State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

October 29 - 30, 2009

Panel A	**October 29**	**9:00 a.m. - 12:00 p.m.**
Panel B	**October 29**	**9:00 a.m. - 12:00 p.m.**
Executive Committee	**October 29**	**1:00 p.m. - 2:30 p.m.**
Wellness Committee	**October 29**	**2:30 p.m. - 3:30 p.m.**
Access to Care Committee	**October 29**	**3:30 p.m. - 4:30 p.m.**
PACE Visit	**October 29**	**5:00 p.m. - 6:30 p.m.**
Application Review Committee	**October 30**	**8:30 a.m. - 9:00 a.m.**
Full Board	**October 30**	**9:00 a.m. - 4:00 p.m.**

MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

Marriott Courtyard
2592 Laning Road
San Diego, CA 92106

October 29-30, 2009

Thursday, October 29

- **9:00 a.m. – 12:00 p.m.** — Panel A – Liberty Hall Room
  (Members: Duruisseau, Carreon, Chin, Salomonson, Zerunyan)
- **9:00 a.m. – 12:00 p.m** — Panel B – Liberty Hall Room
  (Members: Chang, Levine, Low, Moran, Schipske)
- **12:00 p.m. – 1:30 p.m.** — Lunch
  (All Members)
- **1:00 p.m. – 2:30 p.m.** — Executive Committee - Liberty Hall Room
  (Members: Yaroslavsky, Chang, Gitnick, Salomonson, Zerunyan)
- **2:30 p.m. – 3:30 p.m.** — Wellness Committee – Liberty Hall Room
  (Members: Duruisseau, Carreon, Chin, Giang, Gregg, Moskowitz, Norcross)
- **3:30 p.m. – 4:30 p.m.** — Access to Care Committee – Liberty Hall Room
  (Members: Gitnick, Chang, Duruisseau, Schipske, Yaroslavsky, Zerunyan)
- **5:00 p.m. – 6:30 p.m.** — Physician Assessment & Clinical Education Program (PACE) Visit –
  (All Members)

Friday, October 30

- **8:30 a.m. – 9:00 a.m.** — Application Review Committee – Liberty Hall Room
  (Members: Gitnick, Levine, Low, Salomonson, Schipske)
- **9:00 a.m. – 4:00 p.m.** — Full Board Meeting – Liberty Hall Room
  (All Members)

MEDICAL BOARD OF CALIFORNIA
Executive Office

MEMBERS OF THE BOARD
Barbara Yaroslavsky, President
Frank V. Zerunyan, J.D., Vice President
Hedy Chang, Secretary
Jorge Carreon, M.D.
John Chin, M.D.
Shelton Duruisseau, Ph.D.
Gary Gitnick, M.D.
Sharon Levine, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.

QUARTERLY BOARD MEETING

October 30, 2009

Marriott Courtyard - San Diego Airport / Liberty Station
Liberty Hall Room
2592 Laning Road
San Diego, CA 92106
619-221-0900

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

AGENDA

9:00 a.m. to 4:00 p.m.

ORDER OF ITEMS IS SUBJECT TO CHANGE

Open Session:

1. Call to Order / Roll Call

2. 9:00 a.m. REGULATIONS – PUBLIC HEARING – Ms. Threadgill and Ms. Scuri Disciplinary Guidelines Regulations: (CCR, Title 16, Section 1316). This proposal amends the Manual of Model Disciplinary Orders and Disciplinary Guidelines to reflect changes in law, clarify existing language, and make technical changes to reflect the current probationary environment.

Closed Session: (Pursuant to Government Code Section 11126(e)(2)(A))

3. Pending Litigation

Return to Open Session:

4. Approval of Minutes from the July 23 - 24, 2009 meeting

5. Public Comment on Items not on the Agenda

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. Board Member Communications with Interested Parties – Ms. Yaroslavsky

7. President's Report - Ms. Yaroslavsky

8. Executive Director's Report – Ms. Johnston
   A. Budget Overview and Staffing Update
   B. Update on Board Evaluation

9. Legislation – Ms. Whitney
   A. Status of Regulatory Action
   B. 2009 Legislation Discussion and Implementation Plans
   C. Consideration of 2010 Proposed Legislation

10. Presentation on Federation Credentials Verification Service (FCVS) – Ms. Sandra Waters, Consultant, Federation of State Medical Boards

11. Licensing Chief's Report – Ms. Pellegrini
   A. Demonstration of Web Application
   B. Licensing Program Update
   C. Report on Graduate Medical Education Administrators' Meeting
   D. Midwifery Advisory Council Update

12. Presentation on Controlled Substance Utilization Review and Evaluation System (CURES) – Ms. Threadgill and Ms. Katherine Ellis, Manager, CURES Program

13. 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 Utilization Report

14. Vertical Enforcement Program Report – Ms. Threadgill and Mr. Ramirez

15. Proposal for Continuing Medical Education Committee – Ms. Cordray

16. Executive Committee Update and Consideration of Committee Recommendations - Ms. Yaroslavsky
   A. Report on October 1, 2009 Licensing Update Meeting
   B. Report on Evaluation of Executive Director

17. Wellness Committee Update and Consideration of Committee Recommendations – Dr. Duruisseau

18. Access to Care Committee Update and Consideration of Committee Recommendations – Dr. Gitnick

19. Physician Assistant Committee Update – Dr. Low

20. Strategic Plan Update – Ms. Johnston

21. Agenda Items for January 28-29, 2010 Meeting

22. Adjournment

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting 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.

****

For additional information call (916) 263-2389.

State of California
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, Ca 95815
www.mbc.ca.gov

Memorandum

Date: October 7, 2009

To: Members

From: Janie Cordray,
Research Program Manager

Subject: Comments proposing revisions to the 11th edition of the *Manual of Disciplinary Guidelines and Model Disciplinary Orders,* incorporated by reference in the proposed rulemaking.

Since the proposed rulemaking was noticed, we have received requests from staff at the Attorney General's Health Quality Enforcement Section and the Board's Enforcement Program that further modifications be made to the 11th edition *of Manual of Disciplinary Guidelines and Model Disciplinary Orders.*

As the members can see in the rulemaking materials, the proposed regulation incorporates the *Manual* by reference, and, therefore, any modifications not already noticed must be adopted by the members as part of the regulatory process. (Procedurally speaking, at the regulatory hearing, if the members are agreeable to the changes they will delegate their adoption authority to the Executive Director, staff will publish a 15-day notice, and the Director will adopt them on the Board's behalf after the public comment period has ended.)

The following are the requested modifications (in **bold** print):

24~~5~~. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. ***Prohibited*** Solo practice includes, but is not limited to, a practice where: 1) ***respondent*** ~~physicians~~ merely share***s*** office space ***with another physician*** but ***is*** ~~**are**~~ not affiliated for purposes of providing patient care, or 2) ***where*** respondent ***is*** ~~**would be**~~ the sole physician practitioner at that location.

34. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine ***in California*** as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours per month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete a clinical training program that meets the criteria of Condition 19 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

To date, these are the only comments received. Any future comments submitted in writing during the comment period will be forwarded to the members for their consideration at the public hearing.

TITLE 16. Medical Board of California

NOTICE IS HEREBY GIVEN that the Medical Board of California is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments orally or in writing relevant to the action proposed at a hearing to be held at the Courtyard by Marriott San Diego Airport/Liberty Station, 2592 Laning Road, San Diego, CA 92106 at **9:00 a.m.**, on **October 30, 2009**. Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office not later than 5:00 p.m. **on October 26, 2009** or must be received by the Board at the hearing. The Board, upon its own motion or at the instance of any interested party, may thereafter adopt the proposals substantially as described below or may modify such proposals if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the proposal.

Authority and Reference: Pursuant to the authority vested by Sections 2018 and 2220 of the Business and Professions Code, and to implement, interpret or make specific Sections 2228, 2229 and 2234 of said Code, as well as Sections 11400.20, 11400.21, 11425.50(e) of the Government Code, the Medical Board of California is considering changes to Division 13 of Title 16 of the California Code of Regulations as follows:

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Amend Section 1361 in Article 4 of Chapter 2, Division 13, relating to the *Manual of Disciplinary Guidelines and Model Disciplinary Orders* to reflect current law and make technical changes.

The *Manual of Model Disciplinary Orders and Disciplinary Guidelines* referenced in the current regulation (10th Edition/2008) must be made consistent with current law. The proposed regulation will reference the 11th Edition/2009 of the *Manual of Model Disciplinary Orders and Disciplinary Guidelines*, reflecting changes in law, as well as making technical changes to address unnecessary and duplicative elements, as well as some technical changes to reflect the current probationary environment.

The *Manual of Model Disciplinary Orders and Disciplinary Guidelines* referenced by the current regulation has been amended to conform to statutory changes, including those in the California Uniform Controlled Substance Act, augment and delete language for reasons of consistency and clarity, as well as make some minor but significant changes to probationary conditions for disciplined physicians. In addition to changes to conform to current law and amendments for consistency, the *Guidelines* have been amended to:

- Require probationers to cease the practice of medicine when testing positive in a biological fluid test for unlawfully prescribed substances or alcohol;
- Expand and define "Biological Fluid Testing" to include blood, urine, breathalyzer, and hair follicle testing;
- Expand acceptable continuing medical education courses beyond classroom, conference, and seminars, to reflect other types of educational delivery systems;
- Allow for participation in equivalent programs other than those provided by the Physician Assessment & Clinical Education (PACE) Program offered by UCSD, if approved by the Medical Board;
- Add a condition for participation in "Anger Management" programs;
- Allow for an oral competency examination in the event there are no appropriate clinical

training programs available;

- Require documentation for medical evaluation;
- Within 7 days of the effective date of a decision, require disciplined physicians to provide a copy of the decision and accusation to the Chiefs of Staff at every hospital where the physician has privileges, and;
- Require probationers that cease practice for over 18 months to complete a training program before resuming practice, and prohibit non-practice over 2 years.

The 11th Edition of the *Manual* amends language made obsolete or inconsistent due to changes in law. A complete summary of changes is attached. (Medical Board of California Disciplinary Guidelines Interested Parties Meeting, June 18, 2009) The materials may be downloaded at: http://www.mbc.ca.gov/board/meetings/materials_2009_06-18_disciplinary.pdf

FISCAL IMPACT ESTIMATES

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

Nondiscretionary Costs/Savings to Local Agencies: None

Local Mandate: None

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

Business Impact:

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

AND

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

There are no costs associated with the proposed regulatory action. The proposed only relates to physicians disciplined by the Medical Board of California.

Impact on Jobs/New Businesses:

The Medical Board of California has determined that this regulatory proposal will not have

_____ a significant

____x____ any

impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California.

Cost Impact on Representative Private Person or Business:

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

This proposed regulation only reflects the current law, and will only have an impact on physicians disciplined by the Medical Board of California.

Effect on Housing Costs: None

EFFECT ON SMALL BUSINESS

The Medical Board of California has determined that the proposed regulations would not affect small businesses. This proposed regulation only will have an impact on physicians disciplined by the Medical Board of California.

The new edition of the *Manual of Disciplinary Guidelines and Model Disciplinary Orders*, incorporated by reference, makes no changes that would result in an increase of costs to licensees or small businesses.

CONSIDERATION OF ALTERNATIVES

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

The proposed regulation reflects changes in current law, as well as makes technical changes to remove and replace unnecessary and duplicative elements. There is no reasonable alternative to the proposed changes.

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

INITIAL STATEMENT OF REASONS AND INFORMATION

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

TEXT OF PROPOSAL

Copies of the exact language of the proposed regulations and of the initial statement of reasons, and all of the information upon which the proposal is based, may be obtained at the hearing or prior to the hearing upon request from the Medical Board of California at 2005 Evergreen Street, Suite 1200, Sacramento, California 95815.

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

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

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

CONTACT PERSON

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

Name:	Janie Cordray Medical Board of California
Address:	2005 Evergreen Street, Suite 1200 Sacramento, CA 95815
Telephone No.:	(916) 263-2389
Fax No.:	(916) 263-2387
E-Mail Address:	jcordray@mbc.ca.gov

The backup contact person is:

Name:	Kevin A. Schunke Medical Board of California
Address:	2005 Evergreen Street, Suite 1200 Sacramento, CA 95815
Telephone No.:	(916) 263-2389
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

Website Access: Materials regarding this proposal can be found at http://www.medbd.ca.gov/laws/regulations_proposed.html .

Medical Board of California
Disciplinary Guidelines
Specific Language

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

1361. Disciplinary Guidelines.

In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), the Medical Board of California shall consider the disciplinary guidelines entitled "Manual of Disciplinary Guidelines and Model Disciplinary Orders" (~~10th Edition/2008~~ 11th Edition/2009) which are hereby incorporated by reference. Deviation from these guidelines and orders, including the standard terms of probation, is appropriate where the Medical Board of California in its sole discretion determines by adoption of a proposed decision or stipulation that the facts of the particular case warrant such a deviation -- for example: the presence of mitigating factors; the age of the case; evidentiary problems.

NOTE: Authority cited: Sections 2018, Business and Professions Code; and Sections 11400.20 and 11400.21, Government Code. Reference: Sections 2227, 2228, 2229, and 2234, Business and Professions Code; and Sections 11400.20 and 11425.50(e), Government Code.

State of California
State and Consumer Services Agency
MEDICAL BOARD OF CALIFORNIA
MANUAL OF MODEL DISCIPLINARY ORDERS
AND DISCIPLINARY GUIDELINES
11~~10~~th Edition
~~2008~~2009
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA

~~Richard Fantozzi, M.D.~~
Barbara Yaroslavsky
President
~~Cesar Aristeiguita, M.D.~~
Frank Zerunyan
Vice President
Hedy Chang
Secretary

The Board produced this Manual of Model Disciplinary Orders and Disciplinary Guidelines, 11~~10~~th Edition for the intended use of those involved in the physician disciplinary process: Administrative Law Judges, defense attorneys, physicians-respondents, trial attorneys from the Office of the Attorney General, and the Board's disciplinary panel members who review proposed decisions and stipulations and make final decisions. These guidelines are not binding standards.

The Federation of State Medical Boards and other state medical boards have requested and received this manual. All are welcome to use and copy any part of this material for their own work.

For additional copies of this manual, please write to the address below or visit www.mbc.ca.gov:

Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
Phone (916) 263-2466

Revisions to the Manual of Model Disciplinary Orders and Disciplinary Guidelines~~,~~ are made periodically. Listed below are the most recent changes included in the 11~~10~~th edition approved by the Board following open discussion at a public meeting.

Summary of Changes
Model Condition Number:

5. Controlled Substances – Total Restriction
Eliminated the term "good faith" prior examination to reflect amendments made to statute which now requires an "appropriate prior examination and a medical indication" and adds "furnish" to the list of prohibited activities.

~~6. Controlled Substances - Surrender of DEA Permit~~

~~References to the "Division" (Division of Medical Quality) changed to "Board."~~

7. Controlled Substances – Partial Restriction
Eliminated the term "good faith" prior examination to reflect amendments made to statute which now requires an "appropriate prior examination and a medical indication" and adds "furnish" to the list of prohibited activities.

8. Controlled Substances - Maintain Records and Access To Records and Inventories
~~References to the "Division" (Division of Medical Quality) changed to "Board."~~
Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

9. Controlled Substances - Abstain From Use
~~References to the "Division" (Division of Medical Quality) changed to "Board."~~
Added language that respondent shall cease the practice of medicine based upon a positive biological fluid test and that the Board must meet time requirements for filing an Accusation and/or Petition to Revoke and hold a hearing.

10. Alcohol - Abstain From Use
Added language that respondent shall cease the practice of medicine based upon a positive biological fluid test and that the Board must meet requirements for filing an Accusation and/or Petition to Revoke and hold a hearing.

11. Biological Fluid Testing
Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. Expands the parameters of biological fluid testing to include various testing mechanisms. Added language that respondent shall be cease the practice of medicine based upon a positive biological fluid test and that the Board must meet requirements for filing an Accusation and/or Petition to Revoke and hold a hearing.

~~The following language was deleted:~~

~~*Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon the request of the Division or its designee. A certified copy of any laboratory test results may be received in evidence in any proceedings between the Board and the respondent. Failure to submit to, or failure to complete the required biological fluid testing, is a violation of probation.*~~

~~The following language replaces the above:~~

~~*Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon request of the Board or its designee. Prior to practicing medicine, respondent shall, at respondent's expense, contract with a laboratory or service - approved in advance by the Board or its designee - that will conduct random, unannounced, observed, urine testing a minimum of four times each month. The contract shall require results of the urine tests to be transmitted by the laboratory or service directly to Board or its designee within four hours of the results becoming available. Failure to maintain this laboratory or service during the period of probation is a violation of probation. A*~~

~~*certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and respondent. Failure to submit to or comply with the time frame for submitting to, or failure to complete the required biological fluid testing, is a violation of probation."*~~

~~**Former # 12 "Diversion Program" was eliminated:**~~
~~# 12 was formerly entitled "Diversion Program." As the Diversion Program is eliminated on June 30, 2008, the following language was deleted:~~

~~*Within 30 calendar days from the effective date of this Decision, respondent shall enroll and participate in the Board's Diversion Program until the Diversion Program determines that further treatment and rehabilitation are no longer necessary. Upon enrollment, respondent shall execute a release authorizing the Diversion Program to notify the Division of the following: 1) respondent requires further treatment and rehabilitation; 2) respondent no longer requires treatment and rehabilitation; and 3) respondent may resume the practice of medicine. Respondent shall execute a release authorizing the Diversion Program to provide confirmation to the Division whenever the Diversion Program has determined that respondent shall cease the practice of medicine.*~~

~~*Within 5 calendar days after being notified by the Diversion Program of a determination that further treatment and rehabilitation are necessary, respondent shall notify the Division in writing. The Division shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Diversion Program determines that further treatment and rehabilitation are no longer necessary. Within 24 hours after being notified by the Diversion Program of a determination that respondent shall cease the practice of medicine, respondent shall notify the Division and respondent shall not engage in the practice of medicine until notified in writing by the Division or its designee of the Diversion Program's determination that respondent may resume the practice of medicine. Failure to cooperate or comply with the Diversion Program requirements and recommendations, quitting the program without permission, or being expelled for cause is a violation of probation.*~~

12. Community Service - Free Services
Reworded the language regarding non-medical community service.
~~Formerly # 13, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

13. Education Course
Deleted language limiting the education program or course to classroom, conference or seminar settings.
~~Formerly # 14, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

14. Prescribing Practices Course
Added language to require the course be equivalent to the course offered at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine. Also added language requiring the respondent to provide pertinent documents to the program and amended the language regarding completion of the course.
~~Formerly # 15, it is re-numbered to reflect the deletion of former #12." Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

15. Medical Record Keeping Course
Added language to require the course be equivalent to the course offered at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine. Also added language requiring the respondent to provide pertinent documents to the program and amended the language regarding completion of the course.
~~Formerly # 16, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

16. Professionalism Program (Ethics Course)
Amended the name and language to comport with subsequent regulations setting requirements for a professionalism program (previously referred to as an ethics course). Also added language requiring the respondent to provide pertinent documents to the program and amended the language regarding completion of the course.
~~Formerly # 17, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

17. Professional Boundaries Program
Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. Added language permitting discretionary acceptance of a course taken prior to the effective date of the decision.
~~Formerly # 18, it is re-numbered to reflect the deletion of former #12." Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

18. Anger Management for Healthcare Professionals Program
Added new condition for an anger management course

19~~8~~. Clinical Training Program
Formerly #18, it is re-numbered to reflect the addition of a new condition. Also amended the language regarding completion of program and replaced the terms specialty and sub specialty with area of practice in which respondent was deficient. Added language that the Board must meet requirements for filing an Accusation and/or Petition to Revoke and hold a hearing.

Also eliminated the subsequent optional term and made it a requirement.
~~Formerly # 19, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

20~~19~~. Oral or Written Examination
Formerly #19, it is re-numbered to reflect the addition of a new condition. Also added that if the examination is an oral examination to be administered in accordance with Business and Professions Code section 2293(a) and (b). Also eliminated the subsequent optional term and made it a requirement. Made technical changes.
~~Formerly # 20, it is re-numbered to reflect the deletion of former #12." Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

21~~20~~. Psychiatric Evaluation
Formerly #20, it is re-numbered to reflect the addition of a new condition. Deleted language that failure to comply is a violation of probation because the language is

unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.
~~Formerly # 21, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

22~~21~~. Psychotherapy
Formerly #21, it is re-numbered to reflect the addition of a new condition. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.
~~Formerly # 22, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

23~~22~~. Medical Evaluation and Treatment
Formerly #22, it is re-numbered to reflect the addition of a new condition. Also added language requiring the respondent to provide pertinent documents/information to the evaluating physician. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.
~~Formerly # 23, it is re-numbered to reflect the deletion of former #12." Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

24~~23~~. Monitoring - Practice/Billing
Formerly #23, it is re-numbered to reflect the addition of a new condition. Also restructured the formatting to clarify the type of monitor required. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. Added language that respondent shall cease the practice of medicine until they obtain a monitor if they do not meet the required timeline for obtaining a monitor.
~~Formerly # 24, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

25~~24~~. Solo Practice Prohibition
Clarified the title to show it was a prohibition and clarified what constitutes solo practice.
~~Formerly # 25, it is re-numbered to reflect the deletion of former #12.~~

26~~25~~. Third Party Chaperone
Formerly #25, it is re-numbered to reflect the addition of a new condition. Also restructured the formatting to clarify the type of patient in which respondent is required to have a chaperone. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. In addition, language was added prohibiting employment termination of a chaperone for reporting to the Board.
~~Formerly # 26, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

27~~26~~. Prohibited Practice
Formerly #26, it is re-numbered to reflect the addition of a new condition. Also restructured the formatting of the condition to clarify the type of practice prohibition. Deleted language that failure to comply is a violation of probation because the language

is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.
~~Formerly # 27, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

28~~27~~. Notification
Formerly #27, it is re-numbered to reflect the addition of a new condition. Also required notification to be within seven days of the effective date of the decision rather than prior to practicing medicine.
~~Formerly # 28, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

29~~28~~. Supervision of Physician Assistants
Formerly #28, it is re-numbered to reflect the addition of a new condition.
~~Formerly # 29, it is re-numbered to reflect the deletion of former #12.~~

30~~29~~. Obey All Laws
Formerly #29, it is re-numbered to reflect the addition of a new condition.
~~Formerly # 30, it is re-numbered to reflect the deletion of former #12.~~

31~~30~~. Quarterly Declarations
Formerly #30, it is re-numbered to reflect the addition of a new condition.
~~Formerly # 31, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

32~~31~~. General Probation Requirements ~~Unit Compliance~~
Formerly #31, it is re-numbered to reflect the addition of a new condition. Also reformatted the conditions and added clarification regarding notification of residence or practice out-of-state and of email and telephone number.
~~Formerly # 32, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

33~~32~~. Interview with the Board or its designee
Formerly #32, it is re-numbered to reflect the addition of a new condition. Also, reworded condition for clarity.
~~Formerly # 33, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

***Formerly* 33. Residing or Practicing Out-of-State**
Deleted condition due to combining conditions 33 and 34 to clarify non-practice regardless of physician location.
~~Formerly # 34, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

***Formerly* 34. Failure to Practice Medicine- California Resident**
Deleted condition due to combining conditions 33 and 34 to clarify non-practice regardless of physician location.
~~Formerly # 35, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

34. Non-Practice While on Probation
Clarified non-practice regardless of physician location. Added clinical training for non-practice of more than 18 calendar months, defined non-practice, and required physician to practice in two years.

~~**35. Completion of Probation**~~
~~Formerly # 36, it is re-numbered to reflect the deletion of former #12.~~

~~**36. Violation of Probation**~~
~~Formerly # 37, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

Formerly **37. Cost Recovery**
Deleted condition due to elimination of authority to order cost recovery. See Business and Professions Code section 125.3(k).
~~Formerly # 38, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

37~~38~~. License Surrender
Formerly 38, reworded condition for clarity.
~~Formerly # 39, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

38~~39~~. Probation Monitoring Costs
Formerly 39, deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.
~~Formerly # 40, it is re-numbered to reflect the deletion of former #12. Also, all references to the "Division" (Division of Medical Quality) changed to "Board."~~

Draft

STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
MODEL DISCIPLINARY ORDERS AND
DISCIPLINARY GUIDELINES

Business and Professions Code section 2229 mandates protection of the public shall be the highest priority for the Medical Board and for the Administrative Law Judges of the Medical Quality Hearing Panel. Section 2229 further specifies that, to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees. To implement the mandates of section 2229, the Board has adopted the Manual of Model Disciplinary Orders and Disciplinary Guidelines (guidelines), 11~~10~~th Edition. Consistent with the mandates of section 2229, these guidelines set forth the discipline the Board finds appropriate and necessary for the identified violations. In addition to protecting the public and, where not inconsistent, rehabilitating the licensee, the Board finds that imposition of the discipline set forth in the guidelines will promote uniformity, certainty and fairness, and deterrence, and, in turn, further public protection.

The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, ~~and~~ demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

The Model Disciplinary Orders contain three sections: three (3) Disciplinary Orders; twenty-four~~three~~ (24~~3~~) Optional Conditions whose use depends on the nature and circumstances of the particular case; and eleven ~~thirteen~~ (11~~3~~) Standard Conditions that generally appear in all probation cases. All orders should place the Order(s) first, optional condition(s) second, and standard conditions third.

~~The Model Disciplinary Guidelines list proposed terms and conditions for more than twenty-four (24) sections of the Business and Professions Code.~~

MODEL DISCIPLINARY ORDERS
INDEX

Model No. **Page No.**

DISCIPLINARY ORDERS

1. Revocation - Single Cause 11
2. Revocation - Multiple Causes 11
3. Standard Stay Order 11

OPTIONAL CONDITIONS

4. Actual Suspension 11
5. Controlled Substances - Total Restriction 11
6. Controlled Substances - Surrender of DEA Permit 12
7. Controlled Substances - Partial Restriction 12
8. Controlled Substances - Maintain Records and Access To Records and Inventories 13
9. Controlled Substances - Abstain From Use 13
10. Alcohol - Abstain From Use 14
11. Biological Fluid Testing 14
12. Community Service - Free Services 15
13. Education Course 15
14. Prescribing Practices Course 15
15. Medical Record Keeping Course 16
16. Professionalism Program (Ethics Course) 16
17. Professional Boundaries Program 17
18. Anger Management for Healthcare Professionals Program 18
19~~18~~. Clinical Training Program 19
20~~19~~. Oral or Written Examination 20
21~~20~~. Psychiatric Evaluation 21
22~~21~~. Psychotherapy 22
23~~22~~. Medical Evaluation and Treatment 23
24~~23~~. Monitoring - Practice/Billing 24
25~~24~~. Solo Practice Prohibition 25
26~~25~~. Third Party Chaperone 25
27~~26~~. Prohibited Practice 26

STANDARD CONDITIONS

28~~27~~. Notification 27
29~~28~~. Supervision of Physician Assistants 27
30~~29~~. Obey All Laws 27
31~~30~~. Quarterly Declarations 27

Draft

Model No.	Page No.
32~~31~~. General Probation Requirements ~~Unit Compliance~~	27
33~~32~~. Interview with the Board or its designee	28
~~33. Residing or Practicing Out-of-State~~	~~26~~
~~34. Failure to Practice Medicine- California Resident~~	~~27~~
34. Non-Practice While on Probation	29
35. Completion of Probation	30
36. Violation of Probation	30
~~37. Cost Recovery~~	~~23~~
37~~38~~. License Surrender	30
38~~39~~. Probation Monitoring Costs	30

Draft

MODEL DISCIPLINARY ORDERS

1. Revocation - Single Cause

Certificate No._____ issued to respondent _____ is revoked.

2. Revocation - Multiple Causes

Certificate No. _____ issued to respondent _____ is revoked pursuant to Determination of Issues (e.g. I, II, and III), separately and for all of them.

3. Standard Stay Order

However, revocation stayed and respondent is placed on probation for (e.g., ten) years upon the following terms and conditions.

OPTIONAL CONDITIONS

4. Actual Suspension

As part of probation, respondent is suspended from the practice of medicine for (e.g., 90 days) beginning the sixteenth (16th) day after the effective date of this decision.

5. Controlled Substances - Total Restriction

Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section11362.5.

If respondent forms the medical opinion, after an appropriate ~~good faith~~ prior examination and a medical indication, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior ~~good faith~~ examination and a medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Draft

6. Controlled Substances - Surrender of DEA Permit

Respondent is prohibited from practicing medicine until respondent provides documentary proof to the Board or its designee that respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms. Thereafter, respondent shall not reapply for a new DEA permit without the prior written consent of the Board or its designee.

7. Controlled Substances - Partial Restriction

Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule(s)_____(e.g., IV and V) of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section11362.5. If respondent forms the medical opinion, after an appropriate ~~good faith~~ prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior ~~good faith~~ examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Note: Also use Condition 8, which requires that separate records be maintained for all controlled substances prescribed.

(Option)
Respondent shall immediately surrender respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, respondent shall submit proof that respondent has surrendered respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, ~~the~~ respondent shall submit a true copy of the permit to the Board or its designee.

8. Controlled Substances- Maintain Records and Access to Records and Inventories

Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

~~Failure to maintain all records, to provide immediate access to the inventory, or to make all records available for immediate inspection and copying on the premises, is a violation of probation.~~

9. Controlled Substances - Abstain From Use

Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawfully prescribed ~~lawful prescription~~ medications, respondent shall notify the Board or its designee of the: issuing practitioner's name, address, and telephone number; medication name, ~~and~~ strength, and quantity; and issuing pharmacy name, address, and telephone number.

If respondent has a positive biological fluid test for any substance not legally prescribed and not reported to the Board or its designee, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

Draft

10. Alcohol - Abstain From Use

Respondent shall abstain completely from the use of products or beverages containing alcohol.

If respondent has a positive biological fluid test for alcohol, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

11. Biological Fluid Testing

Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon request of the Board or its designee. "Biological fluid testing" may include, but is not limited to, urine, blood, breathalyzer, hair follicle testing, or similar drug screening approved by the Board or its designee. Within 30 calendar days of this Decision, ~~Prior to practicing medicine,~~ respondent shall~~, at respondent's expense,~~ contract with a laboratory or service approved in advance by the Board or its designee that will conduct random, unannounced, observed, ~~urine~~ biological fluid testing~~ a minimum of four times each month~~. The contract shall require results of the ~~urine~~ tests to be transmitted by the laboratory or service directly to the Board or its designee within four hours of the results becoming available. Respondent shall ~~Failure to~~ maintain this laboratory or service contract during the period of probation ~~is a violation of probation~~.

A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and respondent. ~~Failure to submit to or comply with the time frame for submitting to, or failure to complete the required biological fluid testing, is a violation of probation."~~

If respondent fails to cooperate in a random biological fluid testing program within the specified time frame, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good

cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

12. Community Service - Free Services

[Medical community service shall only be authorized in cases not involving quality of care.]

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval a community service plan in which respondent shall within the first 2 years of probation, provide_____ hours of free services (e.g., medical or nonmedical) to a community or non-profit organization. If the term of probation is designated for 2 years or less, the community service hours must be completed not later than 6 months prior to the completion of probation.

Prior to engaging in any community service respondent shall provide a true copy of the Decision(s) to the chief of staff, director, office manager, program manager, officer, or the chief executive officer at every community or non-profit organization where respondent provides community service and shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall also apply to any change(s) in community service.

Community service performed prior to the effective date of the Decision shall not be accepted in fulfillment of this condition. ~~Note: In quality of care cases, only non-medical community service is allowed unless respondent passes a competency exam or otherwise demonstrates competency prior to providing community service.~~

13. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified~~. limited to classroom, conference, or seminar settings~~. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

14. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices~~, at respondent's expense,~~ equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program,

University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. Respondent shall pay all expenses associated with the course. ~~Failure to successfully complete the course during the first 6 months of probation is a violation of probation.~~

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

15. Medical Record Keeping Course

Within 60 calendar days of the effective date of this ~~d~~Decision, respondent shall enroll in a course in medical record keeping~~, at respondent's expense,~~ equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. Respondent shall pay all expenses associated with the course. ~~Failure to successfully complete the course during the first 6 months of probation is a violation of probation.~~

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

16. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1 ~~course in ethics, at respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation~~. Respondent shall participate

in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. Respondent shall pay all expenses associated with the program.

A~~n ethics course~~ A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the ~~course~~ program would have been approved by the Board or its designee had the program ~~course~~ been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program ~~course~~, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

17. Professional Boundaries Program

Within 60 calendar days from the effective date of this Decision, respondent shall enroll in a professional boundaries program, at respondent's expense, equivalent to the Professional Boundaries Program~~,~~ offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine ("Program"). Respondent, at the Program's discretion, shall undergo and complete the Program's assessment of respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant. The Program shall evaluate respondent at the end of the training and the Program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire Program not later than six (6) months after respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on respondent's performance in and evaluations from the assessment, education, and training, the Program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that respondent can practice medicine safely. Respondent shall comply with Program recommendations. At the completion of the Program, respondent shall submit to a final evaluation. The Program shall provide the results of the evaluation to the Board or its designee.

The Program has the authority to determine ~~'s determination~~ whether or not respondent successfully completed the Program~~ shall be binding~~.

A professional boundaries course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

~~Failure to participate in and complete successfully all phases of the Program, as outlined above, is a violation of probation.~~

(Option # 1: Condition Precedent)
Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the Board or its designee in writing.

(Option # 2: Condition Subsequent)
If respondent fails to complete the Program within the designated time period, respondent shall cease the practice of medicine within ~~72 hours~~ three (3) calendar days after being notified by the Board or its designee that respondent failed to complete the Program.

18. Anger Management for Healthcare Professionals Program

Within 60 calendar days from the effective date of this Decision, respondent shall enroll in an anger management program, at respondent's expense, equivalent to the Anger Management for Healthcare Professionals Program offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine ("Program"). At the program's discretion, respondent shall undergo and complete both the program's assessment of respondent's competency, mental health and/or neuropsychological performance, and a minimum of a 24-hour program of interactive education and training in the area of anger management, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant.

Respondent shall complete the program not later than six (6) months after initial enrollment. Based on respondent's performance in and evaluations from the assessment, education, and training, the program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that respondent can practice medicine safely. Respondent shall comply with all program recommendations. At the completion of the program, respondent shall submit to a final evaluation.

Determination as to whether respondent successfully completed the program is solely within the program's jurisdiction.

An anger management course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

(Option # 1: Condition Precedent)
Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the Board or its designee in writing.

(Option # 2: Condition Subsequent)
If respondent fails to complete the program within the designated time period, respondent shall cease the practice of medicine within three (3) calendar days after

being notified by the Board or its designee that respondent failed to complete the program.

19~~8~~. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program"). Respondent shall successfully complete the Program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's area of practice in which respondent was alleged to be deficient~~specialty or sub-specialty~~, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. ~~The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.~~ Determination as to whether respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction.

~~Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Board or its designee agrees in writing to a later time for completion.~~

~~Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.~~

[**Note:** The following language shall be included in this condition unless Option #1 is included: If respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the

accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.]

(Option #1: Condition Precedent)
Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the Board or its designee in writing, except that respondent may practice in a clinical training program approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

~~**(Option#2: Condition Subsequent)**~~
~~If respondent fails to complete the clinical training program within the designated time period, respondent shall cease the practice of medicine within 72 hours after being notified by the Board or its designee that respondent failed to complete the clinical training program.~~

(Option#2~~3~~)
Within 60 days a~~A~~fter respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

~~Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation.~~

~~19~~20. Oral and/or Written Examination

[**NOTE:** This condition should **only** be used where a clinical training program is not appropriate.]

Within 60 calendar days of the effective date of this Decision, respondent shall take and pass an oral and/or written examination, administered by the Board or its designee ~~Probation Unit~~. The Board or its designee shall designate a subject matter and administer the oral and/or written examination~~ in a subject to be designated by the Board or its designee and~~.~~the oral examination shall be audio tape recorded~~.

If the examination is an oral examination, it shall be conducted in accordance with section 2293(a) and (b) of the Code.

If respondent is required to take and pass a written exam, that examination shall be either the Special Purpose Examination (SPEX) or an equivalent examination as determined by the Board or its designee.

If respondent fails the first examination, respondent shall be allowed to take and pass a second examination~~, which may consist of an oral and/or written examination. The waiting period between the first and second examinations shall be at least 90 calendar days.~~

Failure to pass the required oral and/or written examination within 180 calendar days after the effective date of this Decision is a violation of probation. Respondent shall pay the costs of all examinations. ~~For purposes of this condition, if respondent is required to take and pass a written exam, it shall be either the Special Purpose Examination (SPEX) or an equivalent examination as determined by the Board or its designee.~~
[**Note:** The following language shall be included in this condition unless Option #1 is included: If respondent fails to pass the first examination, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not practice medicine until respondent successfully passes the examination, as evidenced by written notice to respondent from the Board or its designee.]

~~(Continue with either one of these two options:)~~

(Option 1: Condition Precedent)
Respondent shall not practice medicine until respondent has passed the required examination and has been so notified by the Board or its designee in writing. This prohibition shall not bar respondent from practicing in a clinical training program approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

Note: The condition precedent option is particularly recommended in cases where respondent has been found to be incompetent, repeatedly negligent, or grossly negligent.

~~**(Option 2: Condition Subsequent)**~~
~~If respondent fails to pass the first examination, respondent shall be suspended from the practice of medicine. Respondent shall cease the practice of medicine within 72 hours after being notified by the Board or its designee that respondent has failed the examination.~~

~~Respondent shall remain suspended from the practice of medicine until respondent successfully passes a repeat examination, as evidenced by written notice to respondent from the Board or its designee.~~

2~~0~~1. Psychiatric Evaluation

Within 30 calendar days of the effective date of this Decision, and on ~~a~~ whatever periodic basis thereafter may be required by the Board or its designee, respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who shall consider any

information provided by the Board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

~~Failure to undergo and complete a psychiatric evaluation and psychological testing, or comply with the required additional conditions or restrictions, is a violation of probation.~~

(Option: Condition Precedent)
Respondent shall not engage in the practice of medicine until notified by the Board or its designee that respondent is mentally fit to practice medicine safely. The period of time that respondent is not practicing medicine shall not be counted toward completion of the term of probation.

2~~1~~2. Psychotherapy

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval the name and qualifications of a board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Board or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent.

Respondent shall have the treating psychotherapist submit quarterly status reports to the Board or its designee. The Board or its designee may require respondent to undergo psychiatric evaluations by a Board-appointed board certified psychiatrist. If, prior to the completion of probation, respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Board determines that respondent is mentally fit to resume the practice of medicine without restrictions.

Respondent shall pay the cost of all psychotherapy and psychiatric evaluations. ~~Failure to undergo and continue psychotherapy treatment, or comply with any required modification in the frequency of psychotherapy, is a violation of probation.~~

Note: This condition is for those cases where the evidence demonstrates that the respondent has had impairment (impairment by mental illness, alcohol abuse and/or

drug self-abuse) related to the violations but is not at present a danger to respondent's patients.

2~~2~~3. Medical Evaluation and Treatment

Within 30 calendar days of the effective date of this Decision, and on a periodic basis thereafter as may be required by the Board or its designee, respondent shall undergo a medical evaluation by a Board-appointed physician who shall consider any information provided by the Board or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the Board or its designee. Respondent shall provide the evaluating physician any information and documentation that the evaluating physician may deem pertinent.

Following the evaluation, respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after being notified by the Board or its designee. If respondent is required by the Board or its designee to undergo medical treatment, respondent shall within 30 calendar days of the requirement notice, submit to the Board or its designee for prior approval the name and qualifications of a California licensed treating physician of respondent's choice. Upon approval of the treating physician, respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the Board or its designee.

The treating physician shall consider any information provided by the Board or its designee or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports to the Board or its designee indicating whether or not the respondent is capable of practicing medicine safely. Respondent shall provide the Board or its designee with any and all medical records pertaining to treatment~~, that~~ the Board or its designee deems necessary.

If, prior to the completion of probation, respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Board determines that respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

~~Failure to undergo and continue medical treatment or comply with the required additional conditions or restrictions is a violation of probation.~~

(Option- Condition Precedent)
Respondent shall not engage in the practice of medicine until notified in writing by the Board or its designee of its determination that respondent is medically fit to practice safely.

Note: This condition is for those cases where the evidence demonstrates that medical illness or disability was a contributing cause of the violations.

2~~3~~4. Monitoring - Practice/Billing

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a _____ ~~(i.e.,~~ **[insert:** practice, billing, or practice and billing~~)~~] monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's _____ ~~(i.e.,~~ **[insert:** practice, billing, or practice and billing~~)~~] shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standard~~s~~ of practice of **[insert:** medicine or billing, or both], and whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. ~~be suspended from~~ Respondent shall cease the practice of medicine until a replacement

monitor is approved and ~~prepared to~~ assumes ~~immediate~~ monitoring responsibility. ~~Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Board or its designee.~~

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

~~Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.~~

24~~5~~. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Solo practice includes, but is not limited to, a practice where: 1) physicians merely share office space but are not affiliated for purposes of providing patient care, or 2) respondent would be the sole physician practitioner at that location.

2~~5~~6. Third Party Chaperone

During probation, respondent shall have a third party chaperone present while consulting, examining or treating _____ ~~(e.g.,~~ [**insert:** male, female, or minor~~)~~] patients. Respondent shall, within 30 calendar days of the effective date of the Decision, submit to the Board or its designee for prior approval name(s) of persons who will act as the third party chaperone.

Each third party chaperone shall ~~initial~~ sign (in ink or electronically) and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision(s) and the Accusation(s), and fully understand the role of the third party chaperone.

Respondent shall maintain a log of all patients seen for whom a third party chaperone is required. The log shall contain the: 1) patient ~~name~~ initials, address and telephone number; 2) medical record number; and 3) date of service. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation. ~~Failure to maintain a log of all patients requiring a third party chaperone, or to make the log available for immediate inspection and copying on the premises, is a violation of probation.~~

Respondent is prohibited from terminating employment of a Board-approved third party chaperone solely because that person provided information as required to the Board or its designee.

Draft

(Option)

Respondent shall provide written notification to respondent's patients that a third party chaperone shall be present during all consultations, examination, or treatment with ~~(e.g.,~~ [**insert:** male, female or minor~~)~~] patients. Respondent shall maintain in the patient's file a copy of the written notification, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the notification for the entire term of probation.

~~Note: Sexual offenders should normally be placed in a monitored environment.~~

2~~6~~7. Prohibited Practice

During probation, respondent is prohibited from _____~~(e.g.,~~ [**insert:** practicing, performing, or treating~~)~~] _____ ~~(e.g.,~~ [**insert:** a specific medical procedure; surgery; on a specific patient population~~)~~]. After the effective date of this Decision, ~~the first~~ each time ~~that~~ a patient seeking the prohibited services makes an appointment, ~~orally~~ respondent shall verbally notify the patient that respondent does not _____~~(e.g.,~~ [**insert:** practice, perform or treat~~)~~] _____~~(e.g.,~~ [**insert** a specific medical procedure; surgery; on a specific patient population~~)~~]. Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order~~,~~; shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee~~,~~; and shall retain the log for the entire term of probation. ~~Failure to maintain a log as defined in the section, or to make the log available for immediate inspection and copying on the premises during business hours is a violation of probation.~~

In addition to the required ~~oral~~ verbal notification, after the effective date of this Decision, ~~the first~~ each time ~~that~~ a patient who seeks the prohibited services presents to respondent, respondent shall provide a written notification to the patient stating that respondent does not _____~~(e.g.,~~ [**insert:** practice, perform or treat~~)~~]_____~~(e.g.,~~ [**insert:** a specific medical procedure; surgery; on a specific patient population~~)~~]. Respondent shall maintain a copy of the written notification in the patient's file, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the notification for the entire term of probation. ~~Failure to maintain the written notification as defined in the section, or to make the notification available for immediate inspection and copying on the premises during business hours is a violation of probation.~~

STANDARD CONDITIONS

2~~7~~8. Notification

~~Prior to engaging in the practice of medicine~~ Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this~~e~~ Decision~~(s)~~ and Accusation~~(s)~~ to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

2~~8~~9. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

~~29~~30. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

3~~0~~1. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

3~~1~~2. General Probation Requirements ~~Unit Compliance~~

Compliance with Probation Unit
Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes
Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Draft

Place of Practice
Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal
Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California
Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

32~~2~~3. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office~~, with the Board or its designee upon request at various intervals and either~~ with or without prior notice throughout the term of probation.

