anxiety by providing explanations and flexible deadlines and listening to concerns, a number of entities and their attorneys have criticized the study methodology during the study. We have endeavored to articulate this criticism and the ways in which we mitigated any negative effects.

Chapter IV: Results

This chapter first presents a description of the sample, including the study respondents and non-respondents. Next, we detail the study findings and list the results from the various data collection methods under the relevant study requirements as specified in the B & P Code Section 805.2 (see Table 1.1). We conclude with the measures taken to validate the study.

Sample Description

The overall study response rate was 75.6%. Even though every entity did not respond to all the study phases, this responses rate is very good, given that survey response rate estimates of 50% are considered good[115] (see Table 4.1). The majority of entities sent some documents and participated in the survey. However, the peer review committee minutes (see Table 4.5) were omitted by many entities.

As required by the MBC, a list of entities that declined or did not respond to our communication, including the e-mail and letters detailing the reasons for non-participation, is in Appendix VI: Organizations that Declined or Made No Comment. The main reason offered was a lack of resources to gather the information. The next most common reason was per the advice of an attorney.

Figures 4.1 and 4.2 are graphic representations of the selected sample and the final participants in relationship to the location of the entities within the State. It is clear from these figures that the sample and the participants represent all geographic regions of California.

Figure 4.1: Map of Study Sample

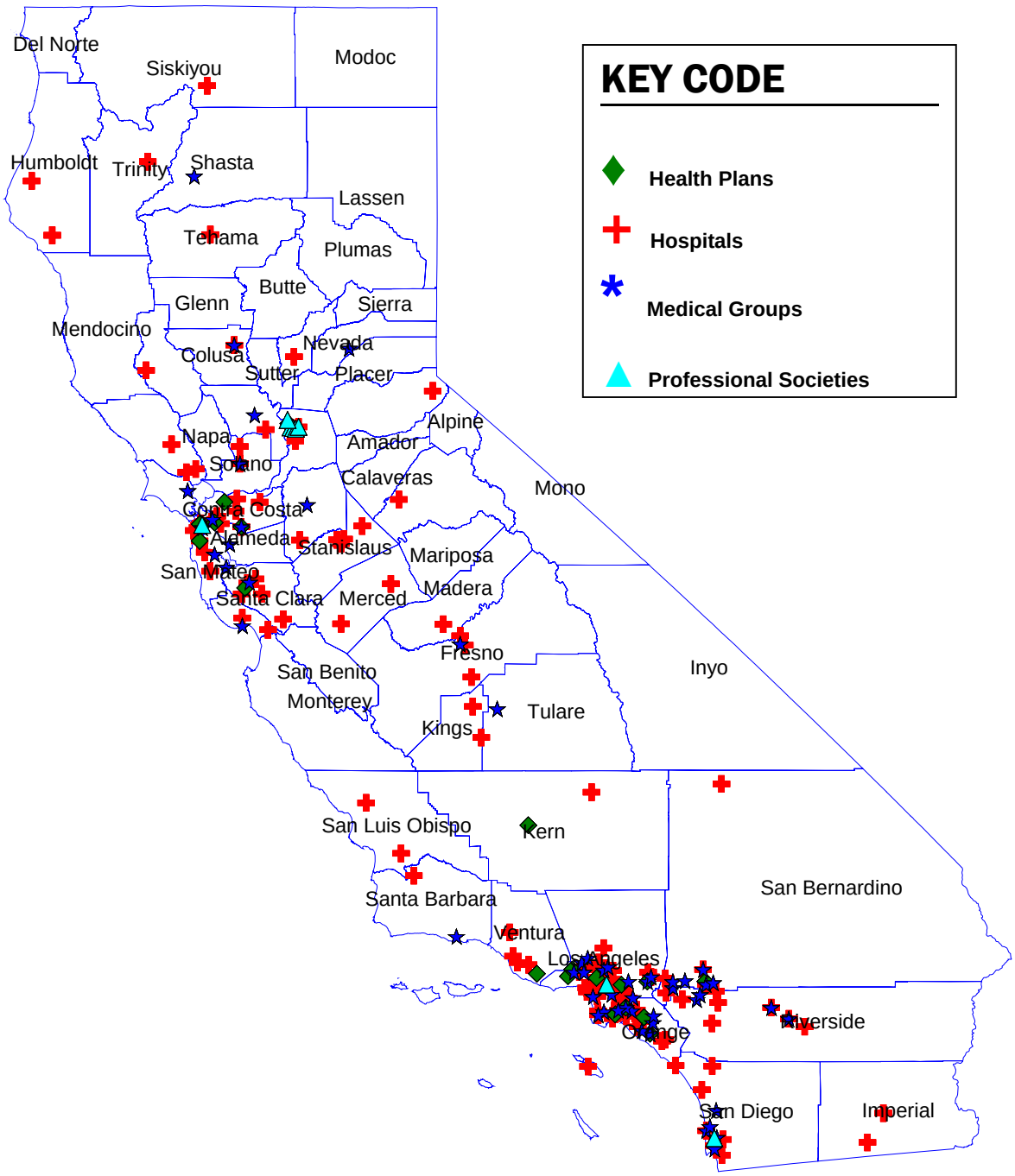


Figure 4.2: Map of Study Participants

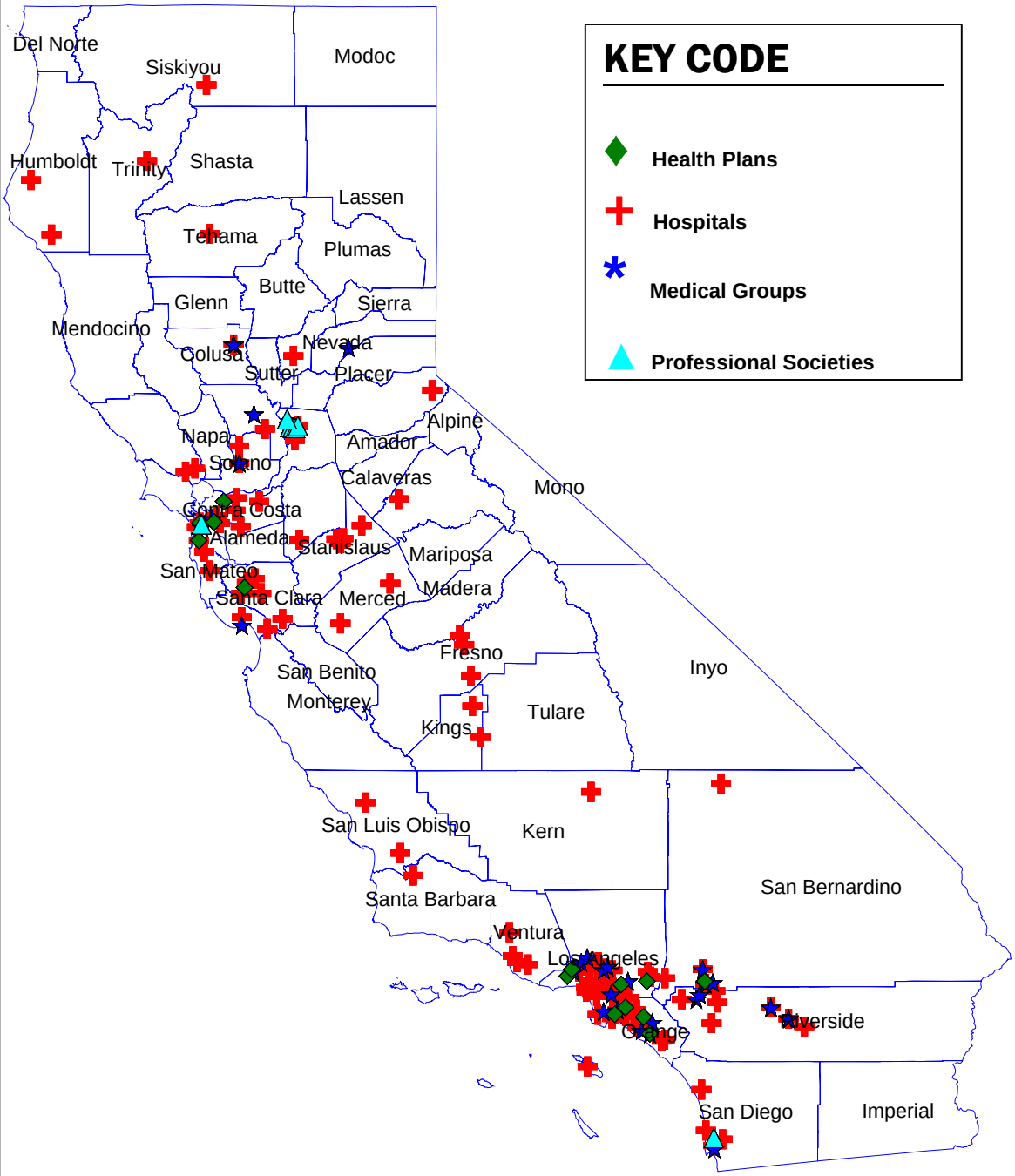


Table 4.1: Entity Participation by Study Phase

Entity type	Final Sample n (% of sample)	Participation in Study n (% of sample)	Declined or Did Not Participate n (% of sample)	Phase I Document Submits n (% of sample)	Phase II Survey n (% of sample)	Phase III* Site Visits	Phase IV** Focus Groups	Phase V Validation Parts 1 & 2
Hospitals	132 (100%)	117 (88.6%)	15 (11.4%)	109 (82.6%)	70 (53.0%)	6	**	5/6
Healthcare plans	28 (100%)	22 (78.6%)	6 (21.4%)	21 (75.0%)	13 (46.4%)	1	**	1/1
Professional Societies	9 (100%)	8 (88.9%)	1 (11.1%)	8 (88.9%)	1 (11.1%)	0	**	1/0
Medical groups/clinics	76 (100%)	38 (50.0%)	38 (50.0%)	34 (44.7%)	23 (30.3%)	3	**	1/3
Total	**245 (100%)**	**185 (75.5%)**	**60 (24.5%)**	**172 (70.2%)**	**107 (43.7%)**	**10**	**	**8/10**

*Two sites included two entities each; one site visit included two hospitals, and one site visit included one medical group and one hospital. This occurred because one department in an entity performed quality/peer review for more than one entity.
**Focus group participants and key informant interviewees were invited based on specific characteristics described in Chapter IV.

As Tables 4.1, 4.2, 4.3, and 4.4 illustrate, the non-respondents were distributed randomly throughout our strata and did not differ from the respondents. Because of the concern expressed about the generalizability of the findings to the population, we took the extra precaution of comparing the population, sample, and participants by strata percentages. Although some of the information is redundant from previous tables, it is important to demonstrate the fact that the participants are sufficiently representative of the sample and the sample is representative of the population (see Tables 4.2, 4.3, and 4.4).

When reviewing these percentages, it becomes apparent that the participating entities are representative of both the overall population of California and of the individual strata from which they were drawn. Therefore, we are confident that the sample is generalizable to the State and to the various regions in the State. In addition to highlighting the generalizability of the sample to the population, the tables display sample characteristics

Table 4.2: Comparison of Hospital Participants Stratified to Sample

		Population (N=366)		Final Sample (n=132)		Study Participants (n=117)	
Variable	**Level**	**N**	**%**	**n**	**%**	**n**	**%**
Region	01 – Northern California	31	**8.5%**	7	**5.3%**	6	**5.1%**
	02 - Golden Empire	18	**4.9%**	7	**5.3%**	7	**6.0%**
	03 - West Bay	14	**3.8%**	5	**3.8%**	4	**3.4%**
	04 - North Bay	20	**5.5%**	7	**5.3%**	6	**5.1%**
	05 - East Bay	20	**5.5%**	7	**5.3%**	7	**6.0%**
	06 - North San Joaquin	21	**5.7%**	8	**6.1%**	8	**6.8%**
	07 - Santa Clara	12	**3.3%**	5	**3.8%**	5	**4.3%**
	08 – Mid Coast	11	**3.0%**	4	**3.0%**	4	**3.4%**
	09 - Central	30	**8.2%**	10	**7.6%**	9	**7.7%**
	10 - Santa Barbara/ Ventura	12	**3.3%**	5	**3.8%**	5	**4.3%**
	11 - Los Angeles County	91	**24.9%**	36	**27.3%**	31	**26.5%**
	12 - Inland Counties	33	**9.0%**	12	**9.1%**	11	**9.4%**
	13 - Orange County	31	**8.5%**	11	**8.3%**	10	**8.5%**
	14 - San Diego/ Imperial	22	**6.0%**	8	**6.1%**	4	**3.4%**
Bed No.	<120	143	**39.1%**	53	**40.2%**	47	**40.2%**
	120-249	128	**35.0%**	47	**35.6%**	41	**35.0%**
	250-499	81	**22.1%**	24	**18.2%**	22	**18.8%**
	500+	14	**3.8%**	8	**6.1%**	7	**6.0%**
Rural/Non	Rural	66	**18.0%**	22	**16.7%**	20	**17.1%**
	Non Rural	300	**82.0%**	110	**83.3%**	97	**82.9%**
Teach/Non	Teaching	26	**7.1%**	9	**6.8%**	7	**6.0%**
	Non Teaching	340	**92.9%**	123	**93.2%**	110	**94.0%**
Profit/Non	City/County/State	26	**7.1%**	9	**6.8%**	6	**5.1%**
	District	46	**12.6%**	12	**9.1%**	10	**8.5%**
	Investor	93	**25.4%**	37	**28.0%**	33	**28.2%**
	Non Profit	201	**54.9%**	74	**56.1%**	68	**58.1%**
System/Non	CHW	28	**7.7%**	11	**8.3%**	11	**9.4%**
	Kaiser	28	**7.7%**	8	**6.1%**	8	**6.8%**
	Tenet	20	**5.5%**	14	**10.6%**	14	**12.0%**
	Sutter	21	**5.7%**	10	**7.6%**	8	**6.8%**
	HCA	5	**1.4%**	1	**0.8%**	1	**0.9%**
	Adventist	14	**3.8%**	4	**3.0%**	4	**3.4%**
	Other	250	**68.3%**	84	**63.6%**	71	**60.7%**

Table 4.3: Comparison of Health Plan Participants Stratified to Sample

		Population (N=51)		Proposed Sample (n=28)		Study Participants (n=22)	
Variable	**Level**	**N**	**%**	**n**	**%**	**n**	**%**
Region	01 – Northern California	0	**0.0%**	0	**0.0%**	0	**0.0%**
	02 - Golden Empire	3	**5.9%**	1	**3.6%**	1	**4.5%**
	03 - West Bay	1	**2.0%**	1	**3.6%**	0	**0.0%**
	04 - North Bay	5	**9.8%**	4	**14.3%**	3	**13.6%**
	05 - East Bay	8	**15.7%**	4	**14.3%**	3	**13.6%**
	06 - North San Joaquin	1	**2.0%**	0	**0.0%**	0	**0.0%**
	07 - Santa Clara	3	**5.9%**	1	**3.6%**	1	**4.5%**
	08 - Midcoast	0	**0.0%**	0	**0.0%**	0	**0.0%**
	09 - Central	2	**3.9%**	1	**3.6%**	0	**0.0%**
	10 - Santa Barbara/ Ventura	2	**3.9%**	1	**3.6%**	0	**0.0%**
	11 - Los Angeles County	16	**31.4%**	11	**39.3%**	11	**50.0%**
	12 - Inland Counties	1	**2.0%**	1	**3.6%**	1	**4.5%**
	13 - Orange County	6	**11.8%**	2	**7.1%**	2	**9.1%**
	14 - San Diego/ Imperial	3	**5.9%**	1	**3.6%**	0	**0.0%**
Rural/Non	Rural medical group	0	**0.0%**	0	**0.0%**	0	**0.0%**
	Non Rural medical group	51	**100.0%**	28	**100.0%**	22	**100.0%**

Table 4.4: Comparison of Medical Group Participants Stratified to Sample

		Population (N=123)		Sample (n=76)		Participants (n=38)	
Variable	**Level**	**N**	**%**	**n**	**%**	**n**	**%**
Region	01 – Northern California	2	**1.6%**	2	**2.6%**	2	**5.3%**
	02 - Golden Empire	5	**4.1%**	3	**3.9%**	3	**7.9%**
	03 - West Bay	5	**4.1%**	3	**3.9%**	2	**5.3%**
	04 - North Bay	5	**4.1%**	2	**2.6%**	1	**2.6%**
	05 - East Bay	6	**4.9%**	4	**5.3%**	2	**5.3%**
	06 - North San Joaquin	4	**3.3%**	2	**2.6%**	0	**0.0%**
	07 - Santa Clara	5	**4.1%**	3	**3.9%**	0	**0.0%**
	08 - Midcoast	3	**2.4%**	2	**2.6%**	1	**2.6%**
	09 - Central	4	**3.3%**	2	**2.6%**	0	**0.0%**
	10 - Santa Barbara/ Ventura	4	**3.3%**	2	**2.6%**	0	**0.0%**
	11 - Los Angeles County	41	**33.3%**	26	**34.2%**	14	**36.8%**
	12 - Inland Counties	18	**14.6%**	12	**15.8%**	9	**23.7%**
	13 - Orange County	10	**8.1%**	5	**6.6%**	3	**7.9%**
	14 - San Diego/ Imperial	11	**8.9%**	8	**10.5%**	1	**2.6%**
Medical Group Size	1-100	12	**9.8%**	9	**11.8%**	6	**15.8%**
	100-500	48	**39.0%**	31	**40.8%**	14	**36.8%**
	501+	16	**13.0%**	7	**9.2%**	3	**7.9%**
	Unknown	47	**38.2%**	29	**38.2%**	15	**39.5%**
Rural/ Non Rural	Rural medical group	3	**2.4%**	3	**3.9%**	3	**7.9%**
	Non Rural medical group	120	**97.6%**	73	**96.1%**	35	**92.1%**

Findings

The Process of Peer Review

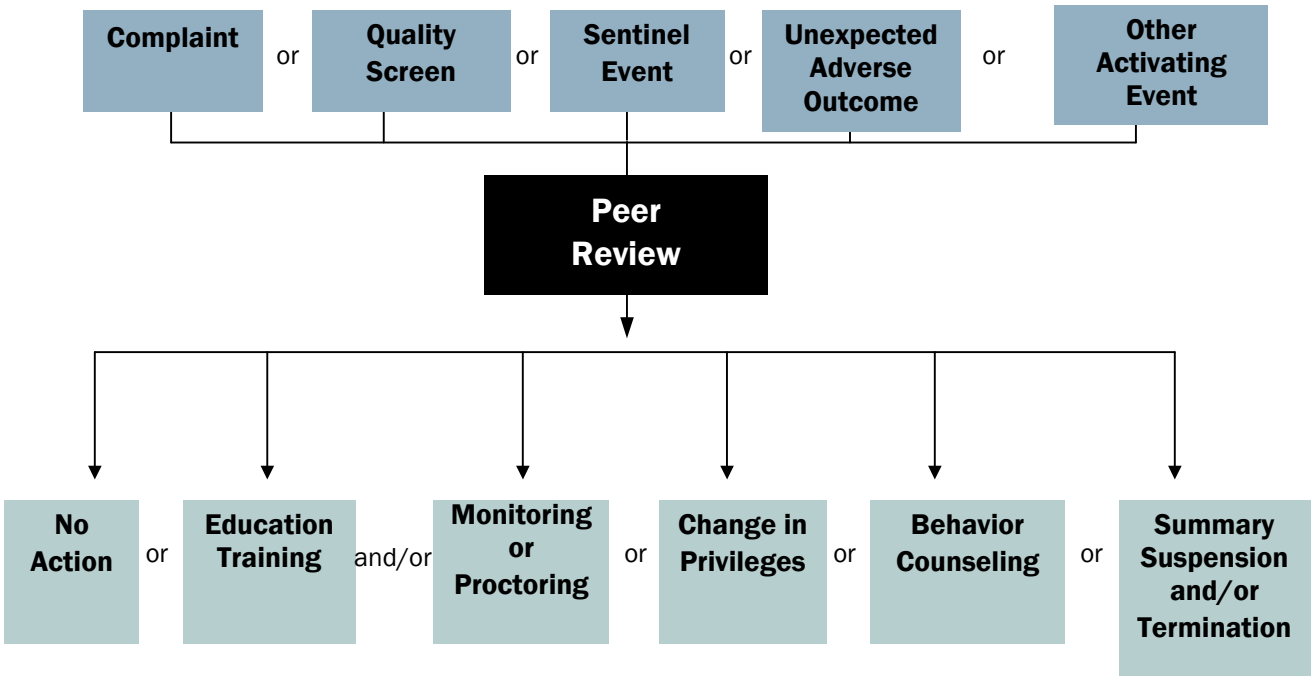
As explained earlier, medical peer review is used to determine whether medical care administered by physicians meets the standards set by an entity to ensure quality and safety in the entity's patient populations. If it does, the physician is allowed to continue to be affiliated with the entity and to treat patients within the context of the entity.

The determination of whether or not physicians' actions meet the standards set by the entity is made by "peer" medical physicians within the entity. Although most medical care entities develop policies and procedures that adhere to standards set by accrediting agencies or professional entities, the entity documents we reviewed indicated that standards within an entity are set by medical staff members who are affiliated with the entity. Oversight by State and federal licensing and credentialing entities provides direction as to standards that should or must be included, but the medical staff members in the entities make the final decisions.

Figure 4.3 displays the peer review process we typically found described in entity documents. Entity peer review policies indicated that there are numerous ways to trigger the peer review process, including routine quality screens done at the medical department level or in various committees in the entity. Peer review also may be triggered by a complaint, an unusual event, a sentinel event, or other methods.

The outcome of peer review likewise is varied. The peer review process may determine that there is no action needed, education may be needed, monitoring is required, or more severe action is needed, including summary suspension or termination. But what actually happens in the "black box" of peer review?

Figure 4.3: The California Peer Review Process



The remainder of this chapter presents evidence to answer this “black box” /"peer review" question. The precipitating events and outcomes of peer review in different entities are highly variable and specific to each entity. The following section details the findings from our document review and comments from participant individuals. The findings are organized by their relevance to the specific requirements of 805.2 legislation.