~~**33. Residing or Practicing Out-of-State**~~

~~In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.~~

~~All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.~~

~~Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.~~

~~**(Optional)**~~

~~Any respondent disciplined under B&P Code sections 141(a) or 2305 (another state discipline) may petition for modification or termination of penalty: 1) if the other state's discipline terms are modified, terminated or reduced; and 2) if at least one year has elapsed from the effective date of the California discipline.~~

~~**34. Failure to Practice Medicine - California Resident**~~

~~In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.~~

~~All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.~~

~~Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.~~

34. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours per month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete a clinical training program that meets the criteria of Condition 19 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

35. Completion of Probation

Respondent shall comply with all financial obligations (e.g., ~~cost recovery,~~ restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

36. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

~~**37. Cost Recovery**~~

~~Within 90 calendar days from the effective date of the Decision or other period agreed to by the Board or its designee, respondent shall reimburse the Board the amount of $_____ for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve the respondent his/her obligation to reimburse the Board for its costs.~~

37~~8~~. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement~~,~~ or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to ~~the voluntary~~ surrender ~~of~~ his or her ~~respondent's~~ license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation ~~and the surrender of respondent's license shall be deemed disciplinary action~~. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

38~~9~~. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. ~~Failure to pay costs within 30 calendar days of the due date is a violation of probation.~~

DISCIPLINARY GUIDELINES
INDEX

B&P Sec.	Page No.
141(a) Discipline Action Taken By Others	32
651 Advertising: Fraudulent, Misleading, Deceptive	32
725 Excessive Prescribing	32
725 Excessive Treatments	32
726 Sexual Misconduct	33
729 Sexual Exploitation	33
820 Mental or Physical Illness	33
2232 Registration as a Sex Offender	33
2234 Unprofessional Conduct	34
2234(b) Gross Negligence	34
2234(c) Repeated Negligent Acts	34
2234(d) Incompetence	34
2234(e) Dishonesty Related to Patient Care, Treatment, Management, or Billing	34
2234(e) Dishonesty Not Related to Patient Care, Treatment, Management, or Billing	34
2235 Procuring License by Fraud	34
2236 Conviction of Crime Related to Patient Care, Treatment, Management or Billing	35
2236 Conviction of Crime - Felony Conviction Not Related to Patient Care, Treatment, Management or Billing	35
2236 Conviction of Crime - Misdemeanor Conviction Not Related to Patient Care, Treatment, Management or Billing	35
2237 Conviction of Drugs Violations	36
2238 Violation of Drug Statutes	36
2238 Illegal Sales of Controlled Substance	36
2239 Excessive Use of Controlled Substance	36
2239 Excessive Use of Alcohol	36
2241 Prescribing to Addicts	37
2242 Prescribing Without an Appropriate Prior Examination	32
2252 Illegal Cancer Treatment	37
2258 Illegal Cancer Treatment	37
2261 Making False Statements	37
2262 Alteration of Medical Records	37
2264 Aiding and Abetting Unlicensed Practice	37
2266 Failure to Maintain Adequate Records	34
2271 False or Misleading Advertising	32
2280 Practice Under the Influence of Narcotic	36
2280 Practice Under the Influence of Alcohol	36
2285 Fictitious Name Violation	38
2288 Impersonation of Applicant in Exam	38
2305 Discipline by Another State	32
2306 Practice During Suspension	38
2417 Business Organization in Violation of Chapter	38
----- Violation of Probation	38

Draft

DISCIPLINE BY ANOTHER STATE [B&P 141(a) & 2305]
Minimum penalty: Same for similar offense in California
Maximum penalty: Revocation
~~1. Oral or Written Examination as a condition precedent to practice in California~~

MISLEADING ADVERTISING (B&P 651 & 2271)
Minimum penalty: Stayed revocation, 1~~5~~ year~~s~~ probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Professionalism Program (Ethics Course) [16]
4. Monitoring-Practice/Billing [23]
5. Prohibited Practice [26]

EXCESSIVE PRESCRIBING (B&P 725), or
PRESCRIBING WITHOUT AN APPROPRIATE PRIOR EXAMINATION (B&P 2242)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances-Total DEA restriction [5],
Surrender DEA permit [6] or,
Partial DEA restriction [7]
3. Maintain Records and Access to Records and Inventories [8]
4. Education Course [13]
5. Prescribing Practices Course [14]
6. Medical Record Keeping Course [15]
7. Professionalism Program (Ethics Course) [16]
8. Clinical Training Program [18] ~~or Oral or Written Examination [19]~~
9. Monitoring-Practice/Billing [23]

EXCESSIVE TREATMENTS (B&P 725)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Medical Record Keeping Course [15]
4. Professionalism Program (Ethics Course) [16]
5. Clinical Training Program [18] ~~or Oral or Written Examination [19]~~
6. Monitoring-Practice/Billing [23]
7. Prohibited Practice [26]

Draft

SEXUAL MISCONDUCT (B&P 726)
Minimum penalty: Stayed revocation, 7 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Professionalism Program (Ethics Course) [16]
4. Professional Boundaries Program [17]
5. Psychiatric Evaluation [20]
6. Psychotherapy [21]
7. Monitoring-Practice/Billing [23]
8. Third Party Chaperone [25]
9. Prohibited Practice [26]

SEXUAL EXPLOITATION (B&P 729)
Minimum penalty: Revocation
Effective January 1, 2003, Business and Professions Code 2246 was added to read, "Any proposed decision or decision issued under this article that contains any finding of fact that the licensee engaged in any act of sexual exploitation, as described in paragraphs (3) to (5), inclusive, of subdivision (b) of Section 729, with a patient shall contain an order of revocation. The revocation shall not be stayed by the administrative law judge."

MENTAL OR PHYSICAL ILLNESS (B&P 820)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Oral or Written Examination [19]
2. Psychiatric Evaluation [20]
3. Psychotherapy [21]
4. Medical Evaluation and Treatment [22]
5. Monitoring-Practice/Billing [23]
6. Solo Practice Prohibition [24]
7. Prohibited Practice [26]

REGISTRATION AS A SEX OFFENDER (B&P 2232)
Minimum penalty: Revocation
Effective January 1, 2004 section 2232(a) was added to the Business and Professions Code read, "Except as provided in subdivisions (b), (c), and (d), the Board shall promptly revoke the license of any person who, at any time after January 1, 1947, has been required to register as a sex offender pursuant to the provisions of section 290 of the Penal Code."

Draft

GENERAL UNPROFESSIONAL CONDUCT (B&P 2234), or
GROSS NEGLIGENCE [B&P 2234 (b)], or
REPEATED NEGLIGENT ACTS [B&P 2234(c)], or
INCOMPETENCE [B&P 2234(d)], or
FAILURE TO MAINTAIN ADEQUATE RECORDS (B&P 2266)
Minimum penalty: Stayed revocation, 5 years probation
NOTE: In cases charging repeated negligent acts with one patient, a public reprimand may, in appropriate circumstances, be ordered.
Maximum penalty: Revocation
1. Education course [13]
2. Prescribing Practices Course [14]
3. Medical Record Keeping Course [15]
4. Professionalism Program (Ethics Course) [16]
5. Clinical Training Program [18]
6. Oral or Written Examination [19] ~~(preferably Condition Precedent)~~
7. Monitoring-Practice/Billing [23]
8. Solo Practice Prohibition [24]
9. Prohibited Practice [26]

DISHONESTY - Substantially related to the qualifications, functions or duties of a physician and surgeon and *arising from* or occurring during patient care, treatment, management or billing [B&P 2234(e)]
Minimum penalty: Stayed revocation, one year suspension at least 7 years probation
Maximum penalty: Revocation
1. Professionalism Program (Ethics Course) [16]
~~2. Oral or Written Examination [19]~~
2~~3~~. Psychiatric Evaluation [20]
3~~4~~. Medical Evaluation [22]
4~~5~~. Monitoring-Practice/Billing [23]
5~~6~~. Solo Practice Prohibition [24]
6~~7~~. Prohibited Practice [26]
7. Victim Restitution

DISHONESTY - Substantially related to the qualifications, function or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing [BP 2234 (e)]
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Professionalism Program (Ethics Course) [16]
3. Psychiatric Evaluation [20]
4. Medical Evaluation [22]
5. Monitoring-Practice/Billing (if financial dishonesty or conviction of financial crime) [23]
6. ~~Restitution to~~ Victim Restitution
7. Community Service [12]

PROCURING LICENSE BY FRAUD (B&P 2235)
1. Revocation [1] [2]

Draft

CONVICTION OF CRIME - Substantially related to the qualifications, functions or duties of a physician and surgeon and *arising from* or occurring during patient care, treatment, management or billing (B&P 2236)
Minimum penalty: Stayed revocation, one year suspension, at least 7 years probation
Maximum penalty: Revocation
1. Professionalism Program (Ethics Course) [16]
~~2. Oral or Written Examination [19]~~
2~~3~~. Psychiatric Evaluation [20]
3~~4~~. Medical Evaluation and Treatment [22]
4~~5~~. Monitoring-Practice/Billing [23]
5~~6~~. Solo Practice Prohibition [24]
6~~7~~. Prohibited Practice [26]
7. Victim Restitution
8. Anger Management Course [18]
9. Community Service [12]

CONVICTION OF CRIME - Felony conviction substantially related to the qualifications, functions or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing (B&P 2236)
Minimum penalty: Stayed revocation, 7 years probation
Maximum penalty: Revocation
1. Suspension of 30 days or more [4]
2. Professionalism Program (Ethics Course) [16]
3. Psychiatric Evaluation [20]
4. Medical Evaluation and Treatment [22]
5. Monitoring-Practice/Billing (if dishonesty or conviction of a financial crime) [23]
6. Victim Restitution
7. Anger Management Course [18]
8. Community Service [12]

CONVICTION OF CRIME - Misdemeanor conviction substantially related to the qualifications, functions or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing (B&P 2236)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Professionalism Program (Ethics Course) [16]
2. Psychiatric Evaluation [20]
3. Medical Evaluation and Treatment [22]
4. Victim Restitution
5. Anger Management Course [18]
6. Community Service [12]

Draft

CONVICTION OF DRUG VIOLATIONS (B&P 2237), or
VIOLATION OF DRUG STATUTES (B&P 2238), or
EXCESSIVE USE OF CONTROLLED SUBSTANCES (B&P 2239), or
PRACTICE UNDER THE INFLUENCE OF NARCOTIC (B&P 2280)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances - Total DEA restriction [5],
Surrender DEA permit [6], or
Partial DEA restriction [7]
3. Maintain Drug Records and Access to Records and Inventories [8]
4. Controlled Substances - Abstain From Use [9]
5. Alcohol-Abstain from Use [10]
6. Biological Fluid Testing [11]
7. Education Course [13]
8. Prescribing Practices Course [14]
9. Medical Record Keeping Course [15]
10. Professionalism Program (Ethics Course) [16]
~~11. Oral or Written Examination [19]~~
11~~2~~. Psychiatric Evaluation [20]
12~~3~~. Psychotherapy [21]
13~~4~~. Medical Evaluation and Treatment [22]
14~~5~~. Monitoring-Practice/Billing [23]
15~~6~~. Prohibited Practice [26]

ILLEGAL SALES OF CONTROLLED SUBSTANCES (B&P 2238)
Revocation [1] [2]

EXCESSIVE USE OF ALCOHOL (B&P 2239) or
PRACTICE UNDER THE INFLUENCE OF ALCOHOL (B&P 2280)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances-Abstain From Use [9]
3. Alcohol-Abstain from Use [10]
4. Biological Fluid Testing [11]
5. Professionalism Program (Ethics Course) [16]
~~6. Oral or Written Examination [19]~~
6~~7~~. Psychiatric Evaluation [20]
7~~8~~. Psychotherapy [21]
8~~9~~. Medical Evaluation and Treatment [22]
9~~10~~. Monitoring-Practice/Billing [23]

Draft

PRESCRIBING TO ADDICTS (B&P 2241)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Controlled Substances- Total DEA restriction [5],
Surrender DEA permit [6], or
Partial restriction [7]
3. Maintain Drug Records and Access to Records and Inventories [8]
4. Education Course [13]
5. Prescribing Practices Course [14]
6. Medical Record Keeping Course [15]
7. Professionalism Program (Ethics Course) [16]
8. Clinical Training Program [18]
~~9. Oral or Written Examination [19]~~
9~~10~~. Monitoring-Practice/Billing [23]
10~~1~~. Prohibited Practice [26]

ILLEGAL CANCER TREATMENT (B&P 2252 and 2258)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education course [13]
3. Professionalism Program (Ethics Course) [16]
4. Clinical Training Program [18]
5. Prescribing Practices Course [14]
~~5. Oral or Written Examination [19]~~
6. Monitoring-Practice/Billing [23]
7. Prohibited Practice [26]

MAKING FALSE STATEMENTS (B&P 2261), or
ALTERATION OF MEDICAL RECORDS (B&P 2262)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Medical Record Keeping Course [15]
3. Professionalism Program (Ethics Course) [16]
4. If fraud involved, see "Dishonesty" guidelines

AIDING AND ABETTING UNLICENSED PRACTICE (B&P 2264)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation
1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Professionalism Program (Ethics Course) [16]
~~4. Oral or Written Examination [19]~~
4~~5~~. Monitoring-Practice/Billing [23]
5~~6~~. Prohibited Practice [26]

Draft

FICTITIOUS NAME VIOLATION (B&P 2285)
Minimum penalty: Stayed revocation, one year probation
Maximum penalty: Revocation

IMPERSONATION OF APPLICANT IN EXAM (B&P 2288)
1. Revocation [1] [2]

PRACTICE DURING SUSPENSION (B&P 2306)
1. Revocation [1] [2]

BUSINESS ORGANIZATION IN VIOLATION OF CHAPTER (B&P 2417)
Minimum penalty: Revocation
Effective January 1, 2002, Business and Professions Code section 2417 was added to read, in part, "(b) A physician and surgeon who practices medicine with a business organization knowing that it is owned or operated in violation of Section 1871.4 of the Insurance Code, Section 14107 or 14107.2 of the Welfare and Institutions Code, or Section 549 or 550 of the Penal Code shall have his or her license to practice permanently revoked."

VIOLATION OF PROBATION
Minimum penalty: 30 day suspension
Maximum penalty: Revocation
The maximum penalty should be given for repeated similar offenses or for probation violations revealing a cavalier or recalcitrant attitude. A violation of any of the following conditions of probation should result in, at minimum, a 60 day suspension:
1. Controlled Substances -Maintain Records and Access to Records and Inventories [8]
2. Biological Fluid Testing [11]
3. Professional Boundaries Program [17]
4. Clinical Training Program [18]
5. Psychiatric Evaluation [20]
6. Psychotherapy [21]
7. Medical Evaluation and Treatment [22]
8. Third Party Chaperone [25]

Draft

MEDICAL BOARD OF CALIFORNIA

INITIAL STATEMENT OF REASONS

Hearing Date: October 30, 2009

Subject Matter of Proposed Regulations:
To amend the *Manual of Model Disciplinary Orders and Disciplinary Guidelines* to reflect changes in law, clarify existing language, and make technical changes to reflect the current probationary environment.

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

Specific purpose of each adoption, amendment, or repeal:
The current *Manual of Model Disciplinary Orders and Disciplinary Guidelines* referenced in the regulation (10th Edition/2008) must be made consistent with current law. The proposed regulation will reference the 11th Edition/2009 of the *Manual of Model Disciplinary Orders and Disciplinary Guidelines*, reflecting changes in law, as well as making technical changes to address unnecessary and duplicative elements, and some technical changes to reflect the current probationary environment.

Factual Basis/Rationale:
The *Manual of Model Disciplinary Orders and Disciplinary Guidelines* referenced by the current regulation has been amended to conform to statutory changes, including those in the California Uniform Controlled Substance Act, augment and delete language for reasons of consistency and clarity, as well as make some technical changes to probationary conditions for disciplined physicians. In addition to changes to conform to current law and amendments for clarity and consistency, the *Guidelines* have been amended to:

- Require probationers to cease the practice of medicine when testing positive in a biological fluid test for illegal or unlawfully prescribed substances or alcohol.

  Due to a change in law, the Medical Board no longer has a Diversion Program to monitor physicians with substance abuse problems. In the past, the physicians were ordered into the Diversion Program, and the program had the authority to order physicians, when testing positive from a biological fluid test, to cease practicing medicine. While the previous *Guidelines* were amended to reflect the elimination of the Diversion Program, it did not contain the specific condition that the Board could order physicians testing positive to cease practice.

- Expand and define "Biological Fluid Testing" to include blood, urine, breathalyzer, and hair follicle testing.

  Due to technological changes in drug testing, it is preferable to define "Biological Fluid Testing" to include other methods that may be able to detect some substances that are not picked up by a urine test. This is necessary to protect the public by allowing for better drug and alcohol testing.

- Expand acceptable continuing medical education courses beyond classroom, conference, and seminars, to reflect other types of educational delivery systems.

  There has been a change in the educational environment, and probationers may be able to complete more appropriate coursework not offered in the traditional classroom. Online courses, CD Rom courses, workshops, and other methods of education may be more suitable to probationers' deficiencies. For this reason, the Board is proposing to allow other types of courses, rather than only those didactic courses taught in a classroom environment.

- Allow for participation in equivalent programs other than those provided by the Physician Assessment & Clinical Education (PACE) Program offered by UCSD, if approved by the Medical Board.

  There are some physician competency assessment and educational programs in various locations other than the San Diego PACE Program. The new *Guidelines* will allow physicians to attend alternative but equivalent programs.

- Add a condition for participation in "Anger Management" programs.

  Some physicians being disciplined have violated the standard of care not because of competency or skill problems, but due to impulse and anger control issues. For those physicians, it is of more value, and has more potential to protect the public, to order "Anger Management" courses, rather than the traditional practice courses. For that reason, the new *Guidelines* will allow probation to contain an order to take these types of courses.

- Allow for an oral competency examination in the event there are no appropriate clinical training programs available.

  Occasionally, there are no courses available for physicians to address certain practice competency problems. In those instances, the only alternative is to order a competency examination to ensure protection of the public.

- Require that disciplined physicians provide pertinent documentation to the physician conducting a medical evaluation as part of a probationary condition

As a condition of probation for physicians who may be suffering from a medical condition that may affect their medical practice skills, a medical evaluation conducted by a physician may be ordered. In order for physicians conducting the evaluations to effectively do their work, full cooperation is needed. For that reason, the *Guidelines* have been amended to require the disciplined physician to cooperate with the evaluator and provided any relevant documentation requested.

- Within 7 days of the effective date of a decision, require disciplined physicians to provide a copy of the decision and accusation to the Chiefs of Staff at every hospital where the physician has privileges.

  The past edition of the *Guidelines* contained the condition of probation that required physicians to notify facilities where they practiced of their disciplinary action, but did not contain a time-frame to fulfill the notification requirement. The new *Guidelines* are more specific, in that it provides that within 7 days, the physicians must notify facilities of their disciplinary actions. While physicians must notify facilities before they practice in them, facilities should be notified in advance in preparation for scheduling of procedures, etc. Seven days will give physicians who have privileges in multiple facilities ample time to notify all appropriate chiefs of staff.

- Require probationers that cease practice for over 18 months to complete a training program before resuming practice, and prohibit non-practice over 2 years.

  Disciplined physicians may choose to cease practice while on probation for various reasons. A lengthy absence from practice has been shown to affect the competency of physician's medical practice skills. For this reason, the condition has been added to require training before they fully resume practice if out-of-practice for 18 months. The previous *Guidelines* provided for physician's licenses to be cancelled following two years of non-practice, without providing for due process for the licensee. The new *Guidelines* require the disciplined physician to practice within 2 years. If they do not, that will constitute a violation of probation, which allows for the individual to request a hearing and go through the administrative process

Underlying Data:

As specified above, the 10th Edition (1999) of the *Manual of Model Disciplinary Orders and Disciplinary Guidelines* is referenced in current regulation. The 11th Edition (2009) of the *Guidelines* has been amended to reflect changes in law, changes in educational and probationary environments, and has also been amended for clarity and consistency.

The Medical Board has worked on the changes in the *Guidelines* for several months, culminating with a meeting on June 18, 2009 with interested parties, including professional associations and consumer organizations, defense counsels and prosecutors. (Minutes attached.) Suggestions made at that meeting, if appropriate, were incorporated into the 11th Edition of the *Guidelines*. In summary, the proposed changes were not controversial, and the Board would expect little comment, if any, in opposition to this rulemaking as a result of the comments heard at that meeting.

As discussed in the "Factual Basis" above, changes to the Guidelines have been made to clarify conditions, tighten requirements, remedy ambiguities in the previous edition, and offer alternatives that reflect the current law, educational opportunities, technological advances, and the probationary environment. The Board consulted with all interested parties, including prosecutors, defense counsels, professional organizations, probation officers and individual physicians to solicit comment into the proposed changes.

Business Impact

___x__ This regulation will not have a significant adverse economic impact on businesses. This initial determination is based on the following facts or evidence/documents/testimony:

This regulation only impacts physicians disciplined by the Medical Board.

_____ Description of alternatives which would lessen any significant adverse impact on business:

Not applicable, as the proposed regulation has no business or economic impact.

Specific Technologies or Equipment:

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

_____ This regulation mandates the use of specific technologies or equipment. Such mandates or prescriptive standards are required for the following reasons:

Consideration of Alternatives:

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

MEDICAL BOARD OF CALIFORNIA
Executive Office

Medical Board of California
Hearing Room
2005 Evergreen Street
Sacramento, CA 95815

July 23 -24, 2009

MINUTES

In order to remain consistent with the record, the agenda items presented in these minutes are listed in the order discussed at the July 23-24, 2009 meeting.

Agenda Item 1 Call to Order/ Roll Call
Ms. Yaroslavsky called the meeting of the Medical Board of California (Board) to order on July 23, 2009 at 3:43p.m. A quorum was present and notice had been sent to interested parties.

Members Present:
Barbara Yaroslavsky, President
Jorge Carreon, M.D.
Hedy Chang, Secretary
John Chin, M.D.
Shelton Duruisseau, Ph.D.
Gary Gitnick, M.D.
Sharon Levine, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Frank V. Zerunyan, J.D., Vice President

Members Absent:
Gerrie Schipske, R.N.P., J.D.
Richard Fantozzi, M.D.

DRAFT

Staff Present:

Barb Johnston, Executive Director
Kimberly Kirchmeyer, Deputy Director
Nicola Biasi, Investigator
Susan Cady, Enforcement Manager
Candis Cohen, Public Information Officer
Janie Cordray, Research Specialist
Abbie French, Telemedicine Manager
Scott Johnson, Information Systems Analyst
Arlene Krysinski, Discipline Program Analyst
Ross Locke, Business Services Office
Armando Melendez, Business Services Office
Kelly Nelson, Legislative Analyst
Pat Park, Licensing Analyst
Debbie Pellegrini, Chief of Licensing
Paulette Romero, Associate Analyst
Kevin Schunke, Regulation Coordinator
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Cheryl Thompson, Executive Assistant
Renee Threadgill, Chief of Enforcement
Linda Whitney, Chief of Legislation

Members of the Audience:

Yvonne Choong, California Medical Association
Zennie Coughlin, Kaiser Permanente
Frank Cuny, California Citizens for Health Freedom
Erica Eisenlaver, Department of Consumer Affairs
Julie D'Angelo Fellmeth, Center for Public Interest Law
Laurie Gregg, M.D.
Jose Guerrero, Supervising Deputy Attorney General
Tom Kopko, California Citizens for Health Freedom
Christine Nelson, M.D.
Rosielyn Pulmano, Senate Business and Professions Committee
Carlos Ramirez, Senior Assistant Attorney General
Rehan Sheikh
John Toth, M.D., California Citizens for Health Freedom

Agenda Item 2 Approval of Minutes from the May 8, 2009 Meeting

Ms. Chang made a motion to approve the minutes from the May 8, 2009 meeting. Dr. Moran seconded the motion; motion carried.

Agenda Item 3 Public Comment on Items Not on the Agenda

Dr. Gitnick stated the Board is confronted with progressively fewer resources to work within carrying out its mandate of public protection. Dr. Gitnick reported he previously had made a

motion which was passed unanimously by the Board, requesting the Board regularly undergo an independent outside review. The review, which would be commissioned and paid for by the Board and be conducted approximately every two years, would examine the Board's role and evaluate its success in carrying out that role. Further, the review would examine the Board's resources and obligations, and would make recommendations for the best use of those resources. Dr. Gitnick indicated the motion was reaffirmed by the Board last year. He asked for an update on the status of the review and whether it was ready to move forward.

Ms. Johnston indicated staff is aware of the Board's motion and have been working on this issue. She stated the motion would be fully implemented before the next Board meeting.

Frank Cuny, California Citizens for Health Freedom, asked the Board to make changes to the Health and Safety code that would enable physicians and licensed naturopathic doctors to offer alternative cancer treatments under specific conditions. He noted California is currently the only state in the nation where it a criminal offense for a licensed physician to perform treatments other than chemotherapy, radiation, and surgery for cancer. Tom Kopko and Dr. John Toth echoed Mr. Cuny's request for changes to the code.

Agenda Item 4 Board Member Communications with Interested Parties
None of the members had any communications to disclose.

Agenda Item 7 Legislation

B. 2009 Legislation
Ms. Whitney referred Members to the 2009 Legislative packet and the color-coded tracker listing in the packet that was mailed to members and made available to the public.

AB 501 (Emmerson) Licensing: Limited License, Use of M.D., Fee/Fund
Ms. Whitney reported this Board-sponsored bill has been amended to address concerns raised by the Public Safety Committee over the wording "under penalty of perjury". Language has been added to reflect that anyone who untruthfully signs the limited license agreement would be subject to any sanctions available to the Board. Hence, the protections remain essentially the same. The bill has support from all the medical schools in California and continues to move forward.

AB 1070 (Hill) Enforcement Enhancements: reporting, public reprimand
This Board-sponsored bill, which contains revisions to malpractice reporting and the extension of the vertical enforcement/prosecution model, is currently in Senate Appropriations. There is considerable Republican opposition to the bill and extensive work will be required when it goes to the Governor's desk. Ms. Whitney indicated she will enlist the Board's help in encouraging the Governor's signature on the bill.

AB 245 (Ma) Disclosure Verification
The Board had previously taken an oppose position on the bill; however, the bill has been amended to delete the requirement that the Board verify the accuracy of information posted on its website regarding enforcement actions or other items requiring posting and now only requires the Board to remove information within 90 days of notification that an expungement has occurred by the court. The Executive Committee recommended a revised neutral position on this bill. Dr. Duruisseau made a motion to take a neutral position on AB245; s/Moran; motion carried.

AB 526 (Fuentes) Public Protection and Physician Health Program Act of 2009
Ms. Whitney indicated this bill is the California Medical Association's Physician Health Program bill for the monitoring of physicians prior to the cause of any harm to patients. The Board had previously taken a watch position. The bill was amended to require the Board to collect the fees to support the program, thus, the Executive Committee recommended an oppose position on the bill. Dr. Gitnick made a motion to oppose the bill; s/Chang; motion carried.

SB 674 (Negrete McLeod) Outpatient settings / Advertising
This bill covers a variety of subjects, including advertising outpatient settings, accreditation requirements, supervision of laser and intense pulse light device procedures, the wearing of nametags, and public information. The requirement that assisted reproductive technology clinics fall under outpatient surgery guidelines was deleted when the bill was amended; however, in vitro clinics will still fall under these guidelines. The requirement the Board perform the inspections of all settings every three years was also removed, with the accreditation agency now responsible for performing this function. This amendment has eliminated the mandatory cost associated with the bill. Staff recommended no action on this bill at this time.

SB 726 (Ashburn) Hospitals: employment of physician; pilot project revision
Previously, there were three bills addressing the employment of physicians by district and rural hospitals. The Board took a support in concept position, supporting the expansion so a full evaluation of the employment of physicians in hospitals could be performed, but preferred only one of the three bills move forward. SB 726 was amended to retain some of the components in the current program and expand others. The bill limits the hiring to two physicians per hospital (as the current program does) but gives the Board the ability to approve up to three more physicians. The bill includes both rural and district hospitals in the pilot, for a potential of 84 settings, and allows for the approval of the hire by the CEO, versus the hospital medical committee. Additionally, the amended bill requires a hospital to show 12 months of need (an unsuccessful 12 month recruitment period) and requires the new hires to come from outside the area. Dr. Moran made a motion to support the bill; s/Chang; motion carried; one abstention.

SB 820 (Negrete McLeod & Aanestad) Peer Review
Ms. Whitney indicated the language from SB 700, which did not move forward, was incorporated in this bill. The code section 805.01 requires the filing of a report after a formal investigation and prior to an 809.2 hearing if the physician is accused of gross negligence, drug or alcohol abuse, repeated acts of excessive prescribing, and sexual misconduct. The bill also authorizes the Board to inspect and copy documents in the record of any investigation, including

obtaining certified medical records. If the peer review report is found by a court to have been conducted in bad faith, then the report would be expunged from the Board's website.

Rosielyn Pulmano, consultant from the Senate Business and Professions and Economic Development Committee, stated SB 820 provides the Medical Board with the necessary enforcement tools needed to pursue substandard care and asked the Board for its support.

Ms. Chang made a motion to take a support position on SB 820; s/Gitnick; motion carried.

Agenda Item 5 "The Role of Hospitalists"

Dr. Christine Nelson made a presentation to the Board on the growing role of hospitalists in medical care. Hospitalists are defined as physicians who spend 25% or more of their time taking care of patients who are in-patients. They represent all of the various specialties including internal medicine, family medicine, pediatrics, and surgery, with various niche subspecialties such as psychiatry, orthopedics, and obstetrics/gynecology in the future. The number of hospitalists is growing by 10-20% per year. Most hospitalists have both patient care and administrative roles within their institutions.

Dr. Low expressed his concern that there were no exams, national standards, or specialty training program for hospitalists. He felt there should be a specialty board for hospitalists and greater regulation. Dr. Nelson indicated the move to create a specialty board is in process.

Agenda Item 6 Appointment of Board Member to the Health Professions Education Foundation

Ms. Chang made a motion to appoint Dr. Duruisseau as the Board's representative on the Health Professions Education Foundation; s/Moran; motion carried.

Agenda Item 8 Federation of State Medical Boards Update

Ms. Chang provided an overview of the organization of the Federation of State Medical Boards (FSMB). FSMB consists of 70 boards, 350 employees located in Dallas, numerous committees, and 16 board members (12 physician members, 2 public members, and 2 executive directors). She discussed the various standing committees, including the Nominating Committee on which Dr. Moran serves, the Education Committee on which Dr. Salomonson serves, and the Advisory Council of Board Executives on which Barb Johnston serves. Ms. Chang serves on the Board of Directors.

Agenda Item 9 Education Committee Update

Ms. Yaroslavsky reported the Committee met on July 23, 2009 and discussed educating the public and the medical profession regarding sexual misconduct and the physician-patient relationship; presentations were made by Dr. Chris Searles from the UC San Diego Physician

Assessment and Clinical Education Program (PACE) and Robert McKim Bell, J.D., from the Los Angeles Attorney General's Office. The Committee decided to move forward with website enhancements to make information on this topic more accessible.

Agenda Item 10 Wellness Committee Update

Dr. Duruisseau reported the Committee met on July 23, 2009 where Dr. William Norcross reported on a new healthy students program at UC San Diego. Dr. Peter Yellowlees from UC Davis Medical Center made a presentation on their well-being committee and offered to collaborate with the Board to create a series of videos that would be CME accredited and available on both UC Davis' and the Board's website to address physician health issues and provide valuable information to physicians. The Committee asked staff and the university to develop a plan that the Committee could consider in the future.

Dr. Duruisseau reported on the status of the Committee's meeting with the Governor's Office regarding potential legislation for formalizing a physician wellness program into law. The Committee will follow up by providing language for this potential legislation and will continue to work with the Governor's staff on this issue. The Committee also discussed the value of conducting a survey to identify wellness activities, or the lack of activities, in various healthcare settings, particularly in hospitals, throughout California.

Agenda Item 11 Physician Assistant Committee Update

Dr. Low reported on the important issues before the Physician Assistant Committee (PAC), which met in May 2009 in Sacramento. He indicated legislation in 2008 authorized the PAC to require a licensee to complete continuing education as a condition of license renewal. A workgroup suggested the requirement should be 50 hours of Category 1 CME every two years. This proposed language was approved by the PAC, and a regulatory hearing will be set for the August 2009 meeting.

In keeping with the State's budget concerns, Dr. Low stated the PAC has been taking measures to improve efficiencies and reduce costs. Conversely, due to the increased number of PAs participating in the Diversion Program, the PAC has submitted a budget change proposal for about $50,000.

Dr. Low reported that physicians who supervise students at clinical rotation sites are called preceptors. Per current regulations, a preceptor may not supervise more than one preceptee at a time. The PAC has initiated discussion on the ratio of preceptors and their students and will discuss this further at future meetings.

The PAC has a licensing outreach program where PAC staff visit colleges to speak to future applicants about the licensing process. In addition, Dr. Low indicated PAC participated in the Department's roundtable meeting for health boards and the Substance Abuse Coordination Committee to create uniform standards applicable to healing arts substance abusing licensees.

The Assembly Speaker recently appointed a new public member. However, there currently are two additional vacancies on the Committee; both are to be filled by physician assistants.

Dr. Low reported the next Committee meeting will be August 13, 2009 in Sacramento.

Agenda Item 12 Action on Recommendation of Specialty Faculty Permit Review Committee

Dr. Gitnick reported the Special Faculty Permit Review Committee met by phone on June 16, 2009 to review the qualifications and credentials of candidate Dr. Osamu Ukimura. The Committee recommends approval contingent upon the applicant obtaining and submitting fingerprint clearances and confirming a legal visa. Ms. Chang made a motion to approve the Committee's recommendation on Dr. Ukimura; s/Levine; motion carried.

Ms. Yaroslavsky adjourned the meeting at 4:58 p.m.

****

Agenda Item 13 Call to Order/ Roll Call

Ms. Yaroslavsky called the meeting to order on July 24, 2009 at 9:05 a.m. A quorum was present and notice had been sent to interested parties.

Members Present:

Barbara Yaroslavsky, President
Jorge Carreon, M.D.
Hedy Chang, Secretary
John Chin, M.D.
Shelton Duruisseau, Ph.D.
Gary Gitnick, M.D.
Sharon Levine, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Frank V. Zerunyan, J.D., Vice President

Members Absent:

Gerrie Schipske, R.N.P., J.D.
Richard Fantozzi, M.D.

Staff Present:

Barb Johnston, Executive Director
Kimberly Kirchmeyer, Deputy Director
Nicola Biasi, Investigator
Susan Cady, Enforcement Manager
Candis Cohen, Public Information Officer
Janie Cordray, Research Specialist
Abbie French, Telemedicine Manager
Ross Locke, Business Services Office

DRAFT

Armando Melendez, Business Services Office
Kelly Nelson, Legislative Analyst
Pat Park, Licensing Analyst
Debbie Pellegrini, Chief of Licensing
Paulette Romero, Associate Analyst
Kevin Schunke, Regulation Coordinator
Anita Scuri, Department of Consumer Affairs Supervising Legal Counsel
Cheryl Thompson, Executive Assistant
Renee Threadgill, Chief of Enforcement
Linda Whitney, Chief of Legislation

Members of the Audience:

Jack Bruner, M.D., California Society of Plastic Surgeons
Yvonne Choong, California Medical Association
Zennie Coughlin, Kaiser Permanente
Erica Eisenlaver, Department of Consumer Affairs
Julie D'Angelo Fellmeth, Center for Public Interest Law
Beth Grivett, PA-C, California Academy of Physician Assistants
Jose Guerrero, Supervising Deputy Attorney General
Suzanne Kilmer, M.D., American Society for Dermatologic Surgery
Mary Knight Johnson
Tim Madden, California Society of Plastic Surgeons
Tina Minasian, Patient Advocate
Charles Modica, St. George's University
Tom Monihan, Government of Grenada
James Nuovo, M.D., UC Davis
Paul Phinney, M.D., California Medical Association
Rosielyn Pulmano, Senate Business and Professions Committee
Carlos Ramirez, Senior Assistant Attorney General
Harold Simon, M.D., Ph.D., Medical Consultant
Rehan Sheikh
John Valencia, American Society for Dermatologic Surgery
Bindhu Varghese, Consumers Union

Agenda Item 15 President's Report

Ms. Yaroslavsky stated she is looking forward to serving as the Board's president in the coming year and has already been working with staff on a variety of issues for the Board. On May 13, 2009, she and Ms. Johnston met with Secretary Fred Aguiar and Undersecretary Scott Reid of the State and Consumer Services Agency to discuss current issues before the Board. She and Ms. Johnston also met with Deborah Pellegrini, Chief of Licensing, to review the entire licensing program and the current concerns it is facing. On July 23, 2009, Ms. Yaroslavsky and Ms. Johnson attended a meeting with Secretary Aguiar regarding the Board's and other healing arts boards' enforcement program.

On June 29, 2009, Ms. Yaroslavsky reported she testified on AB 1070, the Board's enforcement legislation, at the Senate Business and Professions Committee. She was present to also testify on the Board's licensing legislation, AB 501, but this was approved as a consent item and, thus, testimony was not required.

Ms. Yaroslavsky noted, with the addition of new Members to the Board over the past several months, it would be timely to review the Board's committees and discuss ways to balance out participation by Members. She directed Members to page 45 of their packets to view the current committee roster and invited suggestions from the Members who would like to change or add their name to another committee.

Dr. Levine asked to be added to the Education Committee. Dr. Carreon asked to be added to the Cultural and Linguistic Competency Work Group, the Education Committee, and the Wellness Committee.

Agenda Item 16 Executive Director's Report

A. Budget Overview and Staffing Update

Ms. Johnston directed Members to page 47 of their packets to the Budget Overview. She reported, due to the Governor's executive orders over the past few months, the Board was required to implement a two-day furlough beginning in February 2009 and more recently, was mandated to furlough staff three days per month which reduces staff salaries by 15%. Staff productivity and morale have been affected by the furloughs.

Ms. Johnston stated the backlog in processing applications has been growing. Staff has tried to find creative ways to deal with this issue, including using overtime and temporary help, but the budgets for these line items have been exhausted. Ms. Johnston indicated the Chief of Licensing and Chief of Enforcement will address the impact of the staff's time reduction and its affect on timelines in their reports. In addition to the mandated furloughs, the Department of Consumer Affairs and the State and Consumer Services Agency have requested that the Board cut its operating budget by 15%. Ms. Johnston expressed her concern over the Board's ability to meet its public protection mandate in light of these cuts.

Ms. Johnston responded to questions from Members on specific line items in the budget, including the loan of $6 million from the Board's fund to the General Fund, and the overtime expenditures.

B. Proposed Meeting Dates for 2010

Ms. Johnston directed Members to page 56 of their packets for the proposed 2010 meeting dates. She asked the Board's permission to allow the Executive Director, if required by further executive orders, to move the meeting dates, if necessary. She reported some of the executive orders have required canceling contracts, thereby requiring the Board to move its meetings to Sacramento since it is unable to enter into new contracts with meeting facilities. It is anticipated that the meeting dates, if changed, would remain within the same week and would only shift one

day. Ms. Yaroslavsky suggested that San Jose be considered as a location for future quarterly meetings.

Dr. Duruisseau made a motion to approve the meeting dates and to allow the Executive Director to change the dates if necessary; s/Chang; motion carried.

Ms. Johnston reported she was appointed in May to the FSMB Advisory Council of Board Executives to provide guidance and feedback to FSMB senior staff. She and Ms. Pellegrini have been in discussion with FSMB regarding license portability issues, their Universal License application, and the Federation's certification and verification.

Ms. Johnston continues to meet with DCA and other executive officers as a member of the SB 1441 Substance Abuse Coordination Committee which is developing standards for substance abusing licensees. Mr. Johnston and staff have met with David Chaney and Carlos Ramirez of the Attorney General's Office on the vertical enforcement model. She has also met with Bill Barcellona of the California Association of Physician Groups (CAPG) to discuss physician health, and with

Dr. Carlisle of OSHPD to discuss their Health Professional Clearinghouse project. In addition, Ms. Johnston reported she participated in a teleconference with the American Telemedicine Association and the FSMB to discuss challenges and solutions for dealing with physicians who want to practice in multiple states.

Agenda Item 14 Public Comment on Items not on the Agenda
There was no public comment.

Agenda Item 17 Officers' Term of Office
Ms. Whitney presented information on the history of the election of Board officers and their terms of office. Ms. Kirchmeyer presented staff's recommendation that elections be held at the third quarter meeting (July meeting) since the membership of the Board is usually determined by this time and it would allow the officers to serve a full one year term without interruption. The elected officers would begin their term at the end of the July meeting. Staff also recommended that if the election time was changed, the current slate of officers continue in their positions until July 2010. Dr. Salomonson made a motion to move the elections to July of each year, to have the officers take over at the end of the July meeting, and to have the current slate of officers continue in their positions until July 2010; s/Moran.

Ms. Yaroslavsky asked about the benefit of holding the elections in May and take office in July in order to allow time for the newly elected officers to become acclimated to their new positions. Ms. Whitney stated a May election could be implemented with the addition of a "president-elect" position with a reconfirmation in July. She agreed with Ms. Yaroslavsky that the transition period was helpful, but noted the past president typically remains part of the Executive Committee and could accompany the new president to legislative hearings. Ms. Whitney

explained the downside of a May election date is the Members' terms of office typically end June 1, thus creating the possibility of a newly elected officer not being reappointed.

Mr. Zerunyan stated, in local government, elected officers automatically move from one position to the next in a prescribed manner of succession. For example, the secretary moves to the office of vice president, and the vice president moves to the office of president. Rather than electing a whole new slate of officers each year, this succession model would eliminate the issue of acclimation.

Ms. Yaroslavsky called for the vote and the motion to hold elections at the July meeting, have the officers take over at the end of the July meeting, and to accept the current slate of officers as the officers for 2009-2010 carried.

Agenda Item 18 REGULATIONS – PUBLIC HEARING

Ms. Yaroslavsky opened the public hearing on the proposed regulation to amend Section 1314.1 of Title 16 of the California Code of Regulations as described in the notice published in the California Regulatory Notice Register and sent by mail to those on the Board's mailing list. The Board seeks to amend the regulation relating to the review of international medical schools to keep the language current and useful. Specifically, this rulemaking updates and adds specificity to the existing standards and methodology that the Board uses to review international medical schools in order to determine their compliance with Business and Professions Code sections 2089 and 2089.5. For the record, Ms. Yaroslavsky stated the date was July 24, 2009; the hearing began at approximately 9:40 a.m. No written testimony was received by the July 20, 2009 deadline.

Ms. Scuri explained the regulations have been in effect for approximately six years; during this time, Board staff and the Board's expert medical consultants have identified deficiencies in the current regulations. These additional provisions, if adopted, would add greater specificity to the process for the review of international medical schools. Ms. Scuri noted the regulations were originally adopted based on Liaison Committee on Medical Education (LCME) standards which have since changed. The proposal would bring the regulations up to date. She referred Members to page 59 of their packets for details of the wording of the proposed regulations.

Oral testimony in support of the proposed regulation was offered by Dr. Harold Simon, Professor of International Health Policy at the UC San Diego School of Medicine and consultant to the Board on the evaluation and recognition of international medical schools.

Charles Modica, Chancellor of St. George's University in Grenada, offered his support for the proposal from the perspective of a medical school that falls under the regulations. Given the wide disparity in the quality of the medical schools in the Caribbean, he stated the need for the regulations is clear. He noted California has the most rigorous scrutiny of foreign medical schools in the nation and felt this scrutiny makes the schools and programs better.

Ms. Yaroslavsky closed the hearing. Dr. Gitnick made a motion to adopt the regulation; s/Chang; motion carried.

Agenda Item 19 REGULATIONS – PUBLIC HEARING

Ms. Yaroslavsky opened the public hearing on the proposed regulation to adopt Section 1355.4 of Title 16 of the California Code of Regulations as described in the notice published in the California Regulatory Notice Register and sent by mail to those on the Board's mailing list. The Board seeks to adopt language which will require physicians to notify patients that they are licensed and regulated by the Medical Board of California. Physicians may provide the notice in one of the specifically enumerated options: prominently posting a sign, including it in a written notice to be signed by the patient and kept in his or her medical record, or including it just above the signature line on a document given to the patient that the patient signs. For the record, Ms. Yaroslavsky stated the date was July 24, 2009; the hearing began at approximately 9:55 a.m. Ms. Yaroslavsky reported written testimony received by the July 20, 2009 deadline was distributed to Board Members.

Ms. Scuri reported the recommendation for this proposal came from the Education Committee; written testimony will become part of the record.

Tina Minasian, patient advocate, offered oral testimony in support of the proposal. She stated she was unaware of the existence of the Board and its enforcement role following injury sustained at the hands of a physician. She felt doctors should be required to notify the public of who regulates them, just as auto repair shops, realtors, and construction sites are required to do. She also urged the Board to sponsor legislation repealing, or at least lengthening, the statute of limitations for filing physician complaints. Ms. Minasian stated the adoption of Section 1355.4 will make consumers better informed and will increase communication between consumers and the Board.

Dr. Paul Phinney, California Medical Association, offered testimony in opposition to the proposed regulations. Dr. Phinney stated the regulations are unnecessary since state law already requires physicians to post their medical license or wear a nametag. He felt the regulation would place an additional administrative burden on physicians and would increase costs. He also stated the regulations do not provide a meaningful benefit to patients, the doctor-patient relationship, or the health care delivery system in general and were a waste of resources. In addition, Dr. Phinney stated failure to comply with the regulations constitutes a new and unnecessary cause of action for discipline against physicians. He stated callers may contact the Board out of confusion and, in dealing with these calls, may further impede the Board's ability to fulfill its role. He urged the Board to withdraw the proposal and focus its efforts on educating physicians about existing responsibilities to identify themselves and post their license.