Requirement I: A comprehensive description of the various steps and decision makers in the peer review process as it is conducted by peer review bodies throughout the State, including the role of other related committees of acute care health facilities and clinics involved in the peer review process.

Document Review

To respond to Requirement I, we used document review and on-line surveys. We requested documents related to peer review activities from all selected entities (see initial request in Appendix I: Study Results), including policies, procedures, bylaws, charters, and minutes from quality, well being, peer review, or department committees for the time period 2002-2007.

We were seeking details of the entities’ processes of peer review and event reporting decision-making. We made no fewer than three attempts to contact each entity asking for these documents (see Table 4.3) and responded to over 400 telephone, e-mail, and fax inquiries about the project.

Based on comments from participants and documents from entities, we learned that the term “peer review” is used to mean different activities in different entities. However, in this study, we only studied and reported on medical peer review done by medical peers. Peer review committee minutes and activities are protected from discovery by California Evidence Code 1157[55], and the peer review committee meetings are typically closed to anyone other than recording staff and peers.

Policies and procedures indicate that peers may be physicians in the entity, physicians of a specific specialty or expertise, or physicians external to the entity (external review) depending on the event to be reviewed. The entities make an attempt to create peer review activities that are unbiased and objective, and focus first on remediation rather than disciplinary action whenever possible. However, most medical groups are small enough or the specialty is small enough that it is impossible for reviewers to be unaware of the identity of the physician being reviewed.

Credentialing of a physician by an entity can be thought of as the initial peer review interaction. The physician applies for privileges and presents credentials and other documents testifying to his/her qualifications. It is incumbent upon the physician to convince the entity that he/she is qualified to be a member of the medical staff. Medical executive bylaws that were reviewed indicate that the medical staff members make a determination about the application for privileges in the entity and either grant or deny the right to practice in the entity.

Re-credentialing of each physician who is granted privileges is done on a periodic basis in each entity. In re-credentialing, if the membership is terminated or restricted, it is incumbent upon the entity to demonstrate that the physician is no longer qualified to be a member of the medical staff.

Based on policy, procedure, and minutes review, peer review activities occur between the periodic re-credentialing of physicians. A peer review can be triggered in a number of ways (see Figure 4.3), but most frequently it is part of the quality/safety/risk process of an entity. Policies indicated that it may be started in various committees such as quality assurance/improvement, risk management,

utilization review/management committees, but it is frequently begun in a medical staff department committee.

Most participant entities routinely screen a certain percentage of patient records to check for evidence of substandard care that may be related to system problems, violations of discipline-specific standards, or violation of entity policies and procedures. A complicating factor in understanding the initiation of medical staff peer review issues is that the entity committee minutes indicated that all types of risk management events and actions are combined and discussed in "peer review" committees. Additionally, based on our review of committee minutes, medical staff committees often combine risk management/peer review issues with mundane issues related to running the business of the entity, such as fee increases, other financial issues, and other concerns.

The usual start of the peer review process in many organizations is when a non-physician support staff member (frequently a nurse) performs an explicit review (a review of the record using a structured format and procedure) of a medical record. If the non-physician support staff member using explicit review finds records that "fall outside the screen" (outside the standards of care for the entity), or if there are events that are questionable, the staff member forwards the record for review to the chair of a peer review committee or to the entire committee, depending on the policy and procedure. The record may then be forwarded to a higher-level committee of medical staff for more intensive medical staff review and evaluation.

Depending on the size and structure of the entity and the committees, the more intensive review may be at the departmental level, the medical executive committee, or other responsible medical staff groups, or any variation of these. If there is substantial deviation from the standard of care, the patient record follows the entity procedure and is eventually reviewed by the highest-level medical committee for decision-making and determination if any action should be taken against the physician.

As indicated in Figure 4.3, and based on our review of policies and procedures, events other than routine screening of records also can trigger peer review. Depending on the severity, as determined by the person who learns of the event and those persons who become involved in reviewing the details of the event, the peer review process can move quickly. Generally, however, our review of committee minutes demonstrated that the process is very lengthy involving months or years of re-review, review of more records, interviews with the physician, and/or other investigation methods within the entity.

The medical executive/decision making committee may require a focused review, which is a larger sample of patient records for targeted review of the physician in question. The focused review may require other physicians in the entity to review records and may require discussions about what the standard of care is for the particular event. If there are only a few physicians in the entity with limited expertise in the area of the event, an external review may be initiated. A contracted expert outside the entity conducts an external review, which may further delay any potential action taken as a result of the event.

There are many steps in the peer review process that allow variation. The entity policy defines what is reviewed, but typically a non-physician hospital staff/committee support employee is responsible for the initial review, maintenance of the quality, safety, risk, or credentialing processes and committees minutes, and tracking of events and physician behavior over time. To summarize, there is variation in what is subject to peer review, determined not only by the procedure that initiates peer review, but also by the individual support staff member and committee chairs' knowledge and tenacity in tracking events and physicians over time.

As indicated in Chapter III, we reviewed documents and minutes using a structured format (see Appendix IV: Structured Review Forms) that included assessment of whether:

- A bylaws template was used.
- The process for quality and safety assessment was outlined in bylaws or policies.
- There was a method for a fair hearing.
- There was a process for dealing with impaired physicians.

We also assessed whether the entity had a tracking system that allowed for systematic follow-up for events that potentially would be reported to the MBC, and whether the overall quality/safety/risk management program was organized and easy to understand and follow. Table 4.5 presents some of the findings of our structured review. Rather than submitting minutes, some entities provided a summary of an event to be used as an example of how the entity handled reporting through 805 or deciding not to report.

Table 4.5: Summary of Documents Submitted by Entity Type

Entity Type	Number in Final Sample	Number Submitting Any documents	Number Submitting No Minutes	Number Submitting Any Minutes	Number Submitting Five years Minutes	Number Submitting < Five Years Minutes	Number Providing Event Summary
Hospitals	132	109	104	28	17	11	30
Healthcare plans	28	21	12	16	14	2	11
Professional societies	9	8	9	0	0	0	0
Medical groups/ clinics	76	34	52	24	19	5	6
Total	**245**	**172**	**177**	**68**	**50**	**18**	**47**

Professional societies behave differently than the other three entity types. Of the eight that responded to our document request, four stated that they did not perform peer review and the other four reported that they were rarely involved in peer review. Of the four who were involved in peer review, three have policies and procedures but report any 805s to a professional board rather than the MBC. The remaining entity only accepts complaints about its members and refers other complaints to the MBC, so professional societies/entities have only minor role in the process of peer review.

One hundred-fifty entities (61.2% of 245) described the peer review process used in the entity through policies, procedures, or bylaws. Ninety-seven hospitals (78.5% of 132) used a template for medical staff bylaws, which provided a systematic way to include all the required elements necessary for description of peer review, and the disciplinary process that might occur (see Appendix IV: Structured Review Forms). Fifty-five and a half percent of the entities (136 of 245) described the 805 reporting process, and 55.1% (135 of 245) described the due process/fair hearing procedure. However, only 21.2% (52 of 245) mentioned or described the process for dealing with an impaired physician.

One third (33.1% of 245) of the entities used an event category or rating system based on severity, and a similar percentage (31% of 245) had a rating system for actions taken as a result of an event.

43.3% of the 245 entities had explicit definitions of events that initiated peer review and actions that resulted. Using a scale of 0 to 5 with 0 being no definitions, 1 being the poorest definitions, and 5 being the best definitions, as judged by the research team, entities scored an average of 1.2 (sd=1.7) in having explicit definitions of different categories of events or actions. Hospitals (mean=2.0 [1.8]) and health plans (mean=1.0 [1.7]) had the most explicit definitions, while medical groups (mean=.92 [1.4]) and professional groups (mean=.89 [1.8]) had less specific definitions.

Tracking events over time is an essential part of peer review because of the length and complexity of internal investigations. We scored the entities on whether the tracking systems were comprehensive based on evidence in minutes, policies, and procedures using a 0 (no evidence of tracking) to 5 (most comprehensive) scale based on the judgment of the research team. We determined "comprehensiveness" by reviewing policies and procedures to see if there were specific time frames specified for reviews and evaluating minutes to see if the policies were then followed.

We found that entities scored 0.5 (sd=1.0) overall with health plans averaging .89 (sd=1.6); hospitals averaged .82 (sd=1.5), and medical groups averaged .28 (sd=.9). None of the professional societies provided documents that indicated if they had a tracking system for peer review cases.

Based on the minutes reviewed in submitted documents and site visits, we found that entities generally follow their own policies and procedures related to peer review with the most common policy violation being the length of time it takes to complete an investigation and review. But tracking systems are limited and difficult to follow, and there is a great deal of variation in the specificity of policies and procedures about events that are investigated.

Online Survey

Information gleaned from the surveys is discussed next. One hundred-fifteen entities responded to the online survey from 245 eligible entities (see Table 4.6).

Table 4.6: Online Survey - Entity Response Rate

	Returned Survey	Eligible	Entity Response Rate
Entities	115	245	46.9%

Twenty percent of respondents were chairs of peer review committees, 21.1% were physician reviewers, 8% were physicians who had been reviewed, 41.1% were non physician support staff, 8.6% were attorneys representing entities, and 1.1% were attorneys representing a reviewed physician (see Table 4.7). Each of the four entity types was represented in the survey respondents; 62.9% were hospitals (see Table 4.8).

Table 4.7: Number of Online Survey - Individual Responses by Entity Type and Individual Role in Entity

	Entity Type				Total	%
Role	Hospital	Health Plan	Medical Group	Professional Society		
Peer Review Chair	44	7	15	4	70	20.0%
Physician Reviewer	30	21	21	2	74	21.1%
Physician Reviewed	21	1	5	1	28	8.0%
Non Physician Staff	97	8	32	7	144	41.1%
Attorney Representing Entity	25	0	2	3	30	8.6%
Attorney Representing Physician	3	0	1	0	4	1.1%
Total	**220**	**37**	**76**	**17**	**350**	**100.0%**

Table 4.8: Number of Online Survey - Responses by Entity Type

Entity Type.	n	%
Healthcare Plan	37	10.6%
Hospital	220	62.9%
Medical Group	76	21.7%
Professional Society	17	4.9%
Total	**350**	**100.0%**

Because we used six different versions of the study, we had varying numbers of potential or eligible respondents for each question. We provide the number of persons **eligible** to answer the question. In order to give an accurate representation of missing data, we also provide the number of respondents used as the denominator of the % when we report percentages.

The most common name of the decision-making/final authority committee was the Medical Staff Executive committee, followed by the Peer Review committee and Quality or Quality Improvement committee. The average number of members on the decision-making committee was 16 with an additional four non-physician hospital staff support members. Committees averaged eight different medical specialties represented and three other disciplines (see Table 4.9). Internal medicine, family practice, and surgery were the most frequently mentioned specialties on the committee and the usual length of time a member serves on a committee is for two or more years (see Table 4.10).

Table 4.9: Online Survey - Peer Review Body Composition
(214 eligible respondents)

What is the Composition of the Peer Review Body?	n	Mean	sd*
Total number (#) of members	137	16.4	9.2
Number (#) of committee members who are non-physician staff	140	3.8	3.2
Number (#) of disciplines represented besides medicine (nursing, medicine, pharmacy, etc)	135	2.8	3.7
Number (#) of different medical specialties represented (surgery, pediatrics, etc)	134	7.7	4.6
Number (#) of committee members who are generalists	120	3.4	5.9

*sd - standard deviation

Table 4.10: Online Survey - Peer Review Body Length of Term
(70 eligible respondents; 52 actual respondents; percentages based on a denominator of 52)

What is the usual term for each member who serves on the peer review body?	n	%
1 year	4	7.7%
2 years	14	26.9%
More than 2 years	24	46.2%
Other (please specify term)	10	19.2%
Total	**52**	**100%**

The decision-making committees reported multiple responsibilities, including managing overall quality of care issues, complaint/sentinel event investigation, monitoring physician practice and practice patterns, determining disciplinary action, and filing 805 reports. The respondents said that the committee was also responsible for monitoring utilization, initial screening activities, 809 hearings, and submitting 821.5 reports.

The committees have oversight responsibility for physician practice quality and safety issues, such as gross or flagrant care issues, limitation of practice, practice patterns not consistent with standards of care, egregious events, repeated errors, multiple patient complaints, and multiple physician complaints. They also are frequently responsible for monitoring required proctoring, quality screening issues, employee complaints, health plan complaints, and utilization review and risk management issues (see Table 4.11).

Membership on peer review committees involves a certain time commitment, and we were interested in knowing how difficult it was to replace members on the committee. Based on our survey data, on average, one person declined to be on the peer review committee for every four that were asked (see Table 4.12). We also asked physicians why they agreed to serve on a peer review committee (see Table 4.13). Most indicated a willingness or interest in peer review; others had experience in peer review; or it was required by the entity (see Table 4.13).

Table 4.11: Online Survey - Peer Review Body Tasks
(214 eligible respondents; 123 actual respondents; percentages based on a denominator of 123)

Indicate responsibilities of the peer review body: (check all that apply)	n	%
Quality of care concern (evaluate)	112	91.1%
Series of complaints/events about physician	107	87.0%
Sentinel event	98	79.7%
Secondary or final determination of action, if any, to be taken for a patient care issue related to a physician's practice	97	78.9%
Tracking or monitoring of a physician's practice issue	92	74.8%
Utilization of care (evaluate)	87	70.7%
A physician's practice pattern	87	70.7%
Submit an 805 report	72	58.5%
Submit an 821.5 report	60	48.8%
Initial screening for patient care issue related to a physician's practice	59	48.0%
Convene or oversight of an 809 hearing	57	46.3%
Initial screening for patient care issue related to an entity or systems-problem	50	40.7%
Other	20	16.3%

Table 4.12: Online Survey - Peer Review Body Membership Changes
(214 eligible respondents)

In the last calendar year,	n	Mean	sd
How many new members were added to the peer review body?	128	3	5.7
How many individuals were approached to serve on a peer review body?	101	4.1	6.5
If applicable, of those approached, how many refused?	73	1.1	2.3
How many unanticipated member changes have occurred in the peer review body?	127	0.5	1.1

Table 4.13: Online Survey - Peer Review Body Reasons for Serving
(74 eligible responses; 64 actual respondents; percentages based on a denominator of 64)

Identify the reason(s) you agreed to serve on the Peer Review Body? (check all that apply)	n	%
Willingness to serve	52	81.3%
Interest in peer review	46	71.9%
Experience in peer review	29	45.3%
Requirement for affiliation/employment	9	14.1%
Other	7	10.9%
Payment is offered by entity	4	6.3%
Scheduled/rotating obligation	3	4.7%
Requirement for hospital privileges	2	3.1%

Depending on the entity, various individuals and committees are responsible for determining whether to refer an issue/event to a higher level review, including the committee chair or a majority of members of peer review committees, credentialing committees, department committees, professional affairs committees, and risk management committees.

Fifty-six percent of the respondents indicated that a majority vote of the initial committee was required to refer the issue to a higher-level review body within the entity, and 69.5% of the respondents reported that the committee chair made the decision (see Table 4.14). Fifty-six percent of respondents reported that the decision to forward an 805 report to the MBC was made by a majority of the final decision-making committee (see Table 4.11).

Table 4.14: Online Survey - Peer Review Body Referral Mechanisms
(214 eligible respondents; 118 actual responses; percentage based on denominator of 118)

Indicate the position of the person, committee, or mechanism that determines whether to refer an issue to a secondary or higher review body in the entity:	n	%
Peer review chair	82	69.5%
A majority vote of the initial screening committee	67	56.8%
Credentialing Committee decision	66	55.9%
Medical Department Chair	62	52.5%
Chair of initial screening committee	53	44.9%
Entity policies & procedures	48	40.7%
Risk Management Committee decision	33	28.0%
A majority vote of the Medical Department members	24	20.3%
Professional Affairs Committee decision	14	11.9%

Table 4.15: Online Survey - Peer Review Body Reporting Mechanism
(214 eligible respondents; 124 actual respondents; percentages based on a denominator of 124)

Indicate the person, committee, or mechanism that determines whether an issue (805 or 821.5) is reported to the Medical Board of California (MBC):	n	%
A majority vote of the final review committee	70	56.5%
Other	50	40.3%
Chair of secondary or final determination committee	25	20.2%
Entity policies & procedures	23	18.5%
Peer review chair	18	14.5%
Credentialing Committee decision	15	12.1%
Risk Management Committee decision	5	4.0%
Medical Department Chair	4	3.2%
A majority vote of the Medical Department members	4	3.2%
Professional Affairs Committee decision	3	2.4%

Most respondents (69%) knew that an 805 or 821.5 report must be submitted within 15 days of the event being reported (see Table 4.16), and 67% knew that a supplemental report was to be submitted within 30 days of the physician completing the terms of the discipline.

Fifty-six percent of the respondents knew that an 821.5 report was to be submitted to the MBC within 15 days of the initiation of a formal investigation and knew the timeframe within which the MBC diversion program administrator must contact the reporting peer review body (see Table 4.16).

Table 4.16: Online Survey - Reporting Time Frames
(214 eligible respondents; actual respondents are listed in "Total" row; percentages calculated using the actual respondents as the denominator)

	After a reportable event (805 or 821.5), the entity's designated peer review officer must submit a report to the relevant agency within how many days		After the licentiate has satisfied the terms of a disciplinary action, a supplemental report is made to the relevant agency within how many days:		After initiating a formal investigation of a potential 821.5 event, the entity's designated peer review officer must submit a report within how many days:		Upon receipt of an 821.5 report, the MBC diversion program administrator shall contact the reporting peer review body within how many days:	
	n	%	n	%	n	%	n	%
Correct	78	69.0%	76	67.3%	64	55.7%	70	63.6%
Not correct	35	31.0%	37	32.7%	51	44.3%	40	36.4%
Total	**113**	**100.0%**	**113**	**100.0%**	**115**	**100.0%**	**110**	**100.0%**

Most respondents knew some of the criteria for filing 805 or 821.5 reports (see Tables 4.17 and 4.18). However, the items listed in Tables 4.17 and 4.18 are all criteria for completing 805 or 821.5 reports so each respondent should have checked all of the items except "other." The respondents indicated various resources to use when they needed information with the most frequently cited source for information being the law or code itself (see Table 4.19).

Table 4.17: Online Survey - Peer Review Body Criteria for Filing 805 Reports
(350 eligible respondents; 212 actual respondents; percentages based on a denominator of 212)

Indicate the criteria used for filing an 805 report: (check all that apply)	n	%
When a peer review body takes an action that terminates or revokes a licentiate's membership, staff privileges, or employment	162	76.4%
When a peer review body imposes or a licentiate voluntarily accepts restrictions on staff privileges, membership, or employment for 30 days or more for any 12-month period, for medical disciplinary cause or reason	156	73.6%
When a peer review body denies or rejects a licentiate's application for a medical disciplinary cause or reason	140	66.0%
The imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days	136	64.2%
After notice of either an impending investigation or the denial or rejection of the application for a membership, privilege, or employment for a medical disciplinary cause or reason	111	52.4%
Other	42	19.8%
Resignation or leave of absence, withdrawal or abandonment of a licentiate's application, or request for renewal of privileges or membership	39	18.4%

Table 4.18: Online Survey - Peer Review Body Criteria for Filing 821.5 Reports
(214 eligible respondents; 117 actual respondents; percentages based on a denominator of 117)

Indicate the criteria used for filing an 821.5 report for a physician or surgeon POSING A THREAT TO PATIENT CARE: (check all that apply)	n	%
Physician or surgeon suffering from a disabling mental condition	98	83.8%
Physician or surgeon suffering from a disabling physical condition	93	79.5%
Physician or surgeon suffering from a substance abuse condition	90	76.9%
Other	18	15.4%

Table 4.19: Online Survey - Peer Review Body Resources
(70 eligible respondents; 46 actual respondents; percentages based on a denominator of 46)

For either the 805/821.5 report, identify the resources available to assist you in your determination for filing:	n	%
Review of 805/821.5 legal codes	37	80.4%
Web sites	27	58.7%
Entity documents	27	58.7%
Discussions with licensing authorities	24	52.2%
Other	17	37.0%
None	1	2.2%

Summary of Requirement I
Based on the study results, a summary of the findings for Requirement I follows.

1. Variation exists across entities in how they define and conduct "peer review," including:
   - Events that trigger peer review.
   - Procedures that are followed after peer review.
   - Tracking of peer review issues.
   - Expertise of the non-physician support employees and the physician reviewers and chairs.

2. Peer review by entities in California involves common procedures or practices, including:
   - Using remediation for substandard physician care that may last for 12-24 months before taking an action requiring an 805 report.
   - Credentialing of a physician as the initial peer review interaction with peer review activities occurring between the periodic re-credentialing of physicians.
   - Routinely screening a certain percentage of patient records to check for evidence of substandard care.
   - Combining and discussing all types of risk management events and actions (not just activities involving physicians and medical staff) in "peer review" committees, as well as mundane issues related to running the business of the entity.
   - Initiating peer view with a non-physician support staff member performing an explicit review of a medical record.

3. The identification and timeframe for resolving peer review issues depends on a number of factors within each entity, including:
   - The severity of an event, as determined by the person who learns of the event and those persons who become involved in this process. (Our review of committee minutes demonstrated that the process is very lengthy, involving months or years of re-review, review of more records, interviews with the physician, remediation, and/or other investigation methods within the entity.)
   - The entities' own policies and procedures related to peer review.
   - Decision-making committees having multiple responsibilities, including managing overall quality of care issues and complaint/sentinel event investigation, monitoring physician practice and practice patterns, determining disciplinary action, filing 805 reports, conducting utilization, initial screening activities, and 809 hearings, submitting 821.5 reports, proctoring, employee complaints, and working with health plan complaints and risk management issues.

4. Survey respondents knew some, but not all, of the criteria for filing 805 and 821.5 reports and 809 hearings.

Requirement II: A survey of peer review cases to determine the incidence of peer review by peer review bodies and whether they are complying with the reporting requirement in Section 805.