Yvonne Choong, California Medical Association, opposed the regulations and stated the proposal, as written, places the burden of complying with the regulation on the physician, even though compliance may be out of the physician's control, such as would be the case for physicians who work in hospitals or large group practices.

Julie D'Angelo Fellmeth, Center for Public Interest Law, speaking in support of the regulations, stated Business and Professions Code Section 138 mandates the Board require its licensees to provide notice to their patients that they are licensed by the State of California. She stated a

nametag does not do this. She indicated the Legislature wants patients to know where to file a complaint and to avail themselves of the information and services provided by regulators. Ms. Fellmeth reported she saw countless cases where the Board was unable to take action because patients filed their complaints after the running of the statute of limitations, being unaware of the Board's existence and its role until it was too late. She also reported she saw many cases where the Board's investigators, in investigating a case, checked the Civil Index and found numerous medical malpractice actions filed against a physician by patients who had never filed a complaint with the Board. Ms. Fellmeth stated the regulations had been written to eliminate any undue burden on physicians and provided options for compliance to doctors who do not have office space practices. She stated there was ample precedence for the regulation with hospitals and health facilities, pharmacists, optometrists, and many other licensed professionals required to post signage about their regulation. She concluded by saying the regulations were not burdensome, confrontational or adversarial, but merely informational and consistent with the Board's public protection priority. Ms. Fellmeth also suggested the Board consider requiring the posting of the sign in languages other than English by physicians whose patients don't speak English as their first language.

Bhindu Varghese, speaking on behalf of the Consumers Union, the California Public Interest Research Group, the Consumer Federation of California, the California Pan Ethnic Health Network, and the California Safe Patient Network, urged the Board to adopt the regulations. She stated patient awareness of the Board's existence and disciplinary function is essential in identifying problem doctors and performing public protection. Ms. Varghese urged the Board to consider strengthening the regulation by requiring physicians to both post the notice in a prominent place in the waiting area and provide notice on a document sent home with the patient (exempting physicians without an office from the posted notice requirement). Further, Ms. Varghese suggested the regulation be amended to include the language "complaints about care may be submitted to the Medical Board of California". Finally, she urged the Board to require the notice be posted in English as well as in any other language regularly encountered by the physician and staff, with these translations being provided by the Board to physicians on its website.

Mary Knight Johnson, member of the public, stated she was unaware of her option to file a complaint with the Board over the treatment she received from a physician until that morning when she saw a report on the television news. She supported the regulation for physicians to inform their patients of the Board's existence and role.

Hearing no further testimony, Ms. Yaroslavsky closed the hearing.

Rather than providing physicians with three options for compliance, Mr. Zerunyan suggested the regulation be worded to require physicians to post a sign *and* provide patients with a separate written statement about regulation by the Board *or* include this information on other documents given to patients where the notice is placed immediately above the signature line for the patient.

Dr. Salomonson stated that offering three options allowed physicians who do not have an office practice and have no control over signage to comply with the law.

In responding to a question by Ms. Yaroslavsky on the cost of compliance, Ms. Cohen reported the cost to a solo practitioner was calculated to be, at most, $4.50 per office: $.05 to download the signage from the Board's website and $4.45 for printing and a frame (as quoted by a local office supply store) if the physician chooses to frame the sign.

Dr. Salomonson made a motion to adopt the proposed regulation as it is written; s/Dr. Duruisseau.

Board members discussed the flexibility for physicians to comply with the regulation. Dr. Gitnick stated the issue would likely become more complex in the future as telemedicine and out of state consultations via video become more commonplace. He indicated the Board may need to revisit this issue at some point.

Ms. Yaroslavsky called for a vote; the motion to adopt the proposed regulation as written carried.

Agenda Item 21 Licensing Chief's Report

A. Licensing Program Update

Ms. Pellegrini provided an update on the licensing program. She reported the licensing program had established a priority system to process applications by type of application rather than date order. Top priority was given to California residents needing licensure to continue their training, followed by incoming fellows and residents starting their training July 1, 2009. Staff was able to review 1200 applications for residents and fellows by the deadline and licensed 90% of the applicants identified. Incoming fellows comprised most of the 10% that were not licensed by July 1st, but many of them have since been licensed. She reported 34 letters were sent to residents to cease their training until they were licensed as they had not submitted all required documents, had applied after June 15th, or had documented criminal convictions and post graduate training issues that required significantly more staff time to gather all the documents. Overall, the changes in this year's July 1st residency priority program were valuable and saved considerable processing time and improved customer satisfaction.

Ms. Pellegrini reported she and Mr. Schunke are setting up meetings with the program directors state-wide this fall to inform them about the backlog and to encourage all the residents in training programs to submit their applications by December 31st.

Ms. Pellegrini stated the licensing department is once again taking applications in date order. The major contributing factor to the growing backlog is the three day a month furlough

program which has resulted in a 15% loss in productivity and a loss of 810 employee work hours per month. Ms. Pellegrini indicated the department, with furloughs, is being staffed for processing 4500 applications per year when in fact there have been 6600 applications received over the past year. Currently, there are 673 applications that have not been reviewed within the mandatory timeline of 60 working days. As a consequence of this backlog, staff spends a significant amount of time responding to frustrated applicants, program directors, and employers. Ms. Pellegrini hopes to get the backlog to about four and a half months from the date an

application arrived to when it is initially reviewed. If an application is complete, it will be licensed within the same week; if items are missing, then a deficiency letter is sent informing the applicant of what needs to be submitted.

Ms. Pellegrini described the Web Application Look-Up Project which will allow applicants to review the status of their applications online. Once implemented, this should provide a new service for applicants, reduce time consuming phone interactions, and allow more time for processing applications.

Ms. Pellegrini reported the call center typically receives 500 - 520 calls a day. However, the number of calls has increased to 850 – 920 on the Mondays following a furlough day. Staff must be pulled from licensing operations to answer the phones on these days.

The business process re-engineering study for the licensing program, mentioned at the last Board meeting, has been delayed due to the Governor's order restricting contracts. Once the state budget is signed and the Board's reduction plan is approved, staff will proceed with this project which will determine necessary staffing levels and identify processes to improve efficiencies within the licensing department. Budget change proposals have been submitted to increase both the call center and licensing staff to more appropriate levels.

Dr. Gitnick reported he has received multiple phone calls and emails from deans and directors of medical education at different University of California campuses because of the problems that have evolved regarding licensing. He recommended a letter be sent from the Board, addressed to each of the deans and the directors of medical education and any other constituents affected by licensing delays, flatly stating it is imperative when they accept someone for a position at a medical center the person immediately move forward with developing the dossier for licensure. Additionally, he stated the onus for making that dossier complete falls on the applicant, not on the staff of the Board. Dr. Gitnick stated educational institutions will likely need to start notifying applicants of their acceptance or rejection into fellowship programs more than 6 months in advance. Additionally, deans may have to move back fellowship reviews in order to ensure licensure by July 1.

Dr. Salomonson expressed her desire to have a metric in addition to speed for evaluating the success of the licensing process. While timeliness is important, it is also critical to conduct a thorough review in order to protect the public from individuals who should not have a license. Preventing inappropriate licensure should also be a measure of success.

Dr. Carreon stated the need for careful review given the media's recent examination of various boards. He suggested a comparison of licensing data in the last five years to show the impact the current restrictions have had on licensing. He requested suggestions for improvement and offered the Board's assistance.

Mr. Zerunyan stressed the need to search for additional efficiency improvements, citing the web application look-up project as a positive start. He suggested researching what similar agencies

are doing with regard to licensing to cope with the 15% loss of productivity in order to identify efficiencies the Board might also utilize.

Dr. Levine suggested applicants be asked to keep their employer or future employer apprised of the status of their application to avoid duplicate calls to licensing staff. In addition, she recommended informing those who employ physicians in the state, both universities and group practices, that the applicant will soon have the ability to track the exact status of the application and they should talk to the applicant, rather than to the Medical Board, with their questions.

Dr. Low felt the current situation constituted a crisis since licensing is a core responsibility of the Board. Beyond looking at ways to be more efficient in the future, he stressed the need to address the current backlog now. He suggested curtailing all other non-essential activities in order clear the backlog. He also recommended posting information about the backlog on the Board's website and also describing what is being done to address it. Ms. Yaroslavsky agreed a proactive approach would be beneficial.

Dr. Chin was impressed with what staff was able to accomplish given a 50% increase in workload and a 15% reduction in work force hours. He felt the Board should find additional resources to assist staff in addressing the problem. He suggested letting applicants and others know up front how long the licensing process might take in order to manage expectations.

Dr. Duruisseau indicated the UC system, given the cuts they are faced with, has decided to delay some faculty recruiting. If this is adopted system wide, future licensing requests may decline. In the meantime, he challenged the Executive Committee and the Executive Director to explore the possibility of redirecting funds to address the backlog. Ms. Johnston responded that we cannot shift funds from enforcement to licensing.

Ms. Johnston asked for the Board's help in getting the contract for the licensing re-engineering study approved; currently the contract is suspended due to the executive order.

There was lengthy questioning by Members on the licensing backlog and the possibility of appealing the furlough of the Medical Board and its staff since it is a special fund department.

Ms. Yaroslavsky encouraged all Members to go through Candis Cohen, the Board's Public Information Officer, when approached by the media in order to ensure the Board is speaking with a united voice. Additionally, when speaking to the press, she asked members to preface their remarks by stating they are not speaking on behalf of the Board.

Kevin Schunke provided an overview of the outreach he conducts to the teaching hospitals in California. During new resident orientation programs, he provides an overview of the licensing process and encourages the residents to begin the licensing process early and also explains the consequences of being dishonest on the application. He also participates in license fairs (where the teaching hospital brings in a notary, a finger printer, and a photographer to facilitate licensing for residents) by answering questions and taking a quick look at applications to identify potential problems.

During public comment, Yvonne Choong, California Medical Association, stated they have also been receiving calls about the lengthy licensure timelines and expressed her relief that the Board is making this issue a priority. She indicated physicians who come from other states are losing job offers because they are unable to start due to the delay in receiving a California license. Ms. Choong expressed CMA's willingness to work with the Board, including the possibility of producing a webinar on the licensing process to post on CMA's website, expanding the concept of licensing fairs to apply to working physicians, not just residents, and using medical societies to educate physicians on the licensing process.

Agenda Item 20 Discussion of Medical Spas and Issues Related to the Board

A. Senate Bill 674 and Related Supervision Issues

Ms. Whitney reported Senator Figueroa introduced legislation in 2006 to address growing unlicensed activity and corporate practice of medicine issues arising from cosmetic surgery and other procedures being done in medical spas.

Janie Cordray, Research Specialist for the Board, reported Senator Figueroa's legislation required the Board, in conjunction with the Board of Registered Nursing and in consultation with the Physician Assistant Committee and professionals in the field, to review issues and problems surrounding use of laser or intense pulse devices for elective cosmetic procedures. The Boards were to look at issues including the appropriate level of physician supervision, training required, and guidelines for standardized procedures and protocols. It also required the two boards to promulgate regulations by January 1, 2009. She reported the boards held three joint forums in 2007 which were well attended by the stakeholders. Staff analyzed the relevant laws and regulations and reported back on the current environment and what was needed to provide adequate public protection. Dr. Salmonson and Dr. Moran chaired these forums.

Dr. Salomonson stated the forums amply demonstrated there was indeed a problem. The public has a false perception that what is happening at medical spas must be legal or it would not be allowed to continue. She stated this is more than a turf battle where established physicians feel threatened by the competition from these medical spas; the medical spas are dangerous and patients are being harmed. She stated requiring an on-site physician to be present did not guarantee patient safety since the physician may or may not have training in certain core specialties. There was a need to refine legislation and enforce what was already law.

Dr. Jerry Potozkin, President of CalDerm, addressed the need to enforce existing law, including the unlicensed practice of medicine. He reported on procedures being conducted by completely unlicensed individuals, as well as licensed professionals, such as registered nurses, who are performing laser procedures and injecting materials into patients without an appropriate prior examination by a physician. In addition, Dr. Potozkin noted there are relationships in violation of existing corporate practice of medicine laws. Physicians are being hired as medical directors for spas owned by lay people and registered nurses are hiring physicians to be their "supervising physician" in order to procure injectibles such as botulinum toxin. He reported these laws are not being enforced. He questioned the ability of a doctor in another state to supervise an aesthetic

procedure being done in California, particularly if that doctor has received no training in that procedure. Patients are often left with nowhere to turn when they have a complication or an injury from one of these procedures.

Ms. Cordray reported the forums revealed the problems were not due to the lack of law and regulation, but from lack of enforcement. She referenced her memo to Members in Agenda Item 20 for an explanation of why the existing laws were not being enforced.

As a result of the forums, the committee and Full Board adopted the following recommendations:

- Publish a statement clearly outlining the current laws and responsibilities of physicians in providing laser treatments; this may be viewed on the Board's website.
- Re-write and distribute the article "Medical Spas – What You Need to Know" for consumers; this is also available on the Board's website.
- Support the re-establishment of Operation Safe Medicine, which addresses the unlicensed practice of medicine and enforces the laws and regulations related to cosmetic procedures. Ms. Threadgill will report on the implementation of this recommendation.
- Direct staff to work with the Nursing Board to develop an enhanced communication system in cases involving physicians and nurses. This is being done on an on-going basis.
- Direct staff to use the citation and fine process to deter future violations. Ms. Threadgill will report on the implementation of this item.
- Direct staff, before January 1, 2009, to report to the Legislature on the Board's actions and intentions. Ms. Whitney has been working with the legislature.

Ms. Cordray reported there is legislation pending which may affect how these issues are addressed, and the recent furlough of Board employees reduces the resources for enforcement. Regardless of these recent developments, Ms. Cordray stated the Board only has jurisdiction over physicians and enforcing the standards and laws relating to physicians. Nurses, physician assistants, and other allied health professions fall under their separate boards. The Medical Board is responsible to tell the physicians what laws relate to them, their responsibility in supervision, and what discipline the Board will impose for violations.

Rosielyn Pulmano, Senate Business and Professions and Economic Development Committee, addressed the Board on SB 674. She stated the bill included a provision requiring the Board on or before January 1, 2011 to adopt regulations regarding the appropriate level of physician availability needed within clinics or other settings using laser or intense pulse light devices for elective cosmetic procedures, usually referred to as medispas. This provision was included in light of arrangements involving roving physicians, or physicians who enter into a contractual arrangement with a medispa to serve as a medical director in name only and are never available, even in emergency situations. Having a name only physician raises serious concerns for consumer safety.

Astrid Meghrigian, California Medical Association, reported CMA supports SB 674. She indicated CMA has formed a working group to look into the issue of supervision of allied health

professionals and ancillary providers; initial recommendations were made that will proceed to their board of trustees this week. The recommendations for supervision vary depending on the level of complexity of the services being performed moving from general, to direct (where the physician must be on site), to personal supervision (where the physician must be with the patient).

B. Corporate Practice of Medicine Laws

Ms. Scuri provided a review of what the Board has done in the past with regard to the corporate practice of medicine. The prohibition of the corporate practice of medicine originated from case law which held that a corporation may not directly or indirectly engage in the practice of medicine and is currently codified in the Business and Professions Code Section 2400. In addition, Section 2052 makes it a misdemeanor for any person to engage in the unlicensed practice of medicine. There are exceptions to this prohibition which are codified in statute such as professional medical corporations, licensed community clinics, health care service plans, and health maintenance organizations. The prohibition of corporate practice of medicine is intended to protect the public from potential abuses that might stem from the commercial exploitation of the practice of medicine. A physician should not be forced to choose between the employer's dictates and the best interests of the patients.

Ms. Meghrigian, CMA, reported CMA is working with various district attorneys to address sham medical clinics operating in California. She reported there are for-profit educational companies offering consulting services to physicians on how to open a sham medical clinic. Completely non-licensed individuals are directing the physicians in these clinics for the purpose of obtaining workers compensation payments. The district attorney has developed a coalition with the insurance industry to address some of these sham clinics since they cost the state and the insurance companies a lot of money.

Ms. Whitney indicated the Board has actively reviewed and taken positions on laws or bills that would try to delete corporate practice provisions. The Board has also been in support of some exemptions, including narcotic treatment programs and the pilot program allowing district hospitals to employ a limited number of physicians as an opportunity to address access to care issues in certain locations.

D. Specialty Society Presentations

Tim Madden, California Society of Plastic Surgeons (Society), agreed current law seems to be sufficient and enforcement is the solution. He indicated the Society would be willing to participate in a task force or advisory committee to work with Operation Safe Medicine to protect patients.

John R. Valencia and Dr. Suzanne Kilmer, American Society for Dermatologic Surgery (ASDS), reported patients mistakenly assume they are being treated by licensed health care professionals in these medispa settings. ASDS has focused on negative medispa patient outcomes which are neither transient nor minor and, in some cases involve permanent scarring. Missed diagnoses of skin conditions or lesions by medispas have resulted in serious complications and even death. Mr. Valencia noted AB 252, which the Board supports, will improve recovery when the Board effectuates a successful prosecution. Dr. Kilmer reported she routinely treats patients who have

been harmed at medispas. She noted the need for a physician to be present at all times since so many complications are possible. Both Mr. Valencia and Dr. Kilmer offered their help in supporting enforcement and an advisory committee.

C. Operation Safe Medicine

Ms. Threadgill, Chief of Enforcement, indicated the Board's first office of Operation Safe Medicine (OSM) was established in 2000, however, it was closed in 2003 due to the budget shortfalls. The major emphasis of the unit previously was unlicensed activity and backroom clinics. In 2007, the Board voted to re-establish OSM to address the prevention of unlicensed practice and corporate practice of medicine violations and the increasing issues resulting from the rise in medispas. In March 2008, the Board was given approval to re-establish OSM for two years, effective July 1, 2009, but required funding within existing resources. She reported the unit is now functioning and directed Members to the organization chart in Agenda Item 20, tab D to show how OSM fits within the larger enforcement unit. Ms. Threadgill stated, if the workload justifies expansion, a Northern California office may be established. Complaints for this unit should be directed, as all others, to the Board's Central Complaint Unit for processing and assignment in OSM. The Board will be required to submit another budget request in 2010 for Fiscal Year 11/12 to obtain authorization to extend the program and the monies to fund the program.

Ms. Threadgill reported the program's objectives are twofold: first, to detect, investigate, and enforce against unlicensed practice of medicine in those clinics that prey on sick and desperate patients. Second, to detect and enforce against corporate practice of medicine violations. Ancillary violations such as unfair business practice and advertising violations can also be addressed. Although these objectives are similar and overlap, they may involve two distinctly different types of investigations. Unlicensed practice of medicine violations will include investigation of individuals presenting themselves as physicians. Corporate practice violations are more complex and may involve taking administrative action as well as criminal action against practitioners. Even without the OSM resources, Ms. Threadgill noted the enforcement unit continued to conduct enforcement in these areas, but was unable to give it the same priority as will be possible under OSM.

Jose Guerrero, Supervising Attorney General with the Health Quality Enforcement Section, reported the Board adopted a precedential decision in a case that gave clarification and underscored several previous written articles on unlicensed practice and the corporate practice of medicine. The decision also clarified which intense pulse light services or laser treatment procedures other allied health licensees could perform under the direct supervision of a physician. The decision educated consumers as well as the lawyers who advise physicians on what is permitted and prohibited by the law.

E. Formation of Task Force / Advisory Committee

In anticipation of the passage of SB 674, Ms. Yaroslavsky directed the Board's Legislative staff to work on the establishment of a committee to: reflect the recommendations made today; set objectives for the work it will need to do on the hearings; and make recommendations on the

membership and structure of the committee. She asked staff to report back to the Board at the October 2009 quarterly meeting during the Legislative update.

John Caldwell, Public Policy Advocates, and Dr. Jerry Potozkin, CalDerm, have informed Ms. Whitney they would like to participate and work with the Board on these issues.

Agenda Item 23 Recognition of St. George University School of Medicine (Branch Campus in England)

Ms. Pellegrini stated staff recommends the Board grant recognition to St. George's University Branch Campus in England based on the medical consultant's positive findings and recommendations. Dr. James Nuovo, Associate Dean of Graduate Medical Education at UC Davis and consultant to the Board, reported he had reviewed the school's self-assessment report which demonstrates the school meets the accreditation training requirements, and found it acceptable. The branch campus offers the opportunity for students to complete their first year of basic sciences and education in the UK. The curriculum is identical to the curriculum at the main campus in the Caribbean with connections between the two campuses such that the students receive the same type of training and feedback. He recommends the branch campus be approved with the approval being retroactive to January 2007 when the program began.

Dr. Duruisseau made a motion to grant approval of the UK branch campus of the St. George University School of Medicine retroactive to its founding in January 2007; s/Chang; motion carried.

Agenda Item 22 Midwifery Advisory Council Appointment

Ms. Pellegrini reported the Midwifery Advisory Council (MAC) has six members, including 3 licensed midwives and 3 public members, of which 2 are obstetrician/gynecologists (ob/gyn) and 1 is a member of the Board. Staff recommends the open ob/gyn position be filled by appointing Dr. William Frumovitz. Dr. Levine made a motion to approve Dr. Frumovitz's appointment to the MAC; s/Chang; motion carried.

Agenda Item 24 Executive Committee Update

A. Vertical Enforcement Report to the Legislature

Ms. Yaroslavsky reported the draft Vertical Enforcement (VE) Report to the Legislature was discussed at length at the June 18, 2009 Executive Committee meeting. The Executive Committee members approved the report in concept, but asked for a two member committee to review the final report and approve it so it could be delivered to the Legislature by the July1, 2009 deadline. Ms. Yaroslavsky and Mr. Zerunyan reviewed the final report prior to its submission to the Legislature.

Ms. Threadgill directed members to tab 24 in their packets for the staff report and executive summary of the VE report with recommendations. She reported Ken Kobrin and Joan Kawada, Integrated Solutions for Business and Government (ISBG), presented the report to the Executive Committee and received input from the Committee, the Department of Justice Health Quality Enforcement Section, and the Center for Public Interest Law. Adjustments were made to the report to reflect the input and a final report was submitted which was approved for distribution by two members of the Executive Committee. The final report was submitted to the Legislature on July 1, 2009.

Dr. Moran made a motion to approve the final Vertical Enforcement Report recommendations listed in the staff report; s/Levine; motion carried.

Agenda Item 25 Enforcement Chief's Report

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

Mr. Zerunyan made a motion to approve the orders; s/Moran; motion carried.

B. Expert Utilization Report

Ms. Threadgill directed members to the Expert Utilization Report in the agenda packets for review.

C. Enforcement Program Update

Ms. Threadgill reported the Operation Safe Medicine (OSM) unit has been reformed under the command of Robin Braafladt and Supervising Investigator Carmen Aguilar-Marquez. The unit's four investigator positions are fully staffed with internal transfers. Currently, 17 unlicensed practice of medicine cases have been assigned to them, 3 of which were presented for criminal filing this week. Ms. Threadgill will provide quarterly updates of the progress and activity of the OSM unit.

The investigator vacancy rate is currently 8, even though vacancies were created due to the transfer of experienced investigators to OSM. Ms. Threadgill stated she anticipates the hiring process will be slower in the coming months due to the need to eliminate unqualified individuals who are on the State Restriction On Hiring list (SROA).

Ms. Threadgill reported the Enforcement unit has made it a priority to reduce the case age average as a matter of public protection. The average case age for closed investigations decreased in five of the twelve district offices in June of 2009. Ms. Threadgill reported an age case council concept was implemented in May 2009 where investigators have been instructed to appear before a council composed of herself, the Deputy Chief, and a representative of the Attorney General's office to explain the obstacles preventing the forward movement of older or stalled cases. Fourteen cases were originally identified for discussion at the first council session

which will be held July 30, 2009. As a result of identifying these fourteen cases, the investigators already have reached disposition on 4 of the cases, 3 went to expert review post haste, and meaningful progress occurred on 2 other cases. This leaves only 5 cases for discussion at the upcoming council.

Ms. Threadgill reported every case over one year old must be reviewed monthly by the supervising investigator, which also helps move cases forward. In addition, a statewide competition among offices to reduce closed case averages has been instituted. The goals vary by the staffing levels and experience in the offices.

Two offices are piloting a concept of attaching a due date to a case at the date of assignment by projecting the necessary steps needed to resolve the matter. This was just implemented so results are not yet available.

Ms. Threadgill reported the impact of the three mandatory days off per month for enforcement staff will result in the loss of 4,272 hours of work per month; this is almost the equivalent of losing 28 or 29 positions each month or like shutting down 4 or 5 district offices every month. She stated this will be extremely damaging to their ability to decrease enforcement timelines.

Previously, Ms. Threadgill reported on her disappointment with the pay classification report received from the contracted vendor. The vendor was contacted and has agreed to provide additional work in order to provide a product more in line with the Board's scope and expectations.

Ms. Threadgill reported on the status of the Complaint Resolution and Information Management System (CRIMS). The CRIMS system is a tracking and case management system that will increase efficiencies and interface with the Attorney General's Office. She indicated her satisfaction with the way the project is progressing and provided a brief overview of how the system will work. She noted this is a multi-year project that will take time to complete and implement.

Mr. Zerunyan noted the various recommendations that were made in the Vertical Enforcement Report and asked Ms. Threadgill about any plans and timelines for implementing these recommendations.

With regard to the report's recommendation to deal with staffing vacancies, Ms. Threadgill reported it is difficult to develop timelines given the SROA restrictions described earlier in her report. The recommendation to obtain a common server is currently being addressed via the CRIMS project which is a scheduled to continue through 2012. Statewide training is being addressed in conjunction with the Attorney General's Office. Training on subpoena enforcement issues for investigators and deputies is being developed and will soon be ready to implement. Consistent uniformity of the vertical enforcement process is being addressed on a subject by subject basis by Ms. Threadgill and Mr. Ramirez.

Mr. Zerunyan suggested Ms. Threadgill and Mr. Ramirez should focus their efforts on those areas identified in the vertical enforcement report that showed increased timelines and decreased efficiencies. He urged Ms. Threadgill to use the Board as a conduit to the public to inform them of the enforcement challenges faced and plans to address these challenges.

D. Disciplinary Guidelines Update

Ms. Threadgill reported an interested parties meeting was convened on June 18, 2009 to discuss the proposed regulatory changes to the disciplinary guidelines to allow for public comment from stakeholders. Representatives from the defense bar, insurance carriers, CMA, and other health care consumers participated. Proposed changes consistent with the comments were reviewed and resulted in minor changes and refinements to the guidelines. Ms. Threadgill reported the Members have already approved proceeding to regulatory hearing with the guidelines, which will occur at the October 2009 Board meeting.

Agenda Item 26 Agenda Items for October 29-30, 2009 Meeting

Dr. Duruisseau requested a presentation to the Board at a future meeting on telemedicine to better understand how patient care is delivered in these settings.

Ms. Yaroslavsky concluded by thanking staff on behalf of the Board for their work and dedication in spite of the current situation.

Action Item 27 Adjournment

There being no further business, the meeting was adjourned at 2:33 p.m.

_____

Barbara Yaroslavsky, M.D., President

_____

Hedy Chang, Secretary

_____

Barb Johnston, Executive Director

DRAFT

0758 - Medical Board
Analysis of Fund Condition
(Dollars in Thousands)

		Actual 2008-09	2009-10	2010-11	2011-12	2012-13
BEGINNING BALANCE		$ 23,866	$ 24,379	$ 22,893	$ 19,575	$ 16,730
Prior Year Adjustment		$ 613	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 24,479	$ 24,379	$ 22,893	$ 19,575	$ 16,730
REVENUES AND TRANSFERS						
Revenues:						
125600	Other regulatory fees	$ 371	$ 379	$ 386	$ 386	$ 386
125700	Other regulatory licenses and permits	$ 5,557	$ 5,650	$ 5,633	$ 5,633	$ 5,633
125800	Renewal fees	$ 44,670	$ 43,692	$ 44,037	$ 44,429	$ 44,821
	$22 credit to licensees who renewed in 08/09			$ (1,210)		
125900	Delinquent fees	$ 101	$ 101	$ 101	$ 101	$ 101
142500	Miscellaneous services to the public	$ 22	$ 20	$ 20	$ 20	$ 20
150300	Income from surplus money investments	$ 572	$ 429	$ 364	$ 308	$ 237
160400	Sale of fixed assets	$ 1	$ 1	$ 1	$ 1	$ 1
161000	Escheat of unclaimed checks and warrants	$ 19	$ 14	$ 14	$ 14	$ 14
161400	Miscellaneous revenues	$ -	$ -	$ -	$ -	$ -
164300	Penalty assessments - Probation Monitoring	$ -	$ 1,000	$ 1,000	$ 1,000	$ 1,000
Totals, Revenues		$ 51,313	$ 51,286	$ 50,346	$ 51,892	$ 52,213
Transfers:						
GENERAL FUND LOAN		$ (6,000)				
Totals, Revenues and Transfers		$ 45,313	$ 51,286	$ 50,346	$ 51,892	$ 52,213
Totals, Resources		$ 69,792	$ 75,665	$ 73,240	$ 71,468	$ 68,944
EXPENDITURES						
Disbursements:						
0840 State Controller (State Operations)		$ 2	$ -	$ -	$ -	$ -
Budget Act of 2007						
1110 Program Expenditures (State Operations) - Galley 3		$ 45,411	$ 52,612	$ 53,664	$ 54,738	$ 55,832
2009-10 BCPs: Program						
OHR Various Positions 1111-01			$ 22	$ -	$ -	$ -
OIS 1111-02			$ 29	$ -	$ -	$ -
Public Affairs Webcasting 1111-05			$ 101	$ -		
Internal Audits 1111-06			$ 8	$ -		
Probation Monitoring 1110-19			$ -	$ -	$ -	$ -
Operation Safe Medicine 1110-17			$ -	$ -		
Total Disbursements		$ 45,413	$ 52,772	$ 53,664	$ 54,738	$ 55,832
FUND BALANCE						
Reserve for economic uncertainties		$ 24,379	$ 22,893	$ 19,575	$ 16,730	$ 13,111
Months in Reserve		5.5	5.1	4.3	3.6	2.8

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2009-10 AND BEYOND

B. INTEREST ON FUND ESTIMATED AT 2%

10/12/2009

Medical Board of California

FY 09/10
Budget Expenditure Report
(As of August 31, 2009)
(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)	15,553,918	2,025,511	13.0	13,528,407
Board Members	31,500	0	0.0	31,500
Phy Fitness Incentive Pay	29,623	2,015	6.8	27,608
Temp Help	1,144,410	164,097	14.3	980,313
Overtime	12,142	18,928	155.9	(6,786)
Staff Benefits	6,503,207	822,320	12.6	5,680,887
Salary Savings	(836,251)			(836,251)
TOTALS, PERS SERVICES	22,438,549	3,032,871	13.5	19,405,678
OPERATING EXP & EQUIP				
General Expense	145,386	10,251	7.1	135,135
Fingerprint Reports	373,448	20,738	5.6	352,710
Printing	733,196	370,604	50.5	362,592
Communications	507,441	15,769	3.1	491,672
Postage	496,411	35,069	7.1	461,342
Insurance	41,053	0	0.0	41,053
Travel In-State	394,929	6,445	1.6	388,484
Travel Out-of-State	2,031	0	0.0	2,031
Training	66,336	0	0.0	66,336
Facilities Operation (Rent)	2,702,140	2,033,329	75.2	668,811
Consult/Prof Services	982,594	672,219	68.4	310,375
Departmental Prorata	4,318,843	0	0.0	4,318,843
Consolidated Data Center	646,809	66,998	10.4	579,811
Data Processing	119,492	26,841	22.5	92,651
Central Admin Svcs (Statewide Prorata)	1,699,376	424,844	25.0	1,274,532
Attorney General Services	13,347,280	2,331,913	17.5	11,015,367
Office of Administrative Hearings	1,862,591	117,480	6.3	1,745,111
Court Reporter Services	175,000	1,941	1.1	173,059
Evidence/Witness	1,893,439	107,656	5.7	1,785,783
Major Equipment	333,000	0	0.0	333,000
Minor Equipment	291,650	0	0.0	291,650
Vehicle Operation/Other Items	262,006	34,735	13.3	227,271
TOTALS, OE&E	31,394,451	6,276,832	20.0	25,117,619
TOTALS, EXPENDITURES	53,833,000	9,309,703	17.3	44,523,297
Scheduled Reimbursements	(384,000)	(54,628)	14.2	(329,372)
Distributed Costs	(677,000)	(136,168)	20.1	(540,832)
NET TOTAL, EXPENDITURES	52,772,000	9,118,907	17.3	43,653,093
Unscheduled Reimbursements		(72,923)		
		9,045,984		

Budget Expenditure Report.xls
Date: October 1, 2009

Medical Board of California

FY 08/09
Budget Expenditure Report
(As of June 30, 2009)
(100% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	14,297,471	13,405,733	93.8	891,738
Board Members	31,500	23,813	75.6	7,687
Phy Fitness Incentive Pay	29,623	18,980	64.1	10,643
Temp Help	1,144,410	1,321,095	115.4	(176,685)
Overtime	12,142	195,920	1613.6	(183,778)
Staff Benefits	6,169,846	5,327,202	86.3	842,644
Salary Savings	(807,252)			(807,252)
TOTALS, PERS SERVICES	20,877,740	20,292,743	97.2	584,997
OPERATING EXP & EQUIP				
General Expense	876,732	362,843	41.4	513,889
Fingerprint Reports	373,448	332,443	89.0	41,005
Printing	873,205	762,765	87.4	110,440
Communications	577,350	404,964	70.1	172,386
Postage	464,499	306,620	66.0	157,879
Insurance	38,414	13,689	35.6	24,725
Travel In-State	369,590	377,612	102.2	(8,022)
Travel Out-of-State	2,031	1,423	70.1	608
Training	62,072	89,095	143.5	(27,023)
Facilities Operation (Rent)	2,528,431	2,172,784	85.9	355,647
Consult/Prof Services	925,994	869,910	93.9	56,084
Departmental Prorata	4,063,966	3,670,645	90.3	393,321
Consolidated Data Center	605,228	299,583	49.5	305,645
Data Processing	111,810	224,051	200.4	(112,241)
Central Admin Svcs (Statewide Prorata)	2,323,465	2,323,465	100.0	0
Attorney General Services	12,419,270	11,881,433	95.7	537,837
Office of Administrative Hearings	1,731,603	1,098,930	63.5	632,673
Court Reporter Services	175,000	128,246	73.3	46,754
Evidence/Witness	1,771,718	1,519,474	85.8	252,244
Major Equipment	185,000	-8,968	-4.8	193,968
Minor Equipment	207,000	344,044	166.2	(137,044)
Vehicle Operation/Other Items	245,163	299,718	122.3	(54,555)
Memorandum of Costs	0	10,171		(10,171)
Misc SCO Expenditures	0	1,589		(1,589)
TOTALS, OE&E	30,930,989	27,486,529	88.9	3,444,460
TOTALS, EXPENDITURES	51,808,729	47,779,272	92.2	4,029,457
Scheduled Reimbursements	(384,000)	(329,461)	85.8	(54,539)
Distributed Costs	(677,000)	(677,000)	100.0	0
Internal Cost Recovery		(144,771)		144,771
NET TOTAL, EXPENDITURES	50,747,729	46,628,040	91.9	4,119,689
Unscheduled Reimbursements		(1,215,080)		1,215,080
		45,412,960		5,334,769

Budget Expenditure Report.xls
Date: August 28, 2009

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2009 - AUGUST 31, 2009

	FY 09/10 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,005,218	321,079	current
Staff Benefits	857,578	122,072	current
TOTAL PERSONAL SERVICES	2,862,796	443,151	
OPERATING EXPENSES & EQUIPMENT			
General Expense	5,000	398	1-2
Fingerprint Reports*	369,248	20,604	1
Printing	35,000	16,719	1-2
Communications	55,000	682	1-2
Postage	146,890	16,997	1-2
Travel In-State	25,000	376	1-2
Training	4,000	0	1-2
Facilities Operation	225,000	213,234	current
Consult/Professional Services	506,873	174,449	1-2
Departmental Services	370,989	0	current
Data Processing	1,000	6,403	1-2
Central Administrative Services	145,976	36,494	current
Attorney General	190,000	22,738	current
Evidence/Witness Fees	7,500	1,200	1-2
Major Equipment	12,000	0	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	2,099,476	510,294	
SCHEDULED REIMBURSEMENTS	(384,000)	(54,628)	
DISTRIBUTED COSTS	(43,723)	0	
TOTAL BUDGET/EXPENDITURES	**4,534,549**	**898,817**	

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

g/admin/licensn2.xls
9/29/2009

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2009 - AUGUST 31, 2009

	FY 09/10 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	10,090,819	1,325,462	current
Staff Benefits	3,991,538	487,983	current
TOTAL PERSONAL SERVICES	14,082,357	1,813,445	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	54,584	4,680	1-2
Printing	326,734	327,828	1-2
Communications	278,000	12,175	1-2
Postage	105,338	17,818	1-2
Insurance	38,378	0	current
Travel In-State	183,139	2,076	1-2
Training	24,188	0	1-2
Facililties Operations	2,007,140	1,505,608	current
Consultant/Professional Services	300,000	96,248	1-2
Departmental Services	3,169,598	0	current
Data Processing	8,994	8,438	1-2
Central Administrative Services	1,247,172	311,793	current
Attorney General 1/	13,157,280	2,309,175	current
OAH	1,862,591	117,480	current
Evidence/Witness Fees	1,820,939	104,206	1-2
Court Reporter Services	175,000	1,941	1-2
Major Equipment	220,000	0	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	81	11,242	1-2
Vehicle Operations	204,425	18,561	1-2
Minor Equipment	92,000	0	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	25,275,581	4,849,269	
DISTRIBUTED COSTS	(629,942)	(136,168)	
TOTAL BUDGET/EXPENDITURES	**38,727,996**	**6,526,546**	
Unscheduled Reimbursements		(5,947)	
		6,520,599	

1/See next page for monthly billing detail

9/30/09
g/admin/enfrcbud.exl

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 09/10
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

		Number of Hours	Rate	Amount
July	Attorney Services	6,642.00	170.00	1,129,140.00
	Paralegal Services	303.00	120.00	36,360.00
	Auditor/Analyst Services	110.00	99.00	10,890.00
	Cost of Suit			
				1,176,390.00
August	Attorney Services	6,384.75	170.00	1,085,407.50
	Paralegal Services	318.50	120.00	38,220.00
	Auditor/Analyst Services	92.50	99.00	9,157.50
	Cost of Suit			
				1,132,785.00
September	Attorney Services		170.00	0.00
	Paralegal Services		120.00	0.00
	Auditor/Analyst Services		99.00	0.00
	Cost of Suit			
				0.00
October	Attorney Services		170.00	0.00
	Paralegal Services		120.00	0.00
	Auditor/Analyst Services		99.00	0.00
	Cost of Suit			
				0.00
November	Attorney Services		170.00	0.00
	Paralegal Services		120.00	0.00
	Auditor/Analyst		99.00	0.00
	Cost of Suit			
				0.00
December	Attorney Services		170.00	0.00
	Paralegal Services		120.00	0.00
	Auditor/Analyst		99.00	0.00
	Cost of Suit			
				0.00
			July - Aug Total =	**2,309,175.00**
			09/10 FY Budget =	**13,157,280.00**

Revised 9/17/09

ENFORCEMENT/PROBATION RECEIPTS
MONTHLY PROFILE: JULY 2007 - AUGUST 2009

	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	2,935	6,569	3,616	4,564	8,445	14,535	2,716	5,585	3,650	5,200	77,734
Criminal Cost Recovery	0	5,694	0	0	0	0	3,500	0	0	0	0	0	9,194
Probation Monitoring	56,999	17,107	28,739	109,603	53,626	75,517	218,781	232,169	82,153	52,220	44,309	40,703	1,011,926
Exam	825	75	50	3,495	50	2,150	125	5,740	100	75	75	50	12,810
Cite/Fine	3,050	3,200	9,050	2,400	1,500	5,650	4,300	10,400	9,415	5,375	5,700	8,300	68,340
MONTHLY TOTAL	78,943	27,926	40,774	122,067	58,792	87,881	235,151	262,844	94,384	63,255	53,734	54,253	1,180,004
FYTD TOTAL	78,943	106,869	147,643	269,710	328,502	416,383	651,534	914,378	1,008,762	1,072,017	1,125,751	1,180,004	

	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	FYTD Total
Invest Cost Recovery	4,486	1,050											5,536
Criminal Cost Recovery	0	0											0
Probation Monitoring	46,225	21,354											67,579
Exam	150	250											400
Cite/Fine	3,500	3,025											6,525
MONTHLY TOTAL	54,361	25,679	0	0	0	0	0	0	0	0	0	0	80,040
FYTD TOTAL	54,361	80,040	80,040	80,040	80,040	80,040	80,040	80,040	80,040	80,040	80,040	80,040	

excel:enfreceiptsmonthlyprofile.xls.revised 9/21/09.

Medical Board of California
Board Members' Expense Report
July 1, 2009 - August 31, 2009

	*Per Diem**			*Travel Expenses**	*Total July-Aug*	***Total FYTD***
	JULY	AUG	TOTAL			
Dr. Carreon	1,300	0	1,300	0.00	1,300.00	1,300.00
Ms. Chang	0	0	0	0.00	0.00	0.00
Dr. Chin	0	0	0	0.00	0.00	0.00
Dr. Duruisseau	600	1,000	1,600	118.10	1,718.10	1,718.10
Dr. Gitnick	0	0	0	567.63	567.63	567.63
Ms. Levine	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	0	0	0	0.00	0.00	0.00
Ms. Schipske	0	0	0	0.00	0.00	0.00
Ms. Yaroslavsky	600	1,200	1,800	768.90	2,568.90	2,568.90
Mr. Zerunyan	600	900	1,500	1,105.12	2,605.12	2,605.12
BOARD TOTAL	3,100	3,100	6,200	2,559.75	8,759.75	**8,759.75**

*includes claims paid/submitted through October 1, 2009

Board Members Expense Report.xls
Date: October 5, 2009

MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	DIVERSION	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
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	2,158,000	36,659,000		4,599,000	2,048,000		3,370,000	1,914,000	50,748,000
$ Spent	1,875,000	34,026,000		4,522,000	1,697,000		2,668,000	625,000	45,413,000 *
Positions Authorized	8.8	146.6		45.5	15.0		16.0	20.0	251.9
FY 09/10									
$ Budgeted	2,171,000	38,728,000	643,000	4,535,000	1,736,000		3,177,000	1,782,000	52,772,000
$ Spent thru 8/31	661,000	6,521,000	58,000	899,000	298,000		412,000	197,000	9,046,000 *
Positions Authorized	8.8	146.6	6.0	45.5	15.0		16.0	25.0	262.9

* net expenditures (includes unscheduled reimbursements)

10/1/2009
Budget Overview by Program.xls

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***
CME Audits	File finalized and submitted to DCA on 9/1/09	1/30/09	3/13/09	5/8/09	5/8/09	9/1/09		
Re-review of International Medical Schools	File finalized and submitted to DCA on 9/1/09	5/8/09	6/5/09	7/24/09	7/24/09	9/1/09		
Notice to Consumers by Physicians	File finalized and submitted to DCA on 9/1/09	5/8/09	6/5/09	7/24/09	7/24/09	9/1/09		
Disciplinary Guidelines	Noticed on 9/11/09; public comment period ends 10/26/09; hearing set 10/30/09	7/24/09	9/11/09	10/30/09				
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations pending Spring 2010							

* - 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 Oct 13, 2009
For questions, call (916) 263-2368

LEGISLATIVE PACKET

MEDICAL BOARD MEETING

October 30, 2009
San Diego, CA

Medical Board of California
Tracker - Legislative Bill File
10/21/2009

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 120	Hayashi	Peer Review: 809 sections	Vetoed	Watch	7/8/2009
AB 175	Galgiani	Telemedicine: Optometrists	Chapter #419	Support	6/24/2009
AB 245	Ma	Disclosure Verification	Vetoed	Neutral	8/25/2009
AB 252	Carter	Cosmetic surgery: employment of physicians	Vetoed	Support	
AB 356	Fletcher	Radiological Technology: physician assistants	Chapter #434	Support	8/25/2009
AB 501	Emmerson	Licensing: Limited, Use of M.D., Fee/Fund	Chapter #400	Sponsor/Support	7/13/2009
AB 526	Fuentes	Public Protection and Physician Health Program Act of 2009	Sen. Approps.	Oppose	8/19/2009
AB 583	Hayashi	Disclosure of Education and Office Hours	Sen. Inactive	Support (if amended*)	7/8/2009
AB 646	Swanson	Physician employment: district hospital pilot project	Sen. Health	Support in Concept	5/5/2009
AB 648	Chesbro	Rural Hospitals: physician employment	Sen. B&P	Support in Concept	5/28/2009
AB 933	Fong	Workers' Compensation: utilization review	Sen. L. & I.R.	Support	
AB 1070	Hill	Enforcement Enhancements: reporting, public reprimand	Chapter #505	Sponsor/Support	8/24/2009
AB 1071	Emmerson	Sunset Extension	Chapter #270	Support MBC Provisions	9/2/2009
AB 1116	Carter	Cosmetic Surgery: physical examination prior to surgery	Chapter #509	Support	9/3/2009
AB 1310	Hernandez	Healing Arts: database	Sen. Approps.	Support (if amended*)	6/29/2009

* 2-year Bills * Vetoed Bills *Amendments Taken

Medical Board of California
Tracker - Legislative Bill File
10/21/2009

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
SB 132	Denham	Polysomnographic Technologists (urgent)	Enrolled	Support	8/31/2009
SB 294	Negrete McLeod	Healing Arts: Enforcement	Asm. B&P	Rec: None	9/4/2009
SB 389	Negrete McLeod	Fingerprinting	Asm. Pub. S.	Support	6/1/2009
SB 470	Corbett	Prescriptions: labeling	Chaptere #590	Support	4/30/2009
SB 674	Negrete McLeod	Outpatient settings/Advertising	Vetoed	Support	8/17/2009
SB 726	Ashburn	Hospitals: employment of physician; pilot project revision	Asm. Inact.	Support	8/20/2009
SB 819	B&P Comm.	Omnibus: provisions from 2008	Chapter #308	Support MBC provisions	9/12/2009
SB 820	Negrete McLeod and Aanestad	Peer Review	Vetoed	Support	9/4/2009
SB 821	B&P Comm.	Omnibus: MBC provisions	Chapter #307	Support MBC provisions	8/17/2009

* 2-year Bills * Vetoed Bills * Enrolled * Amendments Taken

AB 120

BILL NUMBER: AB 120
VETOED DATE: 10/11/2009

To the Members of the California State Assembly:

I am returning Assembly Bill 120 without my signature.