A substantial amount of anxiety about the study was exhibited by the entities, particularly hospitals. Thirty-seven (49 of 132) percent of hospitals communicated with us through attorneys, although only a few health plans or medical groups communicated using attorneys. A number of hospitals or attorneys sent letters (see Appendix III: Hospital Related Documents) detailing reasons for declining to submit certain documents. Most of the letters refer to laws and case law described in Table 2.2. Some hospitals also invited us to visit the facilities for more information.

Most of the letters also refer to a conference call held on October 5, 2007. This call was arranged by the California Hospital Association, ostensibly to allow Lumetra to answer questions posed by various hospitals. However, a few individuals dominated the call and expressed a desire to substantially change the study design.

We answered the questions as best as possible, referred the individuals to the legislation, and terminated the call after one hour. As a result of this meeting and other indications of general anxiety regarding the study, we set up a Web site that described the study purposes and the pertinent legislation, and posted answers to some frequently asked questions.

Since we also had been contacted by various individuals who wanted to influence the study design, we invited people who visited the Web site to e-mail comments to an e-mail box that could be accessed through the site. In order to maintain our independence from outside influence, we agreed to review the comments at the end of the study and include them in the final report (see Appendix IX: Comments About Study).

As indicated in the letters from entities (see Appendix III: Hospital Related Documents), fear of legal "discovery" of protected information was the main reason given for declining to send peer review minutes. The second most common reason given for declining to send minutes was the effort and personnel required to compile the minutes.

We discovered that most entities do not have the documents in electronic form, and many have them stored offsite. Most entities do not appear to have a readily accessible tracking system that allows the staff members to efficiently follow events over time. Additionally, during the study there were two entities that were purchased and the new owner claimed to have no access to minutes or other documents prior to the time when the purchase occurred.

A large share of entities submitted policies, procedures, and bylaws but declined to submit committee minutes (see Table 4.5). Even after lengthy reassurances and identification of the safeguards imposed in the 805 legislation, there were still 177 entities that refused to send minutes. The ability to review committee minutes was critical to determine whether entities were complying with the reporting requirements. Additionally, it was not sufficient to review only 805 reports because it was also necessary to review events and decision-making that did not trigger 805 reports.

Some entities created event summaries that detailed events leading to 805 reports or events that might lead to 805 reports. Because the histories of the events are important, and the histories occur over months or years, the summaries allowed us to track events more efficiently.

Since the study had time and cost constraints, the document review was our primary way to determine whether entities were in compliance with the law. Therefore, we decided to add a number of site visits to the study in order to review documents that the entities refused to submit. The site visits are discussed in the Study Validation Measures section of this chapter.

We reviewed minutes provided by 68 entities and additionally reviewed minutes during the site visits. We also had access to an entity's sample of events and histories for those entities that provided event summaries. Participant entities screened a large number of cases through the routine monitoring process (typically a set percentage of various diagnoses) and selection of cases. These selected cases are peer reviewed in the various committees generally using implicit peer review (i.e., using the reviewers' professional judgment). One large hospital claimed to have screened over 8,000 cases in the five years for which data were requested (see letters in Appendix III: Hospital Related Documents).

Based on the review of committee minutes and cases and discussions with participants, we estimate that a small percentage of routinely screened cases are forwarded to the medical executive/decision making committee for further review, and a still smaller percentage of those cases forwarded results in an action that limits or terminates a physician's privileges for medical cause or reason, thus triggering an 805 report to the Medical Board (see Table 2.4). We were unable to determine an exact percentage for the following reasons:

1. The tracking of cases over time in most entities is poor or lacking.
2. One of the first actions by an initial peer review committee (such as a department committee) is to ask the subject physician to come to the next meeting to discuss the event or for the chair of the committee to speak with the subject physician to understand the subject physician's thinking about the event.
3. Often the subject physician is delayed or the chair is delayed and the matter is held until the following month's agenda or a later agenda.
4. The event or case was not documented in future minutes to which we had access or because the discussion between the physician and the chair happened away from the committee meeting.
5. Following events through minutes of other committees was difficult or impossible because there might not have been any record in the minutes of a follow-up meeting or the follow-up meeting occurred months after the initial event.
6. The committee minutes include issues other than peer review activities, and in some entities, comments about follow-up cases are often missing or limited.

Because there are proportionally few sentinel events, major employee or physician complaints, or events that are particularly egregious or unexpected per number of patients and related to physician practice, these events are almost always forwarded to a higher-level review committee (see Figure 4.2).

Based on our review, we observed that overall the entities are following the letter of the law regarding 805 reporting. Using minutes and event summaries, we discovered that entities try numerous remedial interventions (peer counseling, education, training, mentoring, observation, behavior counseling, UCSD Physician Assessment and Clinical Education (PACE) Program[32]) before informing the physician that a "final proposed action" is being taken. The process to this point is almost never

shorter than one year. Also adding to the process is the disagreement about how to interpret two parts of the California codes: 805 (c) and 809.2 (h).

Business and Professions Code Section 805 (c) states that an 805 report will be filed "within 15 days after any of the following occur after notice of either an impending investigation or the denial or rejection of the application for a medical disciplinary cause or reason" (see Table 2.4)[1]. However, Business and Professions Code Section 809.2 (h) states, "A hearing under this section shall be commenced within 60 days after receipt of the request for hearing, and the peer review process shall be completed within a reasonable time, after a licentiate receives notice of a final proposed action or an immediate suspension or restriction of clinical privileges (underline added), unless the arbitrator or presiding officer issues a written decision finding that the licentiate failed to comply with subdivisions (d) and (e) in a timely manner, or consented to the delay" (see Table 2.3)[1].

Based on focus group and key informant interview data, we learned that some attorneys advise their client entities to behave in the most conservative manner to ensure physician rights. Thus, these entities do not file any 805 reports until after an 809 hearing when the physician (licentiate) receives notice of a "final proposed action." Other attorneys reported that they interpret the code to mean that the 805 is filed after an 809 hearing, unless there is a summary suspension or immediate termination. Therefore, in those entities, 805 reports would not be filed unless there was a summary suspension of more than 14 days or an immediate termination.

Key informants reported that the 809 hearing for due process can add 2-5 years to the process of filing an 805 report. Several affected physicians reported taking various legal actions that further delay the 805 reporting. Some attorneys expressed that they believed they are guilty of legal malpractice if they do not delay the 805 reports as long as possible for their client.

Although there is disagreement about the potential threat to a career, physicians who have been the subject of an 805 report state that it is difficult or impossible to find a new position, their professional lives are ruined, other entities will not grant privileges even if they have fulfilled the terms of the discipline, and they spend years and hundreds of thousands of dollars in court trying to clear their professional names and reputations.

Based on reviews of the minutes from participant entities and key informant interviews, the most common reasons for cases being referred for peer review to a high level (executive medical staff) committee are 1) disruptive physician behavior/impairment (821.5), 2) substandard technical skills, and 3) failure to document/record patient treatment.

Impairment cases have frequently been referred to the diversion program through the MBC. However, this program was terminated effective June 30, 2008. MBC staff members reported that in the diversion program, records of events are required to be destroyed as soon as the case is closed, so there is no means to track recidivism of drug or alcohol use.

Mental or physical illness that impairs a physician's ability to practice medicine safely is also a reason for changes in privileges that require 821.5 or 805 reporting. Bylaws, policies and procedures indicate that physicians may be referred to the entity's "well-being" committee or other behavior modification committees or programs in order to remediate the substance abuse, anger outbursts, and/or mental or physical health issues that affect physician behavior. Because changing physician privileges triggers an 805 report, while the entity is trying to deal with this impaired or disruptive physician, the physician is allowed to continue to practice.

Minutes and event summaries from some entities indicate that physicians are allowed to commit multiple disruptive actions over many years while various strategies are tried or before any remediation is required. In one instance, a physician attended the PACE program but re-offended with the same disruptive behavior in the following year. All of this may occur before an 821.5 report is filed. It is also not possible to discover whether 821.5 reports are filed appropriately because of the codes protecting the rights of the physician.

Physicians having (or who develop) substandard technical skills can be trained, mentored, proctored, and assisted without triggering an 805 report as long as the training is not for medical cause or reason and there is no change in privileges (see Table 2.4). Minutes indicate that entities attempt these interventions to solve the problem before the behavior results in an event that triggers a reporting requirement.

Another common reason for referral to peer review or 805 reporting is for the physician who does not document medical care in a patient record. The lack of documenting eventually becomes so egregious that the entity is at risk for censure by licensing and accreditation agencies, so the entity withdraws or restricts the offenders' privileges and files an 805 report with the MBC.

During the study, key informants from participant entities suggested the elimination of failure to document as a reason for reporting to the Board because it appears to be a squabble between an entity and a physician who will not keep up on charting. However, if professionals agree that documentation of medical care is required to ensure a safe and quality environment in which to treat patients, then the requirement is no different than any other substandard medical practice.

Requirement II Summary

In summary, collecting the data to address Requirement II was a challenge because many of the entities, especially hospitals, expressed anxiety and concern in providing documents for review, particularly peer review minutes for fear of legal “discovery.” A second concern was the amount of effort, both in time and personnel, to compile these documents, since most entities do not maintain electronic records or store them offsite.

Our finding revealed the following about peer review and 805 reporting.

1. Event tracking capability of entities is limited due to:
    - Lack of a readily available tracking system that allows the staff members to efficiently follow events over time.
    - Lack of access to prior minutes or other documents by new owners when an entity is purchased.

2. Overall, entities follow the letter of the law regarding 805 reporting and screen a large number of cases through routine monitoring, but few cases lead to actual 805 filings, because of the following:
    - Disagreement/or legal interpretation about whether an 809 hearing is required before every 805 report is submitted.
    - 809 hearings for due process adding years to the process and delaying the filing of an 805 report.

3. Entities use other measures to correct physician behavior before resorting to filing an 805 report (which allows physicians to continue to practice and possibly commit multiple actions over many years before any steps are taken), including:

- Remedial interventions (e.g., peer counseling, education, training, mentoring, observation, behavior counseling, PACE Program).
- Referral to the Diversion Program (which is closing) for impairment cases.
- Bylaws, policies, and procedures that allow physicians to be referred to the entity's "well-being" committee or other behavior medication committee/program to remediate the causes affecting the physician behavior.

4. The most common reasons for cases being referred for peer review to a high level (executive medical staff) committee are 1) disruptive physician behavior/impairment (821.5), 2) substandard technical skills, and 3) failure to document/record patient treatment.

5. Most responses indicated people knew that mental or physical illness that impairs a physician's ability to practice medicine safely is also a reason for changes in privileges that require 821.5 or 805 reporting.

6. It is possible that some physicians would never be subject to peer review because they have practices that do not fit any peer review requirements.

Requirement III: A description and evaluation of the roles and performance of various State agencies, including the State Department of Health Services and occupational licensing agencies that regulate healing arts professionals, in receiving, reviewing, investigating, and disclosing peer review actions, and in sanctioning peer review bodies for failure to comply with Section 805.

In earlier chapters, we listed various State agencies, codes, and regulations that govern the entities in the study (see Table 1.1, 2.2; 2.7). The Department of Managed Care provides governance for HMOs and health plans; Title 22 and OSHPD have some governing responsibility for acute care hospitals. The Office of the Patient Advocate and OSHPD have some control over medical clinics. However, because of the limited timeframe, the focus of this study is on the Medical Board and the regulation of the practice of medicine in California.

In key informant interviews, we found that over the years other professional disciplines have developed State boards of control, so that the MBC only investigates physicians and podiatrists. The discipline-specific boards promulgate regulations governing the practice of individuals who are licensed or certified by the State. We found no systematic communication among these various boards and agencies that would coordinate patient quality and safety issues.

In order to fairly assess the role of the MBC, we reference the standards put forth by the Federation of State Medical Boards (FSMB) of the United States, Inc., which were developed by The Special Committee on Evaluation of Quality of Care and Maintenance of Competence, and approved by the Federation House of Delegates in April 1999[30]. Although some of the standards are beyond the scope of this report, we used quantitative data provided by the MBC and data from structured interviews with MBC staff members to respond to those that are relevant.

FSMB Standard One: State medical boards should develop and implement methods to identify physicians who fail to provide quality care and therefore warrant further evaluation by the State medical board.

This study details the activities that occur within entities prior to and following reporting to the Medical Board of California. The MBC has an extensive procedure to identify physicians who fail to provide quality care. Additionally, the MBC posts numerous public education messages and information on its Web site, which also includes reporting forms for different individuals and entities that are responsible for reporting to the MBC (see Appendix VII: Medical Board of California Documents).

The MBC has 400+ employees in 11 district/field and three probation offices located around the State performing numerous activities in addition to managing the work related to 805 reporting. The efforts to ensure quality are essentially complaint driven, although healthcare entities do provide routine quality screening.

The Board receives over 8,000 complaints (including 805 and all other complaints) annually, which are investigated by physicians and as necessary, MBC staff members with training as law enforcement officers, degrees in criminal justice, or detective-level experience in a police agency. The complaint review process (including 805 reports) is diagramed in Figure 4.4, the enforcement process in Figure 4.5, and the public disclosure process in Figure 4.6.

The diagrams demonstrate the multiple sources of complaints, the multiple ways different complaints are reviewed, and the complex outcomes of the complaints review that would initiate the enforcement process. The Board reviews all complaints to determine whether the complaint falls within the Board's jurisdiction and contacts the physician for a response. After receiving relevant information, the complaint is forwarded to a physician consultant for review of alleged specific standard of care violations. If there is no departure from the standard, the complaint is closed. If the complaint warrants further review, the physician forwards the complaint to one of the field offices for further investigation. In either case, both physician and complainant are notified of the complaint disposition.

The diagrams also illustrate the complexity of the complaint process, the enforcement process and the public disclosure rules. Public disclosure is limited by numerous codes and varies in whether entities or individuals have access to the information, how long a record stays on the Web site and how a request must be made.

An example of a lawsuit that impacted the disclosure laws is the 1993 suit filed by the California Medical Association (CMA) against the MBC to stop public disclosure of an MBC request of the Attorney General's office to file an accusation against a physician [116, 117.]. This ruling protected the interest of the physician, but added to the complexity of the laws governing public disclosure. All of the processes are complex and multi-layered.

During the focus group interviews, some participants stated that the MBC did not appear to investigate all 805 reports, or if reports were investigated, the MBC often did not find any wrongdoing. Other participants stated that the MBC follow-up for 805 reports took frequently as long as a year after the report was submitted. Later in the chapter, we report the actual amount of time the MBC takes to investigate complaints. Based on these comments and actual times, it is not clear whether the Board follow-up is timely, and if not, what factors provide barriers to a more effective and efficient process.

Figure 4.4: The Medical Board of California Complaint Review Process

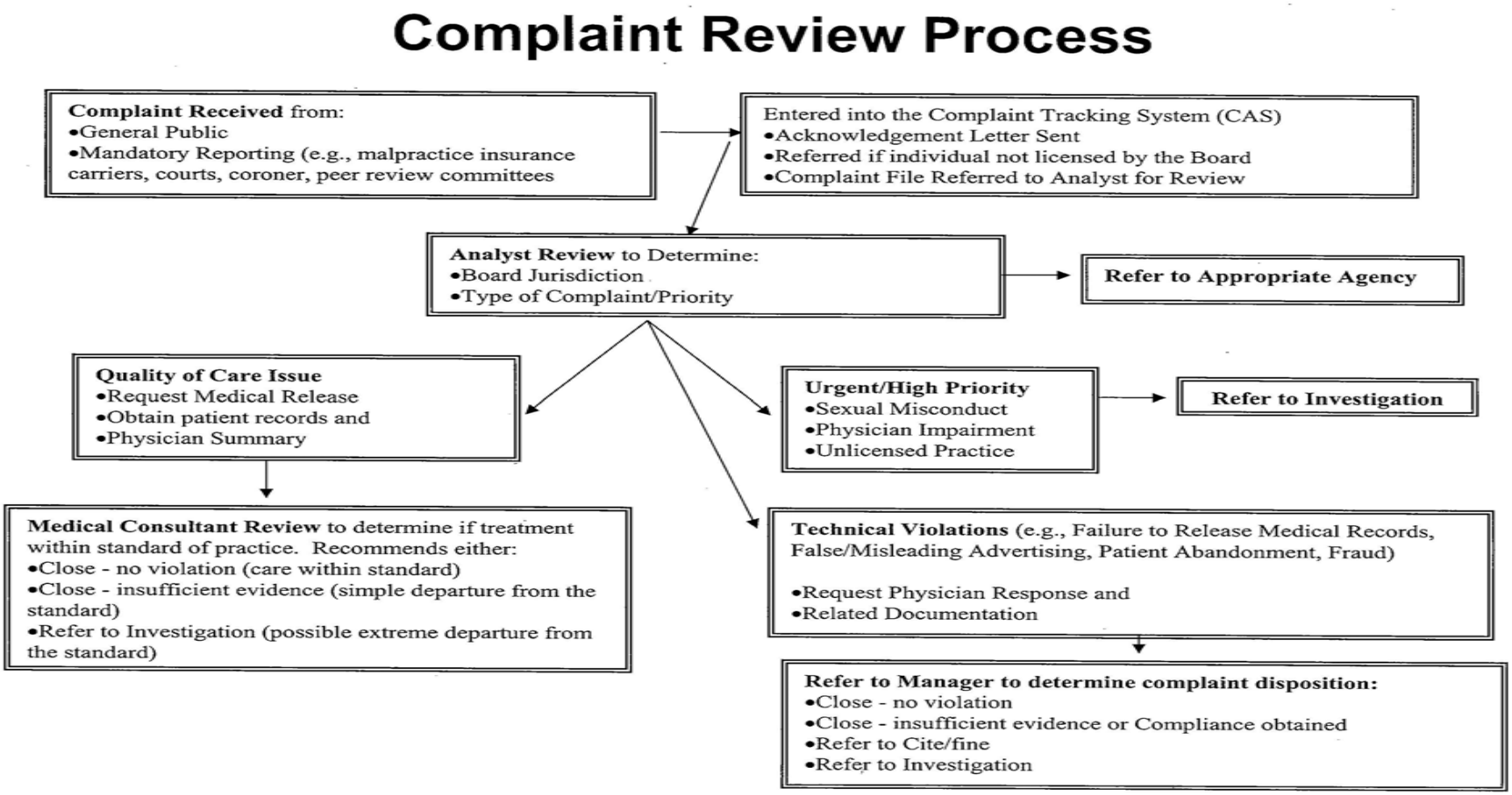


Figure 4.5: The Medical Board of California Enforcement Process

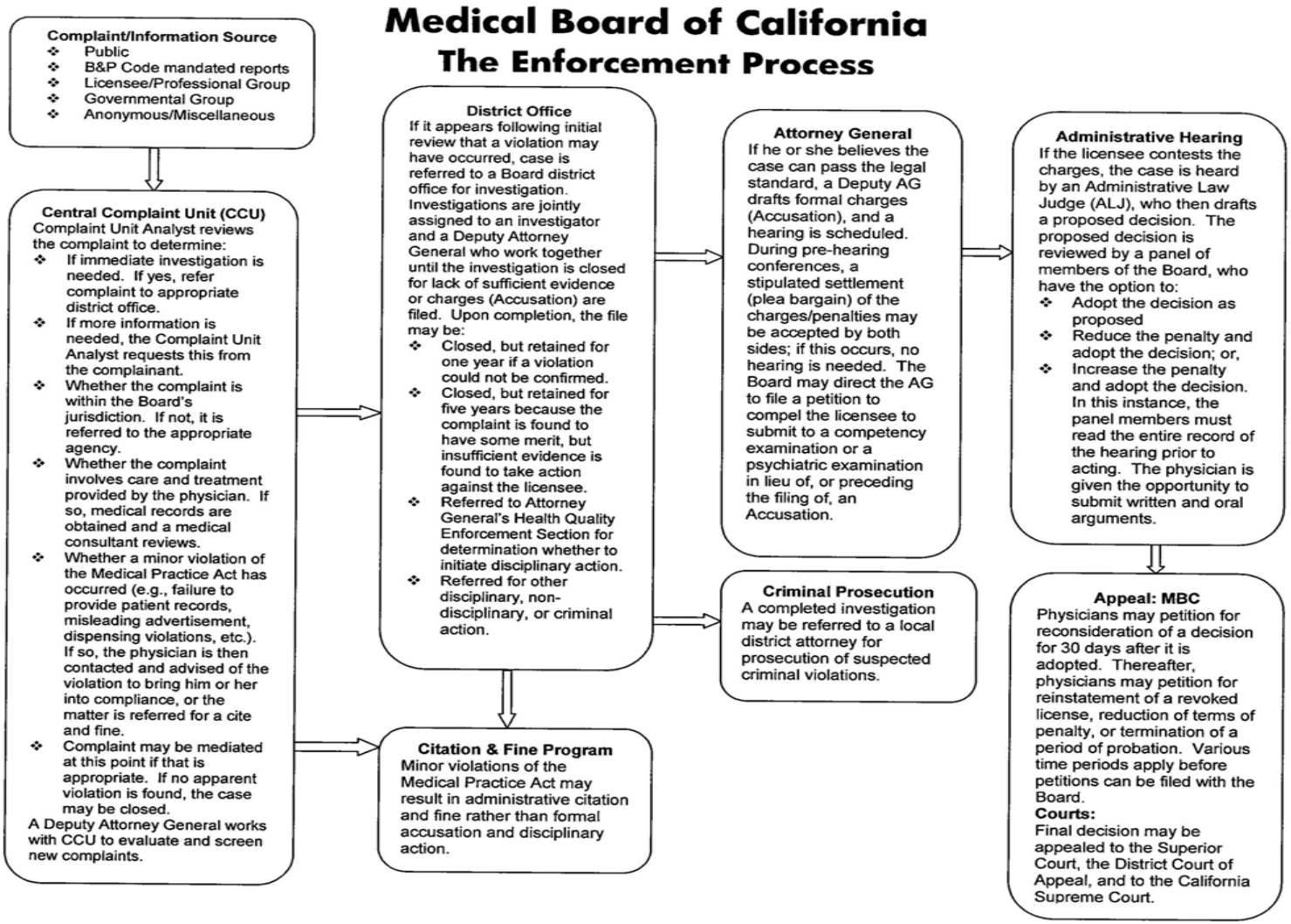


Figure 4.6: The Medical Board of California Public Disclosure Information

MEDICAL BOARD OF CALIFORNIA
PUBLIC DISCLOSURE INFORMATION
Revised January 1, 2007

CAS = Consumer Affairs System; PC = Penal Code; B&P = California Business and Professions Code; CCR = California Code of Regulations; GC = Government Code

		How Long the Document is available to Public	
Document	**When the Document is Made Public**	**Written Request/Walk-In Request**	**Web site/Phone Request**
PENAL CODE (PC) 23 SUSPENSION (Partial or full license restrictions per this code; limited or no practice allowed while suspension is in place)	Date issued by a criminal court	Available indefinitely	Pursuant to B&P 2027, available on physician's profile only during period when physician's license is suspended; deleted from profile/CAS* if suspension is lifted or if an administrative decision becomes effective. Available via Enforcement Public Document Search on the Web site unless suspension has been lifted by the Board.
AUTOMATIC SUSPENSION ORDER (B&P 2236.1) (Licensed suspended per this section; no practice allowed while license is suspended)	Date issued by Medical Board	Available indefinitely	Pursuant to B&P 2027, available on physician's profile only during period when physician's license is suspended; deleted from profile/CAS* if suspension is lifted or if an administrative decision becomes effective. Available via Enforcement Public Document Search on the Web site unless suspension has been lifted by the Board.
INTERIM SUSPENSION ORDER (ISO) (Licensee's practice has been temporarily restricted or suspended by an Administrative Law Judge, ALJ)	Date issued by an ALJ	Available indefinitely	Pursuant to B&P 2027, available on physician's profile only during period when physician's license is suspended; deleted from profile/CAS* if suspension is lifted or if an administrative decision becomes effective. Available via Enforcement Public Document Search on the Web site unless suspension has been lifted by the Board.