This bill is contingent upon the enactment of Senate Bill 820. I have vetoed that bill, and am therefore unable to sign this measure.

I have encouraged the authors and interested stakeholders to work with my Department of Consumer Affairs on streamlining and improving the peer review process in a way that increases the overall effectiveness and reporting mechanisms to the Medical Board of California.

Sincerely,

Arnold Schwarzenegger

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 120
Author: Hayashi
Chapter: VETOED (see attached veto message)
Subject: Peer Review: 809 sections
Sponsor: California Medical Association
Board Position: Watch

DESCRIPTION OF LEGISLATION:

This bill declares the importance of external per review in California. This bill addresses only Business and Professions Code section 809. The bill does not include the areas of peer review that are directly related to the Medical Board (Board).

This bill was amended to specify that it will only be operative if SB 820 is signed. SB 820 is the vehicle carrying the peer review provisions from other 800 sections that pertain to the Board. Some of the provisions are those that were previously in SB 700.

IMPLEMENTATION:

None

October 13, 2009

CHAPTER _____

An act to amend Sections 809, 809.2, and 809.3 of, and to add Sections 809.04, 809.07, and 809.08 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 120, Hayashi. Healing arts: peer review.

Existing law provides for the professional review of specified healing arts licentiates through a peer review process conducted by peer review bodies, as defined.

This bill would encourage a peer review body to obtain external peer review, as defined, for the evaluation or investigation of an applicant, privilegeholder, or member of the medical staff in specified circumstances.

This bill would require a peer review body to respond to the request of another peer review body and produce the records reasonably requested concerning a licentiate under review, as specified. The bill would specify that the records produced pursuant to this provision are not subject to discovery, as specified, and may only be used for peer review purposes.

Existing law requires the governing body of acute care hospitals to give great weight to the actions of peer review bodies and authorizes the governing body to direct the peer review body to investigate in specified instances. Where the peer review body fails to take action in response to that direction, existing law authorizes the governing body to take action against a licentiate.

This bill would prohibit a member of a medical or professional staff from being required to alter or surrender staff privileges, status, or membership solely due to the termination of a contract between that member and a health care facility, except as specified. The bill would specify that a peer review body is entitled to review and make timely recommendations to the governing body of a health care facility, and its designee, if applicable, regarding quality considerations relating to clinical services when the selection, performance evaluation, or any change in the retention or replacement of licensees with whom the facility has a contract

occurs. The bill would require the governing body to give great weight to those recommendations.

Existing law provides various due process rights for licentiates who are the subject of a final proposed disciplinary action of a peer review body, including authorizing a licensee to request a hearing concerning that action. Under existing law, the hearing must be held before either an arbitrator selected by a process mutually acceptable to the licensee and the peer review body or a panel of unbiased individuals, as specified. Existing law prohibits a hearing officer presiding at a hearing held before a panel from, among other things, gaining direct financial benefit from the outcome.

This bill would additionally require the hearing officer to be an attorney licensed in California, except as specified, and to disclose all actual and potential conflicts of interest, as specified. The bill would specify that the hearing officer is entitled to determine the procedure for presenting evidence and argument and would give the hearing officer authority to make all rulings pertaining to law, procedure, or the admissibility of evidence. The bill would authorize the hearing officer to recommend termination of the hearing in certain circumstances.

Existing law gives parties at the hearing certain rights, including the right to present and rebut evidence. Existing law requires the peer review body to adopt written provisions governing whether a licensee may be represented by an attorney and prohibits a peer review body from being represented by an attorney where a licensee is not so represented, except as specified.

This bill would give both parties the right to be represented by an attorney but would prohibit a peer review body from being represented if the licensee notifies the peer review body within a specified period of time that he or she has elected to not be represented, except as specified.

The bill would also provide that it shall become operative only if SB 820 is also enacted and becomes operative.

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

SECTION 1. Section 809 of the Business and Professions Code is amended to read:

809. (a) The Legislature hereby finds and declares the following:

(1) In 1986, Congress enacted the Health Care Quality Improvement Act of 1986 (Chapter 117 (commencing with Section 11101) of Title 42 of the United States Code), to encourage physicians to engage in effective professional peer review, but giving each state the opportunity to "opt-out" of some of the provisions of the federal act.

(2) Because of deficiencies in the federal act and the possible adverse interpretations by the courts of the federal act, it is preferable for California to "opt-out" of the federal act and design its own peer review system.

(3) Peer review, fairly conducted, is essential to preserving the highest standards of medical practice.

(4) It is essential that California's peer review system generate a culture of trust and safety so that health care practitioners will participate robustly in the process by engaging in critically important patient safety activities, such as reporting incidents they believe to reflect substandard care or unprofessional conduct and serving on peer review, quality assurance, and other committees necessary to protect patients.

(5) Peer review that is not conducted fairly results in harm both to patients and healing arts practitioners by wrongfully depriving patients of their ability to obtain care from their chosen practitioner and by depriving practitioners of their ability to care for their patients, thereby limiting much needed access to care.

(6) Peer review, fairly conducted, will aid the appropriate state licensing boards in their responsibility to regulate and discipline errant healing arts practitioners.

(7) To protect the health and welfare of the people of California, it is the policy of the State of California to exclude, through the peer review mechanism as provided for by California law, those healing arts practitioners who provide substandard care or who engage in professional misconduct, regardless of the effect of that exclusion on competition.

(8) It is the intent of the Legislature that peer review of professional health care services be done efficiently, on an ongoing basis, and with an emphasis on early detection of potential quality problems and resolutions through informal educational interventions. It is further the intent of the Legislature that peer

review bodies be actively involved in the measurement, assessment, and improvement of quality and that there be appropriate oversight by the peer review bodies to ensure the timely resolution of issues.

(9) Sections 809 to 809.8, inclusive, shall not affect the respective responsibilities of the organized medical staff or the governing body of an acute care hospital with respect to peer review in the acute care hospital setting. It is the intent of the Legislature that written provisions implementing Sections 809 to 809.8, inclusive, in the acute care hospital setting shall be included in medical staff bylaws that shall be adopted by a vote of the members of the organized medical staff and shall be subject to governing body approval, which approval shall not be withheld unreasonably.

(10) (A) The Legislature thus finds and declares that the laws of this state pertaining to the peer review of healing arts practitioners shall apply in addition to Chapter 117 (commencing with Section 11101) of Title 42 of the United States Code, because the laws of this state provide a more careful articulation of the protections for both those undertaking peer review activity and those subject to review, and better integrate public and private systems of peer review. Therefore, California exercises its right to opt out of specified provisions of the Health Care Quality Improvement Act relating to professional review actions, pursuant to Section 11111(c)(2)(B) of Title 42 of the United States Code. This election shall not affect the availability of any immunity under California law.

(B) The Legislature further declares that it is not the intent or purposes of Sections 809 to 809.8, inclusive, to opt out of any mandatory national databank established pursuant to Subchapter II (commencing with Section 11131) of Chapter 117 of Title 42 of the United States Code.

(b) For the purpose of this section and Sections 809.1 to 809.8, inclusive, "healing arts practitioner" or "licentiate" means a physician and surgeon, podiatrist, clinical psychologist, marriage and family therapist, clinical social worker, or dentist; and "peer review body" means a peer review body as specified in paragraph (1) of subdivision (a) of Section 805, and includes any designee of the peer review body.

SEC. 2. Section 809.04 is added to the Business and Professions Code, to read:

809.04. (a) It is the public policy of the state that licentiates who may be providing substandard care be subject to the peer review hearing and reporting process set forth in this article.

(b) To ensure that the peer review process is not circumvented, a member of a medical or professional staff, by contract or otherwise, shall not be required to alter or surrender staff privileges, status, or membership solely due to the termination of a contract between that member and a health care facility. However, with respect to services that may only be provided by members who have, or who are members of a medical group that has, a current exclusive contract for those identified services, termination of the contract, or termination of the member's employment by the medical group holding the contract, may result in the member's ineligibility to provide the services covered by the contract.

(c) The peer review body of a health care facility shall be entitled to review and make timely recommendations to the governing body of the facility and its designee, if applicable, regarding quality considerations relating to clinical services whenever the selection, performance evaluation, or any change in the retention or replacement of licentiates with whom the health care facility has a contract occurs. The governing body shall give great weight to those recommendations.

(d) This section shall not impair a governing body's ability to take action against a licentiate pursuant to Section 809.05.

SEC. 3. Section 809.07 is added to the Business and Professions Code, to read:

809.07. (a) It is the policy of the state that in certain limited circumstances, external peer review may be necessary to promote and protect patient care in order to eliminate perceived bias, obtain needed medical expertise, or respond to other particular circumstances.

(b) A peer review body is encouraged to obtain external peer review for the evaluation or investigation of an applicant, privilegeholder, or member of the medical staff in the following circumstances:

(1) Committee or department reviews that could affect a licentiate's membership or privileges do not provide a sufficiently clear basis for action or inaction.

(2) No current medical staff member can provide the necessary expertise in the clinical procedure or area under review.

(3) To promote impartial peer review.

(c) For purposes of this section, the following definitions apply:

(1) "Peer review body" has the meaning provided in paragraph (1) of subdivision (a) of Section 805.

(2) "External peer review" means peer review provided by licentiates who do not practice in the same health care facility as the licentiate under review, who are impartial, and who have the necessary expertise in the clinical procedure or area under review.

SEC. 4. Section 809.08 is added to the Business and Professions Code, to read:

809.08. (a) The Legislature hereby finds and declares that the sharing of information between peer review bodies is essential to protect the public health.

(b) Upon receipt of reasonable copying and processing costs, a peer review body shall respond to the request of another peer review body and produce the records reasonably requested concerning a licentiate under review to the extent not otherwise prohibited by state or federal law. The responding peer review body shall have the discretion to decide whether to produce minutes from peer review body meetings. The records produced by a peer review body pursuant to this section shall be used solely for peer review purposes and shall not be subject to discovery to the extent provided in Sections 1156.1 and 1157 of the Evidence Code and any other applicable provisions of law. The peer review body responding to the request shall be entitled to all confidentiality protections and privileges provided by law as to the information and records disclosed pursuant to this section. The licentiate under review by the peer review body requesting records pursuant to this section shall, upon request, release the responding peer review body, its members, and the health care entity for which the responding peer review body conducts peer review, from liability for the disclosure of records, and the contents thereof, in compliance with this section. If the licentiate does not provide a reasonable release that is acceptable to the responding peer review body, the responding peer review body shall not be obligated to produce records pursuant to this section.

SEC. 5. Section 809.2 of the Business and Professions Code is amended to read:

809.2. 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:

(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, factfinder, or initial decisionmaker in the same matter, and which shall include, where feasible, an individual practicing the same specialty as the licentiate.

(b) (1) 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 disclose all actual and potential conflicts of interest within the last five years reasonably known to the hearing officer, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

(2) The hearing officer shall be an attorney licensed to practice law in the State of California. This paragraph shall not apply to a hearing held before a panel of a dental professional society peer review body.

(3) Except as otherwise agreed by the parties, an attorney from a firm utilized by the hospital, the medical staff, or the involved licentiate within the preceding two years shall not be eligible to serve as a hearing officer.

(4) The hearing officer shall endeavor to ensure that all parties maintain proper decorum and have a reasonable opportunity to be heard and present all relevant oral and documentary evidence. The hearing officer shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions pertaining to matters of law, procedure, or the admissibility of evidence. The hearing officer shall also take all appropriate steps to ensure a timely resolution of the hearing, but may not terminate the hearing process. However, in the case of flagrant noncompliance with the procedural rules governing the hearing process or egregious interference with the orderly conduct of the hearing, the hearing officer may recommend that the hearing

panel terminate the hearing, provided that this activity is authorized by the applicable bylaws of the peer review body.

(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.

SEC. 6. Section 809.3 of the Business and Professions Code is amended to read:

809.3. (a) During a hearing concerning a final proposed action for which reporting is required to be filed under Section 805, both parties shall have all of the following rights:

(1) To be provided with all of the information made available to the trier of fact.

(2) To have a record made of the proceedings, copies of which may be obtained by the licentiate upon payment of any reasonable charges associated with the preparation thereof.

(3) To call, examine, and cross-examine witnesses.

(4) To present and rebut evidence determined by the arbitrator or presiding officer to be relevant.

(5) To submit a written statement at the close of the hearing.

(6) To be represented by an attorney of the party's choice at the party's expense, subject to subdivision (c).

(b) The burden of presenting evidence and proof during the hearing shall be as follows:

(1) The peer review body shall have the initial duty to present evidence which supports the charge or recommended action.

(2) Initial applicants shall bear the burden of persuading the trier of fact by a preponderance of the evidence of their qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications for staff privileges, membership, or employment. Initial applicants shall not be permitted to introduce information not produced upon request of the peer review body

during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(3) Except as provided above for initial applicants, the peer review body shall bear the burden of persuading the trier of fact by a preponderance of the evidence that the action or recommendation is reasonable and warranted.

(c) (1) Except as provided in paragraph (3), a peer review body shall not be represented by an attorney if the licentiate notifies the peer review body in writing no later than 15 days prior to the hearing that he or she has elected to not be represented by an attorney. Except as otherwise agreed by the parties, this election shall be binding.

(2) If the licentiate does not provide the written notice described in paragraph (1) within the required timeframe, the peer review body may be represented by an attorney even if the licentiate later elects to not be represented by an attorney.

(3) Dental professional society peer review bodies may be represented by an attorney, even if the licentiate declines to be represented by an attorney.

SEC. 7. This act shall become operative only if Senate Bill 820 of the 2009–10 Regular Session is also enacted and becomes operative.

AB 175

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 175
Author: Galgiani
Chapter: #419
Subject: Telemedicine: optometrists
Sponsor: Author
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill further defines "telephthalmology and teledermatology by store and forward."

IMPLEMENTATION:

- Newsletter Article
- Notify Board Staff

October 13, 2009

Assembly Bill No. 175

CHAPTER 419

An act to amend Section 14132.725 of the Welfare and Institutions Code, relating to telemedicine.

[Approved by Governor October 11, 2009. Filed with Secretary of State October 11, 2009.]

LEGISLATIVE COUNSEL'S DIGEST

AB 175, Galgiani. Medical telemedicine: optometrists.

Existing law, the Medical Practice Act, regulates the practice of telemedicine, defined as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

Existing law, until January 1, 2013, authorizes "teleophthalmology and teledermatology by store and forward" under the Medi-Cal program, to the extent that federal financial participation is available. Existing law defines "teleophthalmology and teledermatology by store and forward" as an asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology, where the physician at the distant site reviews the medical information without the patient being present in real time.

This bill would expand the definition of "teleophthalmology and teledermatology by store and forward" to include an asynchronous transmission of medical information to be reviewed at a later time, for teleophthalmology, by a licensed optometrist.

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

SECTION 1. Section 14132.725 of the Welfare and Institutions Code is amended to read:

14132.725. (a) Commencing July 1, 2006, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for teleophthalmology and teledermatology by store and forward. Services appropriately provided through the store and forward process are subject to billing and reimbursement policies developed by the department.

(b) For purposes of this section, "teleophthalmology and teledermatology by store and forward" means an asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology or, for teleophthalmology, by an optometrist who is licensed pursuant to Chapter 7 (commencing with

Section 3000) of Division 2 of the Business and Professions Code, where the physician or optometrist at the distant site reviews the medical information without the patient being present in real time. A patient receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician or optometrist, and shall receive an interactive communication with the distant specialist physician or optometrist, upon request. If requested, communication with the distant specialist physician or optometrist may occur either at the time of the consultation, or within 30 days of the patient's notification of the results of the consultation. If the reviewing optometrist identifies a disease or condition requiring consultation or referral pursuant to Section 3041 of the Business and Professions Code, that consultation or referral shall be with an ophthalmologist or other appropriate physician and surgeon, as required.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all county letters, provider bulletins, and similar instructions.

(d) On or before January 1, 2008, the department shall report to the Legislature the number and type of services provided, and the payments made related to the application of store and forward telemedicine as provided, under this section as a Medi-Cal benefit.

(e) The health care provider shall comply with the informed consent provisions of subdivisions (c) to (g), inclusive, of, and subdivisions (i) and (j) of, Section 2290.5 of the Business and Professions Code when a patient receives teleophthalmology or teledermatology by store and forward.

(f) 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.

O

AB 245

BILL NUMBER: AB 245
VETOED DATE: 10/11/2009

To the Members of the California State Assembly:

I am returning Assembly Bill 245 without my signature.

This bill reduces transparency for consumers. An expunged misdemeanor or felony conviction does not mean a healthcare provider has been found innocent of the crime or that the provider has been successfully rehabilitated. Consumers deserve to know whether their provider has been convicted of a misdemeanor or felony and should be allowed to review the physician's criminal history in its entirety.

The law must always place consumer protection above the protection of a provider's economic interest. I continue to put consumers first.

Sincerely,

Arnold Schwarzenegger

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 245
Author: Ma
Chapter: VETOED (see attached veto message)
Subject: Disclosure Verification
Sponsor: Union of American Physicians and Dentists
Board Position: Neutral

DESCRIPTION OF LEGISLATION:

This bill would require the Medical Board (Board) to verify the accuracy of the information posted on its Website regarding enforcement actions or other items required to be posted. This bill would require the Board to remove any expunged convictions within 30 days.

This bill was amended to remove all requirements for verification of information by the Board. This bill was amended to change the number of days the Board has to remove any expunged convictions from the Web site from 30 days to 90 days.

IMPLEMENTATION:

None

October 13, 2009

CHAPTER _____

An act to add Section 2027.1 to the Business and Professions Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 245, Ma. Physicians and surgeons.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law requires the board to post certain information on the Internet regarding licensed physicians and surgeons, including, but not limited to, felony convictions, certain misdemeanor convictions, and whether or not the licensees are in good standing. Existing law requires that certain information remain posted for 10 years and prohibits the removal of certain other information.

This bill would require the board to remove expunged misdemeanor or felony convictions posted pursuant to those provisions within 90 days of receiving a copy of the expungement order from the licensee.

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

SECTION 1. Section 2027.1 is added to the Business and Professions Code, to read:

2027.1. Notwithstanding subdivision (b) of Section 2027, the board shall remove an expunged misdemeanor or felony conviction posted pursuant to Section 2027 within 90 days of receiving a copy of the expungement order from the licensee.

AB 252

BILL NUMBER: AB 252
VETOED DATE: 08/05/2009

To the Members of the California State Assembly:

I am returning Assembly Bill 252 without my signature.

This bill is duplicative of existing law and unnecessary. The Medical Board of California already has significant legal authority to take action against physicians that violate the Medical Practice Act.

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

Sincerely,

Arnold Schwarzenegger

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 252
Author: Carter
Chapter: VETOED (see attached veto message)
Subject: Cosmetic surgery: employment of physicians
Sponsor: American Society for Dermatological Surgery
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill:

1) Declares it illegal for physicians to be employed by a corporation or artificial entity to practice cosmetic procedures, as prohibited by Business and Professions (B&P) Code section 2400 (restating current law).

2) Adds 2417.5 to the B&P Code, which:
   - Codifies that it is grounds for license revocation for physicians who knowingly violate the corporate practice prohibitions by working for or contracting with a business providing cosmetic medical treatments or procedures.
   - Establishes the legal presumption that physicians "knowingly" are violating the corporate practice prohibitions by contracting to serve as a medical director or otherwise become employed by an organization that they do not own related to cosmetic medical procedures or treatments.
   - Makes it a felony for an entity to provide cosmetic medical treatments or hire or contract with physicians for the providing of treatments, establishing that such a practice violates Penal Code section 550.

IMPLEMENTATION:

None

September 28, 2009

CHAPTER _____

An act to add Section 2417.5 to the Business and Professions Code, relating to the practice of medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 252, Carter. Practice of medicine: cosmetic surgery: employment of physicians and surgeons.

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

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

This bill would authorize the revocation of the license of a physician and surgeon who practices medicine with, or serves or is employed as the medical director of, a business organization that provides outpatient elective cosmetic medical procedures or treatments, as defined, knowing that the organization is owned or operated in violation of the prohibition against employment of licensed physicians and surgeons and podiatrists. The bill would also make a business organization that provides outpatient elective cosmetic medical procedures or treatments, that is owned and operated in violation of the prohibition, and that contracts with or employs a physician and surgeon to facilitate the offer or provision of those procedures or treatments that may only be provided by a licensed physician and surgeon, guilty of a violation of the prohibition against knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit. Because the bill would expand a public offense, it would impose a state-mandated local program.

This bill would state that its provisions are declaratory of existing law.

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. The Legislature finds and declares that the Medical Practice Act restricts the employment of physicians and surgeons by a corporation or other artificial legal entity, as described in Article 18 (commencing with Section 2400) of Chapter 5 of Division 2 of the Business and Professions Code, and that the prohibited conduct described in subdivisions (a) and (b) of Section 2417.5 of the Business and Professions Code, as added by this act, is declaratory of existing law.

SEC. 2. Section 2417.5 is added to the Business and Professions Code, to read:

2417.5. (a) In addition to any other remedies for a violation of Section 2400 involving any other types of medical procedures, a physician and surgeon who practices medicine with a business organization that offers to provide, or provides, outpatient elective cosmetic medical procedures or treatments, knowing that the organization is owned or operated in violation of Section 2400, may have his or her license to practice revoked. A physician and surgeon who contracts to serve as, or otherwise allows himself or herself to be employed as, the medical director of a business organization that he or she does not own and that offers to provide or provides outpatient elective cosmetic medical procedures or treatments that may only be provided by the holder of a valid physician's and surgeon's certificate under this chapter shall be deemed to have knowledge that the business organization is in violation of Section 2400.

(b) A business organization that offers to provide, or provides, outpatient elective cosmetic medical procedures or treatments, that is owned or operated in violation of Section 2400, and that contracts with, or otherwise employs, a physician and surgeon to facilitate its offers to provide, or the provision of, outpatient elective cosmetic medical procedures or treatments that may only

be provided by the holder of a valid physician's and surgeon's certificate is guilty of violating paragraph (6) of subdivision (a) of Section 550 of the Penal Code.

(c) For purposes of this section, "outpatient elective cosmetic medical procedures or treatments" means a medical procedure or treatment that is performed to alter or reshape normal structures of the body solely in order to improve appearance.

SEC. 3. 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.

AB 356

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 356
Author: Fletcher
Chapter: #434
Subject: Radiological Technology: physician assistants
Sponsor: California Association of Physician Assistants (CAPA)
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill would allow physician assistants to take the appropriate licensing exams for fluoroscopy licentiate permits issued by the Radiologic Health Branch of the California Department of Public Health (DPH).

IMPLEMENTATION:

- Newsletter Article
- Notify Board Staff
- Staff to assist the Physician Assistant Committee with any issues.

October 13, 2009

Assembly Bill No. 356

CHAPTER 434

An act to amend Sections 107110, 114850, and 114980 of, and to add Section 114872 to, the Health and Safety Code, relating to radiologic technology.

[Approved by Governor October 11, 2009. Filed with Secretary of State October 11, 2009.]

LEGISLATIVE COUNSEL'S DIGEST

AB 356, Fletcher. Radiologic technology: fluoroscopy.

Existing law sets forth the duties of various agencies relating to the protection of the public health and safety from the harmful effects of radiation, including, among others, the duties of the State Department of Public Health regarding the licensing and regulation of radiologic technology.

Existing law prohibits the administration or use of diagnostic, mammographic, or therapeutic X-ray on human beings in this state by a licentiate of the healing arts unless that person is certified and acting within the scope of that certification. Existing law requires the department to provide for the certification of licentiates of the healing arts to supervise the operation of X-ray machines or to operate X-ray machines, or both, to prescribe minimum standards of training and experience for these licentiates of the healing arts, and to prescribe procedures for examining applicants for certification. Under existing law, licentiate of the healing arts is defined to include any person licensed under the Medical Practice Act, the Osteopathic Act, or a specified initiative act that created the State Board of Chiropractic Examiners, as provided.

Existing law, the Physician Assistant Practice Act, separately establishes the Physician Assistant Committee of the Medical Board of California, and provides for the licensure of physician assistants meeting specified criteria and for the regulation of their practice. Under that act, a physician assistant is authorized to perform certain medical services under the supervision of a physician and surgeon, subject to certain exceptions.

This bill would revise the definition of licentiate of the healing arts, for purposes of a fluoroscopy permit, to also include a physician assistant who is licensed pursuant to the Physician Assistant Practice Act and who practices under the supervision of a qualified physician and surgeon, as provided.

This bill would require the department to issue a licentiate fluoroscopy permit to a qualified licentiate of the healing arts, as defined, and would allow the holder of a licentiate fluoroscopy permit to administer and use diagnostic, mammographic, or therapeutic X-ray on human beings, within the scope of fluoroscopy permit certification. The bill would require a

physician assistant who is issued a licentiate fluoroscopy permit to meet specified continuing education requirements. The bill would also require the supervising physician and surgeon to have, or be exempt from having, a licentiate fluoroscopy permit to perform the functions that he or she is supervising, as provided.

This bill would also allow a physician and surgeon to delegate to a licensed physician assistant specified procedures using fluoroscopy. The bill would specify training requirements that must be met in order for a physician assistant to be delegated this task.

Existing law establishes the Radiation Control Fund for the collection of specified moneys, including fees for use, upon appropriation of the Legislature, to cover the costs of enforcing specified provisions of law relating to radiologic technology.

This bill would allow the department to charge applicants for a licentiate fluoroscopy permit a fee in an amount sufficient to cover the costs of the licensing program, to be deposited in the Radiation Control Fund and used, upon appropriation of the Legislature, to fund implementation of the permit program.

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

SECTION 1. Section 107110 of the Health and Safety Code is amended to read:

107110. It shall be unlawful for any licentiate of the healing arts to administer or use diagnostic, mammographic, or therapeutic X-ray on human beings in this state after January 1, 1972, unless that person is certified pursuant to subdivision (e) of Section 114870, Section 114872, or Section 114885, and is acting within the scope of that certification.

SEC. 2. Section 114850 of the Health and Safety Code is amended to read:

114850. As used in this chapter:

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

(b) "Committee" means the Radiologic Technology Certification Committee.

(c) "Radiologic technology" means the application of X-rays on human beings for diagnostic or therapeutic purposes.

(d) "Radiologic technologist" means any person, other than a licentiate of the healing arts, making application of X-rays to human beings for diagnostic or therapeutic purposes pursuant to subdivision (b) of Section 114870.

(e) "Limited permit" means a permit issued pursuant to subdivision (c) of Section 114870 to persons to conduct radiologic technology limited to the performance of certain procedures or the application of X-rays to specific areas of the human body, except for a mammogram.

(f) "Approved school for radiologic technologists" means a school that the department has determined provides a course of instruction in radiologic technology that is adequate to meet the purposes of this chapter.

(g) "Supervision" means responsibility for, and control of, quality, radiation safety, and technical aspects of all X-ray examinations and procedures.

(h) (1) "Licentiate of the healing arts" means a person licensed under the provisions of the Medical Practice Act, the provisions of the initiative act entitled "An act prescribing the terms upon which licenses may be issued to practitioners of chiropractic, creating the State Board of Chiropractic Examiners and declaring its powers and duties, prescribing penalties for violation thereof, and repealing all acts and parts of acts inconsistent herewith," approved by electors November 7, 1922, as amended, or the Osteopathic Act."

(2) For purposes of Section 114872, a licentiate of the healing arts means a person licensed under the Physician Assistant Practice Act (Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code) who practices under the supervision of a qualified physician and surgeon pursuant to the act and pursuant to Division 13.8 of Title 16 of the California Code of Regulations.

(i) "Certified supervisor or operator" means a licentiate of the healing arts who has been certified under subdivision (e) of Section 114870 or 107111 to supervise the operation of X-ray machines or to operate X-ray machines, or both.

(j) "Student of radiologic technology" means a person who has started and is in good standing in a course of instruction that, if completed, would permit the person to be certified a radiologic technologist or granted a limited permit upon satisfactory completion of any examination required by the department. "Student of radiologic technology" does not include any person who is a student in a school of medicine, chiropractic, podiatry, dentistry, dental radiography, or dental hygiene.

(k) "Mammogram" means an X-ray image of the human breast.

(*l*) "Mammography" means the procedure for creating a mammogram.

SEC. 3. Section 114872 is added to the Health and Safety Code, to read:

114872. (a) The department shall issue a licentiate fluoroscopy permit to a qualified licentiate of the healing arts, as defined in paragraph (2) of subdivision (h) of Section 114850. Notwithstanding any other provision of law, the department shall accept applications for a fluoroscopy permit from a licensed physician assistant who meets the requirements of this section.

(b) A physician and surgeon may delegate to a licensed physician assistant procedures using fluoroscopy. In order to supervise a physician assistant in performing the functions authorized by the Radiologic Technology Act (Section 27), a physician and surgeon shall either hold, or be exempt from holding, a licentiate fluoroscopy permit required to perform the functions being supervised.

(c) A physician assistant to whom a physician and surgeon has delegated the use of fluoroscopy shall demonstrate successful completion of 40 hours

of total coursework, including fluoroscopy radiation safety and protection, recognized by the department. Documentation of completed coursework shall be kept on file at the practice site and available to the department upon request.

(d) Nothing in this section shall be construed to remove the need for a physician assistant to pass a department-approved examination in fluoroscopy radiation safety and protection pursuant to Article 1 (commencing with Section 30460) of Group 5 of Subchapter 4.5 of Chapter 5 of Division 1 of Title 17 of the California Code of Regulations.

(e) A licensed physician assistant who is issued a fluoroscopy permit pursuant to the requirements of this section shall, in the two years preceding the expiration date of the permit, earn 10 approved continuing education credits. The department shall accept continuing education credits approved by the Physician Assistant Committee.

(f) Nothing in this section shall be construed to authorize a physician assistant to perform any other procedures utilizing ionizing radiation except those authorized by holding a licentiate fluoroscopy permit.

(g) Nothing in this section shall be construed to remove the need for a physician assistant to be subject to the permit requirements approved by the department pursuant to Subchapter 4.5 (commencing with Section 30400) of Chapter 5 of Division 1 of Title 17 of the California Code of Regulations.

(h) The department may charge applicants under this section a fee in an amount sufficient, but not greater than the amount required, to cover the department's costs of implementing this section. The fees collected pursuant to this subdivision shall be deposited into the Radiation Control Fund established pursuant to Section 114980.

SEC. 4. Section 114980 of the Health and Safety Code is amended to read:

114980. The Radiation Control Fund is hereby created as a special fund in the State Treasury. All moneys, including fees, penalties, interest earned, and fines, collected under Sections 107100, 107160, 114872, 115045, 115065, and 115080, Article 5.5 (commencing with Section 107115) of Chapter 4 of Part 1, and the regulations adopted pursuant to those sections, shall be deposited in the Radiation Control Fund to cover the costs related to the enforcement of this chapter, including, but not limited to, implementation of Section 114872, Section 115000, Article 6 (commencing with Section 107150) of Chapter 4 of Part 1, and the Radiologic Technology Act (Section 27), and Article 5.5 (commencing with Section 107115) of Chapter 4 of Part 1, and shall be available for expenditure by the department only upon appropriation by the Legislature. In addition to any moneys collected by, or on behalf of, the department for deposit in the Radiation Control Fund, all interest earned by the Radiation Control Fund shall be deposited in the Radiation Control Fund.

O

AB 501

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 501
Author: Emmerson
Chapter: #400
Subject: Licensing: Limited, Use of M.D., Fee/Fund
Sponsor: Medical Board of California
Board Position: Sponsor/Support

DESCRIPTION OF LEGISLATION:

This bill would allow a graduate of an approved medical school, who is enrolled in post graduate training in California, to use the initials M.D. only while that post graduate trainee is under the supervision of a licensed physician from that program. It will allow others who hold an unrestricted license to use these initials as long as they are not representing themselves as physicians who are allowed to practice in California.

This bill would allow the Medical Board (Board) to issue an initial limited license to an applicant for licensure who is otherwise eligible for a medical license in California but is unable to practice all aspects of medicine safely due to a disability.

This bill would establish a cap on the licensing fee imposed by the Medical Board. The cap would be fixed by the Board at a fee equal to or less than seven hundred ninety dollars ($790). This bill would increase the amount of reserve allowed in the Contingent Fund of the Board.

Amendments to this bill further clarify the use of the initials M.D. In addition to graduates of an approved medical school while enrolled in post graduate training in California, a graduate of an approved medical school who has not had their license revoked or suspended may use the initials M.D. as long as they do not represent themselves as a physician who is entitled to practice medicine, do not engage in any of the acts prohibited by Section 2060. All medical schools are in support of this provision.

This bill was amended July 13, 2009 to direct the Office of State Audits and Evaluations within the Department of Finance to perform a review of the Board's financial status instead of the Bureau of State Audits (BSA). The Office of State Audits and Evaluations must make the results of its review available by June 1, 2012. The funding for the review will come from the existing resources of the Office of State Audits and Evaluations within the Department of Finance.

IMPLEMENTATION:

- Newsletter Article
- Notify Board Staff
- Licensing staff to develop requirements, policies and procedures with legal staff, to be in effect by January 1, 2010, for the issuance of limited licenses.
- Notify MBC budget staff of changes to the fee cap in order to evaluate the need and timing for any changes in fees.
- Fund condition projections to be revised using the four-month reserve maximum for January 2010 and ongoing.
- Notify medical schools, hospitals, and training programs of changes to the use of the initials M.D. by January 1, 2010.
- Update Board's website as necessary.

Assembly Bill No. 501

CHAPTER 400

An act to amend Sections 2054 and 2435 of, and to add Section 2088 to, the Business and Professions Code, relating to medicine.

[Approved by Governor October 11, 2009. Filed with Secretary of State October 11, 2009.]

LEGISLATIVE COUNSEL'S DIGEST

AB 501, Emmerson. Physicians and surgeons.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law makes it a misdemeanor for a person who is not licensed as a physician and surgeon under the act to use certain words, letters, and phrases or any other terms that imply that he or she is authorized to practice medicine as a physician and surgeon.

This bill would authorize certain persons who are not licensed as physicians and surgeons under the act to use the words "doctor" or "physician," the letters or prefix "Dr.," or the initials "M.D.," as specified.

Existing law authorizes the board to issue a probationary license subject to specified terms and conditions, including restrictions against engaging in certain types of medical practice. Existing law authorizes a licensee who demonstrates that he or she is unable to practice medicine due to a disability to request a waiver of the license renewal fee. Under existing law, a licensee granted that waiver is prohibited from practicing medicine until he or she establishes that the disability no longer exists or signs an agreement, under penalty of perjury, agreeing to limit his or her practice in the manner prescribed by the reviewing physician. Existing law authorizes the board to commence disciplinary actions relating to physicians and surgeons including, but not limited to, unprofessional conduct, as defined, and to issue letters of reprimand, and suspend and revoke licenses.

This bill would authorize an applicant for a license who is otherwise eligible for a license but is unable to practice some aspects of medicine safely due to a disability to receive a limited license if the applicant pays the license fee and signs an agreement agreeing to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board. The bill would make any person who knowingly provides false information in this agreement subject to any sanctions available to the board. The bill would authorize the board to require the applicant to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving the limited license.

Under existing law, licensees of the board are required to pay licensure fees, including an initial licensing fee of $790 and a biennial renewal fee

of $790. Existing law authorizes the board to increase those fees in certain circumstances and states the intent of the Legislature that, in setting these fees, the board seek to maintain a reserve in the Contingent Fund of the Medical Board equal to 2 months' operating expenditures.

This bill would require those fees to be fixed by the board at a maximum of $790, while retaining the authority of the board to raise those fees in certain circumstances. The bill would state the intent of the Legislature that, in setting those fees, the board seek to maintain a reserve in the Contingent Fund of the Medical Board in an amount not less than 2 nor more than 4 months' operating expenditures. The bill would also require the Office of State Audits and Evaluations within the Department of Finance to commence a preliminary review of the board's financial status by January 1, 2012, and to make the results of that review available upon request by June 1, 2012, as specified.

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

SECTION 1. Section 2054 of the Business and Professions Code is amended to read:

2054. (a) Any person who uses in any sign, business card, or letterhead, or, in an advertisement, the words "doctor" or "physician," the letters or prefix "Dr.," the initials "M.D.," or any other terms or letters indicating or implying that he or she is a physician and surgeon, physician, surgeon, or practitioner under the terms of this or any other law, or that he or she is entitled to practice hereunder, or who represents or holds himself or herself out as a physician and surgeon, physician, surgeon, or practitioner under the terms of this or any other law, without having at the time of so doing a valid, unrevoked, and unsuspended certificate as a physician and surgeon under this chapter, is guilty of a misdemeanor.

(b) A holder of a valid, unrevoked, and unsuspended certificate to practice podiatric medicine may use the phrases "doctor of podiatric medicine," "doctor of podiatry," and "podiatric doctor," or the initials "D.P.M.," and shall not be in violation of subdivision (a).

(c) Notwithstanding subdivision (a), any of the following persons may use the words "doctor" or "physician," the letters or prefix "Dr.," or the initials "M.D.":

(1) A graduate of a medical school approved or recognized by the board while enrolled in a postgraduate training program approved by the board.

(2) A graduate of a medical school who does not have a certificate as a physician and surgeon under this chapter if he or she meets all of the following requirements:

(A) If issued a license to practice medicine in another jurisdiction, has not had that license revoked or suspended by any jurisdiction.

(B) Does not otherwise hold himself or herself out as a physician and surgeon entitled to practice medicine in this state except to the extent authorized by this chapter.

(C) Does not engage in any of the acts prohibited by Section 2060.

(3) A person authorized to practice medicine under Section 2111 or 2113 subject to the limitations set forth in those sections.

SEC. 2. Section 2088 is added to the Business and Professions Code, to read:

2088. (a) An applicant for a physician's and surgeon's license who is otherwise eligible for that license but is unable to practice some aspects of medicine safely due to a disability may receive a limited license if he or she does both of the following:

(1) Pays the initial license fee.

(2) Signs an agreement on a form prescribed by the board in which the applicant agrees to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board.

(b) The board may require the applicant described in subdivision (a) to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving a limited license under this section.

(c) Any person who knowingly provides false information in the agreement submitted pursuant to subdivision (a) shall be subject to any sanctions available to the board.

SEC. 3. Section 2435 of the Business and Professions Code is amended to read:

2435. The following fees apply to the licensure of physicians and surgeons:

(a) Each applicant for a certificate based upon a national board diplomate certificate, each applicant for a certificate based on reciprocity, and each applicant for a certificate based upon written examination, shall pay a nonrefundable application and processing fee, as set forth in subdivision (b), at the time the application is filed.

(b) The application and processing fee shall be fixed by the board by May 1 of each year, to become effective on July 1 of that year. The fee shall be fixed at an amount necessary to recover the actual costs of the licensing program as projected for the fiscal year commencing on the date the fees become effective.

(c) Each applicant who qualifies for a certificate, as a condition precedent to its issuance, in addition to other fees required herein, shall pay an initial license fee, if any, in an amount fixed by the board consistent with this section. The initial license fee shall not exceed seven hundred ninety dollars ($790). An applicant enrolled in an approved postgraduate training program shall be required to pay only 50 percent of the initial license fee.

(d) The biennial renewal fee shall be fixed by the board consistent with this section and shall not exceed seven hundred ninety dollars ($790).

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

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

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

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

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

(h) It is the intent of the Legislature that, in setting fees pursuant to this section, the board shall seek to maintain a reserve in the Contingent Fund of the Medical Board of California in an amount not less than two nor more than four months' operating expenditures.

(i) Not later than January 1, 2012, the Office of State Audits and Evaluations within the Department of Finance shall commence a preliminary review of the board's financial status, including, but not limited to, its projections related to expenses, revenues, and reserves, and the impact of the loan from the Contingent Fund of the Medical Board of California to the General Fund made pursuant to the Budget Act of 2008. The office shall make the results of this review available upon request by June 1, 2012. This review shall be funded from the existing resources of the office during the 2011–12 fiscal year.

O

AB 526

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 526
Author: Fuentes
Bill Date: August 19, 2009, amended
Subject: Public Protection and Physician Health Program Act of 2009
Sponsor: California Medical Association
Board Position: Oppose

STATUS OF BILL:

This bill was held in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Public Protection and Physician Health Committee (Committee) within the State and Consumer Services Agency (SCSA) with the intent of creating a program in California that will permit physicians to obtain treatment and monitoring of alcohol or substance abuse/dependency, or of mental disorder recovery so that physicians do not treat patients while impaired.

This bill was amended to require the Board to increase licensing fees by $22 for the purposes of funding the physician health program. This bill was amended to remove the SCSA from the oversight. The Committee would now it's own governing body with no accountability.

ANALYSIS:

This bill would establish the Public Protection and Physician Health Committee. The Committee would be under the SCSA. This bill would require that the committee must be appointed and hold its first meeting no later than March 1, 2010. The Committee would be required to prepare regulations that provide clear guidance and measurable outcomes to ensure patient safety and the health and wellness of physicians by June 30, 2010. These rules and regulations shall include:

- Minimum standards, criteria, and guidelines for the acceptance, denial, referral to treatment, and monitoring of physicians and surgeons in the physician health program;

- Standards for requiring that a physician and surgeon agree to cease practice to obtain appropriate treatment services;

- Criteria that must be met prior to a physician and surgeon returning to practice;

- Standards, requirements, and procedures for random testing for the use of banned substances and protocols to follow if that use has occurred;

- Worksite monitoring requirements and standards;

- The manner, protocols, and timeliness of reports required;

- Appropriate requirements for clinical diagnostic evaluations of program participants;

- Requirements for a physician and surgeon's termination from, and reinstatement to, the program;

- Requirements that govern the ability of the program to communicate with a participant's employer or organized medical staff about the participant's status and condition;

- Group meeting and other self-help requirements, standards, protocols, and qualifications;

The Committee would be required to recommend one or more non-profit physician health programs to the SCSA. The physician health programs would be required to report annually to the committee on the number of participants served, the number of compliant participants, the number of participants who have successfully completed their agreement period, and the number of participants reported to the board for suspected noncompliance. The physician health programs would also have to agree to submit to periodic audits and inspections of all operations, records, and management related to the physician health program to ensure compliance.

This bill would require the SCSA, in conjunction with the committee, to monitor compliance of the physician health programs, including making periodic inspections and onsite visits.

This bill would permit a physician to enter into a voluntary agreement with a physician health program that must include a jointly agreed upon treatment program and mandatory conditions and procedures to monitor compliance with the treatment program. The physicians' voluntary participation in a physician health program would be confidential unless waived by the physician.

This bill would prohibit any voluntary agreement from being considered a disciplinary action or order by the Board and would prohibit the agreement from being disclosed to the Board nor to the public. Each participant, prior to entering into a voluntary agreement, would be required to disclose to the Committee whether he or she is under investigation by the Board. If a participant fails to disclose such an investigation, upon enrollment or at any time while a participant, the participant shall be terminated from the program.

Physician health programs would be permitted to report to the committee the name of and results of any contact or information received regarding a physician who is suspected of being, or is, impaired and, as a result, whose competence or professional conduct is reasonably likely to be detrimental to patient safety or to the delivery of patient care. The programs would be required to report to the committee if the physician fails to cooperate with any of the requirements of the physician health program, fails to cease practice when required, fails to submit to evaluation, treatment, or biological fluid testing when required, or whose impairment is not substantially alleviated through treatment, or who, in the opinion of the physician health program, is unable to practice medicine with reasonable skill and safety, or who withdraws or is terminated from the physician health program prior to completion.

The participating physician in a voluntary agreement would be responsible for all expenses relating to chemical or biological fluid testing, treatment, and recovery as provided in the written agreement between the physician and the physician health program.

This bill would permit, not require, the Board to increase licensing fees to no less than $22 and not to exceed 2.5% of the license fee. This fee would be expended solely for the purposes of the physician health programs. If the board included this surcharge, it would be collected and transferred to a trust established by this bill. The Board would be required to separately identify, on the licensing fee statement, the amount being collected for the program. If the Board were to opt to increase the licensing fees to fund this program, the bill states that the Board would be allowed to include a statement indicating to licensees that the Public Protection and Physician Health Program is not a program of the Board and that, by collecting this fee, the Board does not necessarily support, endorse, or have any control of or affiliation with the program. The SCSA would be required to contract for a biennial audit to assess the effectiveness, efficiency, and overall performance of the program and make recommendations.

Amendments to this bill taken June 1, 2009 require the Board to increase licensing fees by not less than $22 or 2.5% of the license fee, whichever is greater, to be used solely for the purposes of the physician health programs.

Amendments taken on August 19, 2009 remove the SCSA from its oversight role, making the Committee an autonomous body with no accountability.

FISCAL: Generate revenue for program of approximately $1.5 million.

POSITION: Oppose

October 12, 2009

AMENDED IN SENATE AUGUST 19, 2009

AMENDED IN SENATE JULY 15, 2009

AMENDED IN ASSEMBLY JUNE 1, 2009

AMENDED IN ASSEMBLY APRIL 16, 2009

AMENDED IN ASSEMBLY APRIL 14, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 526

Introduced by Assembly Member Fuentes

February 25, 2009

An act to add and repeal Article 14 (commencing with Section 2340) of Chapter 5 of Division 2 of the Business and Professions Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 526, as amended, Fuentes. Public Protection and Physician Health Program Act of 2009.

Existing law establishes in the Department of Consumer Affairs the Substance Abuse Coordination Committee, comprised of the executive officers of the department's healing arts boards, as specified, and a designee of the State Department of Alcohol and Drug Programs. Existing law requires the committee to formulate, by January 1, 2010, uniform and specific standards in specified areas that each healing arts board shall use in dealing with substance-abusing licensees. The Medical Practice Act establishes in the Department of Consumer Affairs the Medical Board of California, which provides for the licensure and regulation of physicians and surgeons.

This bill would enact the Public Protection and Physician Health Program Act of 2009, which would, until January 1, 2021, establish ~~within the State and Consumer Services Agency~~ the Public Protection and Physician Health *Oversight* Committee, consisting of ~~14~~ members appointed by specified entities, would require the committee to be ~~appointed~~ *formed* and to hold its first meeting by March 1, 2010, and would require ~~agency adoption of related~~ *the committee to adopt* rules and regulations *necessary to implement these provisions* by June 30, 2010. The bill would ~~require the committee to recommend to the agency one or more physician health programs, and would~~ authorize the ~~agency~~ *committee* to contract, including on an interim basis, as specified, with any qualified physician health program for purposes of care and rehabilitation of physicians and surgeons, *including applicants enrolled in an approved postgraduate training program,* with alcohol or drug abuse or dependency problems or mental disorders, as specified. The bill would impose requirements on the physician health program relating to, among other things, monitoring the status and compliance of physicians and surgeons, *as defined,* who enter treatment for a qualifying illness, as defined, pursuant to written, voluntary agreements, and would require the ~~agency and~~ committee to monitor compliance with these requirements. The bill would provide that a voluntary agreement to receive treatment would not be subject to public disclosure or disclosure to the Medical Board of California, except as specified. The bill would require the board to increase physician and surgeon *and applicant* licensure and renewal fees for purposes of the act, and would establish the Public Protection and Physician Health Program Trust Fund for deposit of those funds, which would be subject to appropriation by the Legislature. The bill would also require specified performance audits.

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

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

1 SECTION 1. The Legislature hereby finds and declares that:
2 (a) California has long valued high quality medical care for its
3 citizens and, through its regulatory and enforcement system,
4 protects health care consumers through the proper licensing and
5 regulation of physicians and surgeons to promote access to quality
6 medical care. The protection of the public from harm by physicians

and surgeons who may be impaired by alcohol or substance abuse or dependence or by a mental disorder is paramount.

(b) Nevertheless, physicians and surgeons experience health-related problems at the same frequency as the general population, and many competent physicians and surgeons with illnesses may or may not immediately experience impairment in their ability to serve the public. It has been estimated that at least 10 percent of the population struggles with alcohol or substance abuse or dependence during their lifetime, which may, at some point, impact approximately 12,500 of the state's 125,000 licensed physicians and surgeons.

(c) It is in the best interests of the public and the medical profession to provide a pathway to recovery for any licensed physician and surgeon that is currently suffering from alcohol or substance abuse or dependence or a mental disorder. The American Medical Association has recognized that it is an expression of the highest meaning of professionalism for organized medicine to take an active role in helping physicians and surgeons to lead healthy lives in order to help their patients, and therefore, it is appropriate for physicians and surgeons to assist in funding such a program.

(d) While nearly every other state has a physician health program, since 2007 California has been without any state program that monitors physicians and surgeons who have independently obtained, or should be encouraged to obtain, treatment for alcohol or substance abuse or dependence or for a mental disorder, so that they do not treat patients while impaired.

(e) It is essential for the public interest and the public health, safety, and welfare to focus on early intervention, assessment, referral to treatment, and monitoring of physicians and surgeons with significant health impairments that may impact their ability to practice safely. Such a program need not, and should not necessarily, divert physicians and surgeons from the disciplinary system, but instead focus on providing assistance before any harm to a patient has occurred.

(f) Therefore, it is necessary to create a program in California that will permit physicians and surgeons to obtain referral to treatment and monitoring of alcohol or substance abuse or dependence or a mental disorder, so that they do not treat patients while impaired.

SEC. 2. Article 14 (commencing with Section 2340) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 14. Public Protection and Physician Health Program

2340. This article shall be known and may be cited as the Public Protection and Physician Health Program Act of 2009.

2341. For purposes of this article, the following terms have the following meanings:

~~(a) "Agency" means the State and Consumer Services Agency.~~

~~(b)~~

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

~~(c)~~

(b) "Committee" means the Public Protection and Physician Health *Oversight* Committee established pursuant to Section 2342.

~~(d)~~

(c) "Impaired" or "impairment" means the inability to practice medicine with reasonable skill and safety to patients by reason of alcohol abuse, substance abuse, alcohol dependency, any other substance dependency, or a mental disorder.

~~(e)~~

(d) "Participant" means a physician and surgeon enrolled in the program pursuant to an agreement entered into as provided in Section 2345.

~~(f)~~

(e) "Physician health program" or "program" means the program for the prevention, detection, intervention, monitoring, and referral to treatment of impaired physicians and surgeons, and includes vendors, providers, or entities contracted with by the ~~agency~~ *committee* pursuant to this article.

~~(g)~~

(f) "Physician and surgeon" means a holder of a physician's and surgeon's certificate. *For the purposes of this article only, "physician and surgeon" shall also include a graduate of a medical school approved or recognized by the board while enrolled in a postgraduate training program approved by the board.*

~~(h)~~

(g) "Qualifying illness" means "alcohol or substance abuse," "alcohol or chemical dependency," or a "mental disorder" as those

terms are used in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or subsequent editions.

~~(i) "Secretary" means the Secretary of State and Consumer Services.~~

~~(j)~~

(h) "Treatment program" or "treatment" means the delivery of care and rehabilitation services provided by an organization or persons authorized by law to provide those services.

2342. (a) (1) There is hereby established ~~within the State and Consumer Services Agency~~ the Public Protection and Physician Health ~~Committee~~ *Oversight Committee, which shall have the responsibilities and duties set forth in this article. The committee may take any reasonable actions to carry out the responsibilities and duties set forth in this article, including, but not limited to, hiring staff and entering into contracts*. The committee shall be ~~appointed~~ *formed* and hold its first meeting no later than March 1, 2010. The committee shall be comprised of ~~14 members who shall be appointed as follows~~ *the following members*:

~~(A) Eight members appointed by the secretary, including the following:~~

~~(i)~~

(A) Two members ~~who are~~ *selected by the California Psychiatric Association, unless that entity chooses not to exercise this right of selection. These members shall be* licensed mental health professionals with knowledge and expertise in the identification and treatment of substance abuse and mental disorders. *With respect to the initial members selected pursuant to this subparagraph, one member shall serve a term of two years and one member shall serve a term of three years.*

~~(ii) Six members who are physicians and surgeons with knowledge and expertise in the identification and treatment of alcohol dependence and substance abuse. One member shall be a designated representative from a panel recommended by a nonprofit professional association representing physicians and surgeons licensed in this state with at least 25,000 members in all modes of practice and specialties. The secretary shall fill one each of the remaining appointments from among those individuals as may be recommended by the California Society of Addiction Medicine, the California Psychiatric Association, and the California Hospital Association.~~

(B) (i) Three members selected by a nonprofit professional association representing physicians and surgeons licensed in this state with at least 25,000 members in all modes of practice and specialities, unless that entity chooses not to exercise this right of selection. With respect to the initial members selected pursuant to this clause, one member shall serve a term of two years, one member shall serve a term of three years, and one member shall serve a term of four years.

(ii) Two members selected by the California Society of Addiction Medicine, unless that entity chooses not to exercise this right of selection. With respect to the initial members selected pursuant to this clause, one member shall serve a term of two years and one member shall serve a term of three years.

(iii) One member selected by the California Hospital Association, unless that entity chooses not to exercise this right of selection. The initial member selected shall serve a term of three years.

(iv) The members selected pursuant to this subparagraph shall be physicians and surgeons with knowledge and expertise in the identification and treatment of alcohol dependence and substance abuse.

~~(B)~~

(C) Four members of the public appointed by the Governor, at least one of whom shall have experience in advocating on behalf of consumers of medical care in this state. *With respect to the initial appointees, the Governor shall appoint two members for a two-year term, and two members for a four-year term.*

~~(C)~~

(D) One member of the public appointed by the Speaker of the Assembly. *The initial appointee under this subparagraph shall serve a term of three years.*

~~(D)~~

(E) One member of the public appointed by the Senate Committee on Rules. *The initial appointee under this subparagraph shall serve a term of three years.*

(2) (A) For the purpose of this subdivision, a public member may not be any of the following:

(i) A current or former physician and surgeon or an immediate family member of a physician and surgeon.

(ii) Currently or formerly employed by a physician and surgeon or business providing or arranging for physician and surgeon services, or have any financial interest in the business of a licensee.

(iii) An employee or agent or representative of any organization representing physicians and surgeons.

(B) Each public member shall meet all of the requirements for public membership on ~~the~~ *a* board as set forth in Chapter 6 (commencing with Section 450) of Division 1.

(b) Members of the committee shall serve without compensation, but shall be reimbursed for any travel expenses necessary to conduct committee business.

(c) ~~Committee~~ *Except as provided in subdivision (a), committee* members shall serve terms of four years, and may be reappointed. ~~With respect to the initial appointees, the Governor shall appoint two members for a two-year term, one member for a three-year term, and one member for a four-year term. The Senate Committee on Rules and the Speaker of the Assembly shall each initially appoint one member for a three-year term. The secretary shall initially appoint four members for a two-year term, two members for a three-year term, and two members for a four-year term.~~

(d) The committee shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code)~~, and shall prepare any additional recommended~~ *and the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The committee shall adopt any* rules and regulations necessary ~~or advisable~~ for the purpose of implementing this article, subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The rules and regulations shall include appropriate minimum standards and requirements for referral to treatment, and monitoring of participants in the physician health program, and shall be written in a manner that provides clear guidance and measurable outcomes to ensure patient safety and the health and wellness of physicians ~~and surgeons. The agency shall adopt regulations for the implementation of this article, taking into consideration the regulations recommended by the committee.~~ *and surgeons.*

(e) The rules and regulations required by this section shall be adopted not later than June 30, 2010, and shall, at a minimum, be consistent with the uniform standards adopted pursuant to Section 315, and shall include all of the following:

(1) Minimum standards, criteria, and guidelines for the acceptance, denial, referral to treatment, and monitoring of physicians and surgeons in the physician health program.

(2) Standards for requiring that a physician and surgeon agree to cease practice to obtain appropriate treatment services.

(3) Criteria that must be met prior to a physician and surgeon returning to practice.

(4) Standards, requirements, and procedures for random testing for the use of banned substances and protocols to follow if that use has occurred.

(5) Worksite monitoring requirements and standards.

(6) The manner, protocols, and timeliness of reports required to be made pursuant to Section 2345.

(7) Appropriate requirements for clinical diagnostic evaluations of program participants.

(8) Requirements for a physician and surgeon's termination from, and reinstatement to, the program.

(9) Requirements that govern the ability of the program to communicate with a participant's employer or organized medical staff about the participant's status and condition.

(10) Group meeting and other self-help requirements, standards, protocols, and qualifications.

(11) Minimum standards and qualifications of any vendor, monitor, provider, or entity contracted with by the ~~agency~~ *committee* pursuant to Section 2343.

(12) A requirement that all physician health program services shall be available to all licensed physicians and surgeons with a qualifying illness.

(13) A requirement that any physician health program shall do all of the following:

(A) Promote, facilitate, or provide information that can be used for the education of physicians and surgeons with respect to the recognition and treatment of alcohol dependency, chemical dependency, or mental disorders, and the availability of the physician health program for qualifying illnesses.

(B) Offer assistance to any person in referring a physician and surgeon for purposes of assessment or treatment, or both, for a qualifying illness.

(C) Monitor the status during treatment of a physician and surgeon who enters treatment for a qualifying illness pursuant to a written, voluntary agreement.

(D) Monitor the compliance of a physician and surgeon who enters into a written, voluntary agreement for a qualifying illness with the physician health program setting forth a course of recovery.

(E) Agree to accept referrals from the board to provide monitoring services pursuant to a board order.

(F) Provide a clinical diagnostic evaluation of physicians and surgeons entering the program.

(14) Rules and procedures to comply with auditing requirements pursuant to Section 2348.

(15) A definition of the standard of "reasonably likely to be detrimental to patient safety or the delivery of patient care," relying, to the extent practicable, on standards used by hospitals, medical groups, and other employers of physicians and surgeons.

(16) Any other provision necessary for the implementation of this article.

2343. (a) On and after July 1, 2010, upon adoption of the rules and regulations required by Section 2342, the committee ~~shall recommend one or more physician health programs to the agency, and the agency~~ may contract with any qualified physician health program. The physician health program shall be a nonprofit corporation organized under Section 501(c)(3) of Title 26 of the United States Code. The chief executive officer shall have expertise in the areas of alcohol abuse, substance abuse, alcohol dependency, other chemical dependencies, and mental disorders. In order to expedite the delivery of physician health program services established by this article, the ~~agency~~ *committee* may contract with an entity meeting the minimum standards and requirements set forth in subdivision (e) of Section 2342 on an interim basis prior to the adoption of ~~any additional~~ *the* rules and regulations required to be adopted pursuant to ~~subdivision (d)~~ *subdivisions (d) and (e)* of Section 2342. The ~~agency~~ *committee* may extend the contract when the rules and regulations are adopted, provided that the

physician health program meets the requirements in those rules and regulations.

(b) Any contract entered into pursuant to this article shall comply with all rules and regulations required to be adopted pursuant to this article. No entity shall be eligible to provide the services of the physician health program that does not meet the minimum standards, criteria, and guidelines contained in those rules and regulations.

(c) The contract entered into pursuant to this article shall also require the contracting entity to do both of the following:

(1) Report annually to the committee statistics, including the number of participants served, the number of compliant participants, the number of participants who have successfully completed their agreement period, and the number of participants reported ~~to the board for suspected noncompliance~~ *by the physician health program pursuant to subdivision (c) of Section 2345*; provided, however, that in making that report, the physician health program shall not disclose any personally identifiable information relating to any physician and surgeon participating in a voluntary agreement as provided in this article.

(2) Agree to submit to periodic audits and inspections of all operations, records, and management related to the physician health program to ensure compliance with the requirements of this article and its implementing rules and regulations.

(d) In addition to the requirements of Section 2348, the ~~agency, in conjunction with the committee,~~ *committee* shall monitor compliance of the physician health program with the requirements of this article and its implementing regulations, including making periodic inspections and onsite visits with any entity contracted to provide physician health program services.

2344. The ~~agency~~ *committee* has the sole discretion to contract with a physician health program for licensees of the board and no provision of this article may be construed to entitle any physician and surgeon to the creation or designation of a physician health program for any individual qualifying illness or group of qualifying illnesses.

2345. (a) In order to encourage voluntary participation in monitored alcohol or chemical dependency or mental disorder treatment programs, and in recognition of the fact that mental disorders, alcohol dependency, and chemical dependency are

1 illnesses, a physician and surgeon, certified or otherwise lawfully
2 practicing in this state, may enter into a voluntary agreement with
3 a physician health program. The agreement between the physician
4 and surgeon and the physician health program shall include a
5 jointly agreed upon treatment program and mandatory conditions
6 and procedures to monitor compliance with the treatment program,
7 including, but not limited to, an agreement to cease practice, as
8 defined by the rules and regulations adopted pursuant to Section
9 2342. Except as provided in subdivisions (b), (c), (d), and (e), a
10 physician and surgeon's participation in the physician health
11 program pursuant to a voluntary agreement shall be confidential
12 unless waived by the physician and surgeon.
13 (b) (1) Any voluntary agreement entered into pursuant to this
14 section shall not be considered a disciplinary action or order by
15 the board, shall not be disclosed to the board, and shall not be
16 public information if all of the following are true:
17 (A) The voluntary agreement is the result of the physician and
18 surgeon self-enrolling or voluntarily participating in the physician
19 health program.
20 (B) The board has not referred a complaint against the physician
21 and surgeon to a district office of the board for investigation for
22 conduct involving or alleging an impairment adversely affecting
23 the care and treatment of patients.
24 (C) The physician and surgeon is in compliance with the
25 treatment program and the conditions and procedures to monitor
26 compliance.
27 (2) (A) Each participant, prior to entering into the voluntary
28 agreement described in paragraph (1), shall disclose to the
29 committee whether he or she is under investigation by the board.
30 If a participant fails to disclose such an investigation, upon
31 enrollment or at any time while a participant, the participant shall
32 be terminated from the program. For those purposes, the committee
33 shall regularly monitor recent accusations filed against physicians
34 and surgeons and shall compare the names of physicians and
35 surgeons subject to accusation with the names of program
36 participants.
37 (B) Notwithstanding subparagraph (A), a participant who is
38 under investigation by the board and who makes the disclosure
39 required in subparagraph (A) may participate in, and enter into a
40 voluntary agreement with, the physician health program.

(c) (1) If a physician and surgeon enters into a voluntary agreement with the physician health program pursuant to this article, the physician health program shall do both of the following:

(A) In addition to complying with any other duty imposed by law, report to the committee the name of and results of any contact or information received regarding a physician and surgeon who is suspected of being, or is, impaired and, as a result, whose competence or professional conduct is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

(B) Report to the committee if the physician and surgeon fails to cooperate with any of the requirements of the physician health program, fails to cease practice when required, fails to submit to evaluation, treatment, or biological fluid testing when required, or whose impairment is not substantially alleviated through treatment, or who, in the opinion of the physician health program, is unable to practice medicine with reasonable skill and safety, or who withdraws or is terminated from the physician health program prior to completion.

(2) Within 48 hours of receiving a report pursuant to paragraph (1), the committee shall make a determination as to whether the competence or professional conduct of the physician and surgeon is reasonably likely to be detrimental to patient safety or to the delivery of patient care, and, if so, refer the matter to the board consistent with rules and regulations adopted by the ~~agency~~ *committee*. Upon receiving a referral pursuant to this paragraph, the board shall take immediate action and may initiate proceedings to seek a temporary restraining order or interim suspension order as provided in this division.

(d) Except as provided in subdivisions (b), (c), and (e), and this subdivision, any oral or written information reported to the board pursuant to this section, including, but not limited to, any physician and surgeon's participation in the physician health program and any voluntary agreement entered into pursuant to this article, shall remain confidential as provided in subdivision (c) of Section 800, and shall not constitute a waiver of any existing evidentiary privileges under any other provision or rule of law. However, this subdivision shall not apply if the board has referred a complaint against the physician and surgeon to a district office of the board for investigation for conduct involving or alleging an impairment adversely affecting the care and treatment of patients.

(e) Nothing in this section prohibits, requires, or otherwise affects the discovery or admissibility of evidence in an action against a physician and surgeon based on acts or omissions within the course and scope of his or her practice.

(f) Any information received, developed, or maintained by the ~~agency~~ *committee* regarding a physician and surgeon in the program shall not be used for any other purpose.

2346. The committee shall ~~report to the agency~~ *compile the* statistics received from the physician health program pursuant to Section ~~2343, and the agency shall, thereafter, report to the Legislature the~~ *2343, and shall report to the Legislature, on or before March 1, 2011, and annually thereafter, the* number of individuals served, the number of compliant individuals, the number of individuals who have successfully completed their agreement period, and the number of individuals reported to the board ~~for suspected noncompliance~~ *pursuant to subdivision (c) of Section 2345*; provided, however, that in making that report the ~~agency~~ *committee* shall not disclose any personally identifiable information relating to any physician and surgeon participating in a voluntary agreement as provided herein.

2347. (a) A physician and surgeon participating in a voluntary agreement shall be responsible for all expenses relating to chemical or biological fluid testing, treatment, and recovery as provided in the written agreement between the physician and surgeon and the physician health program.

(b) 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 include a surcharge of not less than twenty-two dollars ($22), or an amount equal to 2.5 percent of the fee set pursuant to Section 2435, whichever is greater, and which shall be expended solely for the purposes of this article. The board shall collect this surcharge and cause it to be transferred monthly to the trust fund established pursuant to subdivision (c). This amount may be separately identified on the fee statement provided to physicians and surgeons as being imposed pursuant to this article. The board may include a conspicuous statement indicating that the Public Protection and Physician Health Program is not a program of the board and the collection of this fee does not, nor shall it be

construed to, constitute the board's endorsement of, support for, control of, or affiliation with, the program.

(c) There is hereby established in the State Treasury the Public Protection and Physician Health Program Trust Fund into which all funds collected pursuant to this section shall be deposited. These funds shall be used, upon appropriation in the annual Budget Act, only for the purposes of this article.

(d) Nothing in this section is intended to limit the amount of funding that may be provided for the purposes of this article. In addition to funds appropriated in the annual Budget Act, additional funding from private or other sources may be used to ensure that no person is denied access to the services established by this program due to a lack of available funding.

(e) All costs of the committee and program established pursuant to this article shall be paid out of the funds collected pursuant to this section.

2348. (a) The ~~agency~~ *committee* shall biennially contract to perform a thorough audit of the effectiveness, efficiency, and overall performance of the program and its vendors. The ~~agency~~ *committee* may contract with a third party to conduct the performance audit, except the third party may not be a person or entity that regularly testifies before the board. This section is not intended to reduce the number of audits the ~~agency~~ *committee* or board may otherwise conduct.

(b) The audit shall make recommendations regarding the continuation of this program and this article and shall suggest any changes or reforms required to ensure that individuals participating in the program are appropriately monitored and the public is protected from physicians and surgeons who are impaired due to alcohol or drug abuse or dependency or mental disorder. Any person conducting the audit required by this section shall maintain the confidentiality of all records reviewed and information obtained in the course of conducting the audit and shall not disclose any information that is identifiable to any program participant.

(c) If, during the course of an audit, the auditor discovers that a participant has harmed a patient, or a patient has died while being treated by a participant, the auditor shall include that information in his or her audit, and shall investigate and report on how that participant was dealt with by the program.

1 (d) A copy of the audit shall be made available to the public by
2 posting a link to the audit on the ~~agency's~~ *committee's* Internet
3 Web site homepage no less than 10 business days after publication
4 of the audit. Copies of the audit shall also be provided to the
5 Assembly and Senate Committees on Business and Professions
6 and the Assembly and Senate Committees on Health within 10
7 business days of its publication.
8 2349. This article shall remain in effect only until January 1,
9 2021, and as of that date is repealed, unless a later enacted statute,
10 that is enacted before January 1, 2021, deletes or extends that date.

O

AB 583

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 583
Author: Hayashi
Bill Date: July 8, 2009, amended
Subject: Disclosure of Education and Office Hours
Sponsor: CA Medical Association and CA Society of Plastic Surgeons
Board Position: Support

STATUS OF BILL:

This bill is currently on the inactive file on the Senate Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require health care practitioners to disclose their license type and highest level of educational degree to patients and physicians would additionally be required to disclose their board certification. Physicians who supervise locations outside their primary office would be required to post the hours they are present at each location.

ANALYSIS:

Existing law requires health care practitioners to either wear a name tag or prominently display their license status in their office. This bill requires health care practitioners to disclose certain information to help the public better understand the qualifications of the health care practitioner they are considering.

This bill intends to make consumers aware of the exact educational level and particular specialty certifications of their health care practitioner. Providing the public with more complete information on health care practitioners will help to alleviate any confusion about the exact qualifications of health care practitioners.

These provisions can be satisfied by either wearing the required information on a name tag, prominently posting the information in the health care practitioner's office (diploma, certificate), or by giving the information to the patient in writing at the initial patient encounter.

This bill will also require a physician, when supervising more than one location, to post the hours the physician is present. In addition, the public may not

know that when they seek care at a physician's office, the physician may not be present. By requiring physicians to post when they are present in the office it will help the patient better understand the physician's availability.

FISCAL: Minor and absorbable enforcement costs

POSITION: Support

September 25, 2009

AMENDED IN SENATE JULY 8, 2009

AMENDED IN SENATE JUNE 22, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 583

Introduced by Assembly Member Hayashi

February 25, 2009

An act to amend Section 680 of the Business and Professions Code, relating to health care practitioners.

LEGISLATIVE COUNSEL'S DIGEST

AB 583, as amended, Hayashi. Health care practitioners: disclosure of education and office hours.

Existing law requires a health care practitioner to disclose, while working, his or her name and practitioner's license status on a name tag in at least 18-point type or *to* prominently display his or her license in his or her office, except as specified.

This bill would require each of those health care practitioners to also display the type of license and, except for nurses, the highest level of academic degree he or she holds either on a name tag in at least 18-point type, in his or her office, or in writing given to patients. The bill would require a physician and surgeon, osteopathic physician and surgeon, and doctor of podiatric medicine who is certified in a medical specialty, as specified, to disclose the name of the certifying board or association either on a name tag in at least 18-point type, in writing given to the patient on the patient's first office visit, or in his or her office. The bill would require a physician and surgeon who supervises an office in addition to his or her primary practice location to conspicuously post in each office a schedule of the regular hours when he or she will be

present in that office and the office hours during which he or she will not be present. The bill would also require an office that is part of a group practice with more than one physician and surgeon to post a current schedule of the hours when a physician and surgeon is present. The bill would exempt health care practitioners working in certain licensed laboratories and health care facilities, as specified, from the requirements to disclose license type, highest level of academic degree, and name of certifying board or association providing certification in the practitioner's specialty or subspecialty.

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

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

1 SECTION 1. Section 680 of the Business and Professions Code
2 is amended to read:
3 680. (a) (1) Except as otherwise provided in this section, a
4 health care practitioner shall disclose, while working, his or her
5 name, practitioner's license status, license type, as granted by this
6 state, and the highest level of academic degree he or she holds, by
7 one of the following methods:
8 (A) On a name tag in at least 18-point type.
9 (B) In writing to a patient at the ~~patent's~~ *patient's* initial office
10 visit.
11 (C) In a prominent display in his or her office.
12 (2) If a health care practitioner or a licensed clinical social
13 worker is working in a psychiatric setting or in a setting that is not
14 licensed by the state, the employing entity or agency shall have
15 the discretion to make an exception from the name tag requirement
16 for individual safety or therapeutic concerns.
17 (3) (A) In the interest of public safety and consumer awareness,
18 it shall be unlawful for any person to use the title "nurse" in
19 reference to himself or herself in any capacity, except for an
20 individual who is a registered nurse or a licensed vocational nurse,
21 or as otherwise provided in Section 2800. Nothing in this section
22 shall be deemed to prohibit a certified nurse assistant from using
23 his or her title.
24 (B) An individual licensed under Chapter 6 (commencing with
25 Section 2700) is not required to disclose the highest level of
26 academic degree he or she holds.

(b) Facilities licensed by the State Department of Social Services, the State Department of Mental Health, or the State Department of Public Health shall develop and implement policies to ensure that health care practitioners providing care in those facilities are in compliance with subdivision (a). The State Department of Social Services, the State Department of Mental Health, and the State Department of Public Health shall verify through periodic inspections that the policies required pursuant to subdivision (a) have been developed and implemented by the respective licensed facilities.

(c) For purposes of this article, "health care practitioner" means any person who engages in acts that are the subject of licensure or regulation under this division or under any initiative act referred to in this division.

(d) An individual licensed under Chapter 5 (commencing with Section 2000) or under the Osteopathic Act, who is certified by (1) an American Board of Medical Specialties member board, (2) a board or association with equivalent requirements approved by that person's medical licensing authority, or (3) a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in that specialty or subspecialty, shall disclose the name of the board or association by one of the following methods:

(1) On a name tag in at least 18-point type.

(2) In writing to a patient at the patient's initial office visit.

(3) In a prominent display in his or her office.

(e) A physician and surgeon who supervises an office in addition to his or her primary practice location shall prominently display in each of those offices a current schedule of the regular hours when he or she is present in the respective office, and the hours during which each office is open and he or she is not present. If the office is a part of a group practice with more than one physician and surgeon, the office shall post a current schedule of the hours when a physician and surgeon is present in the office.

(f) Subdivisions (d) and (e) shall not apply to a health care practitioner working in a facility licensed under Section 1250 of

1 the Health and Safety Code or in a clinical laboratory licensed
2 under Section 1265.

O

AB 646

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 646
Author: Swanson
Bill Date: May 5, 2009, amended
Subject: Authorizing District Hospitals to Employ Physicians
Sponsor: Author
Board Position: Support in Concept

STATUS OF BILL:

This bill is currently in the Senate Health Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill eliminates a current pilot program which allows for the limited direct employment of physicians by district hospitals, and instead, this bill allows for the direct employment of physicians by 1) rural health care districts, to work at any district facility or clinic, or 2) by any public or non-profit hospitals or clinics located in health care districts which serve medically underserved urban populations and communities.

ANALYSIS:

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

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

SB 376 was sponsored by the Association of California Healthcare Districts to enable qualified district hospitals to recruit, hire and employ physicians as full-time paid staff in a rural or underserved community meeting the criteria contained in the bill. Support for this bill was premised upon the belief that the employment of physicians could improve the ability of district hospitals to attract the physicians required to meet the

needs of those communities and also help to ensure the continued survival of healthcare district hospitals in rural and underserved communities, without any cost to the state.

Although it was anticipated that this pilot program would bring about significant improvement in access to healthcare in these areas, only five hospitals throughout all of California have participated, employing a total of six physicians. The last date for physicians to enter into or renew a written employment contract with the qualified district hospital was December 31, 2006, and for a term not in excess of four years.

Current law required the Board to evaluate the program and to issue a report to the Legislature no later than October 1, 2008. In March, 2008, staff sent letters to the six physicians and five hospital administrators participating in the program, asking each to define the successes, problems, if any, and overall effectiveness of this program for the hospital and on consumer protection. Additional input was sought as to how the program could be strengthened, and the participating physicians were asked to share thoughts on how the program impacted them personally.

The Board was challenged in evaluating the program and preparing the required report because the low number of participants did not afford us sufficient information to prepare a valid analysis of the pilot. In summary, while the Board supports the ban on the corporate practice of medicine, it also believes there may be justification to extend the pilot so that a better evaluation can be made. However, until there is sufficient data to perform a full analysis of an expanded pilot, the Board's position as spelled out in the report to the Legislature (September 10, 2008) was that the statutes governing the corporate practice of medicine should not be amended as a solution to solve the problem of access to healthcare.

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

This bill eliminates the pilot program and instead would allow *carte blanche* for the direct employment of physicians by 1) rural health care districts, to work at any district facility or clinic, or 2) by any public or non-profit hospitals or clinics located in health care districts which serve medically underserved urban populations and communities.

In this bill, there are no limitations as to which hospitals could participate. As an example, in the current pilot program: 1) the hospital must be located in smaller counties (a population of less than 750,000); 2) the hospital must provide a majority of care to underserved populations; 3) the hospital must notify the Medical Board.

Also, the intent of the original pilot was to recruit physicians and surgeons to provide medically necessary services in rural and medically underserved communities. This was seen as one avenue through which to improve access to care for underserved

populations. Since this bill does not include such intent, it appears to be an unwarranted infringement on the prohibition of the corporate practice of medicine.

Although this bill offers limited parameters for implementation, it appears to lack adequate constraints to ensure public protections. Patients would be unaware that the physician is an employee. Information about the atypical employment relationship should be provided to patients so they can make an informed decision; informed consent is a cornerstone of patient care. Additional signage should clearly indicate that physicians are licensed by the State (with contact information for the Board) in case a patient has a need to contact the Board.

An important element of the current pilot is missing from this bill – an independent evaluation should be required to define the successes, problems, if any, and overall effectiveness of this program for the hospital, employed physicians, and on consumer protection. Additional input should be sought as to how the program could be strengthened.

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

FISCAL: Unknown

POSITION: Support in Concept

September 25, 2009

AMENDED IN ASSEMBLY MAY 5, 2009

AMENDED IN ASSEMBLY APRIL 13, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 646

Introduced by Assembly Member Swanson
(Coauthors: Assembly Members Beall, Buchanan, Chesbro, Coto, De Leon, *Evans*, Fong, Fuentes, *Furutani*, Hall, Jeffries, Lieu, Bonnie Lowenthal, Ma, Mendoza, Nava, Portantino, Price, ~~Ruskin,~~ Salas, Skinner, and Torres)
(Coauthors: Senators DeSaulnier and Wiggins)

February 25, 2009

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

LEGISLATIVE COUNSEL'S DIGEST

AB 646, as amended, Swanson. Physicians and surgeons: employment.

Existing law, the Medical Practice Act, restricts the employment of licensed physicians and surgeons and podiatrists by a corporation or other artificial legal entity, subject to specified exemptions, and makes it a crime to practice medicine without a license. Existing law establishes, until January 1, 2011, a pilot project to allow qualified district hospitals that, among other things, provide more than 50 percent of patient days to the care of Medicare, Medi-Cal, and uninsured patients, to employ a physician and surgeon, if the hospital does not interfere with, control, or otherwise direct the professional judgment of the physician and surgeon. The pilot project authorizes the direct employment of a total of 20 physicians and surgeons by those hospitals

to provide medically necessary services in rural and medically underserved communities, and specifies that each qualified district hospital may employ up to 2 physicians and surgeons, subject to specified requirements.

This bill would delete ~~the~~ *that* pilot project~~,~~ and would instead authorize a health care district, as defined, ~~or a public or an independent community nonprofit hospital or clinic located in a medically underserved area, as specified,~~ to employ physicians and surgeons if ~~specified requirements are met and the district, hospital, or clinic does not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon~~ *the health care district's service area includes a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP), or has been federally designated as a Health Professional Shortage Area (HPSA); and the chief executive officer of the district provides specified documentation to the Medical Board of California. Upon receipt of that documentation, the bill would require the board to approve the employment of up to 5 primary or specialty care physicians and surgeons by the district, and, upon receipt of additional documentation after that employment, to approve an additional 5 primary or specialty care physicians and surgeons. The bill would provide that a district may, until December 31, 2020, enter into, renew, or extend any employment contract with a physician and surgeon for up to 10 years. The bill would require the Office of Statewide Health Planning and Development, in consultation with the State Department of Public Health and the board, to report to the Legislature by June 1, 2018, with regard to the efficacy of the employment of physicians and surgeons by health care districts, as specified.*

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

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

1 SECTION 1. Section 2401 of the Business and Professions
2 Code is amended to read:
3 2401. (a) Notwithstanding Section 2400, a clinic operated
4 primarily for the purpose of medical education by a public or
5 private nonprofit university medical school, which is approved by
6 the Division of Licensing or the Osteopathic Medical Board of
7 California, may charge for professional services rendered to
8 teaching patients by licensees who hold academic appointments

on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made.

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

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

(d) *(1)* Notwithstanding Section 2400, a health care district ~~that is~~ operated pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code may employ physicians and surgeons, and may charge for professional services rendered by a physician and surgeon, if the physician and surgeon in whose name the charges are made approves the charges~~. However, the district shall not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other provision of law.~~

~~(e) Notwithstanding Section 2400, a public or an independent community nonprofit hospital or clinic located in a medically underserved area, as generally described in Part 5 of Chapter 1 of Title 42 of the Code of Federal Regulations, or an area where unmet priority needs for physicians and surgeons exist, as determined by the California Healthcare Workforce Policy Commission pursuant to Section 128225 of the Health and Safety Code, with a patient census that consists of more than 50 percent medically underserved populations, as defined in Section 127928 of the Health and Safety Code, may employ physicians and surgeons, and may charge for professional services rendered by a physician and surgeon, if the physician and surgeon in whose name the charges are made approves the charges.~~*, and if all of the following conditions are met:*

(A) The service area of the health care district includes a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP), or has been federally designated as a Health Professional Shortage Area (HPSA).

(B) (i) The chief executive officer of the health care district documents that the district has been actively attempting and unable to recruit a primary or specialty care physician and surgeon for any 12 consecutive month period, beginning on or after July 1, 2008.

(ii) The chief executive officer submits an application to the board certifying the district's inability to recruit one or more physicians and surgeons, including all relevant documentation, certifying that the inability to recruit primary or specialty care physicians and surgeons has negatively impacted patient care in the community, and that the employment of physicians and surgeons by the district would meet a critical, unmet need in the community based upon a number of factors, including, but not limited to, the number of patients referred for care outside of the community, the number of patients who experienced delays in treatment, the length of treatment delays, and negative patient outcomes.

(2) Upon receipt and review of the certification of the district's inability to recruit a physician and surgeon as specified in subparagraph (B) of paragraph (1), the board shall approve and authorize the employment of up to five primary or specialty care physicians and surgeons by the district.

(3) Upon receipt and review of subsequent certification of the need for additional primary or specialty care physicians and surgeons by the district, the board shall approve and authorize the employment of up to five additional primary or specialty care physicians and surgeons by the district.

(4) Employment contracts with physicians and surgeons issued pursuant to this subdivision shall be for a period of not more than 10 years, but may be renewed or extended. Districts may enter into, renew, or extend employment contracts with physicians and surgeons pursuant to this subdivision until December 31, 2020.

(5) The Office of Statewide Health Planning and Development, in consultation with the State Department of Public Health and the board, shall conduct an efficacy study of the program under this subdivision to evaluate improvement in physician and surgeon

recruitment and retention in the districts participating in the program, impacts on physician and surgeon and health care access in the communities served by these districts, impacts on patient outcomes, degree of patient and participating physician and surgeon satisfaction, and impacts on the independence and autonomy of medical decisionmaking by employed physicians and surgeons. This study shall be completed and its results reported to the Legislature no later than June 1, 2018.

~~(f) The hospitals or clinics~~

(e) A health care district authorized to employ physicians and surgeons pursuant to subdivision ~~(e)~~ *(d)* shall not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other provision of law. Violation of this prohibition is punishable as a violation of Section 2052, by a fine not exceeding ten thousand dollars ($10,000), by imprisonment in the state prison, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment. This subdivision is declaratory of existing law, and, as such, does not create a new crime or expand the scope of any existing crime.

SEC. 2. Section 2401.1 of the Business and Professions Code is repealed.

O

AB 648

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 648
Author: Chesbro
Bill Date: May 28, 2009, amended
Subject: Authorizing Rural Hospitals to Employ Physicians
Sponsor: California Hospital Association
Board Position: Support in Concept

STATUS OF BILL:

This bill is currently in the Senate Business and Professions Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill allows rural hospitals, as defined, to employ physicians and surgeons to provide medical services at the hospital or any other health facility that the rural hospital owns or operations.

ANALYSIS:

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

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

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

Although it was anticipated that this pilot program would bring about significant improvement in access to healthcare in these areas, only five hospitals throughout all of

California have participated, employing a total of six physicians. The last date for physicians to enter into or renew a written employment contract with the qualified district hospital was December 31, 2006, and for a term not in excess of four years.

Current law required the Board to evaluate the program and to issue a report to the Legislature no later than October 1, 2008. In March, 2008, staff sent letters to the six physicians and five hospital administrators participating in the program, asking each to define the successes, problems, if any, and overall effectiveness of this program for the hospital and on consumer protection. Additional input was sought as to how the program could be strengthened, and the participating physicians were asked to share thoughts on how the program impacted them personally.

The Board was challenged in evaluating the program and preparing the required report because the low number of participants did not afford sufficient information to prepare a valid analysis of the pilot. In summary, while the Board supports the ban on the corporate practice of medicine, it also believes there may be justification to extend the pilot so that a better evaluation can be made. However, until there is sufficient data to perform a full analysis of an expanded pilot, the Board's position as spelled out in the report to the Legislature (September 10, 2008) was that the statutes governing the corporate practice of medicine should not be amended as a solution to solve the problem of access to healthcare.

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

This bill allows rural hospitals, as defined, to employ physicians and surgeons to provide medical services at the hospital or any other health facility that the rural hospital owns or operations. None of the safeguards and limitations of the pilot are included in this bill. Instead, this bill includes few parameters:

1) The rural hospital that employs a physician shall develop and implement a written policy to ensure that each employed physician exercises his or her independent medical judgment in providing care to patients.

2) Each physician employed by a rural hospital shall sign a statement biennially indicating that the physician and surgeon:

a) Voluntarily desires to be employed by the hospital.

b) Will exercise independent medical judgment in all matters relating to the provision of medical care to his or her patients.

c) Will report immediately to the Medical Board of California any action or event that the physician reasonably and in good faith believes constitutes a compromise of his or her independent medical judgment in providing patient care

3) The signed statement shall be retained by the rural hospital for a period of at least three years. A copy of the signed statement shall be submitted by the rural hospital to the Board within 10 working days after the statement is signed by the physician.

4) If a report is filed per 2) c), above, and the Board believes that a rural hospital has violated this prohibition, the Board shall refer the matter to the Department of Public Health (DPH), which shall investigate the matter. If the department believes that the rural

hospital has violated the prohibition, it shall notify the rural hospital. Certain due process procedures are set forth and penalties are outlined.

Although this bill offers limited parameters for implementation, it appears to lack adequate constraints to ensure public protections. Patients would be unaware the physician is an employee. Information about the atypical employment relationship should be provided to patients so they can make an informed decision; informed consent is a cornerstone of patient care. Additional signage should clearly indicate that physicians are licensed by the State (with contact information for the Board) in case a patient has a need to contact the Board.

The written policy and statement (required per Items 1) and 2), above) should be more appropriately submitted to both the Board and the DPH, so both agencies are aware of the policy the hospital has established for the physicians as it relates to public protection.

Further, employment protection must be provided for all employed physicians, so that any report filed per Item 4), above, does not lead to retaliatory action by the hospital.

Lastly, an important element of the current pilot is missing from this bill – an independent evaluation should be required to define the successes, problems, if any, and overall effectiveness of this program for the hospital, employed physicians, and on consumer protection. Additional input should be sought as to how the program could be strengthened.

Until a pilot program as originally envisioned by SB 376 is fully functional and evaluated, this bill seems premature with an unwarranted expansion. Further, it is still of concern that there would be an unlimited number of physicians in California who could be employed, even if the participating hospital is prohibited from interfering with, controlling, or otherwise directing the physician's professional judgment.

FISCAL: Unknown

POSITION: Support in Concept

September 25, 2009

AMENDED IN ASSEMBLY MAY 28, 2009

AMENDED IN ASSEMBLY MAY 5, 2009

AMENDED IN ASSEMBLY APRIL 15, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 648

Introduced by Assembly Member Chesbro
(Principal coauthor: Assembly Member Nielsen)
(Principal coauthor: Senator Cox)
(~~Coauthor: Assembly Member Buchanan~~ *Coauthors: Assembly Members Buchanan, Fuentes, and Miller*)
(Coauthor: Senator ~~Cox~~ *Ducheny*)

February 25, 2009

An act to add and repeal Chapter 6.5 (commencing with Section 124871) of Part 4 of Division 106 of the Health and Safety Code, relating to rural hospitals.

LEGISLATIVE COUNSEL'S DIGEST

AB 648, as amended, Chesbro. Rural hospitals: physician services.

Existing law generally provides for the licensure of health facilities, including rural general acute care hospitals, by the State Department of Public Health.

Existing law requires the department to provide expert technical assistance to strategically located, high-risk rural hospitals, as defined, to assist the hospitals in carrying out an assessment of potential business and diversification of service opportunities. Existing law also requires the department to continue to provide regulatory relief when appropriate through program flexibility for such items as staffing, space, and physical plant requirements.