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		How Long the Document is available to Public	
Document	**When the Document is Made Public**	**Written Request/Walk-In Request**	**Web site/Phone Request**
OUT-OF-STATE AUTOMATIC SUSPENSION ORDER (B&P 2310) (Licensee's practice in California is automatically suspended per notification of suspension or revocation of license in another state)	Date issued by Medical Board	Available indefinitely	Pursuant to B&P 2027, available on physician's profile only during period when physician's license is suspended; deleted from profile/CAS* if suspension is lifted or if an administrative decision becomes effective. Available via Enforcement Public Document Search on the Web site unless suspension has been lifted by the Board.
TEMPORARY RESTRAINING ORDER (TRO) (B&P 125.7) (Licensee's practice has been temporarily restricted or suspended by a court judge)	Date issued by a court judge	Available indefinitely	Pursuant to B&P 2027, available on physician's profile only during period when physician's license is suspended; deleted from profile/CAS* if suspension is lifted or if an administrative decision becomes effective. Available via Enforcement Public Document Search on the Web site unless suspension has been lifted by the Board.
ACCUSATION/PETITION TO REVOKE PROBATION/ACCUSATION AND PETITION TO REVOKE PROBATION (includes any amendments or supplementals)	Date filed by the Medical Board	Available indefinitely; or if withdrawn, available for one year from withdrawal date pursuant to Title 16 CCR Section 1354.5(b)	Available only prior to administrative decision becoming effective; once decision becomes effective, the posting of an Accusation is deleted and the outcome of the decision is posted; if the outcome of the decision is that the document is withdrawn or dismissed, the matter is completely deleted from the Web site pursuant to B&P 2027(a)(4)
STATEMENT OF ISSUES (Document, similar to an accusation, that lists reasons for denial of an application for licensure)	Date filed by the Medical Board	Available indefinitely	This information is not posted on a physician profile; the Statement of Issues is available via Enforcement Public Document Search on the Web site. If the outcome is to issue the license and place it on probation, that outcome is posted to the physician profile on the Web site

		How Long the Document is available to Public	
Document	**When the Document is Made Public**	**Written Request/Walk-In Request**	**Web site/Phone Request**
DISMISSED ACCUSATION (Accusation dismissed after administrative hearing)	Date filed by the Medical Board	Available indefinitely pursuant to GC 11517	Deleted from Web site/CAS pursuant to B&P 2027(a)(4)
CITATION ORDER (Citation is a written order describing the nature of a violation, including the specific code of law violated; it is not a disciplinary action)	Date issued by the Medical Board	Available for 5 years from decision date; if withdrawn or dismissed, it is purged immediately pursuant to Title 16 CCR Section 1364.15	Available for 5 years from decision date, or if withdrawn or dismissed, deleted immediately from Web site/CAS pursuant to Title 16 CCR Section 1364.15
PROBATIONARY CERTIFICATE (Conditional license issued to an applicant on probationary terms and conditions)	On the ordered date, after adoption by Division of Licensing	Available indefinitely	Available for the duration of probation.
PUBLIC LETTER OF REPRIMAND (B&P 2233) [A lesser form of discipline that can be negotiated for minor violations before the filing of formal charges (accusations)]	Date issued by the Medical Board	Available indefinitely	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the effective date of the decision

Document	When the Document is Made Public	How Long the Document is available to Public: Written Request/Walk-In Request	How Long the Document is available to Public: Web site/Phone Request
STIPULATED DECISION = A form of plea bargaining; the case is negotiated and settled prior to trial DEFAULT DECISION = A Decision which is rendered after the physician refuses or fails to participate in the disciplining process			
• Surrender (While charges are pending, licensee surrenders the license)	On the ordered date, after adoption by Medical Board	Available indefinitely	Available indefinitely
• Revocation, suspension, probation, limitation on practice (e.g. placed in disabled, inactive, or retirement status, etc)	On the ordered date, after adoption by Medical Board	Available indefinitely	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the effective date of the decision
• Public Reprimand/Public Letter of Reprimand (whether or not the Accusation is withdrawn)	On the ordered date, after adoption by Medical Board	Available indefinitely	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the effective date of the decision
• Education course, examination, and/or cost recovery reimbursement (whether or not the Accusation is withdrawn)	On the ordered date, after adoption by Medical Board	Available indefinitely.	Not available pursuant to B&P 2227(b)
• Citation Issued with terms and conditions: an education course, examination and/or cost recovery (whether or not the Accusation is withdrawn)	On the ordered date, after adoption by Medical Board	Available five years from decision date pursuant to Title 16 CCR Section 1364.15. (Only citation document available)	Available five years from decision date pursuant to Title 16 CCR Section 1364.15
• Accusation Withdrawn (Accusation filed by AG's Office was withdrawn before administrative hearing)	Date document filed by Medical Board	Available for one year after withdrawal date pursuant to Title 16 CCR Section 1354.5(b)	Not available pursuant to B&P 2027(a)(4)

Document	When the Document is Made Public	How Long the Document is available to Public	
		Written Request/Walk-In Request	Web site/Phone Request
DECISIONS AFTER AN ADMINISTRATIVE PROCEDURES ACT HEARING			
• Revocation, suspension, probation, limitation on practice (e.g. placed in disabled, inactive, or retirement status, etc)	30 days after receipt by Medical Board or upon adoption, whichever occurs first	Available indefinitely	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the effective date of the decision
• Public Reprimand/Public Letter of Reprimand (whether or not the Accusation is withdrawn)	30 days after receipt by Medical Board or upon adoption, whichever occurs first	Available indefinitely	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the effective date of the decision
• Education course, examination, and/or cost recovery reimbursement (whether or not the Accusation is withdrawn)	30 days after receipt by Medical Board or upon adoption, whichever occurs first	Available indefinitely	Not available pursuant to B&P 2227(b)
• Accusation Dismissed (Accusation has been dismissed after administrative hearing)	30 days after receipt by Medical Board or upon adoption, whichever occurs first	Available indefinitely	Not available pursuant to B&P 2027(a)(4)
SURRENDER of LICENSE DURING PROBATION (w/o further administrative action pending)	Date issued by Medical Board	Available indefinitely	Available indefinitely
JUDGMENT/ARBITRATION AWARD (only the information regarding the matter is available, no documents are available from the Medical Board)	Date Medical Board notified or made aware	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the date the Medical Board obtains the information ****	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the date the Medical Board obtains the information
MEDICAL MALPRACTICE SETTLEMENTS (only the information regarding the matter is available, no documents are available from the Medical Board)	When the Medical Board is notified that a licensee has three (low-risk category) or four (high-risk category) settlements within a 10 year period pursuant to 803.1(b)(2)	The information is public during each 10 year period that the licensee has three or four settlements; see B&P 803.1(b)(2)	Pursuant to B&P Code 2027(b)(1), the information is public during each 10 year period that the licensee has three or four settlements; see B&P 803.1(b)(2)

		How Long the Document is available to Public	
Document	**When Public**	**Written Request/Walk-In Request**	**Web site/Phone Request**
FELONY CONVICTION (only the information regarding the conviction is available, no documents are available from the Board)	Date Medical Board notified or made aware	Available indefinitely pursuant to B&P 2027(b)(2)	Available indefinitely pursuant to B&P 2027(b)(2)
MISDEMEANOR CONVICTION (only the information regarding the conviction is available, no documents are available from the Board)	Date Medical Board files an accusation related to the misdemeanor conviction.	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the date the Medical Board obtains the information ****	Pursuant to B&P 2027(b)(1), available for 10 years from January 1, 2003; or after January 1, 2003, for 10 years from the date the Medical Board obtains the information
**805 REPORTS to the public - resulting from termination or revocation of hospital privileges for medical disciplinary cause or reason (only the information regarding the termination/revocation is available, no documents are available from the Board unless requestor is another hospital or HMO pursuant to B&P 805.5 - see below)	Date Medical Board notified or made aware	Indefinitely, unless the privileges are restored; if privileges are restored it is public for 10 years from the restoration date pursuant to B&P 2027(b)(2)****	Indefinitely, unless the privileges are restored; if privileges are restored it is public for 10 years from the restoration date pursuant to B&P 2027(b)(2)
805 REPORTS given to ***authorized requesters pursuant to B&P 805.5 Authorized requesters may receive a copy of any 805 report (denial, removal, or restriction of staff privileges) except for the following: • reports for failure to complete medical records • reports found to be without merit by the Board	Date Medical Board notified or made aware	The information regarding a termination or revocation of hospital privileges is available indefinitely, unless the privileges are restored; if privileges are restored it is public for 10 years from the restoration date pursuant to B&P 2027(b)(2)**** The actual report is only available for 3 years from the date the Board received the report pursuant to 805.5(b)(3)	The information regarding a termination or revocation of hospital privileges is available indefinitely, unless the privileges are restored; if privileges are restored it is public for 10 years from the restoration date pursuant to B&P 2027(b)(2) Information regarding the number of 805 reports for a licensee is posted on the "authorized requestor" Web site for 3 years pursuant to 805.5(b)(3) with the same exceptions as listed under the Document section

* CAS or the Consumer Affairs System, is the database used by the Medical Board to track licensing and enforcement activities.
** 805 Report is a facility initiated discipline report on a physician provided by a hospital, clinic, medical group or clinic, HMO, etc., pursuant to B&P 805.
*** Authorized requestor could be an HMO, hospital, physician requesting for him, or his attorney requesting with written permission from the physician, etc.
**** The law does not require the Board to delete this information from its files, only that the information is no longer displayed on the Board's Web site.

FSMB Standard Two: States should enact mandatory reporting requirements and state medical boards should be provided the authority to impose penalties upon those individuals and institutions failing to comply with reporting requirements. The disciplinary function of all state medical boards is primarily complaint driven. Therefore, a board's effectiveness in handling quality of care cases is enhanced by its ability to receive valid information from reliable sources.

California has multiple codes and laws describing mandatory reporting requirements (see Appendix VII: Medical Board of California Documents) and the Board has the ability to impose penalties ($10,000 fines) on those entities and individuals that fail to comply. During the site visits to the MBC and the review of data and documents that were provided, it was clear that the MBC has internal policies and procedures for initiating "failure to file 805 reports" investigations, as well as how 805 reports are handled within the agency. The MBC staff report that 805 reports are considered urgent complaints and are given top priority within the Central Complaint Unit of the Board.

The MBC staff members reported filing several actions between 2003 and 2008 against entities and individuals for failing to file an 805 report. These actions included five administrative actions against physicians; three active investigations are in process and eight have been closed against physicians or entities; six complaints have been closed; and four civil actions have been filed. Because the Board is dependent on an external source, such as a complaint from the public, to trigger an investigation into an event that should have resulted in an 805, it may be that the Board is not aware of all potential cases of failure to file 805s.

Based on the various interpretations of the 805 and 809 laws by attorneys mentioned earlier in the chapter, it is also not clear that the Board receives valid and complete information from entities or individuals when investigating 805 reports, even with subpoena power. Information provided in the 805 documents is minimal and frequently does not provide the history of events that have occurred prior to the 805 report. It is likewise not evident that the Board receives information in a timely manner, given the interpretation of legislation relating to allowing an 809 hearing prior to filing an 805 report.

Although there is a common perception that all the information about complaints is public information, the Board has multiple restrictions governing the posting of information on the Web site about physician behavior. Although entities can obtain more detailed information, it is often difficult for the general public to obtain the history of a particular physician. The MBC Web site provides frequently asked questions about public information and disclosure and also what is available on the physician license lookup site (see Appendix VII: Medical Board of California Documents). Figure 4.6 summarizes what the MBC can legally disclose, to whom it can be disclosed, and how long the information is allowed to remain on the physician profile Web site.

We were able to investigate in more detail the 805 reports received by the MBC in 2007. In fiscal year 2007, the reports came from 109 different entities involving 144 physicians in 171 events. Twenty-five physicians had multiple 805 reports in 2007. Based on data provided by the MBC about entities, we found that 98% of the entities that filed an 805 did so in less than a year after taking an action against a physician. In slightly more than 1% of the cases, the entities took longer than a year to file an 805 after they had taken an action.

MBC staff members raised the concern that in some instances an entity files an 805 report **after** the MBC takes an action. We investigated this and discovered that in fiscal 2007 there were seven

instances where the MBC hot sheet report specified an action taken by the MBC and the entity filed an 805 report after the hot sheet was circulated.

Table 4.20 displays the reasons for 805 reporting. Note that imposition of summary suspension for longer than 14 days and termination or revocation of privileges for medical cause or reason are the categories that require public reporting on the physicians' Web profile. Therefore, many of the 805s are not available to the public, although some are available to authorized requestors.

Table 4.20: Reasons for 805 Reports in California – 2007

805 Report Description	n	%
Imposition of summary suspension on staff privileges	37	21.6%
Licentiate resigned from staff	18	10.5%
Other - Review Comments	18	10.5%
Restriction(s) imposed on staff privileges	17	9.9%
Restriction(s) voluntarily accepted on staff privileges	12	7.0%
Termination or revocation of membership	11	6.4%
Licentiate resigned from employment	9	5.3%
Licentiate took leave of absence from staff	9	5.3%
Termination or revocation of staff privileges	9	5.3%
Termination or revocation of employment	8	4.7%
Denial/rejection of application for membership	6	3.5%
Licentiate resigned from membership	5	2.9%
Imposition of summary suspension on employment	3	1.8%
Denial/rejection of application for staff privileges	2	1.2%
Imposition of summary suspension on membership	2	1.2%
Restriction(s) imposed on membership	2	1.2%
Licentiate took leave of absence from membership	1	0.6%
Restriction(s) imposed on employment	1	0.6%
Restriction(s) voluntarily accepted on employment	1	0.6%
Total	171	100.0%

Over 43% of the physicians who were the subject of a report had information on the MBC public web profile; conversely, 56% percent did not. So, if a member of the public looked up one of the 78 physicians who were not on the Web site, they would have no reason to suspect that there had been an event that had triggered an 805 report. Of the 60 physicians found on the MBC public Web site nearly one-half of the events had occurred prior to 2007 (see Table 4.21). This indicates that the 805 reports were not posted on the public site until several months after the event. However, if the public date was prior to 2007, the report may represent a different event than the 805 reported in 2007. In any case, only 33 of 138 physicians with 805 reports could be found in the public Web site stemming from their most recent event.

Table 4.21: Public Reporting of 805 Reports in California – 2007

	n	%
Physicians on Public Web site	60	43.5%
Physicians not on Public Web site	78	56.5%
Total Physicians Reported	138	100.0%
	n	%
Public Dates Prior to calendar year 2007	27	45.0%
Public Dates calendar year 2007 or Later	33	55.0%
Total Physicians on Public Web site	**60**	**100.0%**

FSMB Standard Three: State medical boards should develop and implement proactive methods of identifying the individual dyscompetent physician, as well as opportunities for improving physician practice in problematic areas.

The MBC's function is primarily reactive rather than proactive. Although it may be possible to increase the proactive methods, it is not clear whether an agency charged with investigation and disciplinary action is the appropriate agency to proactively identify and remediate dyscompetent/incompetent physicians.

A dyscompetent physician is defined as one who requires retraining or updated training. As mentioned previously, the agency has numerous public information documents on the Web site (in both English and Spanish) to assist the public in understanding the rights and responsibilities of the MBC. There are also many documents that inform physicians about their rights and responsibilities.

The primary concern of the MBC is patient safety and protection. Changing or adding to the perspective of the Board from reactive to proactive would take a specific culture shift, particularly since the current system is deeply grounded in the legal system and uses punitive measures to discipline physicians.

FSMB Standard Four: State medical boards should implement and utilize processes to enhance evaluation and investigation of cases wherein the quality of care rendered is in question.

The MBC has extensive investigation teams throughout the State. Several focus group participants complained that the investigation process was very slow, so we traced through the system a specific event related to a complaint. A hospital submitted two 805s to the MBC, one in December 2006 and the second in March 2007.

The 805 reporting form indicated the reason for the first report was a restriction in privileges and the reason for the second was that the physician resigned from the entity. The supporting documentation submitted with the reports indicated that the physician had first been summarily suspended and then terminated, neither of which was indicated on the reporting form.

When we followed up with questions to the parties about that specific 805, the summary suspension had been for less than 14 days so it was not listed as the reason for the 805 report and the termination/resignation was reported as a resignation. Therefore, the MBC counted the disciplinary actions as restriction and resignation, as reported on the form. The event ultimately raised two issues:

1. Since the 805 was not reported as a summary suspension and termination, the 805 could not be made available to the public, so future patients had no way of knowing the history of this physician. Why did the entity only report the disciplinary action as restriction and resignation? The suspension was for fewer than 14 days and the physician was allowed to "resign."
2. The entity reported that the MBC did not request the patient record for at least six months after the last 805 was filed and has not presently (May 2008) issued a ruling from the investigation.

We investigated whether the forms used by the MBC to report an 805 event were easy to use. The respondents did not find them difficult, so that is not likely a reason for not reporting (see Table 4.22).

Table 4.22: Online Survey - Peer Review Reporting Forms Difficulty
(214 eligible respondents)

	n	Mean	sd
What is the level of difficulty (e.g. user-friendliness, clear documentation) for using the MBC's current 805 reporting forms? (1 = Not Difficult - 5 = Very difficult)	124	2	1

FSMB Standard Five: State medical boards should utilize a list of qualified physicians from which to select peer review panels in the evaluation and investigation of quality of care cases.

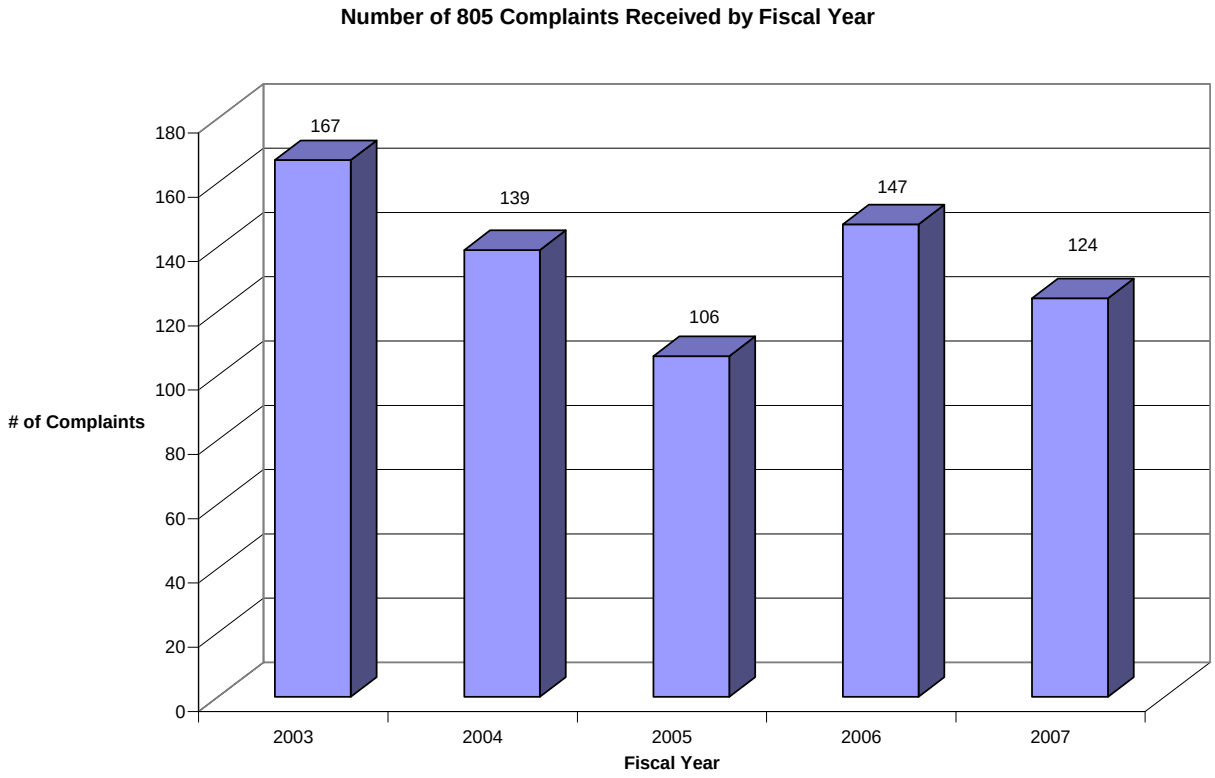
The MBC has policies and procedures in place that provide for the employment of qualified reviewers. The MBC 2006-07 annual report indicates an 11.6% vacancy rate of investigative staff

and that recruitment and retention are a continuing problem. Investigators are able to find employment with higher compensation at agencies where the work is less difficult[118].