This bill would, until January 1, 2020, establish a demonstration project authorizing a rural hospital, as defined, that meets specified conditions, to employ up to 10 physicians and surgeons at one time, except as provided, to provide medical services at the rural hospital or other health facility that the rural hospital owns or operates, and to retain all or part of the income generated by the physicians and surgeons for medical services billed and collected by the rural hospital if the physician and surgeon in whose name the charges are made approves the charges. The bill would require a rural hospital that employs a physician and surgeon pursuant to those provisions to develop and implement a policy regarding the independent medical judgment of the physician and surgeon.

The bill would require these physicians and surgeons to biennially sign a specified statement.

The bill would impose various duties on the department and the Medical Board of California including, not later than January 1, 2019, a requirement that the board deliver a report to the Legislature regarding the demonstration project.

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) Many hospitals in the state are having great difficulty
4 recruiting and retaining physicians.
5 (b) There is a shortage of physicians in communities across
6 California, particularly in rural areas, and this shortage limits access
7 to health care for Californians in these communities.
8 *(c) The average age of physicians in rural and underserved*
9 *urban communities is approaching 60 years of age, with many of*
10 *these physicians planning to retire within the next two years.*
11 ~~(c)~~
12 *(d)* Allowing rural hospitals to directly employ physicians will
13 allow rural hospitals to provide economic security adequate for a
14 physician to relocate and reside in the communities served by the
15 rural hospitals and will help rural hospitals recruit physicians to
16 provide medically necessary services in these communities and

further enhance technological developments such as the adoption of electronic medical records.

~~(d)~~

(e) Allowing rural hospitals to directly employ physicians will provide physicians with the opportunity to focus on the delivery of health services to patients without the burden of administrative, financial, and operational concerns associated with the establishment and maintenance of a medical office, thereby giving the physicians a reasonable professional and personal lifestyle.

~~(e)~~

(f) It is the intent of the Legislature by enacting this act to establish a demonstration project authorizing a rural hospital that meets the conditions set forth in Chapter 6.5 (commencing with Section 124871) of the Health and Safety Code to employ physicians directly and to charge for their professional services.

~~(f)~~

(g) It is the further intent of the Legislature to prevent a rural hospital that employs a physician from interfering with, controlling, or otherwise directing the physician's medical judgment or medical treatment of patients.

SEC. 2. Chapter 6.5 (commencing with Section 124871) is added to Part 4 of Division 106 of the Health and Safety Code, to read:

CHAPTER 6.5. RURAL HOSPITAL PHYSICIAN AND SURGEON SERVICES DEMONSTRATION PROJECT

124871. For purposes of this chapter, a rural hospital means all of the following:

(a) A general acute care hospital located in an area designated as nonurban by the United States Census Bureau.

(b) A general acute care hospital located in a rural-urban commuting area code of 4 or greater as designated by the United States Department of Agriculture.

(c) A rural general acute care hospital, as defined in subdivision (a) of Section 1250.

124872. (a) Notwithstanding Article 18 (commencing with Section 2400) of Chapter 5 of Division 2 of the Business and Professions Code and in addition to other applicable laws, a rural hospital whose service area includes a medically underserved area,

a medically underserved population, or that has been federally designated as a health professional shortage area may employ one or more physicians and surgeons, not to exceed 10 physicians and surgeons at one time, except as provided in subdivision (c), to provide medical services at the rural hospital or other health facility, as defined in Section 1250, that the rural hospital owns or operates. The rural hospital may retain all or part of the income generated by the physician and surgeon for medical services billed and collected by the rural hospital, if the physician and surgeon in whose name the charges are made approves the charges.

(b) A rural hospital may participate in the program if both of the following conditions are met:

(1) The rural hospital can document that it has been unsuccessful in recruiting one or more primary care or speciality physicians for at least 12 continuous months beginning July 1, 2008.

(2) The chief executive officer of the rural hospital certifies to the Medical Board of California that the inability to recruit primary care or speciality physicians has negatively impacted patient care in the community and that there is a critical unmet need in the community, based on a number of factors, including, but not limited to, the number of patients referred for care outside the community, the number of patients who experienced delays in treatment, and the length of the treatment delays.

(c) The total number of licensees employed by the rural hospital at one time shall not exceed 10, unless the employment of additional physicians and surgeons is deemed appropriate by the Medical Board of California on a case-by-case basis. In making this determination the board shall take into consideration whether access to care is improved for the community served by the hospital by increasing the number of physicians and surgeons employed.

124873. (a) A rural hospital that employs a physician and surgeon pursuant to Section 124872 shall develop and implement a written policy to ensure that each employed physician and surgeon exercises his or her independent medical judgment in providing care to patients.

(b) Each physician and surgeon employed by a rural hospital pursuant to Section 124872 shall sign a statement biennially indicating that the physician and surgeon:

(1) Voluntarily desires to be employed by the hospital.

(2) Will exercise independent medical judgment in all matters relating to the provision of medical care to his or her patients.

(3) Will report immediately to the Medical Board of California any action or event that the physician and surgeon reasonably and in good faith believes constitutes a compromise of his or her independent medical judgment in providing care to patients in a rural hospital or other health care facility owned or operated by the rural hospital.

(c) The signed statement required by subdivision (b) shall be retained by the rural hospital for a period of at least three years. A copy of the signed statement shall be submitted by the rural hospital to the Medical Board of California within 10 working days after the statement is signed by the physician and surgeon.

(d) A rural hospital shall not interfere with, control, or direct a physician's and surgeon's exercise of his or her independent medical judgment in providing medical care to patients. If, pursuant to a report to the Medical Board of California required by paragraph (3) of subdivision (a), the Medical Board of California believes that a rural hospital has violated this prohibition, the Medical Board of California shall refer the matter to the State Department of Public Health, which shall investigate the matter. If the department concludes that the rural hospital has violated the prohibition, it shall notify the rural hospital. The rural hospital shall have 20 working days to respond in writing to the department's notification, following which the department shall make a final determination. If the department finds that the rural hospital violated the prohibition, it shall assess a civil penalty of five thousand dollars ($5,000) for the first violation and twenty-five thousand dollars ($25,000) for any subsequent violation that occurs within three years of the first violation. If no subsequent violation occurs within three years of the most recent violation, the next civil penalty, if any, shall be assessed at the five thousand dollar ($5,000) level. If the rural hospital disputes a determination by the department regarding a violation of the prohibition, the rural hospital may request a hearing pursuant to Section 131071. Penalties, if any, shall be paid when all appeals have been exhausted and the department's position has been upheld.

(e) Nothing in this chapter shall exempt a rural hospital from a reporting requirement or affect the authority of the board to take action against a physician's and surgeon's license.

124874. (a) Not later than January 1, 2019, the board shall deliver a report to the Legislature regarding the demonstration project established pursuant to this chapter. The report shall include an evaluation of the effectiveness of the demonstration project in improving access to health care in rural and medically underserved areas and the demonstration project's impact on consumer protection as it relates to intrusions into the practice of medicine.

(b) This chapter shall remain in effect only until January 1, 2020, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2020, deletes or extends that date.

O

AB 933

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 933
Author: Fong
Bill Date: February 26, 2009, introduced
Subject: Workers' Compensation: utilization review
Sponsor: California Society of Industrial Medicine and Surgery
California Society of Physical Medicine and Rehabilitation
Union of American Physicians and Dentists (AFSCME)
Board Position: Support

STATUS OF BILL:

This bill is in the Senate Committee on Labor and Industrial Relations.

DESCRIPTION OF CURRENT LEGISLATION:

This bill clarifies current law to provide that physicians performing utilization review for injured workers must be licensed in California.

ANALYSIS:

Current law does not require physicians who perform utilization reviews of workers' compensation claims to be license in California as long as the physicians are licensed in another state. However, current law does state that performing an evaluation that leads to the modification, delay, or denial of medical treatment is an act of diagnosing for the purpose of providing a different mode of treatment for the patient. Only a licensed physician is allowed to override treatment decisions.

The author and proponents of this bill believe that out-of-state physicians are making inappropriate decisions regarding these utilization reviews in part because there is no regulatory agency holding them accountable.

This bill would ensure that any physician performing a utilization review in California would be regulated by the Medical Board (Board) by requiring all physicians performing these reviews to be licensed in this state.

This bill is similar to last year's AB 2969 (Lieber) which was vetoed. The Board has supported that legislation in the past.

FISCAL: None to the Board

POSITION: Support

September 25, 2009

ASSEMBLY BILL No. 933

Introduced by Assembly Member Fong

February 26, 2009

An act to amend Sections 3209.3 and 4610 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 933, as introduced, Fong. Workers' compensation: utilization review.

Existing workers' compensation law generally requires employers to secure the payment of workers' compensation, including medical treatment, for injuries incurred by their employees that arise out of, or in the course of, employment.

Existing law, for purposes of workers' compensation, defines "psychologist" to mean a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology, as specified, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.

This bill would require the psychologist to be licensed by California state law.

Existing law requires every employer to establish a medical treatment utilization review process, in compliance with specified requirements, either directly or through its insurer or an entity with which the employer or insurer contracts for these services. Existing law provides that no person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services,

and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

This bill would require the physician to be licensed by California state law.

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

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

1 SECTION 1. Section 3209.3 of the Labor Code is amended to
2 read:
3 3209.3. (a) "Physician" ~~includes~~ *means* physicians and
4 surgeons holding an M.D. or D.O. degree, psychologists,
5 acupuncturists, optometrists, dentists, podiatrists, and chiropractic
6 practitioners licensed by California state law and within the scope
7 of their practice as defined by California state law.
8 (b) "Psychologist" means ~~a licensed~~ psychologist *licensed by*
9 *California state law* with a doctoral degree in psychology, or a
10 doctoral degree deemed equivalent for licensure by the Board of
11 Psychology pursuant to Section 2914 of the Business and
12 Professions Code, and who either has at least two years of clinical
13 experience in a recognized health setting or has met the standards
14 of the National Register of the Health Service Providers in
15 Psychology.
16 (c) When treatment or evaluation for an injury is provided by
17 a psychologist, provision shall be made for appropriate medical
18 collaboration when requested by the employer or the insurer.
19 (d) "Acupuncturist" means a person who holds an
20 acupuncturist's certificate issued pursuant to Chapter 12
21 (commencing with Section 4925) of Division 2 of the Business
22 and Professions Code.
23 (e) Nothing in this section shall be construed to authorize
24 acupuncturists to determine disability for the purposes of Article
25 3 (commencing with Section 4650) of Chapter 2 of Part 2, or under
26 Section 2708 of the Unemployment Insurance Code.
27 SEC. 2. Section 4610 of the Labor Code is amended to read:
28 4610. (a) For purposes of this section, "utilization review"
29 means utilization review or utilization management functions that

prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) No person other than a ~~licensed~~ physician *licensed by California state law* who is competent to evaluate the specific

clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements must be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. 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 receipt of information that is reasonably necessary to make this determination.

(2) When the employee's condition is such that the employee 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 employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4062. If a request to perform spinal surgery is denied, disputes shall be resolved in accordance with subdivision (b) of Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be

resolved pursuant to Section 4062, except in cases involving recommendations for the performance of spinal surgery, which shall be governed by the provisions of subdivision (b) of Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative 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. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

O

AB 1070

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1070
Author: Hill
Chapter: #505
Subject: Enforcement Enhancements: reporting, public reprimand
Sponsor: Medical Board of California
Board Position: Sponsor/Support

DESCRIPTION OF LEGISLATION:

This bill is the vehicle carrying enforcement enhancements for the Medical Board (Board). This bill finds and declares the importance of the required reporting under Business and Professions Code section 801.01 and makes various technical changes to this section to enhance the Board's ability to effectively protect consumers.

This bill would allow the Board President to sit on a disciplinary panel when the Board does not have a full complement of members. This bill would require all medical records requested by the Board to be certified.

This bill would allow an administrative law judge to recommend that a licensee be issued a public reprimand that includes additional requirements for education and training.

This bill would require all licensees to report to the Board information regarding any specialty board certifications held and his or her practice status. Licensees would be allowed to report his or her cultural background and foreign language proficiencies. Reporting would occur both at the time of renewal or upon initial licensure.

This bill extends the sunset date of the vertical enforcement and prosecution model from July 1, 2010 to July 1, 2012. This bill also requires the Board to establish and implement a plan to assist in team building between the Board's staff and the Health Quality Enforcement Section of the Department of Justice.

IMPLEMENTATION:

- Newsletter Article
- Notify Board Staff
- Notify Discipline Coordination Staff within the Enforcement division to include the Board President, effective January 1, 2010, in disciplinary panels as needed.
- Work with Enforcement staff on new procedures, to be in place by January 1, 2010, for requiring certified medical records.

- Notify Enforcement staff and Administrative Law Judges of changes to the allowable recommendations for education and training to be included in public reprimands.
- Work with Enforcement staff on any necessary updates to the Disciplinary Guidelines, to be complete by January 1, 2010.
- Work with Licensing Staff to develop the method by which the information regarding licensees' specialty board certifications and practice status will be requested upon license issuance.
- Work with ISB staff to update website and online licensing survey system to reflect new reporting requirements.
- Work with Enforcement Staff to contract with a facilitator to assist in developing a team building plan between the Board's Investigative staff and Deputy Attorney Generals in the Health Quality Enforcement Section of the Department of Justice.

Assembly Bill No. 1070

CHAPTER 505

An act to amend Sections 801.01, 2006, 2008, 2225.5, 2227, and 2425.3 of, and to add Section 804.5 to, the Business and Professions Code, and to amend Sections 12529, 12529.5, 12529.6, and 12529.7 of the Government Code, relating to healing arts.

[Approved by Governor October 11, 2009. Filed with Secretary of State October 11, 2009.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1070, Hill. Healing arts.

(1) Existing law provides for the licensure and regulation of osteopathic physicians and surgeons by the Osteopathic Medical Board of California, physicians and surgeons by the Medical Board of California (Medical Board), and podiatrists by the California Board of Podiatric Medicine. Existing law requires those licensees, insurers providing professional liability insurance to those licensees, and governmental agencies that self-insure those licensees to report specified settlements, arbitration awards, or civil judgments to the licensee's board if based on the licensee's alleged negligence, error, or omission in practice or his or her rendering of unauthorized professional services.

This bill would specify that the reporting requirements apply to the University of California, as specified. With respect to a governmental agency required to submit a report, including a local governmental agency, the bill would require the agency to, prior to submitting a report, provide written notice of its intention to file a report to the affected licensee and provide the licensee with an opportunity to respond to the agency, as specified. By imposing new duties on local agencies, the bill would impose a state-mandated local program.

Existing law requires licensees and insurers required to make these reports to send a copy of the report to the claimant or his or her counsel and requires a claimant or his or her counsel who does not receive a copy of the report within a specified time period to make the report to the appropriate board. Existing law makes a failure of a licensee, claimant, or counsel to comply with these requirements a public offense punishable by a specified fine.

This bill would require any entity or person required to make a report to notify the claimant or his or her counsel that the report has been sent to the appropriate board and would require the claimant or his or her counsel to make the report if the notice is not received within a specified time.

The bill would also make a failure to substantially comply with any of the reporting requirements an infraction punishable by a specified fine. By

expanding the scope of a crime, the bill would impose a state-mandated local program.

Existing law requires these reports to include certain information, including a brief description of the facts of each claim, charge, or allegation, and the amount of the judgment or award and the date of its entry or service.

This bill would eliminate the requirement that this description be brief and would require the description to also include the role of each physician and surgeon or podiatrist in the care or professional services provided to the patient, as specified. The bill would also require the report to include a copy of the judgment or award.

(2) The Medical Practice Act provides for the regulation of physicians and surgeons by the Medical Board, and provides that the protection of the public is the highest priority for the board in exercising its licensing, regulatory, and disciplinary functions.

This bill would prohibit any entity that provides early intervention, patient safety, or risk management programs to patients, or contracts for those programs for patients, from requiring that a patient waive his or her rights to contact or cooperate with the board, or to file a complaint with the board.

(3) Existing law authorizes the Medical Board to appoint panels from its members for the purposes of fulfilling specified obligations and prohibits the president of the board from serving as a member of a panel.

This bill would allow the president of the board to serve as a member of a panel if there is a vacancy in the membership of the board.

(4) Under existing law, a physician and surgeon or podiatrist who fails to comply with a patient's medical record request, as specified, within 15 days, or who fails or refuses to comply with a court order mandating release of records, is required to pay a civil penalty of $1,000 per day, as specified.

This bill would place a limit of $10,000 on those civil penalties and would make other related changes, including providing a definition of "certified medical records," as specified.

(5) Existing law prescribes the disciplinary action that may be taken against a physician and surgeon or podiatrist. Among other things, existing law authorizes the licensee to be publicly reprimanded.

This bill would authorize the public reprimand to include a requirement that the licensee complete educational courses approved by the board.

(6) Existing law requires the Medical Board to request a licensed physician and surgeon to report, at the time of license renewal, any specialty board certification he or she holds, as specified. Existing law also authorizes a licensed physician and surgeon to report to the board, at the time of license renewal, information regarding his or her cultural background and foreign language proficiency.

This bill would instead require licensees to provide that information at the time of license renewal and immediately upon issuance of an initial license, except as specified.

Existing law requires a licensed physician and surgeon to also report, at the time of license renewal, his or her practice status, as specified.

This bill would also require that this information be provided immediately upon issuance of an initial license.

(7) 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 and various other boards. Existing law simultaneously assigns a complaint received by the Medical Board to an investigator and a deputy attorney general, as specified. Existing law makes these provisions inoperative on July 1, 2010. 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, 2009.

This bill would extend the operation of those provisions until January 1, 2013. The bill would require the Medical Board to establish and implement a plan to assist in team building between its enforcement staff and the staff of the Health Quality Enforcement Section in order to ensure a common and consistent knowledge base. The bill would also require the Medical Board to, in consultation with specified agencies, report and make recommendations to the Governor and the Legislature on this enforcement and prosecution model by March 1, 2012. The bill would make other related changes.

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

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

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

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

SECTION 1. Section 801.01 of the Business and Professions Code is amended to read:

801.01. The Legislature finds and declares that the filing of reports with the applicable state agencies required under this section is essential for the protection of the public. It is the intent of the Legislature that the reporting requirements set forth in this section be interpreted broadly in order to expand reporting obligations.

(a) A complete report shall be sent to the Medical Board of California, the Osteopathic Medical Board of California, 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 the settlement is based on the licensee's alleged negligence, error, or omission in practice, or on 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. For purposes of this section "state governmental agency" includes, but is not limited to, the University of California.

(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) The entity, person, or licensee required to report under subdivision (b) shall notify the claimant or his or her counsel, if he or she is represented by counsel, that the report has been sent 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) Failure to substantially comply with this section is a public offense punishable by a fine of not less than five hundred dollars ($500) and not more than five thousand dollars ($5,000).

(g) (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 licensee 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 description or summary of the facts of each claim, charge, or allegation, including the date of occurrence and the licensee's role in the care or professional services provided to the patient with respect to those services at issue in the claim or action.

(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, the date of its entry, and a copy of the judgment; 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 a copy of the judgment or award.

(H) The specialty or subspecialty of the licensee 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.

(h) 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.

(i) 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.

(j) (1) A state or local governmental agency that self-insures licensees shall, prior to sending a report pursuant to this section, do all of the following with respect to each licensee who will be identified in the report:

(A) Before deciding that a licensee will be identified, provide written notice to the licensee that the agency intends to submit a report in which the licensee may be identified, based on his or her role in the care or professional services provided to the patient that were at issue in the claim or action. This notice shall describe the reasons for notifying the licensee. The agency shall include with this notice a reasonable opportunity for the licensee to review a copy of records to be used by the agency in deciding whether to identify the licensee in the report.

(B) Provide the licensee with a reasonable opportunity to provide a written response to the agency and written materials in support of the licensee's position. If the licensee is identified in the report, the agency shall include this response and materials in the report submitted to a board under this section if requested by the licensee.

(C) At least 10 days prior to the expiration of the 30-day reporting requirement under subdivision (d), provide the licensee with the opportunity to present arguments to the body that will make the final decision or to that body's designee. The body shall review the care or professional services provided to the patient with respect to those services at issue in the claim or action and determine the licensee or licensees to be identified in the report and the amount of the settlement to be apportioned to the licensee.

(2) Nothing in this subdivision shall be construed to modify either the content of a report required under this section or the timeframe for filing that report.

(k) For purposes of this section, "licensee" means a licensee of the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine.

SEC. 2. Section 804.5 is added to the Business and Professions Code, to read:

804.5. The Legislature recognizes that various types of entities are creating, implementing, and maintaining patient safety and risk management programs that encourage early intervention in order to address known complications and other unanticipated events requiring medical care. The Legislature recognizes that some entities even provide financial assistance to individual patients to help them address these unforeseen health care concerns. It is the intent of the Legislature, however, that such financial assistance not limit a patient's interaction with, or his or her rights before, the Medical Board of California.

Any entity that provides early intervention, patient safety, or risk management programs to patients, or contracts for those programs for patients, shall not include, as part of any of those programs or contracts, any of the following:

(a) A provision that prohibits a patient or patients from contacting or cooperating with the board.

(b) A provision that prohibits a patient or patients from filing a complaint with the board.

(c) A provision that requires a patient or patients to withdraw a complaint that has been filed with the board.

SEC. 3. Section 2006 of the Business and Professions Code is amended to read:

2006. (a) Any reference in this chapter to an investigation by the board shall be deemed to refer to a joint investigation conducted by employees of the Department of Justice and the board under the vertical enforcement and prosecution model, as specified in Section 12529.6 of the Government Code.

(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. 4. Section 2008 of the Business and Professions Code is amended to read:

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

SEC. 5. Section 2225.5 of the Business and Professions Code is amended to read:

2225.5. (a) (1) A licensee who fails or refuses to comply with a request for the certified medical records of a patient, that is accompanied by that patient's written authorization for release of records to the board, within 15 days of receiving the request and authorization, shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the licensee is unable to provide the documents within this time period for good cause.

(2) A health care facility shall comply with a request for the certified medical records of a patient that is accompanied by that patient's written authorization for release of records to the board together with a notice citing this section and describing the penalties for failure to comply with this section. Failure to provide the authorizing patient's certified medical records to the board within 30 days of receiving the request, authorization, and notice shall subject the health care facility to a civil penalty, payable to the board, of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 30th day, up to ten thousand dollars ($10,000), unless the health care facility is unable to provide the documents within this time period for good cause. This paragraph shall not require health care facilities to assist the board in obtaining the patient's authorization. The board shall pay the reasonable costs of copying the certified medical records.

(b) (1) A licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the date by which the court order requires the documents to be produced, up to ten thousand dollars ($10,000), unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(2) Any licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board is guilty of a misdemeanor punishable by a fine payable to the board not to exceed five thousand dollars ($5,000). The fine shall be added to the licensee's renewal fee if it is not paid by the next succeeding renewal date. Any statute of limitations applicable to the filing of an accusation by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(3) A health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of patient records to the board, that is accompanied by a notice citing this section and describing the penalties for failure to comply with this section, shall pay to the board a civil penalty of up to one thousand dollars ($1,000) per day for

AB 1071

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1071
Author: Emmerson
Chapter: #270
Subject: Sunset Extension
Sponsor: Author
Board Position: Support MBC Provisions

DESCRIPTION OF LEGISLATION:

This bill would extend the sunset dates of the Medical Board to January 1, 2013. This will enable the Board complete the review of its programs and then implement and evaluate the effect of those review findings and address those during the Sunset Review Process. This date also coincides with the sunset dates set forth in the provisions for the Vertical Enforcement model.

IMPLEMENTATION:

- Newsletter Article
- Notify Board staff
- Prepare for performing a Sunset evaluation/report in late 2011, in anticipation of legislation in 2012.

October 14, 2009

Assembly Bill No. 1071

CHAPTER 270

An act to amend Sections 2001, 2020, 2460, 2701, 2708, 3010.5, 3014.6, 3685, 3710, 4001, 4003, 4110, 4127.8, 4160, 4400, and 5810 of, to add and repeal Section 3686 of, and to repeal Section 4127.5 of, the Business and Professions Code, relating to professions and vocations, and making an appropriation therefor.

[Approved by Governor October 11, 2009. Filed with Secretary of State October 11, 2009.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1071, Emmerson. Professions and vocations.

(1) Existing law provides for the licensure and regulation of various healing arts licensees by various boards within the Department of Consumer Affairs, including, but not limited to, the Medical Board of California, the California Board of Podiatric Medicine, the Board of Registered Nursing, the State Board of Optometry, the Respiratory Care Board of California, and the California State Board of Pharmacy. Existing law requires or authorizes these boards, with the exception of the California Board of Podiatric Medicine, to appoint an executive director or officer. Under existing law, these provisions will become inoperative on July 1, 2010, and will be repealed on January 1, 2011.

Under this bill, these provisions would become inoperative and be repealed on January 1, 2013. The bill would also make nonsubstantive changes to similar provisions of the Naturopathic Doctors Act.

(2) Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacies, pharmacists, pharmacy technicians, wholesalers of dangerous drugs or devices, and others by the California State Board of Pharmacy. Existing law imposes fees on these persons and pharmacies for, among other things, application, examination, licensure, and licensure renewal. Under existing law, these fees are fixed by the board based on a fee schedule that sets forth the minimum and maximum fees.

This bill would increase the minimum and maximum fees in that schedule and would make other conforming changes. Because the bill would increase fees that would be deposited into the Pharmacy Board Contingent Fund, which is continuously appropriated, the bill would make an appropriation.

(3) Existing law provides for the certification of interior designers, and repeals these provisions on January 1, 2010.

This bill would instead repeal these provisions on January 1, 2013.

(4) This bill would incorporate additional changes in Section 4110 of the Business and Professions Code proposed by SB 819, to be operative if

SB 819 and this bill become effective on or before January 1, 2010, and this bill is chaptered last.

(5) This bill would incorporate additional changes in Section 4160 of the Business and Professions Code proposed by SB 821, to be operative if SB 821 and this bill become effective on or before January 1, 2010, and this bill is chaptered last.

Appropriation: yes.

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

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

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

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

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

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

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

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

(d) This section shall 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. The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473).

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

2020. (a) The board may employ an executive director exempt from the provisions of the Civil Service Act and may also employ investigators, legal counsel, medical consultants, and other assistance as it may deem necessary to carry into effect this chapter. The board may fix the compensation to be paid for services subject to the provisions of applicable state laws and regulations and may incur other expenses as it may deem necessary. Investigators employed by the board shall be provided special training in investigating medical practice activities.

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

(c) 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. 3. Section 2460 of the Business and Professions Code is amended to read:

2460. (a) There is created within the jurisdiction of the Medical Board of California the California Board of Podiatric Medicine.

(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. The repeal of this section renders the California Board of Podiatric Medicine subject to the review required by Division 1.2 (commencing with Section 473).

SEC. 4. Section 2701 of the Business and Professions Code is amended to read:

2701. (a) There is in the Department of Consumer Affairs the Board of Registered Nursing consisting of nine members.

(b) Within the meaning of this chapter, board, or the board, refers to the Board of Registered Nursing. Any reference in state law to the Board of Nurse Examiners of the State of California or California Board of Nursing Education and Nurse Registration shall be construed to refer to the Board of Registered Nursing.

(c) 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. The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473).

SEC. 5. Section 2708 of the Business and Professions Code is amended to read:

2708. (a) The board shall appoint an executive officer who shall perform the duties delegated by the board and who shall be responsible to it for the accomplishment of those duties.

(b) The executive officer shall be a nurse currently licensed under this chapter and shall possess other qualifications as determined by the board.

(c) The executive officer shall not be a member of the board.

(d) 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. 6. Section 3010.5 of the Business and Professions Code is amended to read:

3010.5. (a) There is in the Department of Consumer Affairs a State Board of Optometry in which the enforcement of this chapter is vested. The board consists of 11 members, five of whom shall be public members.

Six members of the board shall constitute a quorum.

(b) The board shall, with respect to conducting investigations, inquiries, and disciplinary actions and proceedings, have the authority previously vested in the board as created pursuant to Section 3010. The board may enforce any disciplinary actions undertaken by that board.

(c) 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. The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473).

SEC. 7. Section 3014.6 of the Business and Professions Code is amended to read:

3014.6. (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, 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. 8. Section 3685 of the Business and Professions Code, as amended by Section 38 of Chapter 18 of the Fourth Extraordinary Session of the Statutes of 2009, is amended to read:

3685. (a) The repeal of this chapter renders the committee subject to the review required by Division 1.2 (commencing with Section 473).

(b) The committee shall prepare the report required by Section 473.2 no later than September 1, 2010.

SEC. 9. Section 3686 is added to the Business and Professions Code, to read:

3686. This chapter 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. 10. Section 3710 of the Business and Professions Code is amended to read:

3710. (a) The Respiratory Care Board of California, hereafter referred to as the board, shall enforce and administer this chapter.

(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. The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473).

SEC. 11. Section 4001 of the Business and Professions Code is amended to read:

4001. (a) There is in the Department of Consumer Affairs a California State Board of Pharmacy in which the administration and enforcement of this chapter is vested. The board consists of 13 members.

(b) The Governor shall appoint seven competent pharmacists who reside in different parts of the state to serve as members of the board. The Governor shall appoint four public members, and the Senate Committee on Rules and the Speaker of the Assembly shall each appoint a public member who shall not be a licensee of the board, any other board under this division, or any board referred to in Section 1000 or 3600.

(c) At least five of the seven pharmacist appointees to the board shall be pharmacists who are actively engaged in the practice of pharmacy. Additionally, the membership of the board shall include at least one pharmacist representative from each of the following practice settings: an acute care hospital, an independent community pharmacy, a chain community pharmacy, and a long-term health care or skilled nursing facility. The pharmacist appointees shall also include a pharmacist who is a member of a labor union that represents pharmacists. For the purposes of this subdivision, a "chain community pharmacy" means a chain of 75 or more stores in California under the same ownership, and an "independent community pharmacy" means a pharmacy owned by a person or entity who owns no more than four pharmacies in California.

(d) Members of the board shall be appointed for a term of four years. No person shall serve as a member of the board for more than two consecutive terms. Each member shall hold office until the appointment and qualification of his or her successor or until one year shall have elapsed since the expiration of the term for which the member was appointed, whichever first occurs. Vacancies occurring shall be filled by appointment for the unexpired term.

(e) Each member of the board shall receive a per diem and expenses as provided in Section 103.

(f) In accordance with Sections 101.1 and 473.1, 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. The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473).

SEC. 12. Section 4003 of the Business and Professions Code is amended to read:

4003. (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. The executive officer may or may not be a member of the board as the board may determine.

(b) The executive officer shall receive the compensation as established by the board with the approval of the Director of Finance. The executive officer shall also be entitled to travel and other expenses necessary in the performance of his or her duties.

(c) The executive officer shall maintain and update in a timely fashion records containing the names, titles, qualifications, and places of business of all persons subject to this chapter.

(d) The executive officer shall give receipts for all money received by him or her and pay it to the Department of Consumer Affairs, taking its receipt therefor. Besides the duties required by this chapter, the executive officer shall perform other duties pertaining to the office as may be required of him or her by the board.

(e) In accordance with Sections 101.1 and 473.1, 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. 13. Section 4110 of the Business and Professions Code is amended to read:

4110. (a) No person shall conduct a pharmacy in the State of California unless he or she has obtained a license from the board. A license shall be required for each pharmacy owned or operated by a specific person. A separate license shall be required for each of the premises of any person operating a pharmacy in more than one location. The license shall be renewed annually. The board may, by regulation, determine the circumstances under which a license may be transferred.

(b) The board may, at its discretion, issue a temporary permit, when the ownership of a pharmacy is transferred from one person to another, upon the conditions and for any periods of time as the board determines to be in the public interest. A temporary permit fee shall be required in an amount established by the board as specified in subdivision (a) of Section 4400. When needed to protect public safety, a temporary permit may be issued for a period not to exceed 180 days, and may be issued subject to terms and conditions the board deems necessary. If the board determines a temporary permit was issued by mistake or denies the application for a permanent license or registration, the temporary license or registration shall terminate upon either personal service of the notice of termination upon the permitholder or service by certified mail, return receipt requested, at the permitholder's address of record with the board, whichever comes first. Neither for purposes of retaining a temporary permit nor for purposes of any disciplinary or license denial proceeding before the board shall the temporary permitholder be deemed to have a vested property right or interest in the permit.

SEC. 13.5. Section 4110 of the Business and Professions Code is amended to read:

4110. (a) No person shall conduct a pharmacy in the State of California unless he or she has obtained a license from the board. A license shall be required for each pharmacy owned or operated by a specific person. A separate license shall be required for each of the premises of any person operating a pharmacy in more than one location. The license shall be renewed annually. The board may, by regulation, determine the circumstances under which a license may be transferred.

(b) The board may, at its discretion, issue a temporary permit, when the ownership of a pharmacy is transferred from one person to another, upon the conditions and for any periods of time as the board determines to be in the public interest. A temporary permit fee shall be required in an amount established by the board as specified in subdivision (a) of Section 4400. When needed to protect public safety, a temporary permit may be issued for a period not to exceed 180 days, and may be issued subject to terms and conditions the board deems necessary. If the board determines a temporary permit was issued by mistake or denies the application for a permanent license or registration, the temporary license or registration shall terminate

upon either personal service of the notice of termination upon the permitholder or service by certified mail, return receipt requested, at the permitholder's address of record with the board, whichever comes first. Neither for purposes of retaining a temporary permit nor for purposes of any disciplinary or license denial proceeding before the board shall the temporary permitholder be deemed to have a vested property right or interest in the permit.

(c) The board may allow the temporary use of a mobile pharmacy when a pharmacy is destroyed or damaged, the mobile pharmacy is necessary to protect the health and safety of the public, and the following conditions are met:

(1) The mobile pharmacy shall provide services only on or immediately contiguous to the site of the damaged or destroyed pharmacy.

(2) The mobile pharmacy is under the control and management of the pharmacist-in-charge of the pharmacy that was destroyed or damaged.

(3) A licensed pharmacist is on the premises while drugs are being dispensed.

(4) Reasonable security measures are taken to safeguard the drug supply maintained in the mobile pharmacy.

(5) The pharmacy operating the mobile pharmacy provides the board with records of the destruction of, or damage to, the pharmacy and an expected restoration date.

(6) Within three calendar days of restoration of the pharmacy services, the board is provided with notice of the restoration of the permanent pharmacy.

(7) The mobile pharmacy is not operated for more than 48 hours following the restoration of the permanent pharmacy.

SEC. 14. Section 4127.5 of the Business and Professions Code is repealed.

SEC. 15. Section 4127.8 of the Business and Professions Code is amended to read:

4127.8. The board may, at its discretion, issue a temporary license to compound injectable sterile drug products, when the ownership of a pharmacy that is licensed to compound injectable sterile drug products is transferred from one person to another, upon the conditions and for any periods of time as the board determines to be in the public interest. A temporary license fee shall be required in an amount established by the board as specified in subdivision (u) of Section 4400. When needed to protect public safety, a temporary license may be issued for a period not to exceed 180 days, and may be issued subject to terms and conditions the board deems necessary. If the board determines a temporary license was issued by mistake or denies the application for a permanent license, the temporary license shall terminate upon either personal service of the notice of termination upon the licenseholder or service by certified mail, return receipt requested at the licenseholder's address of record with the board, whichever comes first. Neither for purposes of retaining a temporary license nor for purposes of any disciplinary or license denial proceeding before the

board shall the temporary licenseholder be deemed to have a vested property right or interest in the license.

SEC. 16. Section 4160 of the Business and Professions Code is amended to read:

4160. (a) A person may not act as a wholesaler of any dangerous drug or dangerous device unless he or she has obtained a license from the board.

(b) Upon approval by the board and the payment of the required fee, the board shall issue a license to the applicant.

(c) A separate license shall be required for each place of business owned or operated by a wholesaler. Each license shall be renewed annually and shall not be transferable.

(d) The board shall not issue or renew a wholesaler license until the wholesaler identifies a designated representative-in-charge and notifies the board in writing of the identity and license number of that designated representative. The designated representative-in-charge shall be responsible for the wholesaler's compliance with state and federal laws governing wholesalers. A wholesaler shall identify and notify the board of a new designated representative-in-charge within 30 days of the date that the prior designated representative-in-charge ceases to be the designated representative-in-charge. A pharmacist may be identified as the designated representative-in-charge.

(e) A drug manufacturer premises licensed by the Food and Drug Administration or licensed pursuant to Section 111615 of the Health and Safety Code that only distributes dangerous drugs and dangerous devices of its own manufacture is exempt from this section and Section 4161.

(f) The board may issue a temporary license, upon conditions and for periods of time as the board determines to be in the public interest. A temporary license fee shall be required in an amount established by the board as specified in subdivision (f) of Section 4400. When needed to protect public safety, a temporary license may be issued for a period not to exceed 180 days, subject to terms and conditions that the board deems necessary. If the board determines that a temporary license was issued by mistake or denies the application for a permanent license, the temporary license shall terminate upon either personal service of the notice of termination upon the licenseholder or service by certified mail, return receipt requested, at the licenseholder's address of record with the board, whichever occurs first. Neither for purposes of retaining a temporary license, nor for purposes of any disciplinary or license denial proceeding before the board, shall the temporary licenseholder be deemed to have a vested property right or interest in the license.

(g) This section shall become operative on January 1, 2006.

SEC. 16.5. Section 4160 of the Business and Professions Code is amended to read:

4160. (a) A person may not act as a wholesaler of any dangerous drug or dangerous device unless he or she has obtained a license from the board.

(b) Upon approval by the board and the payment of the required fee, the board shall issue a license to the applicant.

(c) A separate license shall be required for each place of business owned or operated by a wholesaler. Each license shall be renewed annually and shall not be transferable.

(d) Every wholesaler shall be supervised or managed by a designated representative-in-charge. The designated representative-in-charge shall be responsible for the wholesaler's compliance with state and federal laws governing wholesalers. As part of its initial application for a license, and for each renewal, each wholesaler shall, on a form designed by the board, provide identifying information and the California license number for a designated representative or pharmacist proposed to serve as the designated representative-in-charge. The proposed designated representative-in-charge shall be subject to approval by the board. The board shall not issue or renew a wholesaler license without identification of an approved designated representative-in-charge for the wholesaler.

(e) Every wholesaler shall notify the board in writing, on a form designed by the board, within 30 days of the date when a designated representative-in-charge ceases to act as the designated representative-in-charge, and shall on the same form propose another designated representative or pharmacist to take over as the designated representative-in-charge. The proposed replacement designated representative-in-charge shall be subject to approval by the board. If disapproved, the wholesaler shall propose another replacement within 15 days of the date of disapproval, and shall continue to name proposed replacements until a designated representative-in-charge is approved by the board.

(f) A drug manufacturer premises licensed by the Food and Drug Administration or licensed pursuant to Section 111615 of the Health and Safety Code that only distributes dangerous drugs and dangerous devices of its own manufacture is exempt from this section and Section 4161.

(g) The board may issue a temporary license, upon conditions and for periods of time as the board determines to be in the public interest. A temporary license fee shall be required in an amount established by the board as specified in subdivision (f) of Section 4400. When needed to protect public safety, a temporary license may be issued for a period not to exceed 180 days, subject to terms and conditions that the board deems necessary. If the board determines that a temporary license was issued by mistake or denies the application for a permanent license, the temporary license shall terminate upon either personal service of the notice of termination upon the licenseholder or service by certified mail, return receipt requested, at the licenseholder's address of record with the board, whichever occurs first. Neither for purposes of retaining a temporary license, nor for purposes of any disciplinary or license denial proceeding before the board, shall the temporary licenseholder be deemed to have a vested property right or interest in the license.

SEC. 17. Section 4400 of the Business and Professions Code is amended to read:

4400. The amount of fees and penalties prescribed by this chapter, except as otherwise provided, is that fixed by the board according to the following schedule:

(a) The fee for a nongovernmental pharmacy license shall be four hundred dollars ($400) and may be increased to five hundred twenty dollars ($520). The fee for the issuance of a temporary nongovernmental pharmacy permit shall be two hundred fifty dollars ($250) and may be increased to three hundred twenty-five dollars ($325).

(b) The fee for a nongovernmental pharmacy license annual renewal shall be two hundred fifty dollars ($250) and may be increased to three hundred twenty-five dollars ($325).

(c) The fee for the pharmacist application and examination shall be two hundred dollars ($200) and may be increased to two hundred sixty dollars ($260).

(d) The fee for regrading an examination shall be ninety dollars ($90) and may be increased to one hundred fifteen dollars ($115). If an error in grading is found and the applicant passes the examination, the regrading fee shall be refunded.

(e) The fee for a pharmacist license and biennial renewal shall be one hundred fifty dollars ($150) and may be increased to one hundred ninety-five dollars ($195).

(f) The fee for a nongovernmental wholesaler license and annual renewal shall be six hundred dollars ($600), and may be increased to seven hundred eighty dollars ($780). The application fee for any additional location after licensure of the first 20 locations shall be two hundred twenty-five dollars ($225) and may be increased to three hundred dollars ($300). A temporary license fee shall be five hundred fifty dollars ($550) and may be increased to seven hundred fifteen dollars ($715).

(g) The fee for a hypodermic license and renewal shall be one hundred twenty-five dollars ($125) and may be increased to one hundred sixty-five dollars ($165).

(h) (1) The fee for application, investigation, and issuance of license as a designated representative pursuant to Section 4053 shall be two hundred fifty-five dollars ($255) and may be increased to three hundred thirty dollars ($330).

(2) The fee for the annual renewal of a license as a designated representative shall be one hundred fifty dollars ($150) and may be increased to one hundred ninety-five dollars ($195).

(i) (1) The fee for the application, investigation, and issuance of a license as a designated representative for a veterinary food-animal drug retailer pursuant to Section 4053 shall be two hundred fifty-five dollars ($255) and may be increased to three hundred thirty dollars ($330).

(2) The fee for the annual renewal of a license as a designated representative for a veterinary food-animal drug retailer shall be one hundred fifty dollars ($150) and may be increased to one hundred ninety-five dollars ($195).

(j) (1) The application fee for a nonresident wholesaler's license issued pursuant to Section 4161 shall be six hundred dollars ($600) and may be increased to seven hundred eighty dollars ($780).

(2) For nonresident wholesalers who have 21 or more facilities operating nationwide the application fees for the first 20 locations shall be six hundred dollars ($600) and may be increased to seven hundred eighty dollars ($780). The application fee for any additional location after licensure of the first 20 locations shall be two hundred twenty-five dollars ($225) and may be increased to three hundred dollars ($300). A temporary license fee shall be five hundred fifty dollars ($550) and may be increased to seven hundred fifteen dollars ($715).

(3) The annual renewal fee for a nonresident wholesaler's license issued pursuant to Section 4161 shall be six hundred dollars ($600) and may be increased to seven hundred eighty dollars ($780).

(k) The fee for evaluation of continuing education courses for accreditation shall be set by the board at an amount not to exceed forty dollars ($40) per course hour.

(*l*) The fee for an intern pharmacist license shall be ninety dollars ($90) and may be increased to one hundred fifteen dollars ($115). The fee for transfer of intern hours or verification of licensure to another state shall be twenty-five dollars ($25) and may be increased to thirty dollars ($30).

(m) The board may waive or refund the additional fee for the issuance of a license where the license is issued less than 45 days before the next regular renewal date.

(n) The fee for the reissuance of any license, or renewal thereof, that has been lost or destroyed or reissued due to a name change shall be thirty-five dollars ($35) and may be increased to forty-five dollars ($45).

(o) The fee for the reissuance of any license, or renewal thereof, that must be reissued because of a change in the information, shall be one hundred dollars ($100) and may be increased to one hundred thirty dollars ($130).

(p) 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 Pharmacy Board Contingent Fund equal to approximately one year's operating expenditures.

(q) The fee for any applicant for a nongovernmental clinic license shall be four hundred dollars ($400) and may be increased to five hundred twenty dollars ($520) for each license. The annual fee for renewal of the license shall be two hundred fifty dollars ($250) and may be increased to three hundred twenty-five dollars ($325) for each license.

(r) The fee for the issuance of a pharmacy technician license shall be eighty dollars ($80) and may be increased to one hundred five dollars ($105). The fee for renewal of a pharmacy technician license shall be one hundred dollars ($100) and may be increased to one hundred thirty dollars ($130).

(s) The fee for a veterinary food-animal drug retailer license shall be four hundred five dollars ($405) and may be increased to four hundred twenty-five dollars ($425). The annual renewal fee for a veterinary food-animal drug

retailer license shall be two hundred fifty dollars ($250) and may be increased to three hundred twenty-five dollars ($325).

(t) The fee for issuance of a retired license pursuant to Section 4200.5 shall be thirty-five dollars ($35) and may be increased to forty-five dollars ($45).

(u) The fee for issuance or renewal of a nongovernmental license to compound sterile drug products shall be six hundred dollars ($600) and may be increased to seven hundred eighty dollars ($780). The fee for a temporary license shall be five hundred fifty dollars ($550) and may be increased to seven hundred fifteen dollars ($715).

SEC. 18. Section 5810 of the Business and Professions Code is amended to read:

5810. (a) This chapter shall be subject to the review required by Division 1.2 (commencing with Section 473).

(b) This chapter 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 13.5 of this bill incorporates amendments to Section 4110 of the Business and Professions Code proposed by this bill and SB 819. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2010, (2) each bill amends Section 4110 of the Business and Profession Code, and (3) this bill is enacted after SB 819, in which case Section 4110 of the Business and Professions Code, as amended by SB 819, shall remain operative only until the operative date of this bill, at which time Section 13.5 of this bill shall become operative, and Section 13 of this bill shall not become operative.

SEC. 20. Section 16.5 of this bill incorporates amendments to Section 4160 of the Business and Professions Code proposed by both this bill and SB 821. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2010, (2) each bill amends Section 4160 of the Business and Professions Code, and (3) this bill is enacted after SB 821, in which case Section 16 of this bill shall not become operative.

O

AB 1116

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1116
Author: Carter
Chapter: #509
Subject: Cosmetic surgery: Physical examination prior to surgery
Sponsor: Author
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill enacts the Donda West Law, and would require that physicians or dentists conduct a physical examination on patients prior to performing elective cosmetic surgery, including liposuction.

The legislation adds Business and Professions Code sections 1638.2 (dentists) and 2259.8 (physicians) which would prohibit performing cosmetic surgery unless the patient has received a physical examination and written clearance from one of the following:

- A licensed physician and surgeon, which may be the surgeon performing the surgery;
- A nurse practitioner;
- A physician assistant, or;
- A dentist licensed to perform surgery under section 1634 of the Business and Professions Code.

The examination must include the taking of a complete medical history.

IMPLEMENTATION:

- Newsletter article
- Notify Board staff

October 14, 2009

Assembly Bill No. 1116

CHAPTER 509

An act to add Sections 1638.2 and 2259.8 to the Business and Professions Code, relating to cosmetic surgery.

[Approved by Governor October 11, 2009. Filed with Secretary of State October 11, 2009.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1116, Carter. Cosmetic surgery.

Existing law, the Dental Practice Act, establishes the Dental Board of California in the Department of Consumer Affairs, which licenses dentists and regulates their practice, including dentists who hold a permit to perform oral and maxillofacial surgery. Existing law, the Medical Practice Act, establishes the Medical Board of California in the Department of Consumer Affairs, which licenses physicians and surgeons and regulates their practice.

The Medical Practice Act requires specified disclosures to patients undergoing procedures involving collagen injections, and also requires the Medical Board of California to adopt extraction and postoperative care standards in regard to body liposuction procedures performed by a physician and surgeon outside of a general acute care hospital. Existing law makes a violation of these provisions a misdemeanor.

This bill would enact the Donda West Law, which would prohibit the performance of an elective cosmetic surgery procedure on a patient unless, within 30 days prior to the procedure, the patient has received an appropriate physical examination by, and has received written clearance for the procedure from, a licensed physician and surgeon, a certified nurse practitioner, or a licensed physician assistant, as specified, or, as applied to an elective facial cosmetic surgery procedure, a licensed dentist or licensed physician and surgeon. The bill would require the physical examination to include the taking of an appropriate medical history, to be confirmed on the day of the procedure. The bill would also provide that a violation of these provisions would not constitute a crime.

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

SECTION 1. This act shall be known and may be cited as the Donda West Law.

SEC. 2. Section 1638.2 is added to the Business and Professions Code, to read:

1638.2. (a) Notwithstanding any other provision of law, a person licensed pursuant to Section 1634 who holds a permit to perform elective

facial cosmetic surgery issued pursuant to this article may not perform elective facial cosmetic surgery on a patient, unless the patient has received, within 30 days prior to the elective facial cosmetic surgery procedure, and confirmed as up-to-date on the day of the procedure, an appropriate physical examination by, and written clearance for the procedure from, either of the following:

(1) A licensed physician and surgeon.

(2) A person licensed pursuant to Section 1634 who holds a permit to perform elective facial cosmetic surgery issued pursuant to this article.

(b) The physical examination described in subdivision (a) shall include the taking of an appropriate medical history.

(c) An appropriate medical history and physical examination done on the day of the procedure shall be presumed to be in compliance with subdivisions (a) and (b).

(d) A violation of this section shall not constitute a crime.

SEC. 3. Section 2259.8 is added to the Business and Professions Code, to read:

2259.8. (a) Notwithstanding any other provision of law, an elective cosmetic surgery procedure may not be performed on a patient unless the patient has received, within 30 days prior to the elective cosmetic surgery procedure, and confirmed as up-to-date on the day of the procedure, an appropriate physical examination by, and written clearance for the procedure from, any of the following:

(1) The physician and surgeon who will be performing the surgery.

(2) Another licensed physician and surgeon.

(3) A certified nurse practitioner, in accordance with a certified nurse practitioner's scope of practice, unless limited by protocols or a delegation agreement.

(4) A licensed physician assistant, in accordance with a licensed physician assistant's scope of practice, unless limited by protocols or a delegation agreement.

(b) The physical examination described in subdivision (a) shall include the taking of an appropriate medical history.

(c) An appropriate medical history and physical examination done on the day of the procedure shall be presumed to be in compliance with subdivisions (a) and (b).

(d) "Elective cosmetic surgery" means an elective surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance, including, but not limited to, liposuction and elective facial cosmetic surgery.

(e) Section 2314 shall not apply to this section.

O

AB 1310

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1310
Author: Hernandez
Bill Date: June 29, 2009, amended
Subject: Healing Arts: database
Sponsor: Author
Board Position: Support

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Office of Statewide Health Planning (OSHPD) to obtain additional information from all healing arts boards.

Amendments to this bill made the collecting of the information permissive instead of mandatory.

ANALYSIS:

Under current law, a healthcare workforce clearinghouse, created by SB 139 (Scott), is charged with collecting data from the various health boards. The intent is to establish an ongoing data stream of changes in California's health workforce and provide the necessary information needed to make complex policy changes to meet California's health workforce needs. Currently, healing arts boards are not mandated to provide any information to the clearinghouse which makes it difficult for the Office of Statewide Health Planning and Development (OSHPD) to produce the necessary results.

This bill would require all of the health licensing boards to collect and submit specific data on age, race, gender, practice location, type of practice to the clearinghouse, etc. This will enhance the state's ability to address health workforce shortages and also identify communities that have the highest need for health professionals.

The Medical Board (Board) already requests much of the data collection required in this bill. According to the author, it was this good work being done by the Board that prompted the drafting of this bill to require the same efforts from all other healing arts boards.

New requirements that are not maintained on our computer system include location of high school, description of primary practice setting, and additional practice locations.

This bill was amended to make the collecting of the information permissive rather than mandatory. This addresses the concerns raised by the Board allowing the position on this bill to transition to 'support' from 'support if amended.'

FISCAL: Unknown

POSITION: Support

September 26, 2009

AMENDED IN SENATE JUNE 29, 2009

AMENDED IN ASSEMBLY JUNE 2, 2009

AMENDED IN ASSEMBLY APRIL 2, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 1310

Introduced by Assembly Member Hernandez

February 27, 2009

An act to add Section 857 to the Business and Professions Code, *and to add Section 128051.5 to the Health and Safety Code,* relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1310, as amended, Hernandez. Healing arts: database.

Existing law provides for the licensure and regulation of various healing arts professions and vocations by boards within the Department of Consumer Affairs. Under existing law, there exists the Healthcare Workforce Development Division within the Office of Statewide Health Planning and Development (OSHPD) that supports health care accessibility through the promotion of a diverse and competent workforce and provides analysis of California's health care infrastructure. Under existing law, there is also the Health Care Workforce Clearinghouse, established by OSHPD, that serves as the central source for collection, analysis, and distribution of information on the health care workforce employment and educational data trends for the state.

This bill would require ~~the Medical Board of California and the Board of Registered Nursing~~ *certain healing arts boards* to ~~add and label as "mandatory" specified fields on an application for initial licensure or~~

~~a renewal form for applicants applying to those boards~~ *collect specified information from their licensees and would require those boards and the Department of Consumer Affairs to, as much as practicable, work with OSHPD to transfer that data to the Health Care Workforce Clearinghouse*. The bill would *further* require ~~the department~~ *OSHPD*, in consultation with the division and th~~e clearinghouse~~ *department*, to select a database and to *also* add ~~some of~~ the *collected* data ~~collected in these applications and renewal forms~~ to the database ~~and to submit the data to the clearinghouse annually on or before January 1~~. The bill would require the clearinghouse to prepare a written report relating to the data and to submit the report annually to the Legislature no later than March 1, commencing March 1, 2012.

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

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

1 SECTION 1. Section 857 is added to the Business and
2 Professions Code, to read:
3 857. (a) ~~Each~~ *Every* healing arts board specified in subdivision
4 ~~(c) shall add and label as "mandatory" the following fields on an~~
5 ~~application for initial licensure or renewal for a person applying~~
6 ~~to that board:~~
7 ~~(1) First name, middle name, and last name.~~
8 ~~(2) Last four digits of social security number.~~
9 ~~(3) Complete mailing address.~~ *(f) shall, in a manner deemed*
10 *appropriate by the board, collect the following information from*
11 *persons licensed, certified, registered, or otherwise subject to*
12 *regulation by that board:*
13 ~~(4)~~
14 *(1)* Educational background and training, including, but not
15 limited to, degree, related school name and location, and year of
16 graduation, and, as applicable, the highest professional degree
17 obtained, related professional school name and location, and year
18 of graduation.
19 ~~(5)~~
20 *(2)* Birth date and place of birth.
21 ~~(6)~~
22 *(3)* Sex.
23 ~~(7)~~

(4) Race and ethnicity.

~~(8)~~

(5) Location of high school.

~~(9) Mailing address of primary practice, if applicable.~~

~~(10)~~

(6) Number of hours per week spent at primary practice location, if applicable.

~~(11)~~

(7) Description of primary practice setting, if applicable.

~~(12)~~

(8) Primary practice information, including, but not limited to, primary specialty practice, practice location ZIP Code, and county.

~~(13)~~

(9) Information regarding any additional practice, including, but not limited to, a description of practice setting, practice location ZIP Code, and county.

~~(b) The department, in consultation with the Healthcare Workforce Development Division and the Health Care Workforce Clearinghouse, shall select a database and shall add the data specified in paragraphs (5) to (13), inclusive, of subdivision (a) to that database.~~

~~(c) The following boards are subject to subdivision (a):~~

~~(1) The Medical Board of California.~~

~~(2) The Board of Registered Nursing.~~

~~(d) (1) The department shall collect the specified data in the database pursuant to subdivision (b) and shall submit that data to Health Care Workforce Clearinghouse annually on or before January 1.~~

~~(2) The Health Care Workforce Clearinghouse shall prepare a written report containing the findings of this data and shall submit the written report annually to the Legislature no later than March 1, commencing March 1, 2012.~~

(b) The information collected pursuant to this section shall be used for the purpose of measuring and evaluating the state's health care workforce development needs. For this purpose, the department and the boards specified in subdivision (f) shall, as much as practicable, work with the Office of Statewide Health Planning and Development to transfer the data collected pursuant to this section to the Health Care Workforce Clearinghouse.

(c) Personally identifiable information collected pursuant to this section shall be confidential and not subject to public inspection.

(d) A board that collects information pursuant to this section shall state in a conspicuous manner that reporting the information is not a condition of license renewal, and that no adverse action will be taken against any licensee that does not report any information.

(e) A board that collects information pursuant to this section shall do so in a manner that minimizes any fiscal impact, which may include, but is not limited to, sending the request for information in a renewal notice, a regular newsletter, via electronic mail, or posting the request on the board's Internet Web site, and by allowing licensees to provide the information to the board electronically.

(f) The following boards are subject to this section:

(1) The Acupuncture Board.

(2) The Dental Hygiene Committee of California.

(3) The Dental Board of California.

(4) The Medical Board of California.

(5) The Bureau of Naturopathic Medicine.

(6) The California Board of Occupational Therapy.

(7) The State Board of Optometry.

(8) The Osteopathic Medical Board of California.

(9) The California State Board of Pharmacy.

(10) The Physical Therapy Board of California.

(11) The Physician Assistant Committee, Medical Board of California.

(12) The California Board of Podiatric Medicine.

(13) The Board of Psychology.

(14) The Board of Registered Nursing.

(15) The Respiratory Care Board of California.

(16) The Speech-Language Pathology and Audiology Board.

(17) The Board of Vocational Nursing and Psychiatric Technicians of the State of California.

(18) The Board of Behavioral Sciences.

SEC. 2. Section 128051.5 is added to the Health and Safety Code, to read:

128051.5. (a) The Office of Statewide Health Planning and Development shall, in consultation with the Healthcare Workforce

1 *Development Division and the Department of Consumer Affairs,*
2 *select a database and shall add the data collected pursuant to*
3 *Section 857 of the Business and Professions Code to that database.*
4 *(b) The Health Care Workforce Clearinghouse shall prepare a*
5 *written report containing the findings of this data and shall submit*
6 *the written report annually to the Legislature no later than March*
7 *1, commencing March 1, 2012.*

O

SB 132

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 132
Author: Denham
Bill Date: August 31, 2009, amended
Subject: Polysomnographic Technologists (urgent)
Sponsor: California Sleep Society
Board Position: Support

STATUS OF BILL:

This bill is currently on Senate Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require registration for individuals assisting physicians in the practice of sleep medicine. This bill further requires such individuals to meet certain qualifications including educational requirements, background checks, and other consumer protections.

ANALYSIS:

Sleep medicine has been recognized as a specialty by the American Medical Association since 1996. Physician sleep specialists are board certified, and the American Board of Sleep Medicine is one of the specialty boards officially recognized and approved by the Medical Board.

Recently, the California Respiratory Care Board has threatened to issue significant fines against those involved in assisting with the practice of sleep medicine. This has threatened the availability of these important medical services.

On August 24, 2007 the California Respiratory Care Board passed a motion to move forward with issuing citations against the unlicensed individuals engaged in the practice of sleep medicine. This has caused a great deal of concern and uncertainty amongst medical professionals who treat patients with sleep disorders.

This bill would provide consumer protections to patients seeking sleep disorder treatment, and helps clarify existing law as it relates to polysomnography. Specifically this bill:

a) establishes the criteria necessary for becoming a certified polysomnographic technologist;
b) requires that the polysomnographic technologists work under the supervision and direction of a licensed physician;

c) requires background checks for polysomnographic technologists;
d) defines the term "polysomnography" and permits polysomnographic technologists to engage in the practice of polysomnography as long as they satisfy the criteria in the bill (this bill places no limitations on other health care practitioners acting within their own scope of practice); and
e) Defines the terms "polysomnographic technician" and "polysomnographic trainee" and permits those individuals to act under the supervision of a certified polysomnographic technologist or licensed physician.

This bill requires the Board to develop regulations relative to the qualifications for registration of these three classifications. This must be done within a year of the effective date of the legislation. According to staff, the Board should be able to meet this requirement for adoption since most of the preliminary work on qualifications was done in the previous year.

In addition, within one year, the Board must adopt regulations regarding the employment of technicians and trainees by the physician. This may include the scope of services and level of supervision. This will require some work with the sponsor and interested parties but should be able to be accomplished in the time frame specified.

Amendments taken in June to this bill change the $100 registration fee to a $50 application fee and a $50 registration fee. This amendment is to make this registration program similar to other licensure and registration programs that are operated on a neutral cost basis. This process will allow the Board to cover the cost of application review and then registration. Fees are split as some applications may be denied registration as a result of the fingerprint or background check thereby allowing the Board to be compensated for its work but not over collecting for work that may not be necessary.

This bill was amended July 6, 2009 to require each applicant to pay a registration fee of no more than $100 with a biennial renewal of $100. This increase from $50 is expected to make the cost of the program "cost neutral" after the initial one year start up.

Amendments to this bill taken August 31, 2009 change the registration renewal fee from $100 to $150 to make the bill cost neutral.

FISCAL: Expenditure of approximately $88,000 for the first year and $58,000 ongoing. Revenue of approximately $54,600 for the first year, $1,200 for the second year, and then $27,800 per year ongoing.

POSITION: Support

September 29, 2009

AMENDED IN ASSEMBLY AUGUST 31, 2009

AMENDED IN ASSEMBLY JULY 6, 2009

AMENDED IN ASSEMBLY JUNE 24, 2009

AMENDED IN SENATE MAY 14, 2009

AMENDED IN SENATE APRIL 27, 2009

SENATE BILL No. 132

Introduced by Senator Denham

February 9, 2009

An act to add Chapter 7.8 (commencing with Section 3575) to Division 2 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

SB 132, as amended, Denham. Polysomnographic technologists: sleep and wake disorders.

Existing law, the Physician Assistant Practice Act, provides for the licensure and regulation of physician assistants by the Physician Assistant Committee of the Medical Board of California. Existing law prescribes the medical services that may be performed by a physician assistant under the supervision of a licensed physician and surgeon.

Existing law, the Respiratory Care Practice Act, provides for the licensure and regulation of respiratory professionals by the Respiratory Care Board of California. Existing law defines the practice of respiratory therapy and prohibits its practice without a license issued by the board, subject to certain exceptions.

This bill would require the Medical Board of California to adopt regulations within one year after the effective date of this act relative to the qualifications for certified polysomnographic technologists, including requiring those technologists to be credentialed by a board-approved national accrediting agency, to have graduated from a board-approved educational program, and to have passed a board-approved national certifying examination, with a specified exception for that examination requirement for a 3-year period. The bill would prohibit a person from using the title "certified polysomnographic technologist" or engaging in the practice of polysomnography unless he or she undergoes a Department of Justice background check, as specified, is registered as a certified polysomnographic technologist, is supervised and directed by a licensed physician and surgeon, and meets certain other requirements. The bill would define polysomnography to mean the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders, as specified. The bill would further require the board, within one year after the effective date of this act, to adopt regulations related to the employment of polysomnographic technicians and trainees.

This bill would require polysomnographic technologists to apply to and register with the Medical Board of California for fees to be fixed by the board at no more than $100 each, and to renew their registration biennially for a fee of no more than ~~$100~~ *$150*. The bill would require the deposit of those fees in the Contingent Fund of the Medical Board of California, a continuously appropriated fund, thereby making an appropriation. The bill would further set forth specified disciplinary standards and procedures.

The bill would specify that these provisions do not apply to diagnostic electroencephalograms conducted in accordance with the guidelines of the American Clinical Neurophysiology Society.

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

Vote: ⅔. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

1 SECTION 1. Chapter 7.8 (commencing with Section 3575) is
2 added to Division 2 of the Business and Professions Code, to read:

Chapter 7.8. Polysomnographic Technologists

3575. (a) For the purposes of this chapter, the following definitions shall apply:

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

(2) "Polysomnography" means the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders. Polysomnography shall include, but not be limited to, the process of analysis, monitoring, and recording of physiologic data during sleep and wakefulness to assist in the treatment of disorders, syndromes, and dysfunctions that are sleep-related, manifest during sleep, or disrupt normal sleep activities. Polysomnography shall also include, but not be limited to, the therapeutic and diagnostic use of oxygen, the use of positive airway pressure including continuous positive airway pressure (CPAP) and bilevel modalities, adaptive servo-ventilation, and maintenance of nasal and oral airways that do not extend into the trachea.

(3) "Supervision" means that the supervising physician and surgeon shall remain available, either in person or through telephonic or electronic means, at the time that the polysomnographic services are provided.

(b) Within one year after the effective date of this chapter, the board shall promulgate regulations relative to the qualifications for the registration of individuals as certified polysomnographic technologists, polysomnographic technicians, and polysomnographic trainees. The qualifications for a certified polysomnographic technologist shall include all of the following:

(1) He or she shall have valid, current credentials as a polysomnographic technologist issued by a national accrediting agency approved by the board.

(2) He or she shall have graduated from a polysomnographic educational program that has been approved by the board.

(3) He or she shall have passed a national certifying examination that has been approved by the board, or in the alternative, may submit proof to the board that he or she has been practicing polysomnography for at least five years in a manner that is acceptable to the board. However, beginning three years after the effective date of this chapter, all individuals seeking to obtain certification as a polysomnographic technologist shall have passed

a national certifying examination that has been approved by the board.

(c) In accordance with Section 144, any person seeking registration from the board as a certified polysomnographic technologist, a polysomnographic technician, or a polysomnographic trainee shall be subject to a state and federal level criminal offender record information search conducted through the Department of Justice as specified in paragraphs (1) to (5), inclusive, of this subdivision.

(1) The board shall submit to the Department of Justice fingerprint images and related information required by the Department of Justice of all polysomnographic technologist, technician, or trainee certification candidates for the purposes of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and also information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her recognizance pending trial or appeal.

(2) When received, the Department of Justice shall forward to the Federal Bureau of Investigation requests for federal summary criminal history information received pursuant to this subdivision. The Department of Justice shall review the information returned from the Federal Bureau of Investigation and compile and disseminate a response to the board.

(3) The Department of Justice shall provide state and federal responses to the board pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(4) The board shall request from the Department of Justice subsequent arrest notification service, pursuant to Section 11105.2 of the Penal Code, for persons described in this subdivision.

(5) The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this subdivision. The individual seeking registration shall be responsible for this cost.

(d) An individual may use the title "certified polysomnographic technologist" and may engage in the practice of polysomnography only under the following circumstances:

(1) He or she is registered with the board and has successfully undergone a state and federal level criminal offender record information search pursuant to subdivision (c).

(2) He or she works under the supervision and direction of a licensed physician and surgeon.

(3) He or she meets the requirements of this chapter.

(e) Within one year after the effective date of this chapter, the board shall adopt regulations that establish the means and circumstances in which a licensed physician and surgeon may employ polysomnographic technicians and polysomnographic trainees. The board may also adopt regulations specifying the scope of services that may be provided by a polysomnographic technician or polysomnographic trainee. Any regulation adopted pursuant to this section may specify the level of supervision that polysomnographic technicians and trainees are required to have when working under the supervision of a certified polysomnographic technologist or licensed health care professional.

(f) This section shall not apply to California licensed allied health professionals, including, but not limited to, respiratory care practitioners, working within the scope of practice of their license.

(g) Nothing in this chapter shall be interpreted to authorize a polysomnographic technologist, technician, or trainee to treat, manage, control, educate, or care for patients other than those with sleep disorders or to provide diagnostic testing for patients other than those with suspected sleep disorders.

3576. (a) A registration under this chapter may be denied, suspended, revoked, or otherwise subjected to discipline for any of the following by the holder:

(1) Incompetence, gross negligence, or repeated similar negligent acts performed by the registrant.

(2) An act of dishonesty or fraud.

(3) Committing any act or being convicted of a crime constituting grounds for denial of licensure or registration under Section 480.

(4) Violating or attempting to violate any provision of this chapter or any regulation adopted under this chapter.

(b) Proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all powers granted therein.

3577. (a) Each person who applies for registration under this chapter shall pay into the Contingent Fund of the Medical Board of California a fee to be fixed by the board at a sum not in excess of one hundred dollars ($100).

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

(c) The registration shall expire after two years. The registration may be renewed biennially at a fee which shall be paid into the Contingent Fund of the Medical Board of California to be fixed by the board at a sum not in excess of one hundred ~~dollars ($100)~~ *fifty dollars ($150)*.

(d) The money in the Contingent Fund of the Medical Board of California that is collected pursuant to this section shall be used for the administration of this chapter.

3578. Nothing in this chapter shall prohibit a clinic or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code from employing a certified polysomnographic technologist.

3579. Nothing in this chapter shall apply to diagnostic electroencephalograms conducted in accordance with the guidelines of the American Clinical Neurophysiology Society.

SEC. 2. 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 protect the health and safety of the general public by providing needed qualifications for, and oversight of, the practice of polysomnography at the earliest possible time, it is necessary that this act take effect immediately.

O

SB 294

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 294
Author: Negrete McLeod
Bill Date: September 4, 2009, amended
Subject: Healing Arts: Enforcement
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Assembly Business and Professions Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish reforms to the enforcement process for all healing arts boards under the Department of Consumer Affairs (DCA).

ANALYSIS:

This bill makes several changes to sections of the Business and Professions Code that pertain to various healing arts boards in order to enhance consumer protection and attempt to decrease enforcement timelines.

Some of these provisions would require boards to develop performance standards that they must then meet. This bill also contains specified changes to the laws regarding establishment of an appropriate burden of proof for discipline and authority to immediately suspend a license based on probable cause that a licensee poses an imminent risk to patients and the public.

FISCAL: Unknown

POSITION: None

October 19, 2009

AMENDED IN ASSEMBLY SEPTEMBER 4, 2009

AMENDED IN ASSEMBLY JULY 1, 2009

AMENDED IN ASSEMBLY JUNE 8, 2009

AMENDED IN SENATE MARCH 31, 2009

SENATE BILL No. 294

Introduced by Senator Negrete McLeod

February 25, 2009

~~An act to add Section 2835.7 to the Business and Professions Code, relating to nurse practitioners.~~ *An act to amend Sections 27, 116, 160, 726, 802.1 803, 803.5, 803.6, 1695.5, 2365, 2663, 2666, 2715, 2770.7, 3534.1, 3534.5, 4365, 4369, and 4870 of, to add Sections 1695.7, 1699.2, 2365.5, 2372, 2669.2, 2770.16, 2770.18, 2835.7, 3534.12, 4375, 4870.5, and 4873.2 to, to add Article 10.1 (commencing with Section 720) to Chapter 1 of Division 2 of, to add and repeal Section 2719 of, and to repeal Article 4.7 (commencing with Section 1695) of Chapter 4 of, Article 15 (commencing with Section 2360) of Chapter 5 of, Article 5.5 (commencing with Section 2662) of Chapter 5.7 of, Article 3.1 (commencing with Section 2770) of Chapter 6 of, Article 6.5 (commencing with Section 3534) of Chapter 7.7 of, Article 21 (commencing with Section 4360) of Chapter 9 of, and Article 3.5 (commencing with Section 4860) of Chapter 11 of, Division 2 of, the Business and Professions Code, relating to healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

SB 294, as amended, Negrete McLeod. ~~Nurse practitioners.~~ *Healing arts.*

Existing law provides for the regulation of healing arts licensees by various boards within the Department of Consumer Affairs. The department is under the control of the Director of Consumer Affairs.

(1) Existing law requires certain boards within the department to disclose on the Internet information on their respective licensees.

This bill would additionally require specified healing arts boards to disclose on the Internet information on their respective licensees.

Existing law authorizes the director to audit and review, among other things, inquiries and complaints regarding licensees, dismissals of disciplinary cases, and discipline short of formal accusation by the Medical Board of California and the California Board of Podiatric Medicine.

This bill would additionally authorize the director to audit and review the aforementioned activities by any of the healing arts boards. The bill would also declare the intent of the Legislature that the department establish an information technology system to create and update healing arts license information and track enforcement cases pertaining to these licensees.

Existing law requires a physician and surgeon, osteopathic physician and surgeon, and a doctor of podiatric medicine to report to his or her respective board when there is an indictment or information charging a felony against the licensee or he or she been convicted of a felony or misdemeanor.

This bill would expand that requirement to any licensee of a healing arts board, as specified, would require these licensees to submit a written report, and would require a report when disciplinary action is taken against a licensee by another healing arts board or by a healing arts board of another state.

Existing law requires the district attorney, city attorney, and other prosecuting agencies to notify the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, the State Board of Chiropractic Examiners, and other allied health boards and the court clerk if felony charges have been filed against one of the board's licensees.

This bill would instead require that notice to be provided to any healing arts board and the court clerk if felony charges are filed against a licensee. By imposing additional duties on these local agencies, the bill would impose a state-mandated local program.

Existing law requires, within 10 days after a court judgment, the clerk of the court to report to the appropriate board when a licentiate has

committed a crime or is liable for any death or personal injury resulting in a specified judgment. Existing law also requires the clerk of the court to transmit to certain boards specified felony preliminary transcript hearings concerning a defendant licentiate.

This bill would instead require the clerk of the court to report that information and to transmit those transcripts to any described healing arts board.

(2) Under existing law, healing arts licensees are regulated by various boards and these boards are authorized to issue, deny, suspend, and revoke licenses based on various grounds and these boards are also authorized to take disciplinary action against their licensees for the failure to comply with its laws and regulations. Existing law requires or authorizes the board to appoint an executive officer or an executive director to, among other things, perform duties delegated by the board.

This bill would authorize the executive officer or the executive director of specified healing arts licensing boards, where an administrative action has been filed by the board to revoke the license of a licensee and the licensee has failed to file a notice of defense, appear at the hearing, or has agreed to surrender his or her license, to adopt a proposed default decision or a proposed settlement agreement. The bill would also provide that the license of a licensee shall be suspended if the licensee is incarcerated after the conviction of a felony and would require the board to notify the licensee of the suspension and of his or her right to a specified hearing. The bill would also specify the timeframes for suspending a license under certain circumstances if the conviction was substantially related to the qualifications, functions, or duties of the licensee's respective board.

The bill would also prohibit a licensee of specified healing arts boards from including certain provisions in an agreement to settle a civil dispute arising from his or her practice, as specified. The bill would make a licensee or a health care facility that fails to comply with a patient's medical record request, as specified, within 15 days, or who fails or refuses to comply with a court order mandating release of records, subject to civil and criminal penalties, as specified. By creating a new crime, the bill would impose a state-mandated local program.

The bill would authorize the Attorney General and his or her investigative agents, and these healing arts boards to inquire into any alleged violation of the laws under the board's jurisdiction and to inspect documents subject to specified procedures.

The bill would require these healing arts boards to report annually, by October 1, to the department and the Legislature certain information, including, but not limited to, the total number of consumer calls received by the board, the total number of complaint forms received by the board, the total number of convictions reported to the board, and the total number of licensees in diversion or on probation for alcohol or drug abuse.

(3) Existing law establishes diversion and recovery programs to identify and rehabilitate dentists, osteopathic physicians and surgeons, physical therapists and physical therapy assistants, registered nurses, physician assistants, pharmacists and intern pharmacists, and veterinarians and registered veterinary technicians whose competency may be impaired due to, among other things, alcohol and drug abuse.

The bill would make the provisions establishing these diversion programs inoperative on January 1, 2012.

Existing law makes a licentiate terminated from a diversion program for failing to comply with the program's requirements subject to disciplinary action by his or her respective board.

This bill would instead provide that the participant's license shall be suspended until the participant petitions the board for reinstatement of his or her license, certificate, or board approval and is granted a probationary or unrestricted license, certificate, or board approval. The bill would also require a third party or state agency or private organization administering the diversion program to report, as specified, to the program manager or chairperson any act of substantial noncompliance, as defined, by the participant with the program.

(4) Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurses by the Board of Registered Nursing. Existing law authorizes the board to employ personnel as it deems necessary to carry out the act's provisions, except that the employment of personnel to provide investigative services shall be in the Division of Investigations within the Department of Consumer Affairs.

This bill would remove that limitation and would authorize the board to employ investigators, nurse consultants, and other personnel as it deems necessary. The bill would also specify that these investigators have the authority of peace officers while carrying out their board duties.

The bill would require the Director of Consumer Affairs, by March 1, 2010, to appoint an enforcement program monitor to serve until October 1, 2011, who would be required to, among other things, monitor

and evaluate the board's disciplinary system and procedures. The bill would prohibit the enforcement program monitor from exercising authority over the board's disciplinary operations or staff. The bill would require the enforcement program monitor, by December 1, 2010, to submit a specified initial written report to the board, the department, and the Legislature and to issue a final written report by October 1, 2011.

Existing law~~, the Nursing Practice Act,~~ provides for the certification and regulation of nurse practitioners and nurse-midwives by the Board of Registered Nursing and specifies requirements for qualification or certification as a nurse practitioner. Under the act, the practice of nursing is defined, in part, as providing direct and indirect patient care services, as specified, including the dispensing of drugs or devices under specified circumstances. The practice of nursing is also described as the implementation, based on observed abnormalities, of standardized procedures, defined as policies and protocols developed by specified facilities in collaboration with administrators and health professionals, including physicians and surgeons and nurses.

This bill would authorize the implementation of standardized procedures that would expand the duties of a nurse practitioner in the scope of his or her practice, as enumerated. The bill would make specified findings and declarations in that regard.

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

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

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

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

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

1 *SECTION 1. Section 27 of the Business and Professions Code*
2 *is amended to read:*

27. (a) Every entity specified in subdivision (b)~~, on or after July 1, 2001,~~ shall provide on the Internet information regarding the status of every license issued by that entity in accordance with the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code). The public information to be provided on the Internet shall include information on suspensions and revocations of licenses issued by the entity and other related enforcement action taken by the entity relative to persons, businesses, or facilities subject to licensure or regulation by the entity. In providing information on the Internet, each entity shall comply with the Department of Consumer Affairs Guidelines for Access to Public Records. The information may not include personal information, including home telephone number, date of birth, or social security number. Each entity shall disclose a licensee's address of record. However, each entity shall allow a licensee to provide a post office box number or other alternate address, instead of his or her home address, as the address of record. This section shall not preclude an entity from also requiring a licensee, who has provided a post office box number or other alternative mailing address as his or her address of record, to provide a physical business address or residence address only for the entity's internal administrative use and not for disclosure as the licensee's address of record or disclosure on the Internet.

(b) Each of the following entities within the Department of Consumer Affairs shall comply with the requirements of this section:

(1) The Acupuncture Board shall disclose information on its licensees.

(2) The Board of Behavioral Sciences shall disclose information on its licensees, including marriage and family therapists, licensed clinical social workers, and licensed educational psychologists.

(3) The Dental Board of California shall disclose information on its licensees.

(4) The State Board of Optometry shall disclose information regarding certificates of registration to practice optometry, statements of licensure, optometric corporation registrations, branch office licenses, and fictitious name permits of their licensees.

(5) The Board for Professional Engineers and Land Surveyors shall disclose information on its registrants and licensees.

(6) The Structural Pest Control Board shall disclose information on its licensees, including applicators, field representatives, and operators in the areas of fumigation, general pest and wood destroying pests and organisms, and wood roof cleaning and treatment.

(7) The Bureau of Automotive Repair shall disclose information on its licensees, including auto repair dealers, smog stations, lamp and brake stations, smog check technicians, and smog inspection certification stations.

(8) The Bureau of Electronic and Appliance Repair shall disclose information on its licensees, including major appliance repair dealers, combination dealers (electronic and appliance), electronic repair dealers, service contract sellers, and service contract administrators.

(9) The Cemetery ~~Program~~ *and Funeral Bureau* shall disclose information on its licensees, including cemetery brokers, cemetery salespersons, crematories, and cremated remains disposers.

(10) The ~~Funeral Directors and Embalmers Program~~ *Cemetery and Funeral Bureau* shall disclose information on its licensees, including embalmers, funeral establishments, and funeral directors.

(11) The Contractors' State License Board shall disclose information on its licensees in accordance with Chapter 9 (commencing with Section 7000) of Division 3. In addition to information related to licenses as specified in subdivision (a), the board shall also disclose information provided to the board by the Labor Commissioner pursuant to Section 98.9 of the Labor Code.

(12) The Board of Psychology shall disclose information on its licensees, including psychologists, psychological assistants, and registered psychologists.

(13) The State Board of Chiropractic Examiners shall disclose information on its licensees.

(14) The Board of Registered Nursing shall disclose information on its licensees.

(15) The Board of Vocational Nursing and Psychiatric Technicians of the State of California shall disclose information on its licensees.

(16) The Veterinary Medical Board shall disclose information on its licensees and registrants.

(17) The Physical Therapy Board of California shall disclose information on its licensees.

(18) The California State Board of Pharmacy shall disclose information on its licensees.

(19) The Speech-Language Pathology and Audiology Board shall disclose information on its licensees.

(20) The Respiratory Care Board of California shall disclose information on its licensees.

(21) The California Board of Occupational Therapy shall disclose information on its licensees.

(22) The Naturopathic Medicine Committee, the Osteopathic Medical Board of California shall disclose information on its licensees.

(23) The Physician Assistant Committee of the Medical Board of California shall disclose information on its licensees.

(24) The Dental Hygiene Committee of California shall disclose information on its licensees.

(c) "Internet" for the purposes of this section has the meaning set forth in paragraph (6) of subdivision (e) of Section 17538.

SEC. 2. Section 116 of the Business and Professions Code is amended to read:

116. (a) The director may audit and review, upon his or her own initiative, or upon the request of a consumer or licensee, inquiries and complaints regarding licensees, dismissals of disciplinary cases, the opening, conduct, or closure of investigations, informal conferences, and discipline short of formal accusation by ~~the Medical Board of California, the allied health professional boards, and the California Board of Podiatric Medicine~~ *any of the healing arts boards established under Division 2 (commencing with Section 500) or under any initiative act referred to in that division*. The director may make recommendations for changes to the disciplinary system to the appropriate board, the Legislature, or both.

(b) The director shall report to the Chairpersons of the Senate Business and Professions Committee and the Assembly Health Committee annually~~, commencing March 1, 1995,~~ regarding his or her findings from any audit, review, or monitoring and evaluation conducted pursuant to this section.

SEC. 3. Section 160 of the Business and Professions Code is amended to read:

160. The Chief and all investigators of the Division of Investigation of the department ~~and~~, all investigators of the Medical Board of California and the ~~Board of Dental Examiners~~ *Dental Board of California, and the designated investigators of the Board of Registered Nursing* have the authority of peace officers while engaged in exercising the powers granted or performing the duties imposed upon them or the division in investigating the laws administered by the various boards comprising the department or commencing directly or indirectly any criminal prosecution arising from any investigation conducted under these laws. All persons herein referred to shall be deemed to be acting within the scope of employment with respect to all acts and matters in this section set forth.

SEC. 4. Article 10.1 (commencing with Section 720) is added to Chapter 1 of Division 2 of the Business and Professions Code, to read:

Article 10.1. Healing Arts Licensing Enforcement

720. (a) Unless otherwise provided, as used in this article, the term "board" shall include all of the following:

(1) The Dental Board of California.

(2) The Medical Board of California.

(3) The State Board of Optometry.

(4) The California State Board of Pharmacy.

(5) The Board of Registered Nursing.

(6) The Board of Behavioral Sciences.

(7) The Board of Vocational Nursing and Psychiatric Technicians of the State of California.

(8) The Respiratory Care Board of California.

(9) The Acupuncture Board.

(10) The Board of Psychology.

(11) The California Board of Podiatric Medicine.

(12) The Physical Therapy Board of California.

(13) The Hearing Aid Dispensers Bureau.

(14) The Physician Assistant Committee of the Medical Board of California.

(15) The Speech-Language Pathology and Audiology Board.

(16) The California Board of Occupational Therapy.

(17) The Osteopathic Medical Board of California.

(18) The Naturopathic Medicine Committee, the Osteopathic Medical Board of California.

(19) The Dental Hygiene Committee of California.

(20) The State Board of Chiropractic Examiners.

(21) The Veterinary Medical Board.

(b) Unless otherwise provided, as used in this article, "licensee" means a licensee of a board described in subdivision (a).

720.2. (a) The executive officer or executive director of a board may adopt a proposed default decision where an administrative action to revoke a license has been filed by the board and the licensee has failed to file a notice of defense or to appear at the hearing and a proposed default decision revoking the license has been issued.

(b) The executive officer or executive director of a board may adopt a proposed settlement agreement where an administrative action to revoke a license has been filed by the board and the licensee has agreed to surrender his or her license.

720.4. (a) The license of a licensee of a board shall be suspended automatically during any time that the licensee is incarcerated after conviction of a felony, regardless of whether the conviction has been appealed. The board shall, immediately upon receipt of the certified copy of the record of conviction from the court clerk, determine whether the license of the licensee has been automatically suspended by virtue of his or her incarceration, and if so, the duration of that suspension. The board shall notify the licensee of the license suspension and of his or her right to elect to have the issue of penalty heard as provided in subdivision (d).

(b) Upon receipt of the certified copy of the record of conviction, if after a hearing before an administrative law judge from the Office of Administrative Law it is determined that the felony for which the licensee was convicted was substantially related to the qualifications, functions, or duties of the licensee, the board shall suspend the license until the time for appeal has elapsed, if no appeal has been taken, or until the judgment of conviction has been affirmed on appeal or has otherwise become final, and until further order of the board.

(c) Notwithstanding subdivision (b), conviction of a charge of violating any federal statutes or regulations or any statute or regulation of this state regulating dangerous drugs or controlled

substances, or a conviction pursuant to Section 187, 261, 262, or 288 of the Penal Code, shall be conclusively presumed to be substantially related to the qualifications, functions, or duties of a licensee and no hearing shall be held on this issue. However, upon its own motion or for good cause shown, the board may decline to impose or may set aside the suspension when it appears to be in the interest of justice to do so, with due regard to maintaining the integrity of and confidence in the practice regulated by the board.

(d) (1) Discipline may be ordered against a license in accordance with the laws and regulations of the board when the time for appeal has elapsed, the judgment of conviction has been affirmed on appeal, or an order granting probation is made suspending the imposition of the sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw his or her plea of guilty and to enter a plea of not guilty, setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

(2) The issue of penalty shall be heard by an administrative law judge from the Office of Administrative Law. The hearing shall not be held until the judgment of conviction has become final or, irrespective of a subsequent order under Section 1203.4 of the Penal Code, an order granting probation has been made suspending the imposition of sentence, except that a licensee may, at his or her option, elect to have the issue of penalty decided before those time periods have elapsed. Where the licensee so elects, the issue of penalty shall be heard in the manner described in subdivision (b) at the hearing to determine whether the conviction was substantially related to the qualifications, functions, or duties of a licensee. If the conviction of a licensee who has made this election is overturned on appeal, any discipline ordered pursuant to this section shall automatically cease. Nothing in this subdivision shall prohibit the board from pursuing disciplinary action based on any cause other than the overturned conviction.

(e) The record of the proceedings resulting in the conviction, including a transcript of the testimony therein, may be received in evidence.

(f) Any other provision of law setting forth a procedure for the suspension or revocation of a license issued by a board shall not apply to proceedings conducted pursuant to this section.

(g) This section shall not apply to a physician and surgeon's certificate subject to Section 2236.1.

720.6. Except as otherwise provided, any proposed decision or decision issued under this article in accordance with the procedures set forth in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, that contains any finding of fact that the licensee or registrant engaged in any act of sexual contact, as defined in Section 729, with a patient, or has committed an act or has been convicted of a sex offense as defined in Section 44010 of the Education Code, shall contain an order of revocation. The revocation shall not be stayed by the administrative law judge. Unless otherwise provided in the laws and regulations of the board, the patient shall no longer be considered a patient of the licensee when the order for services and procedures provided by the licensee is terminated, discontinued, or not renewed by the licensee.

720.8. (a) A licensee of a board shall not include or permit to be included any of the following provisions in an agreement to settle a civil dispute arising from his or her practice, whether the agreement is made before or after the filing of an action:

(1) A provision that prohibits another party to the dispute from contacting or cooperating with the board.

(2) A provision that prohibits another party to the dispute from filing a complaint with the board.

(3) A provision that requires another party to the dispute to withdraw a complaint he or she has filed with the board.

(b) A provision described in subdivision (a) is void as against public policy.

(c) A violation of this section constitutes unprofessional conduct and may subject the licensee to disciplinary action.

(d) If a board complies with Section 2220.7, that board shall not be subject to the requirements of this section.

720.10. (a) Notwithstanding any other provision of law making a communication between a licensee of a board and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted by a board. Members of a board, deputies, employees, agents, the Attorney General's Office, and representatives of the board shall keep in confidence during the course of investigations the names of any patients whose records are reviewed and may not disclose or reveal

those names, except as is necessary during the course of an investigation, unless and until proceedings are instituted. The authority under this subdivision to examine records of patients in the office of a licensee is limited to records of patients who have complained to the board about that licensee.

(b) Notwithstanding any other provision of law, the Attorney General and his or her investigative agents, and a board and its investigators and representatives may inquire into any alleged violation of the laws under the jurisdiction of the board or any other federal or state law, regulation, or rule relevant to the practice regulated by the board, whichever is applicable, and may inspect documents relevant to those investigations in accordance with the following procedures:

(1) Any document relevant to an investigation may be inspected, and copies may be obtained, where patient consent is given.

(2) Any document relevant to the business operations of a licensee, and not involving medical records attributable to identifiable patients, may be inspected and copied where relevant to an investigation of a licensee.

(c) In all cases where documents are inspected or copies of those documents are received, their acquisition or review shall be arranged so as not to unnecessarily disrupt the medical and business operations of the licensee or of the facility where the records are kept or used.

(d) Where documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of any board, they shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. A board may use its authority to cite and fine a licensee for any violation of this section. This remedy is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

(e) Searches conducted of the office or medical facility of any licensee shall not interfere with the recordkeeping format or

preservation needs of any licensee necessary for the lawful care of patients.

(f) If a board complies with Section 2225, that board shall not be subject to the requirements of this section.

720.12. (a) A board, and the Attorney General, shall return any original documents received pursuant to Section 720.12 to the licensee from whom they were obtained within seven calendar days.

(b) If a board complies with Section 2225.3, that board shall not be subject to the requirements of this section.

720.14. (a) (1) A licensee who fails or refuses to comply with a request for the certified medical records of a patient, that is accompanied by that patient's written authorization for release of records to a board, within 15 days of receiving the request and authorization, shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the licensee is unable to provide the documents within this time period for good cause.