FSMB Standard Six: State medical boards should develop and implement systems to efficiently process quality of care complaints processed in a timely and efficient manner.

As mentioned previously, in focus groups and key informant interviews, the MBC has been criticized for failing to investigate all 805 reports and failing to respond to complaints (805s) in a timely manner. Figure 4.7 illustrates the number of 805 reports received by the MBC over a five-year period.

Figure 4.7: Number of 805 Complaints Received by the MBC by Fiscal Year

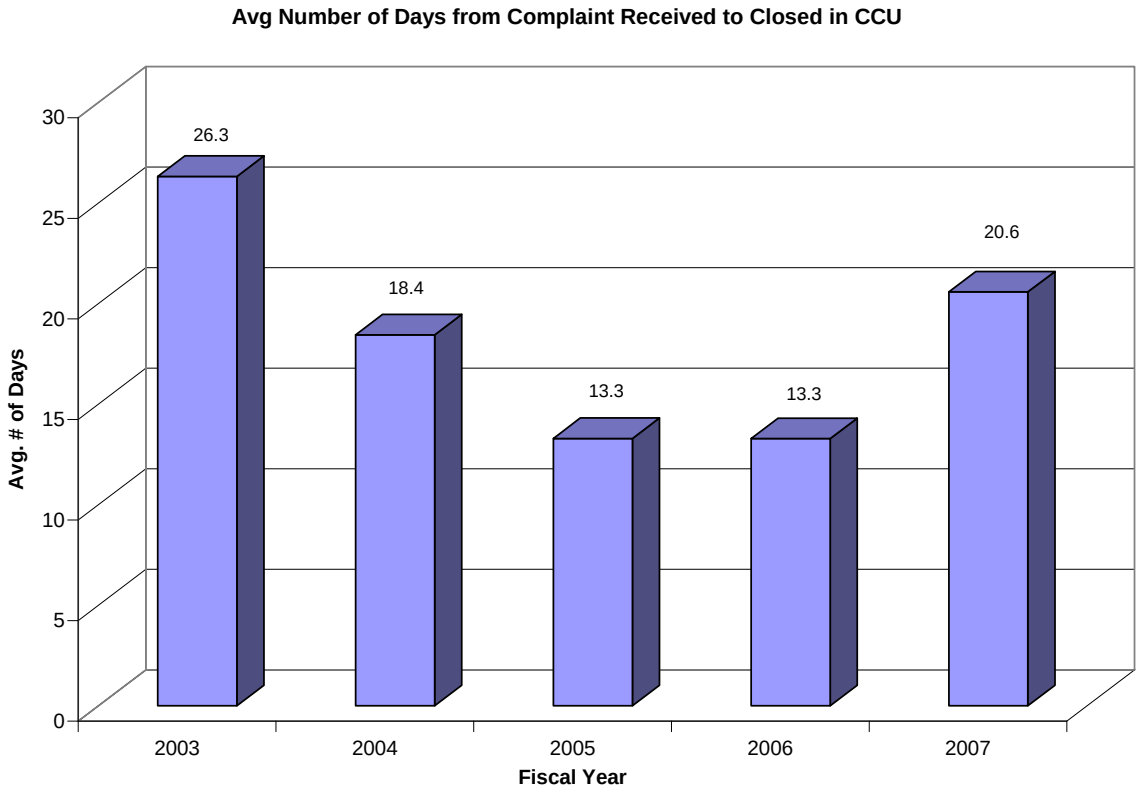


When the Central Complaint Unit (CCU) of the MBC 805 receives a complaint, it is entered into a tracking database and assessed by an analyst. See the Manual of Model Disciplinary Orders and Disciplinary Guidelines in Appendix VII: Medical Board of California Documents. If the complaint is in the correct agency, the analyst determines the next step: 1) medical review related to standard of care; 2) technical violation; or 3) immediate investigation to a field/district office.

Medical review and technical offenses can have various outcomes, including referral to a field office for investigation, but they can also be closed if there is no violation (see Figure 4.4). When the CCU is

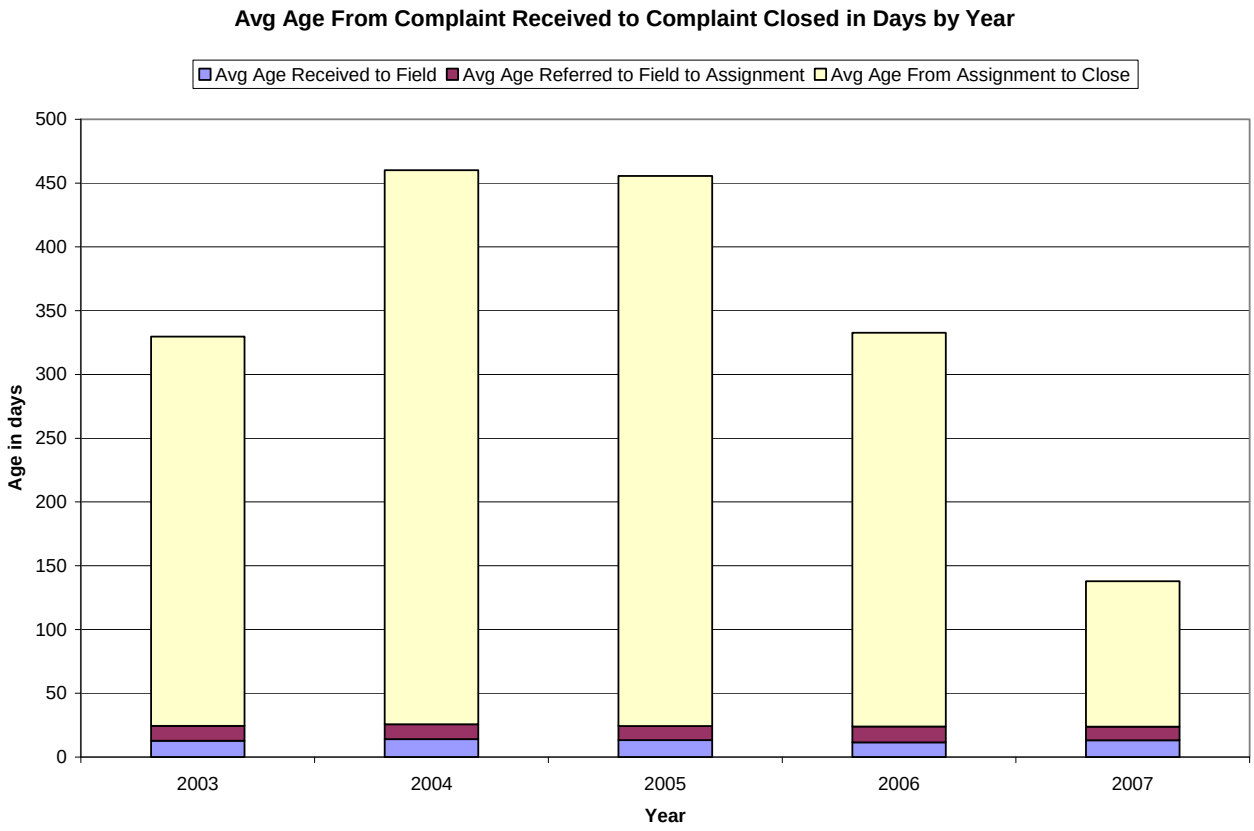
able to close the complaint without referring it to medical review or investigation, Figure 4.8 displays the average number of days to close it.

Figure 4.8: Average Number of Days - 805 Complaint Received at MBC → Closed in Central Complaint Unit



When the 805 is referred to a district/field office for investigation, the time naturally is extended. Figure 4.9 displays the average length of time the district/field office takes to receive the complaint, assign it for investigation, and close it.

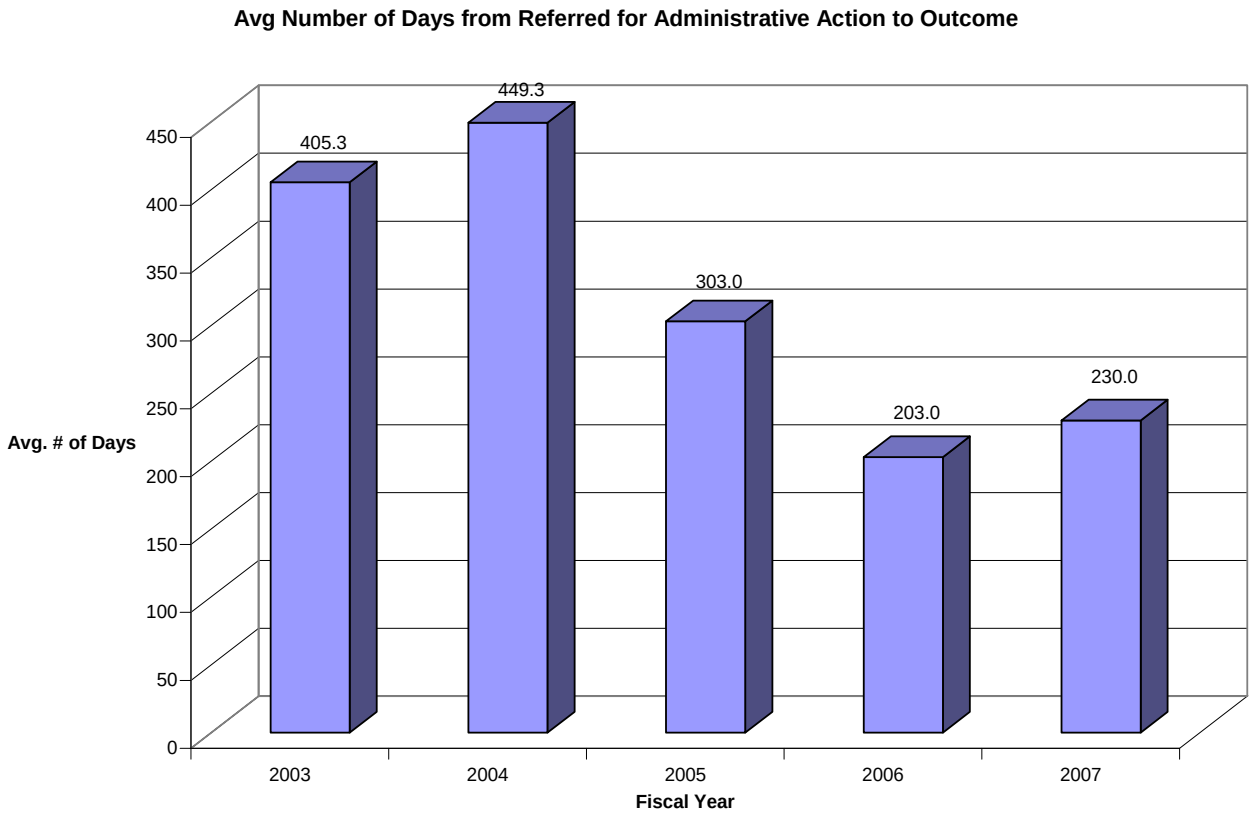
Figure 4.9: Average Number of Days - 805 Complaint Received by MBC → Referred for Field Investigation →Closed Complaint



In 2007, it took two weeks for an 805 to be referred from the CCU to a field/district office; 1½ weeks for an 805 to be assigned to an investigator; and three to four months to close the complaint in the field office. The time for investigation has declined since 2005, but it is still lengthy.

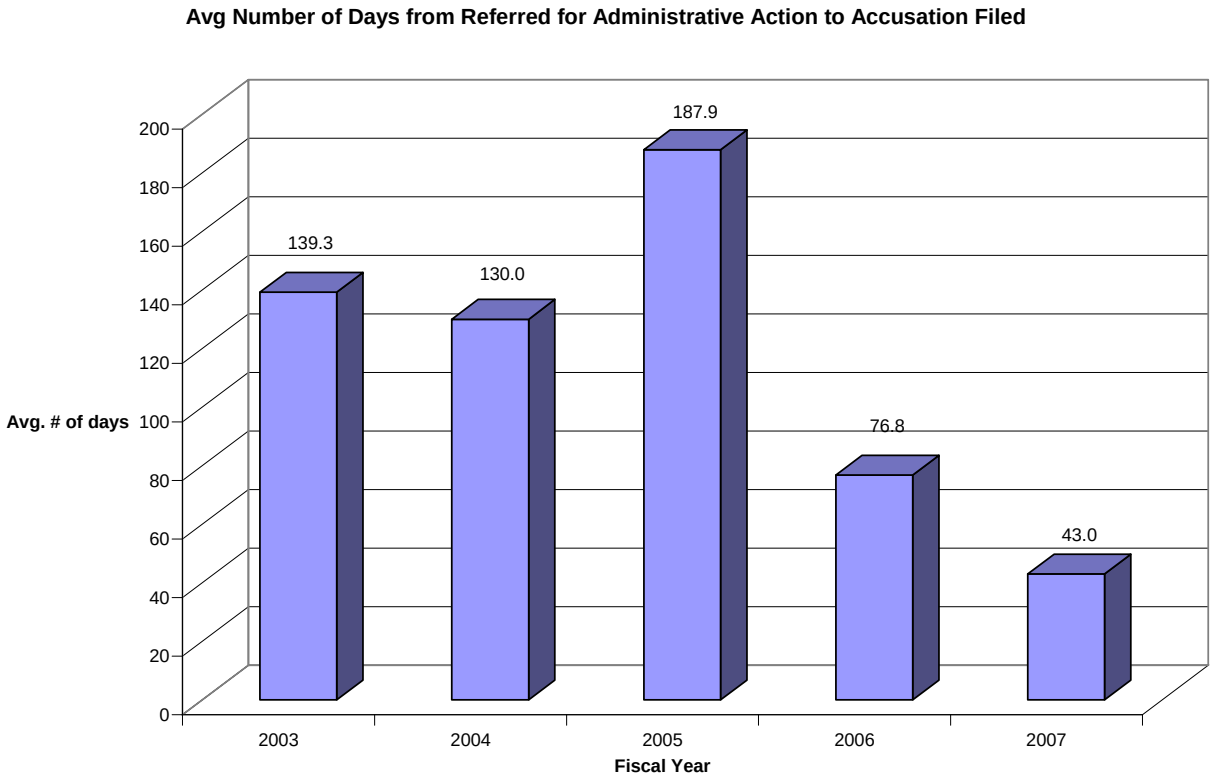
If warranted by the investigation, the 805 complaint is referred for "administrative action." Administrative action can include using sanctions against the physician's license to practice medicine by suspension or revocation, issuing citations for some violations of law, or requiring probation or monitoring. In 2007, the administrative action time averaged an additional seven to eight months (see Figure 4.10).

Figure 4.10: Average Number of Days - MBC Referred for Administrative Action → Outcome



Some issues are referred to the Attorney General's Health Quality Enforcement Section to determine whether to file disciplinary action, such as a formal accusation, which further extends the time. In 2007 the accusation filing took an additional six-plus weeks (see Figure 4.11).

Figure 4.11: Average Number of Days - MBC Referred for Administrative Action → Accusation Filed



Since the accused physician may continue to practice in some capacity throughout this time, it is easy to understand why the focus group participants and key informants reported that the MBC fails to take action or takes too long to take action. There are significant regulations that protect the rights of the physician, but the protections for the physician may conflict with the needs of the public.

Although survey respondents were moderately confident (3.6 on a 1-5 point scale) that the MBC would take action on an 805 that was submitted, focus group members disagreed. A number felt that the medical staff of various entities had become disheartened because MBC action was either absent or very delayed after an 805 was filed (see Figures 4.9 through 4.11, and Table 4.23).

Table 4.23: Online Survey - Confidence in MBC Action
(330 eligible respondents)

	n	Mean	sd
How confident are you that action will be taken by the MBC once an 805 report has been filed? (1 = Not confident - 5 = Very Confident)	225	3.6	1.3

FSMB Standard Seven: State medical boards should broaden the scope of investigation beyond the incident report or complaint…following screening, the investigation of quality of care cases not be limited to the incident…

The MBC is compelled to subpoena documents from entities when they need to investigate quality issues, and since the Dal Cielo ruling, key informants report that it is more difficult to obtain needed documents from hospitals[64].

FSMB Standard Eight: State medical boards should review their Medical Practice Act and pursue legislative support for statutory language to validate the board's subpoena authority and provide the board access to external peer review records.

It is our understanding that the MBC has sufficient subpoena authority to access records, but if the requirement for a subpoena is continued, in order to have a complete picture of events related to the complaint, the Board should broaden the scope of the subpoena to include **any** peer review records and other documents related to the history of behavior leading to the complaint.

FSMB Standard Nine: Based on findings, state medical boards should utilize distinct disciplinary tracks in the disposition of quality of care cases.

The MBC has various methods of discipline available (see Appendix VII: Medical Board of California Documents), including license suspension, license revocation, probation, or reprimand. The MBC also can order testing and examination and education, or dismiss the accusations. These decisions depend on the results of the investigation, but the State is deliberate in any investigation to revoke a medical license given that it is the property and mechanism of livelihood of the license holder.

FSMB Standard Ten: State medical boards should identify and utilize available means of physician assessment and remediation.

The MBC piloted the "Practitioner Remediation to Enhance Patient Safety (PREPS) Program" in 2001-02 with funding from the Health Resources and Services Administration. The goal of this program was to improve patient safety and the quality of care through the directed education and training of identified practitioners in need of remedial training. The Board also uses the Physician Assessment and Clinical Education (PACE) program at the University of California at San Diego School of Medicine, an assessment and skills remediation program in which many physicians disciplined by MBC are required to participate.

Although standards eleven and twelve are not applicable to this study, we list them below to show all the FSMB Standards.

FSMB Standard Eleven: The Federation should collaborate with other entities to develop standards for programs offering remedial medical education.

FSMB Standard Twelve: State medical boards should develop programs to enhance overall physician practice.

Requirement III Summary

Given the study time constraints, we focused on the 805 activities of the Medical Board of California, as they relate to Requirement III. Although other agencies and discipline-specific agencies exist, we found no systematic communication among them that involved coordination of patient quality and safety issues.

To assess the MBC in its management of 805 reporting, we applied the standards of the Federation of State Medical Boards (FSMB) of the United States, Inc. A summary of our findings regarding the MBC's performance follows.

- The MBC has numerous public information documents on its Web site (in both English and Spanish), but it is difficult for the general public to obtain the history of a particular physician.
- It is not clear that the Board receives valid and complete information from entities or individuals when investigating 805 reports, even with subpoena power.
- The Medical Board of California procedures for the complaint process, the enforcement process, and the public disclosure rules are complex and multi-layered.
- The investigation process of an 805 is slow as it moves through the MBC bureaucracy, from when the 805 is first referred to the MBC to closing or resolving the complaint.
- The MBC reports double digit vacancy rates for investigators because of workload and salary.

Requirement IV: An assessment of the cost of peer review to licentiates and the facilities that employ them.

We assessed costs of peer review using the survey, focus group, and key informant interview questions. We asked survey respondents to estimate both dollar and time costs to the entity and to individuals. Most respondents estimated that 0-250 hours were spent on peer review activities in the last calendar year (see Table 4.24). For entities that dealt with an 805 report, this likely added up to a significant cost in time for both physicians and support staff members.

Table 4.24: Online Survey - Total Time Spent for 805 or 821.5 Activities by Entity Role
(see below for eligible respondents)

Question	In the last calendar year, estimate the TOTAL AMOUNT of time IN HOURS spent by the following staff for 805 or 821.5 issues		TOTAL AMOUNT of time IN HOURS you lost from practice in related to being reviewed	TOTAL AMOUNT of time IN HOURS you spent related to your work as a physician reviewer	TOTAL AMOUNT of time IN HOURS you spent on behalf of the entity for 805 or 821.5 issues	TOTAL AMOUNT of time IN HOURS you spent in behalf of your clients for 805 or 821.5 issues
Hours	**Non MD Staff**	**Chairs only**	**Reviewed Physician**	**Physician Reviewer**	**Attorney for Entity**	**Attorney for Reviewed Physicians**
0-250 hours	75	19	11	53	13	0
251-500 hours	15	6	3	10	2	2
501-1000 hours	3	1	2	0	3	0
1000-3000 hours	3	0	2	3	0	0
Greater than 3000 hours	3	1	5	0	1	0
Total respondents	99	27	23	66	19	2
Eligible Respondents	144	70	28	74	30	4

Most survey respondents (69%) estimated that the cost of peer review in the last calendar year was between $0-50,000 to the entity, excluding physician costs in time, with 19% estimating $50-100,000 (see Table 4.25). Please note that is excluding physician time (i.e., the physicians who have privileges in the entity are volunteering their time in exchange for being able to use the facilities of the entity). This, of course, carries forward a practice that was begun over a hundred years ago when modern hospitals were begun. Fifty-seven percent of physicians who have been reviewed estimated the cost at $0-50,000 to the individual physician in the last calendar year (see Table 4.26).

Table 4.25: Online Survey - Total Cost of Entity for 805 or 821.9 Activities
(98 eligible respondents; 64 eligible respondents; percentages based on a denominator of 64)

In the last calendar year, estimate the TOTAL COST IN DOLLARS ($) spent by the entity on the 805 or 821.5 peer review process, including legal fees and all other time and staffing costs.	n	%
$ 0-50,000	44	68.8%
$ 50,001-250,000	12	18.8%
$ 250,001-500,000	1	1.6%
$ 500,000-1,000,000	4	6.3%
Greater than $1,000,000	3	4.7%
Total	**64**	**100.0%**

Table 4.26: Online Survey - Total Cost to Reviewed Physician for 805 or 821.9 Activities
(28 eligible respondents; 21 actual respondents; percentages based on a denominator of 21)

In the last calendar year, estimate the TOTAL COST IN DOLLARS ($) you spent being reviewed in an 805 or 821.5 peer review process, including legal fees and all other time and staffing costs.	n	%
$ 0-50,000	12	57.1%
$ 50,001-250,000	6	28.6%
$ 250,001-500,000	0	0.0%
$ 500,000-1,000,000	2	9.5%
Greater than $1,000,000	1	4.8%
Total	**21**	**100.0%**

There are different contractual arrangements between health plans and medical groups regarding responsibility for peer review. Some contracts place the burden of peer review on health plans and other contracts delegate peer review responsibilities to the medical group. Additionally some management service organizations (MSO) manage multiple medical groups and have contractual obligations to conduct peer review.

The variation in responsibility is a potential point of confusion; this point was verified during one of the focus groups. One participant commented that health plans depend on medical groups for peer review; a second participant said that medical groups depend on health plans; and a third person said both health plans and medical groups depend on hospitals. It became clear that entities did not want to be responsible for filing 805 reports and providing 809 hearings because of the cost, time, and contentiousness of the process.

Requirement IV Summary
In summary, our findings yielded the following about cost of the peer review process and its impact on the entities.

- In the last calendar year, an estimated 0-250 hours per individual physician reviewer, reviewed physician and attorney were spent on peer review activities.
- For 68% of survey respondents, the cost estimate in the last calendar year was between $0-50,000 to the entity, excluding physician costs in time, with 19% estimating $50-100,000,
- Costs to 57% of physicians who were reviewed were estimated at $0-50,000 to the individual physician.

Requirement V: An assessment of the time consumed by the average peer review proceeding, including the hearing provided pursuant to Section 809.2, and a description of any difficulties encountered by either licentiates or facilities in assembling peer review bodies or panels to participate in peer review decision making.

Survey respondents estimated 0-250 hours spent by the entity in the last calendar year on 809 hearings, keeping in mind that almost no entities had 809 hearings (see Table 4.27). Estimates by 86% of survey respondents for the cost of 809 hearings in the last calendar year were $0-50,000 for the entity (see Table 4.28). However, focus group participants estimated that an 809 hearing would never cost less than $100,000, excluding estimates of physician costs in time and legal representation for the person being reviewed, and could cost upwards of several million dollars. One individual stated that an 809 hearing took months to complete because of scheduling problems, hundreds of thousands of dollars, and that one notorious hearing lasted for 17 years! (see Appendix IX: Comments About Study).

Table 4.27: Online Survey - Total Time Spent in 809 Hearings by Entities
(322 eligible respondents, 210 actual respondents, percentages based on a denominator of 210)

For the last calendar year, estimate the TOTAL AMOUNT of time IN HOURS spent by the entity on 809 hearings:	n	%
0-250 hours	196	93.3%
251-500 hours	9	4.3%
501-1000 hours	2	1.0%
1000-3000 hours	1	0.5%
Greater than 3000 hours	2	1.0%
Total	**210**	**100.0%**

Table 4.28: Online Survey - Total Cost of 809 Hearings by Entity
(214 eligible respondents; 124 actual respondents; percentages based on a denominator of 124)

For the last calendar year, estimate the TOTAL COST IN DOLLARS ($) spent by the entity on 809 hearings:	n	%
$ 0-50,000	107	86.3%
$ 50,001-250,000	8	6.5%
$ 250,001-500,000	5	4.0%
$ 500,000-1,000,000	2	1.6%
Greater than $1,000,000	2	1.6%
Total	**124**	**100.0%**

Participants were asked to indicate the reasons they were willing to serve on peer review committees (see Table 4.29). Based on the responses most physicians serve on the committee because they are willing, they are interested and they have experience in peer review.

Table 4.29: Reasons for Serving on Peer Review Body
(74 eligible respondents, 64 actual respondents; percentages are based on a denominator of 64)

Identify the reason(s) you agreed to serve on the Peer Review Body? (check all that apply)	n	%
Willingness to serve	52	81.3%
Interest in peer review	46	71.9%
Experience in peer review	29	45.3%
Requirement for affiliation/employment	9	14.1%
Other	7	10.9%
Payment is offered by entity	4	6.3%
Scheduled/rotating obligation	3	4.7%
Requirement for hospital privileges	2	3.1%

When participants were asked to indicate potential reasons for non-participation (see Table 4.30), some respondents had comments such as, “conflict with other responsibilities,” “refused to agree to a confidentiality agreement,” “outside time constraints,” “all the above,” and “lack of experience” (see Appendix IX: Comments About Study).

Table 4.30: Reasons for Not Participating on Peer Review Body
(214 eligible respondents; 139 respondents; percentages based on denominator of 139)

Indicate reasons for non-participation	N	%
N/A	97	69.8%
Too busy	39	28.1%
Interferes with practice	19	71.9%
Do not like to judge colleagues	7	5.0%

We asked participants whether physicians were willing to serve on peer review committees if asked to do so (see Table 4.31). On average 4 (mean=4.1 sd=6.5) people were asked to serve last year with 1 declining (mean=1.1 sd-2.3) but as indicated by the standard deviation, there was substantial variation in the responses.

Table 4.31: Changes in Peer Review Members
(214 eligible respondents)

In the last calendar year:	n	Mean	sd
How many new members were added to the peer review body?	128	3	5.7
How many individuals were approached to serve on a peer review body?	101	4.1	6.5
If applicable, of those approached, how many refused?	73	1.1	2.3
How many unanticipated member changes have occurred in the peer review body?	127	0.5	1.1

Participants were asked to indicate the reasons for changes in peer review committee membership (see Table 4.32) and most changes were at the expiration of a regular term on the committee. However, over a quarter of the responses indicated that members just dropped out of the committee.

Table 4.32: Reasons for Changes in Peer Review Membership
(214 eligible respondents; 40 respondents; percentages based on denominator of 40)

If applicable, indicate the reason(s) for the changes	n	%
Term expired	20	50.0%
Member moved out of the area	11	27.5%
Dropout	11	27.5%
Member retired	4	10.0%
Moved practice	4	10.0%

Survey participants were asked about the efficiency and effectiveness of the 809 hearing process and reported that it was not efficient but was effective at ensuring physician rights (see Table 4.33). However, 68% (15 of 22) physicians who had been the subject of an 805 reported that they were not offered an 809 hearing (see Table 4.34).

This percentage is substantial and may reflect the confusion among entities about when an 809 hearing must be offered. Some participants understood that an 809 hearing must be offered before any 805 report; others thought it had to be offered before any 805 report, excluding a summary suspension or termination; and others did not know.

Table 4.33: Online Survey - Efficiency and Effectiveness of 809 Hearings
(322 eligible participants)

	n	Mean	sd
How efficient (in relation to timeliness and duration) was the 809 hearing process? (1=Not efficient - 5 = Very Efficient)	48	2.4	1.2
How effective (ensuring individual rights and that the process was followed) was the 809 hearing process? (1=Not Effective - 5 = Very Effective)	48	4.3	1.1

Table 4.34: Online Survey - Opportunity for 809 Hearings for Reviewed Physicians
(28 eligible participants; 22 actual respondents; percentages based on a denominator of 22)

Were you offered the opportunity for an 809 hearing?	n	%
Yes	7	31.8%
No	15	68.2%
Total	**22**	**100.0%**

We asked survey respondents which activities in the following table are required for an 809 hearing (see Table 4.35). The correct response is that all items (except none of the above) are required for an 809 hearing. Based on their responses, many respondents do not know the 809 requirements.

Table 4.35: Online Survey - Requirements of 809 Hearings
(350 eligible respondents; 222 actual respondents; percentages based on a denominator of 222)

Identify requirements of 809 hearings: (check all that apply)	n	%
An arbitrator(s) is selected by a process mutually acceptable to the licentiate and the peer review body or a panel of unbiased individuals, including an individual practicing in the same specialty as the licentiate, who shall gain no direct financial benefit from the outcome, who has not acted as an accuser, investigator, fact finder, or initial decision maker in the matter	161	72.5%
The right of the licentiate to inspect and copy relevant documents	156	70.3%
The parties shall exchange lists of witnesses at the request of either side	143	64.4%
Commencing a hearing within 60 days after receipt of the request	135	60.8%
The right of the licentiate to a reasonable opportunity to challenge the impartiality of the panel members and any hearing officer	128	57.7%
None of the above	45	20.3%

As a method of estimating costs to reviewed physicians and to discover if the peer review/805 processes were functioning as intended, we asked the entities to direct the survey to physicians who had been the subject of peer review (either favorable or unfavorable outcomes), and we also directly surveyed physicians who had been the subject of an 805 in calendar 2007. The responses of reviewed physicians were strikingly different from the responders who had not been the subject of an 805 report and different from the attorneys involved in the peer review/805 processes.

The 805-subject physicians described a process that was highly “political” and was used to eliminate competitors and eliminate peers, based on gender, ethnicity, language, psychiatric illnesses, "get rid of me," or just failure to fit into the culture of a particular medical staff. These 805-subject physicians described not being able to find any position or job after having an 805 report filed and spending three to five years in 809 hearings and other procedures to fight for their reputations, even after the MBC found no wrongdoing on their part. They reported spending thousands of dollars to fight the charges so they could again practice as physicians.

We asked respondents whether they felt the 805 was used for “political” purposes and the variance by who responded is considerable (see Table 4.36). Physicians who had experienced being reported via an 805 stated that having an 805 filed, especially if posted on the physician Web profile, was a “career ender” (see Appendix IX: Comments About Study).

Table 4.36: Online Survey - Use of Peer Review Reporting for Political Reasons
(350 eligible respondents)

How likely is it that 805 reporting is used for "political" reasons in your entity? Rate the following question on a scale of 1-5, with 1 being the least likely and 5 being the most likely .	**n**	**Mean**	**sd**
Peer Review Body Chair	44	1	0.2
Physician reviewer for the entity	62	1.1	0.4
Physician who has been reviewed	21	3.4	1.8
Non-physician entity staff	79	1	0
Attorney who has represented the entity in a peer	19	1.2	0.9
Attorney who has represented a physician being reviewed	2	1	0
Total	**227**	**1.3**	**0.9**

One might speculate that these were just "sour grapes" from physicians who had been caught practicing substandard medicine, but the vehemence with which these statements, phone calls, e-mails, and letters were made begs for further investigation and the question of whether at least some of these statements could be accurate.

Additionally, there are entities that support these physicians in their allegations against "sham peer review" (discussed in Chapter II: Background), such as The Center for Peer Review Justice, Inc. (http://www.peerreview.org/), the Semmelweis Society (http://www.semmelweissociety.net/), the Association of American Physicians and Surgeons, Inc. (http://www.aapsonline.org/), and the Alliance for Patient Safety (http://www.allianceforpatientsafety.org/). Again, it is easy to dismiss these entities and claims out of hand, but they raise questions that remain unanswered (see Appendix IX: Comments About Study).

We also asked survey respondents if they perceived any obstacles to the 805 or 821.9 reporting process. More than half of the respondents thought there were no obstacles. One-third were reluctant to take 805 action against a friend or colleague, and a quarter were reluctant to take 821.5 action. One-fifth of the respondents were fearful of being sued for restricting trade or some other potential retribution (see Table 4.37).

Table 4.37: Online Survey - Obstacles for Peer Review Reporting
(248 eligible respondents; 115 and 96 actual respondents; percentages based on a denominator of 115 (for 805 reporting) or 96 (for 821.5 reporting)

Indicate all obstacles applicable to each type of reporting (805 and 821.5) that you have experienced or would predict: (check all that apply)	805 reporting	%	821.5 reporting	%
No obstacles	48	41.7%	40	41.7%
Reluctance to take action against friend/colleague	39	33.9%	26	27.1%
Fear of being sued for restricting trade of a competitor	25	21.7%	16	16.7%
Reluctance to take action because of potential for retribution	23	20.0%	14	14.6%
N/A	15	13.0%	20	20.8%
Entity uses "internal punishment" (resignation, practice restriction) to reduce reporting	9	7.8%	3	3.1%
Entity encourages an "administrative resolution" (MD agrees to resign in exchange for the entity not filing a report)	9	7.8%	3	3.1%
Other	9	7.8%	5	5.2%

We also asked what recommendations people had to avoid the obstacles in the 805/821.5 process. Even though respondents recognized obstacles, 59% recommended that no change be made in the processes (see Table 4.38).

Table 4.38: Online Survey - Recommendations for Removing Peer Review Reporting Obstacles
(350 eligible respondents; 183 actual respondents; percentages based on a denominator of 183)

Indicate your recommendations to avoid the above obstacles: (check all that apply)	n	%
No changes necessary	108	59.0%
Independent body conducts the peer review (independent of the entity)	34	18.6%
Peer review to be completed by physicians outside the geographic area	33	18.0%
Other	25	13.7%
Non licensing body conducts the peer review (independent of state agencies)	11	6.0%

We asked respondents if they had recommendations to improve the peer review process. Most said no change was necessary, but about 20% suggested using an independent (non-government) agency to manage and conduct peer review (see Table 4.40). However, when we evaluated the responses to the question by entity role, we found only 19% of physicians who had been reviewed thought the process should not be changed, and the rest felt that some change should be made (see Table 4.39).

Interestingly, some of the attorneys in the focus groups thought that there was nothing about the 805 or 809 laws that needed to be changed; nothing was missing, and the language was clear and unambiguous. However, other focus group participants did not agree and made a number of suggestions for change/improvement, such as increasing education of the public and physicians about the peer review process, removing all blame from peer review and resolving patient care issues with physician education, or changing the peer review process to be more efficient.

Table 4.39: Online Survey - No Changes Necessary to Current Peer Review Process by Entity Role

Indicated "No Changes Necessary" to improve the current peer review process	Number Responding	Number Eligible	%
Peer Review Body Chair	33	42	78.6%
Physician reviewer for the entity	35	56	62.5%
Physician who has been reviewed	4	21	19.0%
Non-physician entity staff	58	74	78.4%
Attorney who has represented the entity in a peer	8	16	50.0%
Attorney who has represented a physician being reviewed	1	1	100.0%

Table 4.40: Online Survey - Recommendations for Improving the Current Peer Review Process
(350 eligible respondents; 210 actual respondents; percentages based on a denominator of 210)

Indicate your recommendations to improve the current peer review process: (check all that apply). These changes might relate to modernization, practicality, patient care, or transparency.	n	%
No changes necessary	139	66.2%
Hire an independent entity (non-government) to manage and conduct a peer review	41	19.5%
Other	21	10.0%
Create a statewide government entity that conducts peer review	10	4.8%
Create a statewide government entity that controls credentialing (not just licensing)	10	4.8%
Eliminate peer review	4	1.9%

In some committee minutes, we found indications that an entity would have repeated complaints/allegations against a particular physician without taking action against the individual. We asked survey respondents if that happened in their entity and one third said "yes." (see Table 4.41). When asked why that might happen, respondents checked "other" and provided comments (see Appendix IX: Comments About Study), such as the following two examples.

> "If the allegations are not substantiated, then the physician would be allowed to continue to practice. If the allegations are substantiated, then he/she would not be allowed to continue to practice. Unsubstantiated allegations would not be used to impose a practice restriction but that substantiated allegations would likely result in a practice restriction. The entity does not make peer review and quality decisions based on the amount of revenue a physician brings, on his or longevity with the entity or for any of the other reasons listed on the form."

> "The physician would be allowed to keep their privileges until such time the repeated allegations were investigated and substantiated. If the allegations posed immediate threat to patients the physician would be summarily suspended pending investigation." (see Table 4.42 and Appendix IX: Comments About Study).

Table 4.41: Online Survey - Continued Privileges for Providers with Repeated Allegations
(288 eligible participants; 169 actual respondents; percentages based on a denominator of 169)

In your entity, if repeated allegations are raised against a particular physician, would the entity allow this physician to maintain their practice privileges?	n	%
Yes	55	32.5%
No	114	67.5%
Total	**169**	**100.0%**

Table 4.42: Online Survey - Reasons to Allow Privileges for Providers with Repeated Allegations
(288 eligible participants; 107 actual respondents; percentages based on a denominator of 107)

Please identify potential reasons the entity would allow a physician with repeated allegations raised against them to maintain their practice privileges?	n	%
Other	57	53.3%
The entity would not allow such a physician to practice	30	28.0%
N/A	17	15.9%
The physician is the only specialist of a specific type in the geographic area	9	8.4%
The physician has been with the entity for many years	4	3.7%
The entity cannot find a replacement	4	3.7%
The physician brings in a large amount of revenue	2	1.9%
The physician admits many patients	2	1.9%
Total	**107**	**100.0%**

Requirement V Summary
In summary, our findings indicate that 805 reporting and 809 hearings are a major concern with respondents, not only in the associated costs (in dollars and time) of dealing with an 805 and 809 for both the entity and the affected physician, but also in the potential damage to one's career.

- Survey respondents estimated 0-250 hours and 0-$50,000 spent by the entity in the last calendar year on 809 hearings.
- 805-subject physicians described a peer review process with an agenda to rid entities of certain individuals for various reasons (e.g., ethnicity, gender, language, cultural misfit, etc.).
- 805-subject physicians described the lengthy process being embroiled in 809 hearings (3-5 years) and the difficulty in finding any job much less a physician position, even after MBC found no wrong-doing.

Study Validation Measures
We used a number of mechanisms to ensure the validity and reliability of our study methods and findings. In order to assure entity document evaluation reliability, all minutes, event summaries, and other submitted documents were reviewed by two study staff members; all data analyses were checked by two statistical analysts; data confidentiality was reviewed by a senior statistician; all e-mail comments and letters were reviewed by two staff members; and all focus groups were attended by two to three staff members.

Phase III of the study included site visits to 10 randomly selected entities from our initial site visit sample to check whether entity policies were being followed and to review documents that may not have been submitted. One entity indicated that they used an external audit company for some peer review cases, which extended the length of time required.

Two hospitals indicated that the peer reviews took longer than policies allowed. None of the site visit hospitals provided all the minutes and other documents requested. Two required the site visitor to sign a confidentiality agreement, and two required that she be accompanied at all times during the review. One recently purchased hospital claimed to have access only to peer review minutes that

occurred after the purchase (four months); one hospital only allowed her to review 805 reports with documentation. Given the limited access to documents, it is not clear whether the site visit hospitals are following the policies related to 805 reporting.

Two of the three medical groups and the health plan that were visited provided all documents requested. One medical group had access to only three years of minutes. The health plans and medical groups generally followed the policies and procedures and were meticulous about tracking credentialing. There was variability in tracking in hospitals. All health plans and medical groups used a categorization system that estimated severity of events that occurred and all used the MBC "hot sheets" to check on physicians.

For Phase V of the study, we randomly selected a different 5% sample of the initial sample to use for validation. In the first validation method, the study medical director reviewed patient records and decisions made by peer review committees in the sample entities. We were interested in determining if an independent reviewer would reach the same decision as the committee. Medical records or summaries of cases were made available for review by nine of the ten sampled entities. The entities submitted seven cases in which 805s were filed and five cases of quality concern without 805 filings.

Hospitals generally agreed to supply information on medical staff regulations including privileges, peer review, and disciplinary processes. Few details regarding the extent or nature of peer review were provided. Generally, there was only a brief summary of multiple cases of poor care by a physician, which resulted in a change/restriction/suspension of privileges and then 805 filing. Thus, it was impossible to determine the fairness of the processes for the physician or whether it was effective in eliminating poor care.

The cases demonstrating high level quality concerns (with no 805 filed) usually resulted from a single instance, and remedial actions such as education were prescribed. The role of the medical groups and health plan was generally passive except for removal of offending physician from their physician panel after a hospital filed an 805. They generally did not file the initial 805. The reviews for the individual entities follow.

Entity #1-Hospital (5 cases submitted; 4 with 805/1 not)
Hospital #1 provided copies of the Bylaws and Rules and Regulations of the Professional Staff. It included the investigation and corrective action practices as well as hearing and appeals procedures, including rules of evidence and burdens of proof. These were all separate from 805/809 State processes. Entity #1 then provided a brief summary of four cases for which 805 forms were submitted. Based on the information provided, the Lumetra reviewer found that grounds for filing and 805 were supportable.

Entity #1 also supplied a summary of a high-level quality concern that did not lead to 805. A peer review summary identified issues and MD counseling and educational efforts were planned. The Lumetra reviewer agreed with this decision based on information provided.

Entity #2-health plan (1 case; 0 with 805/1 without)
Entity #2 provided a credentialing department Medicare policy and procedure document, which included peer review committee function and responsibilities. Also noted is an affirmation statement that utilization decisions are based on medical necessity, and no discrimination or conflicts of interest are allowed. The process for filing an 805 is delineated, and the practitioner fair hearing documents are included as well. Peer Review committee minutes from 2006 - 2007 were included

and show the MBC hot sheet review and plan's responses. Entity #2 provided committee minutes of a quality concern that was raised and forwarded to the hospital. The Lumetra reviewer is not sure why this case was identified and reviewed, or what the eventual outcome was.

Entity #3-hospital (1 case; 0 with 805/1 without)
The entity filed no 805 cases in 2007, and there was only one high-level score case that year. A follow-up phone call was made to clarify, and the Lumetra reviewer agreed with the entity action. The entity also provided medical staff bylaws, rules, and regulations that detailed privileges and hearings but did not cite 805 notification or filings. Also included was an 805 report from December 2003, regarding a physician who withdrew his application for staff reappointment following notice of adverse recommendations. No clinical details or case information was provided in this filing.

Entity #4-hosptial (2 cases; 1 with an 805/1 without)
The entity submitted rules and regulations of the governing board, medical staff bylaws (even pages only), hearing procedures, general medical staff rules, and regulations. The entity reported the actions of the medical executive committee regarding the cases. In the first case, mandatory education was imposed first, then summary suspension, and finally termination.

The physician agreed not to practice at hospital pending a hearing and then resigned. This was reported as an 805 twice; first as a suspension and then as a resignation. The Lumetra reviewer agreed with the actions. The second case was a physician who allegedly had physical contact with an employee in the GI lab, which resulted in a two-day summary restriction of privileges to use the lab. The medical executive committee upheld the restriction and provided written warning, and no 805 was filed. The Lumetra reviewer agreed with the action.

Entity #5-medical group (2 cases; 1 with an 805/1 without)
The first example involved one physician and included committee minutes from May 2005 to October 2007 (nearly 2 ½ years). The events included eight case reviews and then ten more, multiple specialty reviews, letters to the physician, and finally termination. There was no information on any hospital actions or reviews during these years. The entity then filed an 805 after their attorney indicated agreement with the action.

The second example involved a physician who refused to see certain patients. The entity review indicated a practice with high compensation and poor patient access. The physician was terminated for not taking a board examination and violating medical group policy; no 805 was filed. The Lumetra reviewer agrees with these decisions.

Entity #6-hospital (4 cases submitted; 2 with 805 and 2 without)

The first example of an 805 event was the denial of reappointment because of failure to disclose suspension and resignation from a nearby hospital in 2005. The second example was a physician who had two years as a provisional staff member but continued to have a low surgical volume and needed additional proctoring. The physician took a leave of absence.

The first example of a non-805 event was two cases for a single physician without any apparent reason for review, peer review, or quality improvement evaluations. The second example was a patient seen in the Emergency Department twice on the same day and admitted; the patient was in jail and was admitted a second time upon release from jail. There was no information provided on the reason for review, peer review, or quality improvement evaluations. Based on very limited information, 805 filings appeared appropriate, and non-805 reviews had no obvious peer review cause for action.

Entity #7-professional society
This entity did not submit records because no peer reviews were performed in 2007.

Entity #8-hospital
This hospital did not submit records.

For the second part of this validation phase we selected a 5% sub sample (10 entities) of the entities and compared the survey responses submitted with the bylaws, policies, and procedures submitted by the entity. We reviewed seven hospitals, one health plan, one medical group and one professional society using a structured format (see Appendix IV: Structured Review Forms) and compared 11 variables.

Surveys from two entities were suspect in that only one person from each entity completed a survey and every response was checked "no" or there was no response. Therefore, these entities had no percentage agreement with the documents. In two entities (one medical group and one hospital) we found 90% agreement between the survey responses (both having six responses) and the documents for the items.

In three entities there was 64% agreement (two entities had one response and the other had one response); and in the last two entities there was 55% agreement in the responses (one entity had two responses and one had one response). These lower percent agreements may indicate that the survey respondents either did not know the entity policies or that the documents provided were not complete. There was one entity (hospital) that failed to provide any records. The high level of agreement between the Lumetra reviewer and the entity reviews provides evidence that some entities are complying with the policies and procedures and complying with the law.

Overall Summary

The overall study response rate for entities was 75.5% and the participants were a clear representation of the medical care entities in the State. Three hundred fifty individuals from 115 entities responded to the on-line survey. Each of the four entity types was represented in the survey respondents, with hospitals representing 62.9%. In summary, our findings revealed the following about "peer review," as it is conducted by entities in California:

1. Variation exists across entities in how they define and conduct "peer review."
   - There is wide variation in all aspects of the peer review/805 processes within different entities, including definition of the term "peer review," policies and procedures, tracking systems, infrastructure (i.e., review and decision-making committees) and responsibilities. Therefore, outcomes are highly variable and specific to each entity.

2. Overall, entities attempt to follow the letter of the law regarding 805 reporting (though perhaps not the spirit of the law).
   - Most entities routinely screen a certain percentage of patient records to check for evidence of substandard care.
   - The most common reasons for cases being referred for peer review to a high level (executive medical staff) committee are 1) disruptive physician behavior/impairment (821.5); 2) substandard technical skills; and 3) failure to document/record patient treatment.
   - Entities screened a large number of cases through the routine monitoring process. However, we estimate that a small percentage of routinely screened cases are forwarded to the

medical executive/decision making committee for further review and even smaller percentage results in an action that limits or terminates a physician's privileges for medical cause or reason, thus triggering an 805 report to the Medical Board.

3. 805 and 809 reporting is subject to interpretation, creates hardship for those affected (e.g., the entity and the physician), and allows many situations to go unresolved.
   - Peer review is lengthy, involving months or years of re-review, review of more records, interviews with the physician, and/or other investigation methods within the entity.
   - The peer review and 805/821.5 reporting processes in entities are highly variable; 805 reports are viewed as something to avoid; the 809 hearing process is inefficient but effective at preserving physician rights.
   - There is disagreement about whether an 809 hearing is required before an 805 report is submitted; 809 hearings for due process can add 2-5 years.
   - Some physicians are allowed to commit multiple disruptive actions over many years before any remediation is required, and it is possible that some physicians are never the subject of peer review.
   - The cost estimate of peer review in the last calendar year was between $0-100,000 to the entity, excluding physician costs in time, costs to physicians who were reviewed were estimated at $0-100,000 to the individual physician.

4. The Medical Board of California procedures for the complaint process, the enforcement process, and the public disclosure rules are complex, circuitous, and multi-layered.
   - The MBC has numerous public information documents on its Web site (in both English and Spanish), but it is difficult for the general public to obtain the history of a particular physician.
   - No systematic communication appears to exist among the various State boards and agencies that would coordinate patient quality and safety issues.
   - It is not clear that the Board receives valid and complete information from entities or individuals when investigating 805 reports, even with subpoena power.
   - The MBC investigation process is slow. In 2007, it took two weeks for an 805 to be referred from the central complaint unit to a field/district office, 1½ weeks for an 805 to be assigned to an investigator; and three to four months to close the complaint in the field office. An administrative action time averaged an additional 7-8 months; an accusation filing took an additional six plus weeks.

Chapter V: Conclusions and Recommendations

Introduction

Peer review and 805 reporting provide a process to review medical care, identify substandard medical care, develop ways to improve physician practice, and report certain events to the MBC for further investigation. The findings of the peer review study demonstrate that these processes have failed in their purpose to ensure the quality and safety of medical care in California. Rather, they allow entities to conduct medical peer review in a clandestine manner, so it is unknown whether the reviews are fair, whether the medical care is judged without bias, or whether or not physician practice is improved.

However, peer review and 805 reporting does succeed in creating the *appearance* of ensuring quality and safety of medical care by generally satisfying accreditation agencies (Joint Commission, Department of Health Services). The processes also cost significant healthcare dollars through actual dollars spent on legal fees, employee salaries, added staff members to ensure compliance with the numerous regulations and requirements, and State agency staff member salaries. Additionally, there are the opportunity costs consumed by these processes: time of physicians away from patient care or in lost off-work/family time; time used by hospital nurses and others in this complex and legalistic system that could be used in more productive patient care activities; and the time, pain, and suffering of patients who may experience injury or death in a system that does not protect them.

In this chapter, we present our conclusions and describe how our medical care quality and safety processes, including peer review and 805 reporting, are not supporting the citizens of California. We also provide for consideration by the MBC and the California legislature recommendations that would improve the peer review and 805 reporting system.

Conclusions

Requirement VI: An assessment of the need to amend Section 805 and Sections 809 to 809.8, inclusive, to ensure that they continue to be relevant to the actual conduct of peer review as described in paragraph (1), and to evaluate whether the current reporting requirement is yielding timely and accurate information to aid licensing boards in their responsibility to regulate and discipline healing arts practitioners when necessary, and to assure that peer review bodies function in the best interest of patient care.

The findings outlined in Chapter IV provide evidence supporting our conclusion that the peer review process, 805 and 821.5 reporting, and 809 hearings do not ensure quality and safety of medical care in California, for the following reasons:

- Excessive variation in policies
- Poor tracking systems
- Potential biased and ineffective reviews
- A too-lengthy process lacking transparency
- Groups of physicians who may never be peer-reviewed
- Burdensome costs to continue the current system

We explore these issues in greater depth in the following section.

Failures of Peer Review

Inconsistency of Peer Review Standards and Policies across Entities

All entities set their own standards for peer review, some more rigorous than others (see Figure 4.3), and some adhere to them more meticulously than others. Additionally, each entity creates its own peer review policies, which can vary substantially. If a physician is found to provide substandard care, that physician may leave or be forced to leave that entity but can practice elsewhere, potentially endangering other patients.

Before a physician's privileges in an entity can be terminated, there is a lengthy (months or years) process during which the potentially substandard care continues to be provided. If an 805 or 821.5 report is eventually filed, there is another lengthy process of investigation designed to protect the legal rights of the physician. Thus, if the physician is providing substandard care, it could be years before a disciplinary action is ever taken.

Lack of Consistent Tracking of Peer Review Events in Entities

In the current system, there is either no tracking or no consistent tracking of peer review events in entities. A physician may have multiple events that indicate substandard care, but the entity has limited ability and resources for follow-up. Peer review events are generally documented within minutes of committees that serve many other functions, such as business functions, monitoring other disciplines, and other entity needs. The tracking of peer-reviewed events requiring entity investigation is buried in these minutes and depends on the persistence and commitment of key individuals in the entity to ensure that the tracking is done and brought back to the attention of the peer review committees.

Lack of Unbiased, Objective, and Confidential Review

Peer review is based on the assumption that the evaluation will be unbiased, objective, and confidential. These requirements are impossible to meet by a medical staff that works together, depends on each other, makes referrals to each other, and provides medical coverage for each other. External reviews are an option but are costly, and typically reserved for events for which the medical staff have limited or no expertise.

Implicit Peer Review Based on Fallacies

“Implicit" peer review (review done by a physician using individual judgment rather than criteria) is based on several fallacies: 1) The science does not exist to determine standards of care in a given situation; 2) You can have a standard based on one person's opinion; and 3) Only a physician can judge medical care. Implicit peer review is not acceptable in a day when there are standards based on science, and we are able to provide a more reliable system of review. At the very least, the reviews must be based on empirical evidence when that evidence exists.

No Standardization in Defining Events that Should Trigger Peer Review

Events, other than routine medical record review, can trigger peer review and lead to reporting, but those events are defined by each entity. There is some consistency in select entities because of requirements of voluntary accrediting agencies (Joint Commission, NCQA), but there is nothing that could be considered standardized. There is evidence from the survey that a number of respondents do not understand what should be reported to trigger a peer review, an 805 report, or an 821.5 report, and that most respondents depend on legal authority or malpractice insurance companies to decide whether or not to report to the MBC.

Lack of Transparency

The peer review and 805/821.5 processes lack transparency, and Evidence Code 1157 is used to protect the entity and the physician. Numerous laws and case law protect information that might harm the physician and entity through litigation. Neither the entity employees (other than the medical staff) nor the public has a right to information regarding peer review, since the activities are proprietary to the entity and are not "discoverable" legally.

Based on our survey and focus group respondents, the MBC is viewed by some as only intermittently responding to 805 reports, focusing particularly on those events that result in patient harm, unacceptably delaying the response, and not reporting public information. Additionally, the MBC is constrained by legislation that requires the agency to strictly limit public information related to 805 reports, including what and to whom the information can be disseminated, whether or not the information can be provided in hard copy, and how long the information can be left on the public Web site (see Table 2.10).

Entities frequently use attorneys to protect proprietary information under the guise of Evidence Code (EC) 1157. The conventional wisdom is that without Evidence Code 1157 protecting physicians from malpractice litigation, practice would not be discussed, mistakes would not be disclosed, and improvement in practice would never occur. Peer review would cease to exist. This assumes that physicians function primarily from the perspective of self-protection. However, because the current peer review system is so opaque, it is not clear what would occur without Evidence Code 1157.

Entities Avoid Following the “Spirit” of the 805 Law

Entities can take multiple steps to follow the letter but avoid the “spirit” of the 805 law by using tactics such as pressuring an offending physician to resign for reasons other than "medical cause or reason," by having summary suspensions less than 14 days, by negotiating with an offending physician privately through attorneys to avoid an 805 report, or by offering extended educational sessions and other remedial opportunities that would not trigger an 805 report.

Several participants reported that health plans and others faithfully review the MBC "Hot Sheets" to see if the MBC has taken an action against any physicians affiliated with their entity (although physicians are supposed to notify all their affiliate entities if an action against them is taken by the Board). If they see an affiliate physician, they then file an 805, although it is redundant and not required. It is reasonable that hospitals should take the major responsibility for peer review because of the rapid and significant injury to individuals that can be caused in the facilities. However, physicians who use hospitals also frequently are members of, or affiliated with, medical groups and health plans, so responsibility should be shared.

It is not ethical to use peer review and 805 reporting for purposes other than intended, such as ridding oneself of a competitor. Given the high rate of recidivism of drug and alcohol abuse, the lack of consistent record for tracking of 821.5 reports of physicians who have used drugs or alcohol, thus endangering patients, is entirely unacceptable.

Beyond initial entity credentialing for which the physician has responsibility, the entities have limited ability or motivation for removing unsafe physicians from the staff. Routine re-credentialing and peer review were designed to be part of the patient quality/safety system, but responsibility rests with the entity to trigger re-credentialing and peer review.

Not All Entities Perform Peer Review

There are medical groups/clinics and health plans that are not required to perform peer review because they do not meet one of the myriad laws defining which entities must report to the MBC. Also, all health plans, medical groups/clinics, ambulatory care centers, outpatient surgery centers, and other facilities where medical treatment is performed and injury to the public can occur, are not licensed by the State, and all physicians are not required to undergo peer review or some type of quality assessment.

Also, the California codes are unclear as to whether an 805 must be reported only after an 809 hearing or can be filed before a hearing; or whether an 809 hearing is only required prior to an 805 when there has been a summary suspension of greater than 14 days or a termination.

Extensive Delays Create Barriers to Public Protection

The delays in the process are extensive and serve as a barrier to the goal of protecting the public. Entity delays through poor tracking, ownership change, hospital staff turnover, reluctance of medical staff to discipline a colleague, ignoring physician behavior, and MBC delays for investigation and decision making and multiple other reasons render the processes impotent in investigating past injury and preventing future injury.

Costs Related to Processes are Prohibitive

The costs of 805, 821.5, and 809 processes are prohibitive, and entities and physicians use all possible means to avoid the time and money that are involved in the lengthy, contentious processes. Some hospitals have suggested that the offending physician split the hospital costs with the entity in addition to the physician's cost of hiring a private attorney and time lost in income.

In summary, these failures of the peer review, 805/821.5, and 809 hearing processes to ensure patient safety call for major changes to the current system. In the following section, we propose recommendations to correct these issues, specifically addressing the last four requirements (VII, VIII, IV, X) of the 805.2 legislation related to recommended changes. Although the legislation asks for what appear to be moderate changes and suggestions to current codes, we recommend major changes and improvements to the peer review/805 system because it cannot be "fixed" with moderate changes.

Requirement VII: Recommendations of additional mechanisms to stimulate the appropriate reporting of peer review actions under Section 805.

As we have indicated, although the entities in the study follow the letter of the 805 reporting law. Recommendations 2, 3, 4, and 5 address changes that would improve the reporting process.

Requirement VIII: Recommendations regarding the Section 809 hearing process to improve its overall effectiveness and efficiency.

The 809 hearing process is rarely used because 805 reports are relatively rare, and the process is inefficient, costly and legalistic, requiring many hours of physician and entity staff time, thousands of dollars, and extensive services of attorneys. Recommendation 7 addresses changes needed to improve the process.

Requirement IX: An assessment of the role of medical professionals, using professionals who are experts and are actively practicing medicine in this State, to review and investigate for the protection of consumers, allegations of substandard practice or professional misconduct.

Creating a system requiring physicians to provide objective and independent review of colleague friends or enemies is an unrealistic expectation. Recommendations 2, 3, 4, 5, and 7 provide a mechanism to engage experts who are practicing medicine in the State and who can be objective, independent and unbiased reviewers. As mentioned, all physicians could be required to provide this service as a requirement of licensure.

Requirement X: An assessment of the process to identify and retain a medical professional with sufficient expertise to review allegations of substandard practice or professional misconduct by a physician and surgeon, if the peer review process is discontinued.

As mentioned previously, Recommendations 2, 3, 4, 5, and 7 provide mechanisms to engage experts who are practicing medicine in the State and who can be objective, independent, and unbiased reviewers. The State could either pay the physicians or require this service as a condition of licensure. Because we have found evidence that the current peer review process, the 805 reporting process, the 821.5 process, and the 809 process are ineffective and inefficient in protecting the public health, we enumerate recommendations to change and improve the entire system.

Recommendations

1. Re-design the peer review process and create an independent review organization [addressing 805.2 (6), (7), (8), (9), & (10)]. Based on the analyses of all data, we recommend that the MBC and legislature change the peer review process in the following ways:
    - Continue to allow healthcare entities to provide first level quality/safety screening of physician practice through random record review of each physician no fewer than twice every year.
    - Define specifically what is required in the first level screens; these could be screens recommended by a professional accrediting agency.

- Refer any physician whose actions related to patient care do not meet the standard of care of the screening, or "fall out" of the screens for any reason, to an unbiased independent peer review organization that has no vested interest in the review outcome except protection of the public.
- The independent organization will be selected by the MBC or the appropriate legislative committee. All further responsibility for making decisions about taking any action toward the physician including 805 or 821.5 reporting would be removed from the healthcare entity.
- After the initial identification by the healthcare entity, the independent organization would take over all further investigation of the issue and make a recommendation to the healthcare entity regarding either filing an 805 report or other action such as recommending physician education and training, recommending PACE (UCSD Physician Assessment and Clinical Education Program, or recommending anger management training. A copy of all recommendations would be sent to the MBC. The healthcare entity would decide to follow or not follow the recommendation.

    - If a healthcare entity has an event (serious event or sentinel event) that requires an expedited or "fast track" review, that event would be reported to the independent entity within five hours. The independent organization would expedite the review/investigation (no longer than three days) and make an action recommendation to the MBC and to the healthcare entity (805, summary suspension if not already imposed, or other action).

    - The independent organization would create a tracking system to follow patient-related care issues by physician over time to monitor trends.

    - If a physician is not affiliated with an entity that performs peer review, the physician is responsible for initiating peer review at least twice annually through a professional entity. There would be substantial financial penalties for failing to being subject to peer review twice annually.

    - All patient, physician, or employee complaints related to patient care would be referred by the healthcare entity to the independent entity for investigation.

    - The independent organization would randomly select entities for assessment of the initial peer review process no fewer than once every three years. The independent entity would perform site audits of quality and safety programs, similar to Medi-Cal site audits.

2. Improve transparency [addressing 805.2 (6), (7), (8), (9), & (10)]
    - MBC would notify complainant and subject immediately when investigation is begun, when the information goes on Web site, and when it is taken off the Web site.
    - The independent entity would be blinded to physician name (using the national ID number). The MBC would be aware of all identifying information.
    - The MBC would increase transparency of reporting to the public by posting on the physician profile on the Web site any action recommendation (including history and outcome) by the independent entity and keep it there indefinitely.

- The MBC would create a user-friendly Web access so that a layperson can understand the sequence of events and find out whether the physician did or did not provide substandard care.

3. Revise role of the MBC [addressing 805.2 (6), (7), (8), (9), & (10)]
   - The independent entity would report all action recommendations to the MBC and to the entity.
   - The MBC would continue to investigate all 805 reports and make a determination about any license action and would be required to initiate an investigation within 48 hours of receiving an 805 report and make recommendations within five days of the completion of the investigation.
   - The responsibility of the 809 hearing would be removed from healthcare entities. The MBC or a designated independent organization would conduct 809 hearings to insure fairness.
   - Through the MBC, oversight for investigations, 809 hearings, and probation monitoring would be under the auspices of a "professional jury" composed of all practicing physicians. This "jury" service would be for a set time period and rotated among all licensed physicians in the State, being sure to only use people who did not have prior direct contact with the parties of the issue.
   - The legislature should either eliminate the requirement for a subpoena by the MBC to obtain needed documents from entities or the MBC should broaden the scope of any subpoena to include all documents related to the history of behavior leading to the complaint and any other relevant documents or medical records related to a patient care issue.

4. Emphasize credentialing [addressing 805.2 (6), (7), (8), (9), & (10)]
   - Routine credentialing and re-credentialing should still occur at the healthcare entity level. The healthcare entity would report any change in credentialing or privilege to practice to the independent entity. The independent entity would investigate and make a recommendation about whether an 805 or other action is warranted.
   - The physician would remain responsible for initiating any credentialing action.
   - The physician would be responsible for notifying the independent organization of any change in certification or credentialing by any professional group or healthcare entity. There would be substantial financial penalties for not reporting to the independent entity.

5. Promote education [addressing 805.2 (6), (7), and (8)]
   - The MBC should create mechanisms to continuously educate and update:

     a) All physicians and employees in entities required to file 805 reports, about the laws regarding peer review, 805, 821.5 and 809.

     b) All California citizens about their rights and how to use the MBC Web site.

     c) All entities about the requirement to not file redundant 805 reports.

6. Clarify codes [addressing 805.2 (6), (7), and (8)]
   - The MBC and legislature should clarify whether or not an 809 hearing is required prior to submission of an 805 report; or whether or not the hearing before the 805 is only waived after a summary suspension of greater than 14 days or a termination/revocation of privileges.

- The MBC and legislature should clarify whether an 805 should be filed for not completing patient records.
- The MBC and legislature should require a consistent and separate tracking system of peer review activities over a five-year period, whether or not the entity is sold or changes ownership; require separate peer review minutes from all other committee or entity business.
- The MBC and legislature should create mechanisms to require all medical groups, clinics, ambulatory care, ambulatory surgical, health plans, and acute care hospitals to perform peer review and report to the MBC through the 805 mechanism.
- The MBC and legislature should create a mechanism to require every licensed physician to submit to peer review.
- The MBC should define peer review and define specifically events that would trigger peer review.

7. Identify Funding Sources

   Funding for the revised peer review system could be handled in a combination of ways without increasing taxes or diverting State funds, including:

   - Increasing physician license fees to support the process and a portion of those fees can be used.
   - Charging malpractice insurance companies a percentage of all policy payments they receive.
   - Attorneys for entities can provide a percentage of their billing income to fund the process.
   - Using a percentage of any malpractice judgment to help fund the process.

Pilot Study and Program Evaluation

Before full implementation of any change to the system, we strongly recommend that a pilot study be conducted, including process evaluations and outcomes evaluations related to patient safety and quality.

Evaluation of a program change is typically ignored because of many reasons, including the desire to be ignorant of the results. However, without a pilot program and an evaluation, the risk is that the change could cost much and gain nothing. With so much at stake in this potential change, every precaution must be taken to assure that the change will yield a great benefit in patient safety and quality. Prior to any change of this magnitude, comprehensive process evaluations must occur to ensure that the changed system is not just a recreation of the current system.

Finally, if there are any changes made, they must and should be phased in over a period of two to three years to provide for adjustment to the many affected systems.

Conclusion

There are negative aspects about the system of peer review and 805/821.5 reporting as mechanisms to ensure patient safety. However, there is one very positive aspect - the people in the system who try to make it function. The vast majority of individuals in the participating healthcare entities, the staff working at the MBC, and the people who provide legal counsel to organizations and individuals try to make this complex, bureaucratic, legalistically dysfunctional system work to protect patients by complying with the complex codes, laws, and regulations.

Multiple and conflicting demands require people to make difficult decisions that often in the end satisfy no one. One physician complained that he lay awake at night worrying that the peer review efforts for which he was responsible had allowed patients or physicians to be harmed. Many attorneys expressed frustration and anger that the system was not working properly, and healthcare administrators wished a better way existed to ensure patient safety and physician rights.

It would be easier and more expedient to make no change at all, and for many participants perhaps no change to the system would be better than changing to something uncertain. No change requires no further costs except to the citizens of California. It is the quality of care that would continue to be impacted by this flawed system.

With any major change to this century-plus old process, there will be widespread opposition from parties vested in the status quo or fearful that a new system might be worse. Based on evidence found in this study, change is imperative to protect the health and medical care of Californians, and it will require the help and support of the people who understand the nuances and complexities of the current system.

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Appendices

State of California

Department of Consumer Affairs

Memorandum

AGENDA ITEM 16C

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

Date: October 1, 2008

From: Susan Goetzinger
Expert Reviewer Program

Subject: Results of the Expert Survey Questionnaires

Questionnaires Sent this quarter (July 1-September 30, 2008)	47
Feedback Received from the questionnaires sent this 3rd quarter	28 (60%)
Total Feedback Received for this 3rd quarter's report	35

Questions 1-9, *positive response*: Yes
Question 10, *positive response*: No
Questions 11, *positive response*: Yes
Question 12, *positive response:* Yes or No
Questions 13-15, *positive response*: Yes

1	Were you provided sufficient information/evidence to allow you to render a medical opinion?	97 percent YES 3 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? If not, how much time would have been appropriate for this review?	97 percent YES 3 percent NO
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?	94 percent YES 3 percent NO 3 percent did not respond
6	Did the training material provided to you (the Expert Reviewer Guidelines and videotape/DVD) give you adequate information to perform your case review?	97 percent YES 3 percent responded N/A
7	Were you given clear, concise, and easy to follow instructions throughout the process?	91 percent YES 3 percent NO 6 percent responded N/A
8	Was the investigator and/or MBC staff readily available to answer questions or concerns about the case?	97 percent YES 3 percent responded N/A
9	Is the required written report adequate to cover all aspects of your opinion?	97 percent YES 3 percent NO
10	Do you feel the MBC has requested your services more frequently than you would prefer?	97 percent NO 3 percent YES

11	Would you be willing to accept more MBC cases for review?	100 percent YES
12	Did this case go to hearing? If the answer is no (skip 13 & 14) go to question 15.	94 percent NO 6 percent YES
13	If you were required to testify, was the Deputy Attorney General readily available to answer questions and provide direction?	100 percent YES
14	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?	100 percent YES
15	Do you feel the reimbursement amount for case review is appropriate for the work you are required to perform?	63 percent YES 37 percent NO
Level of satisfaction with overall experience performing case reviews for MBC		85 percent HIGH 9 percent AVERAGE 6 percent did not respond

SUGGESTIONS FOR IMPROVEMENT TO THE PROGRAM

I will get a call to possibly review a case and the investigator does not know enough of the details about the case for me to determine if I am qualified to review the case. Investigators will call me about a case, I will ask for more information or clarification and then I may never hear back or it may take weeks for a response. Investigators will call me about a case, I will agree to do the case as I have the time to do the review. The case may take 2-3 months to arrive and by which point I may not have the time to do the review.
Maybe increasing the hourly rate in the future.
Ability to request/receive more documents during review period or as a follow-up (e.g. in a case I just reviewed, certain periods of time were missing from records-helpful if these were made available or explanation given as to why not). In a controlled substance prescribing case, pharmacy records from known locations used by MD/patient are very helpful because CURES is often very incomplete.
More secure shipping of records (mine arrived in ripped open envelope). Provide return envelope with prepaid shipping.
I would like follow-up - how did the case turn out? I think follow-up should be part of the process re-case outcome.
Make CDs Mac-compatible
Consider online (internet based review) rather than by mail correspondence.

COMMENTS REGARDING REIMBURSEMENTS

I have performed similar case reviews for managed care & insurance companies for $300/hour. I agreed to $150/hour for "civic responsibility."
I get $300/hr for private reviews/cases, but $150/hr is better than what it used to be. I enjoy doing this and would even be available if a med reviewer were necessary on a more regular basis.
If possible increase reimbursement as rates are quite low compared to market rates.
Your rate of $150 per hour is low compared to my usual fee for case reviews.
$150/hr is well less than the rate for comparable work in the med-legal personal injury arena. However the MBC work is critically important to patient care and the medical profession, so I'll continue.
$150/hr is okay. I receive double that for privately requested cases. Still have not been paid - that could be more prompt.
$150/hr far below standard expert rates. Willing to review more cases.
Payment is low but then again, it is an important function for Society.
Reimbursement not in line with other medico-legal fees.
Reviews take a lot of time to do correctly and reimbursement is low considering the training and expertise of the reviewers (vs. $450/hr attorneys charge). But I am willing to do reviews for the sake of medicine and because I find the process interesting and challenging.

GENERAL COMMENTS

There are many variables involved in psychiatric treatment and only a few issues are subject to "Standard of Care" whereas many treatment & diagnostic decisions are more controversial or so rare as not to easily be categorized as a "Standard of Care" but more aptly referred to as "preferred practice."
If I am considered as a possible expert in the future, I will not charge for Advice to one who is about to interview or cross examine the DR. to emphasize the most valuable things to ASK. I was happy to be of help to the Medical Board of CA. I await the next case. I am being under utilized or requested too few times.
I am available any time the Board needs my services to review additional cases.

Regarding report format, Consider requiring references. Good program.
My first case was very dense and complicated, took a lot of time to review, also had many + multiple issues that needed documentation and commenting, as well as researching for references. Case took a lot of time to complete to the satisfaction of investigator, but was only compensated for some portion of time spent. There was no doubt that I spent a lot of time on case given finished product, but still not compensated appropriately. Overall, I very much enjoyed this work and would like to participate more in the future. It's likely that future cases will not be so time-intensive.
Everyone was very helpful and timely in responding to any questions or issues.
I have always found working as a Medical Board Expert Reviewer to be an excellent learning experience. It helps to keep me focused and grounded as a clinician and (medical student/resident/fellow) teacher.
This was my first review. My contact with the Board (Chris Figueroa) was excellent. I appreciated his help and thoroughness, which made it easy for me to review the case.

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
Calendar Year 2008

SPECIALTY	Number of cases reviewed/sent to Experts Jan-Sep 2008	Number of Experts used and how often utilized Jan-Sep 2008	Active List Experts Y-T-D (TOTAL= 1,150 ↓)
ADDICTION	3	1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	11
AEROSPACE MEDICINE			1
ALLERGY & IMMUNOLOGY	2	1 LIST EXPERT	10
ANESTHESIOLOGY	18	7 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES	91 ↑
BIOETHICS			1
COLON & RECTAL SURGERY	2	1 LIST EXPERT REVIEWED 2 CASES	5
COMPLEMENTARY/ALTERNATIVE MEDICINE	2	1 LIST EXPERT REVIEWED 2 CASES	14 ↑
CORRECTIONAL MEDICINE	7	5 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	11
DERMATOLOGY	8	2 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 3 CASES	12
EMERGENCY	20	14 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES	60 ↓
ETHICS	1	1 LIST EXPERT	2
FAMILY	47	32 LIST EXPERTS REVIEWED 1 CASE 7 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	94 ↓
HAND SURGERY	1	1 LIST EXPERT	6
HOSPICE & PALLIATIVE CARE	1	1 LIST EXPERT	6 ↓
INTERNAL General Internal Med & sub-specialties not listed below	45	27 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES	229 ↓
INTERNAL - CARDIOLOGY Interventional Cardiology	13 [6]	10 LIST EXPERTS REVIEWED 1 CASE 1 OUTSIDE EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	35 [20 ↓]
INTERNAL-ENDOCRINOLOGY & METABOLISM			8
INTERNAL - GASTROENTEROLOGY	4	4 LIST EXPERTS	17 ↓
INTERNAL -INFECTIOUS DISEASES			10
INTERNAL - NEPHROLOGY			8
INTERNAL - ONCOLOGY			14 ↑
MEDICAL GENETICS			1
MIDWIFE	1	1 LIST EXPERT	12

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
(CALENDAR YEAR TO DATE: JAN - SEP 2008)
Page 2

NEUROLOGICAL SURGERY	10	1 LIST EXPERT REVIEWED 1 CASE 1 OUTSIDE EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 6 CASES	15
NEUROLOGY	4	2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	20
NEUROLOGY (CHILD)			5
OBSTETRICS & GYNECOLOGY	42	11 LIST EXPERTS REVIEWED 1 CASE 6 LIST EXPERTS REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 5 CASES	85 ↓
REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY			6
OCCUPATIONAL MEDICINE	1	1 LIST EXPERT	7 ↓
OPHTHALMOLOGY	15	6 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 9 CASES	45 ↓
ORAL & MAXILLOFACIAL SURGERY			1
ORTHOPAEDIC SURGERY	24	11 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	48 ↓
OTOLARYNGOLOGY	5	1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 4 CASES	32 ↓
PAIN MEDICINE	16	3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES	26
PATHOLOGY	3	1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	13
PEDIATRICS	2	2 LIST EXPERTS	62 ↓
PEDIATRIC CARDIOLOGY	1	1 LIST EXPERT	5
PEDIATRIC CARDIOTHORACIC SURGERY	1	1 LIST EXPERT	2
PEDIATRIC HEMATOLOGY/ONCOLOGY			5
PEDIATRIC INFECTIOUS DISEASES (BOARD CERTIFIED)			3
PEDIATRIC SURGERY			4
PHYSICAL MEDICINE & REHABILITATION			9
PLASTIC SURGERY	24	7 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES	52 ↑
PSYCHIATRY	50	16 LIST EXPERTS REVIEWED 1 CASE 6 LIST EXPERTS REVIEWED 2 CASES 5 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 7 CASES	106 ↓
PUBLIC HEALTH & GENERAL PREVENTIVE MEDICINE			6

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
(CALENDAR YEAR TO DATE: JAN - SEP 2008)
Page 3

RADIOLOGY	15	4 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 5 CASES	35
VASCULAR/INTERVENTIONAL RADIOLOGY (Board Certified)			2
RADIATION ONCOLOGY -4 / THERAPEUTIC RADIOLOGY -3			7
SLEEP MEDICINE			8
SPINE SURGERY (ABSS-MBC APPROVED)			1
SURGERY	17	11 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES	58 ↓
THORACIC SURGERY	6	4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	21 ↑
VASCULAR SURGERY	1	1 LIST EXPERT	6
UROLOGY	5	3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	16 ↓
WORKERS' COMP/QME/IME			12 ↑

/susan (10/1/08)

Medical Board of California

Investigation & Prosecution Timeframes*

	2005	2006		2007		Q1 2008		Q2 2008		Q3 2008		Q1, 2 & 3 2008	
	Prior to VE	All	VE	All	VE	All	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	388	365	398	384	380	361
Median	252	285	134	304	269	332	309	357	339	345	338	344	330
Record Count	827	703	192	648	539	180	171	202	194	131	128	509	489
Calendar Day Age from Request to Suspension Order Granted													
Average	51	44	4	34	38	27	27	22	22	19	16	20	20
Median	17	3	2	22	23	13	13	16	16	14	10	14	13
Record Count	24	21	11	17	13	3	3	3	3	10	8	16	14
Calendar Day Age from Request to Receipt of Medical Records													
Average	58	53	37	59	57	69	37	50	49	50	50	60	52
Median	32	31	26	31	31	29	21	24	23	27	27	28	28
Record Count	475	376	228	264	259	40	37	42	41	43	43	163	159
Calendar Day Age from Request to Physician Interview Completed													
Average	48	51	43	52	50	59	58	52	52	55	55	56	56
Median	36	42	38	37	36	44	44	37	37	48	48	42	43
Record Count	597	453	172	406	371	101	98	120	119	47	47	335	328
Calendar Day Age from Request to Receipt of Expert Opinion													
Average	51	47	35	51	43	46	46	50	50	50	49	48	48
Median	41	35	31	36	35	35	35	35	35	40	39	36	36
Record Count	519	424	82	344	270	73	69	122	116	85	83	305	291
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed													
Average	556	554	140	543	340	649	537	543	462	502	440	560	473
Median	525	504	120	523	339	662	587	535	472	447	425	543	470
Record Count	187	149	17	198	95	36	25	53	43	40	36	129	104
Calendar Day Age from Accusation Filed to Disciplinary Outcome**													
Average	608	602	85	576	188	475	192	758	261	535	255	584	234
Median	526	466	99	426	182	379	197	421	266	357	209	390	235
Record Count	212	195	3	226	29	67	22	55	22	44	15	165	59

*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	Q2 2008	Q3 2008
***Citations Issued**	80	81	76	23	25	33
Citations Issued for Failure to Produce Records	0	6	3	0	1	2
Civil Actions Filed	3	3	1	0	0	1
Civil Actions Filed for Failure to Produce Records	2	2	1	0	0	1

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

MEDICAL BOARD OF CALIFORNIA - ENFORCEMENT PROGRAM
TOTALS FOR PRE 2006 AND POST 2006 CASES ASSIGNED TO INVESTIGATION

TOTALS FOR OPEN COMPLAINTS ASSIGNED PRIOR TO JANUARY 1, 2006

PRE 2006 PHYSICIAN AND SURGEON COMPLAINTS = 5
PRE 2006 ALLIED HEALTH COMPLAINTS = 0
PRE 2006 OSTEOPATHIC COMPLAINTS = 1

TOTALS FOR OPEN COMPLAINTS ASSIGNED ON OR AFTER JANUARY 1, 2006

POST 2006 PHYSICIAN AND SURGEON COMPLAINTS = 1080
POST 2006 ALLIED HEALTH COMPLAINTS = 110
POST 2006 OSTEOPATHIC COMPLAINTS = 36

THE TOTAL NUMBER OF OPEN ASSIGNED COMPLAINTS = 1232

LICENSING PROGRAM CHIEF'S REPORT | JULY - SEPTEMBER 2008 | FISCAL YEAR 08/09

Consumer Information Unit	
Calls Answered	19,428
Calls directly connected to an operator	19,428
Percent of callers experiencing a two-minute wait/longer	Data will be captured beginning Third Quarter

Physicians and Surgeons (P&S) Application Review	
New Applications Received	1,854
New Licenses Issued	1,429
Address Changes	8,293
License Renewals	17,731

P&S SPECIAL PROGRAMS

**Special Program Applications	New	Renewed
2,111	16	17
2,112	2	0
2,113	12	13
2,168	0	1

Special Program Facilities	
2072 Applications Processed (Correctional Facility)	0
Hospital 1327 Renewals/Site Visits	0
Medical School 2111 / 2113 Site Visits	0

ALLIED HEALTH PROGRAMS

Licensed Midwives	
New Applications	13
New Licenses Issued	10
License Renewals	22

New Registered Dispensing Opticians Licenses	
Spectacle Lens Dispenser	60
Contact Lens Dispenser	38
Dispensing Optician	12
Out of State Dispensing Optician	2

Research Psychoanalysts	
Licenses Issued	2
Fictitious Name Permits Issued	
Physicians	363
Podiatrist	11

* Issues concerning training, medical school, post-graduate training, substance abuse, and/or any criminal convictions.
** 2111 - Postgraduate Medical School Study (Visiting Fellow)
2112 - Fellowship Program Non-Citizen (Hospital)
2113 - Certificate of Registration Medical School Faculty Member
2168 - Special Faculty Permit

AGENDA ITEM 18B

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 23, 2008
DEPARTMENT: Licensing Program
SUBJECT: International Medical School Proposed Regulation Changes
STAFF CONTACT: Deborah Pellegrini

REQUESTED ACTION

No action required.

STAFF UPDATE:

Staff plans to implement the following steps to revise the international medical school regulations:

1. Identify all issues needing revision including
   - Changes made by Liaison Committee on Medical Education (LCME) since the regulations were last revised in 2003.
   - Evaluate Dr. Simon's recommendations from the July 2008 Board meeting and other recommendations obtained by Board staff.
   - Clarify and enhance the seven-year reevaluation process and include Board-ordered school site visits.
2. Discuss the regulatory recommendations with the Board's Medical consultants, Dr. Simon and Dr. Nuovo, and draft proposed regulations.
3. Hold an interested parties meeting to obtain stakeholders' input on the proposed regulations.
4. Revise the regulations as needed based on the interested parties' input.
5. Present the proposed regulations to the Board Members for approval to proceed with the regulatory process (publish proposed regulations, hold hearing, revise as needed, etc.).

EXECUTIVE SUMMARY:

The regulations governing its process and standards for reviewing international medical schools took effect in December 2003. These regulations are found in Section 1314.1 of Title 16, California Code of Regulations. The regulations have met the Board's needs over the past five years. However, the Board's medical consultants have recently made suggestions for improvement, LCME has updated several of its standards that could be relevant to the Board's process, and legal counsel has identified areas where amendments should be made in preparation for the reevaluations of recognized international medical schools which the Board will commence in 2010.

Staff will begin developing the proposed amendments to Section 1314.1 including staff and legal counsel compiling input from the medical consultants and interested parties and drafting proposed language to Section 1314.1. Staff will present the proposed amendments to the Board for review at the May 2009 meeting, with the public hearing

held during the following meeting in July 2009. The goal is to have the regulations in place before the Board conducts site inspections of international medical schools due for reevaluation. There is sufficient time to achieve these goals by 2010 if work commences in the next several months.

FISCAL CONSIDERATIONS:
None.

PREVIOUS MBC AND/OR COMMITTEE ACTION:
At the July 2008 Board meeting, the Board requested staff to review current regulations and identify amendments that should be implemented before the Board reevaluates the international medical schools scheduled for review pursuant to the seven-year reevaluation cycle.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	October 23, 2008
ATTENTION:	Medical Board of California
DEPARTMENT:	Licensing Program
SUBJECT:	Special Faculty Permit Review Committee Recommendations
STAFF CONTACT:	Deborah Pellegrini, Chief

REQUESTED ACTION: Board approve the recommendations of the Special Faculty Permit Review Committee (Committee) with respect to 1) the appointments pursuant to Section 2168.1 of the California Business and Professions Code and 2) the waivers of the Business and Professions Code section 2113 appointment limits for the below listed candidates.

STAFF RECOMMENDATION:
Staff recommends that the Board accept the recommendations of the Special Faculty Permit Review Committee.

EXECUTIVE SUMMARY:
Under Article 8.5 of the Medical Practice Act commencing with Section 2168, the Board is authorized to issue a Special Faculty Permit (permit) to a person who is deemed to be academically eminent under the provisions of the statute and meets the other eligibility requirements for issuance of a permit. This permit authorizes a holder to practice medicine only within the facilities of the appointing medical school and any affiliated institutions in which the permit holder is providing instruction.

A review committee was created to review applications and make recommendations to the Board on the approval of such permits and other items - including waivers and position appointments within the medical school. The review committee consists of one representative from each of the eight medical schools in California and two Board members for a total of ten members.

At the September 10, 2008 meeting of the Special Faculty Permit Review Committee, the members reviewed the qualifications and credentials of candidates: Takahiro Shiota, M.D.; Dermot McGovern, M.D.; and Ulf Tylen, M.D. As to candidates Tahahiro Shiota, M.D., and Dermot McGovern, M.D., the Committee recommended contingent approval, the contingency being the receipt of a written agreement between the University of California, Los Angeles and Cedars Sinai Medical Center which clearly specifies the following: 1) UCLA assumes control of the clinical practice of Dermot McGovern and Takahiro Shiota at Cedars Sinai Medical Center; 2) if the University of California, Los Angeles faculty appointment of either individual is terminated, no clinical practice by that individual may be conducted at Cedars Sinai Medical Center; 3) Cedars Sinai Medical Center will provide medical quality/peer review documentation and information to UCLA on a regular, specified basis; and 4) UCLA commits to review of the provided medical quality/peer review documentation and information. This information was provided to the Board on October 22, 2008, and has not been reviewed by counsel to determine its responsiveness. Counsel will make a presentation at the meeting regarding the information provided.

As to candidate Ulf Tylen, M.D, the Committee recommended approval of his request for a permit pursuant to Section 2168.1 of the Business and Professions Code, and the recommendation included granting a waiver of section 2168.1(a)(5) for Ulf Tylen as this applicant has held Special Programs certificates pursuant to Business and Professions Code section 2113 for a period of two years or more preceding the date of application for a Special Faculty Permit.

FISCAL CONSIDERATIONS:
None.

PREVIOUS MBC AND/OR COMMITTEE ACTION:
Not applicable.