(2) A health care facility shall comply with a request for the certified medical records of a patient that is accompanied by that patient's written authorization for release of records to a board together with a notice citing this section and describing the penalties for failure to comply with this section. Failure to provide the authorizing patient's certified medical records to the board within 30 days of receiving the request, authorization, and notice shall subject the health care facility to a civil penalty, payable to the board, of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 20th day, up to ten thousand dollars ($10,000), unless the health care facility is unable to provide the documents within this time period for good cause. This paragraph shall not require health care facilities to assist the boards in obtaining the patient's authorization. A board shall pay the reasonable costs of copying the certified medical records, but shall not be required to pay such cost prior to the production of the medical records.

(b) (1) A licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to a board, shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the

documents have not been produced after the date by which the court order requires the documents to be produced, unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(2) Any licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to a board is guilty of a misdemeanor punishable by a fine payable to the board not to exceed five thousand dollars ($5,000). The fine shall be added to the licensee's renewal fee if it is not paid by the next succeeding renewal date. Any statute of limitations applicable to the filing of an accusation by a board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(3) A health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of patient records to a board, that is accompanied by a notice citing this section and describing the penalties for failure to comply with this section, shall pay to the board a civil penalty of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced, up to ten thousand dollars ($10,000), after the date by which the court order requires the documents to be produced, unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(4) Any health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to a health care license board is guilty of a misdemeanor punishable by a fine payable to the board not to exceed five thousand dollars ($5,000). Any statute of limitations applicable to the filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(c) Multiple acts by a licensee in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) or by imprisonment in a county jail not exceeding six

months, or by both that fine and imprisonment. Multiple acts by a health care facility in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) and shall be reported to the State Department of Public Health and shall be considered as grounds for disciplinary action with respect to licensure, including suspension or revocation of the license or certificate.

(d) A failure or refusal of a licensee to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board constitutes unprofessional conduct and is grounds for suspension or revocation of his or her license.

(e) Imposition of the civil penalties authorized by this section shall be in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Division 3 of Title 2 of the Government Code). Any civil penalties paid to or received by a board pursuant to this section shall be deposited into the fund administered by the board.

(f) For purposes of this section, "certified medical records" means a copy of the patient's medical records authenticated by the licensee or health care facility, as appropriate, on a form prescribed by the licensee's board.

(g) For purposes of this section, a "health care facility" means a clinic or health facility licensed or exempt from licensure pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(h) If a board complies with Section 2225.5, that board shall not be subject to the requirements of this section.

(i) This section shall not apply to a licensee who does not have access to, or control over, certified medical records.

720.16. (a) Each board shall report annually to the department and the Legislature, not later than October 1 of each year, the following information:

(1) The total number of consumer calls received by the board and the number of consumer calls or letters designated as discipline-related complaints.

(2) The total number of complaint forms received by the board.

(3) The total number of reports received by the board pursuant to Section 801, 801.01, and 803, as applicable.

(4) The total number of coroner reports received by the board.

(5) The total number of convictions reported to the board.

(6) The total number of criminal filings reported to the board.

(7) If the board is authorized to receive reports pursuant to Section 805, the total number of Section 805 reports received by the board, by the type of peer review body reporting and, where applicable, the type of health care facility involved, and the total number and type of administrative or disciplinary actions taken by the board with respect to the reports, and their disposition.

(8) The total number of complaints closed or resolved without discipline, prior to accusation.

(9) The total number of complaints and reports referred for formal investigation.

(10) The total number of accusations filed and the final disposition of accusations through the board and court review, respectively.

(11) The total number of citations issued, with fines and without fines, and the number of public letters of reprimand, letters of admonishment, or other similar action issued, if applicable.

(12) The total number of final licensee disciplinary actions taken, by category.

(13) The total number of cases in process for more than six months, more than 12 months, more than 18 months, and more than 24 months, from receipt of a complaint by the board.

(14) The average and median time in processing complaints, from original receipt of the complaint by the board, for all cases, at each stage of the disciplinary process and court review, respectively.

(15) The total number of licensees in diversion or on probation for alcohol or drug abuse or mental disorder, and the number of licensees successfully completing diversion programs or probation, and failing to do so, respectively.

(16) The total number of probation violation reports and probation revocation filings, and their dispositions.

(17) The total number of petitions for reinstatement, and their dispositions.

(18) The total number of caseloads of investigators for original cases and for probation cases, respectively.

(b) "Action," for purposes of this section, includes proceedings brought by, or on behalf of, the board against licensees for unprofessional conduct that have not been finally adjudicated, as well as disciplinary actions taken against licensees.

(c) If a board complies with Section 2313, that board shall not be subject to the requirements of this section.

SEC. 5. Section 726 of the Business and Professions Code is amended to read:

726. *(a)* The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this division~~,~~ *and* under any initiative act referred to in this division~~ and under Chapter 17 (commencing with Section 9000) of Division 3~~.

(b) The commission of, and conviction for, any act of sexual abuse, misconduct or attempted sexual misconduct, whether or not with a patient, or conviction of a felony requiring registration pursuant to Section 290 of the Penal Code shall be considered a crime substantially related to the qualifications, functions, or duties of a healing arts board licensee.

~~This~~

(c) This section shall not apply to sexual contact between a physician and surgeon and his or her spouse or person in an equivalent domestic relationship when that physician and surgeon provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship.

SEC. 6. Section 802.1 of the Business and Professions Code is amended to read:

802.1. (a) (1) ~~A physician and surgeon, osteopathic physician and surgeon, and a doctor of podiatric medicine~~ *Any licensee of a healing arts board established under this division or under any initiative act referred to in this division* shall *submit a written* report~~ either~~ of *any of* the following to the entity that issued his or her license:

(A) The bringing of an indictment or information charging a felony against the licensee.

(B) The conviction of the licensee, including any verdict of guilty, or plea of guilty or no contest, of any felony or misdemeanor.

(C) Any disciplinary action ever taken by another healing arts board of this state or a healing arts board of another state.

(2) The report required by this subdivision shall be made in writing within 30 days of the date of the bringing of the indictment or information or of the conviction *or disciplinary action*.

(b) Failure to make a report required by this section shall be a public offense punishable by a fine not to exceed five thousand dollars ($5,000).

SEC. 7. 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 Science Examiners or from an agency mentioned in subdivision (a) of Section 800 (except a person licensed pursuant to Chapter 3 (commencing with Section 1200))~~ *any of the healing arts boards established under this division or under any initiative act referred to in this division* 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. 8. Section 803.5 of the Business and Professions Code is amended to read:

803.5. (a) The district attorney, city attorney, or other prosecuting agency shall notify ~~the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, the State Board of Chiropractic Examiners, or other appropriate allied health board,~~ *the appropriate healing arts board established under this division or under any initiative act referred to in this division* and the clerk of the court in which the charges have been filed, of any filings against a licensee of that board charging a felony immediately upon obtaining

information that the defendant is a licensee of the board. The notice shall identify the licensee and describe the crimes charged and the facts alleged. The prosecuting agency shall also notify the clerk of the court in which the action is pending that the defendant is a licensee, and the clerk shall record prominently in the file that the defendant holds a license from one of the boards described above.

(b) The clerk of the court in which a licensee of one of the boards is convicted of a crime shall, within 48 hours after the conviction, transmit a certified copy of the record of conviction to the applicable board.

SEC. 9. Section 803.6 of the Business and Professions Code is amended to read:

803.6. (a) The clerk of the court shall transmit any felony preliminary hearing transcript concerning a defendant licensee to ~~the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or other appropriate allied health board, as applicable,~~ *any of the healing arts boards established under this division or under any initiative act referred to in this division* where the total length of the transcript is under 800 pages and shall notify the appropriate board of any proceeding where the transcript exceeds that length.

(b) In any case where a probation report on a licensee is prepared for a court pursuant to Section 1203 of the Penal Code, a copy of that report shall be transmitted by the probation officer to the *appropriate* board.

SEC. 10. 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~~ *The license of a* licentiate *who is* 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.~~ *shall be placed on suspension until the licentiate petitions the board for reinstatement of his or her license and is granted a probationary or unrestricted license.*

SEC. 11. Section 1695.7 is added to the Business and Professions Code, to read:

1695.7. (a) Any third-party vendor under contract with the board for the administration of the diversion program shall report to the program manager within five days any act, by a licentiate, of substantial noncompliance with the program. For purposes of this section, "substantial noncompliance" includes, but is not limited to, a failed drug test, a relapse, refusal to submit to a drug test, failure to comply with any practice limitations, repeated or material failure to comply with other requirements of the program, or termination from the program.

(b) Failure by a third-party vendor to comply with this section is grounds for termination of a contract for the administration of the diversion program.

SEC. 12. Section 1699.2 is added to the Business and Professions Code, to read:

1699.2. This article 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. 13. 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~~ *The license of a* participant *who is* 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.~~ *shall be placed on suspension until the participant petitions the board for reinstatement of his or her certificate and is granted a probationary or unrestricted certificate.*

SEC. 14. Section 2365.5 is added to the Business and Professions Code, to read:

2365.5. (a) Any third-party vendor under contract with the board for the administration of the diversion program shall report to the program manager within five days any act, by a participant, of substantial noncompliance with the program. For purposes of this section, "substantial noncompliance" includes, but is not limited to, a failed drug test, a relapse, refusal to submit to a drug test, failure to comply with any practice limitations, repeated or material failure to comply with other requirements of the program, or termination from the program.

(b) Failure by a third-party vendor to comply with this section is grounds for termination of a contract for the administration of the diversion program.

SEC. 15. Section 2372 is added to the Business and Professions Code, to read:

2372. This article 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 2663 of the Business and Professions Code is amended to read:

2663. *(a)* 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 *or third-party vendor* 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.

(b) (1) Any state agency or private organization or third-party vendor under contract with the board for the administration of the diversion program shall report within five days to the program manager any act, by a participant, of substantial noncompliance with the program. For purposes of this section, "substantial noncompliance" includes, but is not limited to, a failed drug test, a relapse, refusal to submit to a drug test, failure to comply with any practice limitations, repeated or material failure to comply with other requirements of the program, or termination from the program.

(2) Failure by a state agency or private organization or third-party vendor to comply with this subdivision is grounds for termination of a contract for the administration of the diversion program.

SEC. 17. 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.

(d) The license of a physical therapist or the approval of a physical therapy assistant who is terminated from the diversion program for failure to comply with program requirements shall be placed on suspension until the physical therapist or physical

therapy assistant petitions the board for reinstatement of his or her license or board approval and is granted a probationary or unrestricted license or board approval.

SEC. 18. Section 2669.2 is added to the Business and Professions Code, to read:

2669.2. This article 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 2715 of the Business and Professions Code is amended to read:

2715. The board shall prosecute all persons guilty of violating the provisions of this chapter.

~~Except as provided by Section 159.5, the~~

The board, in accordance with the provisions of the Civil Service Law, may employ ~~such~~ *investigators, nurse consultants, and other* personnel as it deems necessary to carry into effect the provisions of this chapter. *Investigators employed by the board shall be provided special training in investigating nursing practice activities.*

The board shall have and use a seal bearing the name "Board of Registered Nursing." The board may adopt, amend, or repeal, in accordance with the provisions of Chapter 4.5 (commencing with Section 11371)~~,~~ *of* Part 1~~,~~ *of* Division 3~~,~~ *of* Title 2 of the Government Code, such rules and regulations as may be reasonably necessary to enable it to carry into effect the provisions of this chapter.

SEC. 20. Section 2719 is added to the Business and Professions Code, to read:

2719. (a) (1) On or before March 1, 2010, the director shall appoint an enforcement program monitor. The director may retain a person for this position through a personal services contract, the Legislature finding, pursuant to Section 19130 of the Government Code, that this is a new state function.

(2) The director shall supervise the enforcement program monitor and may terminate or dismiss him or her from this position.

(b) The director shall advertise the availability of the enforcement program monitor position. The requirements for this position shall include, but not be limited to, experience in conducting investigations and familiarity with state laws,

regulations and rules, procedures pertaining to the board, and relevant administrative procedures.

(c) (1) The enforcement program monitor shall monitor and evaluate the disciplinary system and procedures of the board, making 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.

(2) The enforcement program monitor's duties shall be performed on a continuing basis for a period of 19 months from the date of the enforcement program monitor's appointment. These duties shall include, but not be limited to, reviewing and making recommendations with respect to the following: improving the quality and consistency of complaint processing and investigation, reducing the timeframes for completing complaint processing and investigation, reducing any complaint backlog, assessing the relative value to the board of various sources of complaints or information available to the board about licensees in identifying licensees who practice substandard care causing serious patient harm, and assuring consistency in the application of sanctions or discipline imposed on licensees. These duties shall also include reviewing and making recommendations in the following areas: the accurate and consistent implementation of the laws and rules affecting discipline; appropriate application of investigation and prosecution priorities; an assessment of the concerns of the board, the department's Division of Investigation, the Attorney General's Office, the defense bar, licensees, and patients regarding disciplinary matters or procedures; and the board's cooperation with other governmental entities charged with enforcing related laws and regulations regarding nurses.

(3) The enforcement program monitor shall also evaluate the effectiveness and efficiency of the board's diversion program and make recommendations regarding the continuation of the program and any changes or reforms required to assure that nurses participating in the program are appropriately monitored and the public is protected from nurses who are impaired due to alcohol or drug abuse or mental or physical illness.

(4) (A) The enforcement program monitor shall exercise no authority over the board's disciplinary operations or staff; however, the board, its staff, the department's Division of

Investigation, and the Attorney General's Office shall cooperate with him or her with respect to his or her duties.

(B) The board, its staff, the department's Division of Investigation, and the Attorney General's Office shall provide data, information, and case files as requested by the enforcement program monitor to perform all of his or her duties. The provision of confidential data, information, and case files by the board to the enforcement program monitor at any time after the appointment of the monitor 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.

(5) The director shall assist the enforcement program monitor in the performance of his or her duties, and the enforcement program monitor shall have the same investigative authority as the director.

(d) On or before December 1, 2010, the enforcement program monitor shall submit an initial written report of his or her findings and conclusions to the board, the department, and the Legislature, and be available to make oral reports to each, if requested to do so. The enforcement program monitor may also provide additional information to either the department or the Legislature at his or her discretion and at the request of either the department or the Legislature. The enforcement program monitor shall make his or her reports available to the public and the media. The enforcement program monitor shall make every effort to provide the board with an opportunity to reply to any facts, findings, issues, or conclusions in his or her reports with which the board may disagree.

(e) The board shall reimburse the department for all of the costs associated with the employment of an enforcement program monitor.

(f) On or before October 1, 2011, the enforcement program monitor shall issue a final written report. The final report shall include final findings and conclusions on the topics addressed in the reports submitted by the monitor pursuant to subdivision (d).

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

SEC. 21. 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~~ *The license of a* registered nurse *who is* 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.~~ *shall be placed on suspension until the licentiate petitions the board for reinstatement of his or her license and is granted a probationary or unrestricted license.*

SEC. 22. Section 2770.16 is added to the Business and Professions Code, to read:

2770.16. (a) Any third-party vendor under contract with the board for the administration of the diversion program shall report within five days to the program manager any act, by a registered nurse, of substantial noncompliance with the program. For purposes of this section, "substantial noncompliance" includes, but is not limited to, a failed drug test, a relapse, refusal to submit to a drug test, failure to comply with any practice limitations, repeated or material failure to comply with other requirements of the program, or termination from the program.

(b) Failure by a third-party vendor to comply with this section is grounds for termination of a contract for the administration of the diversion program.

SEC. 23. Section 2770.18 is added to the Business and Professions Code, to read:

2770.18. This article 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.

~~SECTION 1. The Legislature finds and declares all of the following:~~

~~(a) Nurse practitioners are registered nurses who have a graduate education and clinical training, and who provide a wide range of services and care.~~

~~(b) Under current law, nurse practitioners have the same statutory authority to provide services and care as do registered nurses. However, the law allows those registered nurses who the Board of Registered Nursing has determined meet the standards for a nurse practitioner to provide care and services beyond those specified in statute for registered nurses where those services are performed pursuant to standardized procedures and protocols developed through collaboration among administrators and health professionals, including physicians and surgeons, in the organized health care system in which a nurse practitioner practices.~~

~~(c) The Legislature reiterates its intention to allow each organized health care system in which a nurse practitioner practices to define those services nurse practitioners may perform in standardized procedures developed pursuant to Section 2725 of the Business and Professions Code.~~

~~(d) Notwithstanding the foregoing, the Legislature finds that there may be some ambiguity in current law regarding what services and functions to be performed by nurse practitioners may be included in standardized procedures and protocols.~~

~~(e) Therefore, to remove this ambiguity, the Legislature hereby clarifies that standardized procedures and protocols may include the specified services and functions set forth in this act so that health care entities may allow nurse practitioners to engage in those activities if the entities choose to do so, and that third-party payors understand that those services and functions can be performed by nurse practitioners if they are included in an entity's standardized procedures and protocols.~~

~~SEC. 2.~~

SEC. 24. Section 2835.7 is added to the Business and Professions Code, to read:

2835.7. (a) In addition to any other practices that meet the general criteria set forth in statute or regulation for inclusion in standardized procedures developed through collaboration among administrators and health professionals, including physicians and surgeons and nurses, pursuant to Section 2725, standardized procedures may be implemented that authorize a nurse practitioner to do any of the following:

(1) Order durable medical equipment, subject to any limitations set forth in the standardized procedures. Notwithstanding that

authority, nothing in this paragraph shall operate to limit the ability of a third-party payor to require prior approval.

(2) After performance of a physical examination by the nurse practitioner and collaboration with a physician and surgeon, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(3) For individuals receiving home health services or personal care services, after consultation with the treating physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.

(b) Nothing in this section shall be construed to affect the validity of any standardized procedures in effect prior to the enactment of this section or those adopted subsequent to enactment.

SEC. 25. Section 3534.1 of the Business and Professions Code is amended to read:

3534.1. *(a)* 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 *or a third-party vendor* 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.

(b) (1) Any state agency or private organization or third-party vendor under contract with the examining committee for the administration of the diversion program shall report within five days to the program manager any act, by a participant, of substantial noncompliance with the program. For purposes of this section, "substantial noncompliance" includes, but is not limited to, a failed drug test, a relapse, refusal to submit to a drug test, failure to comply with any practice limitations, repeated or material failure to comply with other requirements of the program, or termination from the program.

(2) Failure by a state agency or private organization or third-party vendor to comply with this subdivision is grounds for termination of a contract for the administration of the diversion program.

SEC. 26. Section 3534.5 of the Business and Professions Code is amended to read:

3534.5. *(a)* A participant may be terminated from the program for any of the following reasons: ~~(a) the participant has successfully completed the treatment program; (b) the participant has failed to comply with the treatment program designated for him or her; (c) the participant fails to meet any of the criteria set forth in subdivision (d); or (d) 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~~

(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 Section 3534.4.

(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.

(b) 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 medicine by that individual creates too great a risk to the public health and safety, that fact shall be reported to the executive officer of the examining committee 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 examining committee. ~~Each~~

(c) The license of a physician assistant who is terminated from the diversion program for failure to comply with program requirements shall be placed on suspension until the licentiate petitions the board for reinstatement of his or her license and is granted a probationary or unrestricted license.

(d) Each physician 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~~

(e) The examination committee shall inform each participant in the program of the procedures followed in the program, of the rights and responsibilities of a physician assistant in the program, and the possible results of noncompliance with the program.

SEC. 27. Section 3534.12 is added to the Business and Professions Code, to read:

3534.12. This article 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. 28. Section 4365 of the Business and Professions Code is amended to read:

4365. *(a)* The board shall contract with one or more qualified contractors to administer the pharmacists recovery program.

(b) (1) Any third-party vendor under contract with the board for the administration of the pharmacists recovery program shall report within five days to the program manager any act, by a participant, of substantial noncompliance with the program. For purposes of this section, "substantial noncompliance" includes, but is not limited to, a failed drug test, a relapse, refusal to submit to a drug test, failure to comply with any practice limitations, repeated or material failure to comply with other requirements of the program, or termination from the program.

(2) Failure by a third-party vendor to comply with this subdivision is grounds for termination of a contract for the administration of the pharmacists recovery program.

SEC. 29. Section 4369 of the Business and Professions Code is amended to read:

4369. (a) Any failure to comply with the treatment contract, determination that the participant is failing to derive benefit from the program, or other requirements of the pharmacists recovery program may result in the termination of the pharmacist's or intern pharmacist's participation in the pharmacists recovery program. ~~The name and license number of a pharmacist or intern pharmacist~~

~~who is terminated from the pharmacists recovery program and the basis for the termination shall be reported to the board.~~

(b) The license of a pharmacist or intern pharmacist terminated from the pharmacists recovery program for failure to comply with program requirements shall be placed on suspension until the licentiate petitions the board for reinstatement of his or her license and is granted a probationary or unrestricted license.

~~(b)~~

(c) Participation in the pharmacists recovery program shall not be a defense to any disciplinary action that may be taken by the board.

~~(c)~~

(d) No provision of this article shall preclude the board from commencing disciplinary action against a licensee who is terminated from the pharmacists recovery program.

SEC. 30. Section 4375 is added to the Business and Professions Code, to read:

4375. This article 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. 31. Section 4870 of the Business and Professions Code is amended to read:

4870. *(a)* Each veterinarian and registered veterinary technician who requests participation in a diversion program shall agree to cooperate with the treatment program designed by a diversion evaluation committee. Any failure to comply with the provisions of a treatment program may result in termination of the veterinarian's or registered veterinary technician's participation in a program.

(b) The license of a veterinarian or registration of a registered veterinary technician who is terminated from the diversion program for failure to comply with program requirements shall be placed on suspension until the veterinarian or registered veterinary technician petitions the board for reinstatement of his or her license or registration.

SEC. 32. Section 4870.5 is added to the Business and Professions Code, to read:

4870.5. (a) Any third-party vendor under contract with the board for the administration of the diversion program shall report

within five days to the appropriate chairperson any act, by a veterinarian or registered veterinary technician, of substantial noncompliance with the program. For purposes of this section, "substantial noncompliance" includes, but is not limited to, a failed drug test, a relapse, refusal to submit to a drug test, failure to comply with any practice limitations, repeated or material failure to comply with other requirements of the program, or termination from the program.

(b) Failure by a third-party vendor to comply with this section is grounds for termination of a contract for the administration of the diversion program.

SEC. 33. Section 4873.2 is added to the Business and Professions Code, to read:

4873.2. This article 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. 34. (a) It is the intent of the Legislature that the Department of Consumer Affairs shall, on or before December 31, 2012, establish an enterprise information technology system necessary to electronically create and update healing arts license information, track enforcement cases, and allocate enforcement efforts pertaining to healing arts licensees. The Legislature intends the system to be designed as an integrated system to support all business automation requirements of the department's licensing and enforcement functions.

(b) The Legislature also intends the department to enter into contracts for telecommunication, programming, data analysis, data processing, and other services necessary to develop, operate, and maintain the enterprise information technology system.

SEC. 35. The Legislature finds and declares all of the following with respect to Section 2835.7 of the Business and Professions Code, as added by Section 24 of this act:

(a) Nurse practitioners are registered nurses who have a graduate education and clinical training, and who provide a wide range of services and care.

(b) Under current law, nurse practitioners have the same statutory authority to provide services and care as do registered nurses. However, the law allows those registered nurses who the Board of Registered Nursing has determined meet the standards

for a nurse practitioner to provide care and services beyond those specified in statute for registered nurses where those services are performed pursuant to standardized procedures and protocols developed through collaboration among administrators and health professionals, including physicians and surgeons, in the organized health care system in which a nurse practitioner practices.

(c) The Legislature reiterates its intention to allow each organized health care system in which a nurse practitioner practices to define those services nurse practitioners may perform in standardized procedures developed pursuant to Section 2725 of the Business and Professions Code.

(d) Notwithstanding the foregoing, the Legislature finds that there may be some ambiguity in current law regarding what services and functions to be performed by nurse practitioners may be included in standardized procedures and protocols.

(e) Therefore, to remove this ambiguity, the Legislature hereby clarifies that standardized procedures and protocols may include the specified services and functions set forth in this act so that health care entities may allow nurse practitioners to engage in those activities if the entities choose to do so, and that third-party payors understand that those services and functions can be performed by nurse practitioners if they are included in an entity's standardized procedures and protocols.

SEC. 36. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, 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.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

O

SB 389

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 389
Author: Negrete McLeod
Bill Date: June 1, 2009, amended
Subject: Fingerprinting
Sponsor: Author
Board Position: Support

STATUS OF BILL:

This bill is currently in the Assembly Public Safety Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill will require a licensee who has not been previously fingerprinted or for whom a record does not exist, to successfully complete a fingerprint record search at time of renewal. It will require notification by the licensee at time of renewal if he or she has been convicted of a felony or misdemeanor since the last renewal.

Staff has researched the requirements in this bill related to our licensees and has determined that the Board has fingerprints on licensees dating back to 1945. Therefore, the Board is already in compliance with the provisions in this bill.

ANALYSIS:

The Medical Board has been fingerprinting its licensees for many years. Staff is in the process of verifying how far back this requirement has been in place, as it was a requirement prior to being placed in law. For purposes of this bill, staff will need to determine what records no longer exist at the Department of Justice (DOJ).

Staff has reported to the board that the number of physicians not fingerprinted may be up to 45,000, although through licensing record searches, this number may be lower than 11,000. The issue will be whether the DOJ still has a flag on the file of those licensed prior to 1986.

The Medical Board passed a motion in November of 2008 to have fingerprint records for all physicians who are licensed in this state.

Staff has further researched and discovered that the Board currently

maintains fingerprints on licensees dating back to 1945. There would be no new requirement in this bill, as the Board is already compliant as any physician licensed after 1945 would be at least 80 years old and more likely 85+ years.

FISCAL: None to MBC

POSITION: Support

September 28, 2009

AMENDED IN SENATE JUNE 1, 2009

AMENDED IN SENATE MAY 5, 2009

SENATE BILL No. 389

Introduced by Senator Negrete McLeod

February 26, 2009

An act to amend Section 144 of, and to add Sections 144.5 and 144.6 to, the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

SB 389, as amended, Negrete McLeod. Professions and vocations.

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 various grounds, including, but not limited to, conviction 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. Existing law requires applicants to certain boards to provide a full set of fingerprints for the purpose of conducting criminal history record checks.

This bill would make that fingerprinting requirement applicable to the Dental Board of California, the Dental Hygiene Committee of California, the Professional Fiduciaries Bureau, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the State Board of Chiropractic Examiners. The bill would require *new* applicants for a license ~~and,~~ *and petitioners for reinstatement of a revoked, surrendered, or canceled license, to successfully complete a state and federal level criminal record information search. The bill would also require,* commencing January 1, 2011, licensees who have

not previously submitted fingerprints, or for whom a record of the submission of fingerprints no longer exists, to ~~successfully~~ complete *the process necessary for* a state and federal level criminal offender record information search, as specified. The bill would require licensees *applying for license renewal* to certify compliance with that requirement, as specified, and would subject a licensee to disciplinary action for making a false certification. The bill would also require a licensee to, as a condition of renewal of the license, notify the board on the license renewal form if he or she*, or any member of the personnel of record of the licensee,* has been convicted, as defined, of a felony or misdemeanor since ~~his or her~~ *the* last renewal, or if this is the licensee's first renewal, since the initial license was issued. *The bill would provide that the Contractors' State License Board shall implement the provisions pertaining to renewal licenses on a specified schedule, after an appropriation is made for this purpose, utilizing its applicable fees.*

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

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

1 SECTION 1. Section 144 of the Business and Professions Code
2 is amended to read:
3 144. (a) Notwithstanding any other provision of law, an agency
4 designated in subdivision (b) shall require an applicant for a license
5 *or a petitioner for reinstatement of a revoked, surrendered, or*
6 *canceled license* to furnish to the agency a full set of fingerprints
7 for purposes of conducting criminal history record checks and
8 shall require the applicant *or petitioner* to successfully complete
9 a state and federal level criminal offender record information search
10 conducted through the Department of Justice as provided in
11 subdivision (c) or as otherwise provided in this code.
12 (b) Subdivision (a) applies to the following:
13 (1) California Board of Accountancy.
14 (2) State Athletic Commission.
15 (3) Board of Behavioral Sciences.
16 (4) Court Reporters Board of California.
17 (5) State Board of Guide Dogs for the Blind.
18 (6) California State Board of Pharmacy.
19 (7) Board of Registered Nursing.
20 (8) Veterinary Medical Board.

(9) Registered Veterinary Technician Committee.
(10) Board of Vocational Nursing and Psychiatric Technicians.
(11) Respiratory Care Board of California.
(12) Hearing Aid Dispensers Bureau.
(13) Physical Therapy Board of California.
(14) Physician Assistant Committee of the Medical Board of California.
(15) Speech-Language Pathology and Audiology Board.
(16) Medical Board of California.
(17) State Board of Optometry.
(18) Acupuncture Board.
(19) Cemetery and Funeral Bureau.
(20) Bureau of Security and Investigative Services.
(21) Division of Investigation.
(22) Board of Psychology.
(23) California Board of Occupational Therapy.
(24) Structural Pest Control Board.
(25) Contractors' State License Board.
(26) Bureau of Naturopathic Medicine.
(27) Dental Board of California.
(28) Dental Hygiene Committee of California.
(29) Professional Fiduciaries Bureau.
(30) California Board of Podiatric Medicine.
(31) Osteopathic Medical Board of California.
(32) State Board of Chiropractic Examiners.

(c) Except as otherwise provided in this code, each agency listed in subdivision (b) shall direct applicants for a license *or a petitioner for reinstatement of a revoked, surrendered, or canceled license* to submit to the Department of Justice fingerprint images and related information required by the Department of Justice for the purpose of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and also information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her recognizance pending trial or appeal. The Department of Justice shall forward the fingerprint images and related information received to the Federal Bureau of Investigation and request federal criminal history information. The Department of Justice shall compile and disseminate state and federal responses to the agency

pursuant to subdivision (p) of Section 11105 of the Penal Code. The agency shall request from the Department of Justice subsequent arrest notification service, pursuant to Section 11105.2 of the Penal Code, for each person who submitted information pursuant to this subdivision. The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this section.

SEC. 2. Section 144.5 is added to the Business and Professions Code, to read:

144.5. (a) Notwithstanding any other provision of law, an agency designated in subdivision (b) of Section 144 shall require a licensee who has not previously submitted fingerprints or for whom a record of the submission of fingerprints no longer exists to, as a condition of license renewal, ~~successfully complete~~ *complete the process necessary for* a state and federal level criminal offender record information search *to be* conducted through the Department of Justice as provided in subdivision (d).

~~(b) (1) A licensee described in subdivision (a) shall, as a condition of license renewal, certify on the renewal application that he or she has successfully completed a state and federal level criminal offender record information search pursuant to subdivision (d).~~

~~(2) The licensee shall retain for at least three years, as evidence of the certification made pursuant to paragraph (1), either a receipt showing that he or she has electronically transmitted his or her fingerprint images to the Department of Justice or, for those licensees who did not use an electronic fingerprinting system, a receipt evidencing that the licensee's fingerprints were taken.~~

(b) (1) As a condition of license renewal, a licensee described in subdivision (a) shall complete the process necessary for a state and federal level criminal offender record information search to be conducted as provided in subdivision (d).

(2) No license of a licensee described in subdivision (a) shall be renewed until certification by the licensee is received by the agency verifying that the licensee has complied with this subdivision. The certification shall be made on a form provided by the agency not later than the renewal date of the license.

(3) As evidence of the certification made pursuant to paragraph (2), the licensee shall retain either of the following for at least three years:

(A) The receipt showing that the fingerprint images required by this section were electronically transmitted to the Department of Justice.

(B) For those licensees who did not use an electronic fingerprinting system, the receipt evidencing that the fingerprint images required by this section were taken.

(c) Failure to provide the certification required by subdivision (b) renders an application for *license* renewal incomplete. An agency shall not renew the license until a complete application is submitted.

(d) Each agency listed in subdivision (b) of Section 144 shall direct licensees described in subdivision (a) to submit to the Department of Justice fingerprint images and related information required by the Department of Justice for the purpose of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and also information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her recognizance pending trial or appeal. The Department of Justice shall forward the fingerprint images and related information received to the Federal Bureau of Investigation and request federal criminal history information. The Department of Justice shall compile and disseminate state and federal responses to the agency pursuant to subdivision (p) of Section 11105 of the Penal Code. The agency shall request from the Department of Justice subsequent arrest notification service, pursuant to Section 11105.2 of the Penal Code, for each person who submitted information pursuant to this subdivision. The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this section.

(e) An agency may waive the requirements of this section if the license is inactive or retired, or if the licensee is actively serving in the military. The agency ~~may~~ *shall* not activate an inactive license or return a retired license to full licensure status for a licensee described in subdivision (a) until the licensee has successfully completed a state and federal level criminal offender record information search pursuant to subdivision (d).

~~(f) With respect to licensees that are business entities, each agency listed in subdivision (b) of Section 144 shall, by regulation, determine which owners, officers, directors, shareholders,~~

~~members, agents, employees, or other natural persons who are representatives of the business entity are required to submit fingerprint images to the Department of Justice and disclose the information on its renewal forms, as required by this section.~~

~~(g)~~

(f) A licensee who falsely certifies completion of a state and federal level criminal record information search under subdivision ~~(b) may be subject to disciplinary action by his or her licensing agency.~~ *(b) shall be subject to disciplinary action.*

(g) (1) As it relates to the Contractors' State License Board, the provisions of this section shall become operative on the date on which an appropriation is made in the annual Budget Act to fund the activities of the Contractors' State License Board to accommodate a criminal history record check pursuant to this section. If this section becomes operative with respect to the Contractors' State License Board on or before July 1, 2012, the Contractors' State License Board shall implement this section according to the following schedule, and shall utilize the fees under its fee cap accordingly:

(A) For licenses initially issued between January 1, 2000, and December 31, 2005, inclusive, the certification required under subdivision (b) shall be submitted during the license renewal period that commences on January 1, 2013.

(B) For licenses initially issued between January 1, 1990, and December 31, 1999, inclusive, the certification required under subdivision (b) shall be submitted during the license renewal period that commences on January 1, 2015.

(C) For licenses initially issued prior to January 1, 1990, the certification required under subdivision (b) shall be submitted during the license renewal period that commences on January 1, 2017.

(2) If this section becomes operative with respect to the Contractors' State License Board after July 1, 2012, the license renewal period commencement dates specified in subparagraphs (A), (B), and (C) of paragraph (1) shall be delayed one year at a time until this section becomes operative with respect to the Contractors' State License Board.

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

SEC. 3. Section 144.6 is added to the Business and Professions Code, to read:

144.6. (a) An agency described in subdivision (b) of Section 144 shall require a licensee, as a condition of license renewal, to ~~notify the board on the license renewal form if he or she has been~~ *notify the agency on the license renewal form if he or she, or any member of the personnel of record of the licensee, has been* convicted, as defined in Section 490, of a felony or misdemeanor ~~since his or her last renewal, or if this is the licensee's first renewal, since the initial license was issued.~~ *since the license was last renewed, or since the license was initially issued if it has not been previously renewed.*

(b) The reporting requirement imposed under this section shall apply in addition to any other reporting requirement imposed under this code.

O

SB 470

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 470
Author: Corbett
Chapter: #590
Subject: Prescriptions: labeling
Sponsor: Author
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill would require every prescription to include on the label, the purpose for which the drug is prescribed, if requested by the patient.

IMPLEMENTATION:

- Newsletter Article
- Notify Board Staff
- Track and work with the Pharmacy Board's implementation plan.

October 15, 2009

Senate Bill No. 470

CHAPTER 590

An act to amend Sections 4040 and 4076 of the Business and Professions Code, relating to pharmacy.

[Approved by Governor October 11, 2009. Filed with Secretary of State October 11, 2009.]

LEGISLATIVE COUNSEL'S DIGEST

SB 470, Corbett. Prescriptions.

Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy and provides that a knowing violation of the law is a crime. Existing law requires a prescription, as defined, to include a legible, clear notice of the condition for which the drug is prescribed, if requested by the patient. Existing law prohibits a pharmacist from dispensing any prescription unless it is in a specified container that is correctly labeled to include, among other information, the condition for which the drug was prescribed if requested by the patient and the condition is indicated on the prescription.

This bill would instead require that every prescription include a legible, clear notice of the condition or purpose for which the drug is prescribed, if requested by the patient. The bill would also require that every prescription container be correctly labeled to include that information if so indicated on the prescription.

By revising these requirements, the knowing violation of which would be a crime, the bill would impose a state-mandated local program.

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

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

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

SECTION 1. Section 4040 of the Business and Professions Code is amended to read:

4040. (a) "Prescription" means an oral, written, or electronic transmission order that is both of the following:

(1) Given individually for the person or persons for whom ordered that includes all of the following:

(A) The name or names and address of the patient or patients.

(B) The name and quantity of the drug or device prescribed and the directions for use.

(C) The date of issue.

(D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification, and his or her federal registry number, if a controlled substance is prescribed.

(E) A legible, clear notice of the condition or purpose for which the drug is being prescribed, if requested by the patient or patients.

(F) If in writing, signed by the prescriber issuing the order, or the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor who issues a drug order pursuant to Section 2746.51, 2836.1, 3502.1, or 3640.5, respectively, or the pharmacist who issues a drug order pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

(2) Issued by a physician, dentist, optometrist, podiatrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7 or, if a drug order is issued pursuant to Section 2746.51, 2836.1, 3502.1, or 3460.5, by a certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor licensed in this state, or pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 by a pharmacist licensed in this state.

(b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug, except for any Schedule II controlled substance, that contains at least the name and signature of the prescriber, the name and address of the patient in a manner consistent with paragraph (3) of subdivision (b) of Section 11164 of the Health and Safety Code, the name and quantity of the drug prescribed, directions for use, and the date of issue may be treated as a prescription by the dispensing pharmacist as long as any additional information required by subdivision (a) is readily retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164 of the Health and Safety Code, Section 11164 of the Health and Safety Code shall prevail.

(c) "Electronic transmission prescription" includes both image and data prescriptions. "Electronic image transmission prescription" means any prescription order for which a facsimile of the order is received by a pharmacy from a licensed prescriber. "Electronic data transmission prescription" means any prescription order, other than an electronic image transmission prescription, that is electronically transmitted from a licensed prescriber to a pharmacy.

(d) The use of commonly used abbreviations shall not invalidate an otherwise valid prescription.

(e) Nothing in the amendments made to this section (formerly Section 4036) at the 1969 Regular Session of the Legislature shall be construed as expanding or limiting the right that a chiropractor, while acting within the scope of his or her license, may have to prescribe a device.

SEC. 2. Section 4076 of the Business and Professions Code is amended to read:

4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except where the prescriber or the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.

(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.

(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for

the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in any commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.

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

O

SB 674

BILL NUMBER: SB 674
VETOED DATE: 10/12/2009

To the Members of the California State Senate:

I am returning Senate Bill 674 without my signature.

While some provisions may provide marginal improvements to consumer protection, I cannot support this bill when it fails to address the need for stronger licensing and oversight of outpatient surgical centers. The continued reliance by the medical community on external accreditation agencies without enforcement capability is an insufficient solution for protecting patients. As outpatient surgeries continue to increase in number and complexity, surgical centers cannot continue to perform procedures in an unregulated and unenforced environment.

I would ask the medical community to work with my Administration next year to bring consistent and effective oversight to this growing industry in the shared interest of protecting patient safety.

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

Sincerely,

Arnold Schwarzenegger

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 674
Author: Negrete McLeod
Chapter: VETOED (see attached veto message)
Subject: Outpatient settings/Advertising
Sponsor: Author
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill covers a variety of subjects, including advertising, outpatient setting accreditation requirements, supervision of laser and IPL device procedures, the wearing of name tags for healthcare professionals, and public information.

IMPLEMENTATION:

None

October 15, 2009

CHAPTER _____

An act to amend Sections 651 and 2023.5 of, and to add Section 2027.5 to, the Business and Professions Code, and to amend Sections 1248, 1248.15, 1248.2, 1248.25, 1248.35, 1248.5, 1248.55, and 1279 of the Health and Safety Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 674, Negrete McLeod. Healing arts.

(1) Existing law provides for the licensure and regulation of various healing arts practitioners and requires certain of those practitioners to use particular designations following their names in specified instances. Existing law provides that it is unlawful for healing arts licensees to disseminate or cause to be disseminated any form of public communication, as defined, containing a false, fraudulent, misleading, or deceptive statement, claim, or image to induce the rendering of services or the furnishing of products relating to a professional practice or business for which he or she is licensed. Existing law authorizes advertising by these healing arts licensees to include certain general information. A violation of these provisions is a misdemeanor.

This bill would require certain healing arts licensees to include in advertisements, as defined, certain words or designations following their names indicating the particular educational degree they hold or healing art they practice, as specified. By changing the definition of a crime, this bill would impose a state-mandated local program.

(2) Existing law requires the Medical Board of California, in conjunction with the Board of Registered Nursing, and in consultation with the Physician Assistant Committee and professionals in the field, to review issues and problems relating to the use of laser or intense light pulse devices for elective cosmetic procedures by their respective licensees.

This bill would require the board to adopt regulations by January 1, 2011, regarding the appropriate level of physician availability needed within clinics or other settings using certain laser or intense pulse light devices for elective cosmetic procedures.

(3) Existing law requires the Medical Board of California to post on the Internet specified information regarding licensed physicians and surgeons.

This bill would require the board to post on its Internet Web site an easy-to-understand factsheet to educate the public about cosmetic surgery and procedures, as specified.

(4) Existing law requires the Medical Board of California, as successor to the Division of Licensing of the Medical Board of California, to adopt standards for accreditation of outpatient settings, as defined, and, in approving accreditation agencies to perform this accreditation, to ensure that the certification program shall, at a minimum, include standards for specified aspects of the settings' operations. Existing law makes a willful violation of these and other provisions relating to outpatient settings a crime.

This bill would include, among those specified aspects, the submission for approval by an accreditation agency at the time of accreditation, a detailed plan, standardized procedures, and protocols to be followed in the event of serious complications or side effects from surgery. The bill would also modify the definition of "outpatient setting" to include facilities that offer in vitro fertilization, as defined.

Existing law also requires the Medical Board of California to obtain and maintain a list of all accredited, certified, and licensed outpatient settings, and to notify the public, upon inquiry, whether a setting is accredited, certified, or licensed, or whether the setting's accreditation, certification, or license has been revoked.

This bill would require the board, absent inquiry, to notify the public whether a setting is accredited, certified, or licensed, or the setting's accreditation, certification, or license has been revoked, suspended, or placed on probation, or the setting has received a reprimand by the accreditation agency.

Existing law requires accreditation of an outpatient setting to be denied if the setting does not meet specified standards. Existing law authorizes an outpatient setting to reapply for accreditation at any time after receiving notification of the denial.

This bill would require the accreditation agency to immediately report to the Medical Board of California if the outpatient setting's certificate for accreditation has been denied. Because a willful violation of this requirement would be a crime, the bill would impose a state-mandated local program.

Existing law authorizes the Medical Board of California, as successor to the Division of Medical Quality of the Medical Board of California, or an accreditation agency to, upon reasonable prior notice and presentation of proper identification, enter and inspect any accredited outpatient setting to ensure compliance with, or investigate an alleged violation of, any standard of the accreditation agency or any provision of the specified law.

This bill would delete the notice and identification requirements. The bill would require that every outpatient setting that is accredited be inspected by the accreditation agency, as specified, and would specify that it may also be inspected by the board, as specified. The bill would require the board to ensure that accreditation agencies inspect outpatient settings.

Existing law authorizes the Medical Board of California to terminate approval of an accreditation agency if the agency is not meeting the criteria set by the board.

This bill would also authorize the board to issue a citation to the agency, including an administrative fine, in accordance with a specified system established by the board.

Existing law authorizes the Medical Board of California to evaluate the performance of an approved accreditation agency no less than every 3 years, or in response to complaints against an agency, or complaints against one or more outpatient settings accreditation by an agency that indicates noncompliance by the agency with the standards approved by the board.

This bill would make that evaluation mandatory.

(5) Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health and requires the department to periodically inspect those facilities, as specified.

This bill would state the intent of the Legislature that the department, as part of its periodic inspections of acute care hospitals, inspect the peer review process utilized by those hospitals.

(6) 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 651 of the Business and Professions Code is amended to read:

651. (a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. A "public communication" as used in this section includes, but is not limited to, communication by means of mail, television, radio, motion picture, newspaper, book, list or directory of healing arts practitioners, Internet, or other electronic communication.

(b) A false, fraudulent, misleading, or deceptive statement, claim, or image includes a statement or claim that does any of the following:

(1) Contains a misrepresentation of fact.

(2) Is likely to mislead or deceive because of a failure to disclose material facts.

(3) (A) Is intended or is likely to create false or unjustified expectations of favorable results, including the use of any photograph or other image that does not accurately depict the results of the procedure being advertised or that has been altered in any manner from the image of the actual subject depicted in the photograph or image.

(B) Use of any photograph or other image of a model without clearly stating in a prominent location in easily readable type the fact that the photograph or image is of a model is a violation of subdivision (a). For purposes of this paragraph, a model is anyone other than an actual patient, who has undergone the procedure being advertised, of the licensee who is advertising for his or her services.

(C) Use of any photograph or other image of an actual patient that depicts or purports to depict the results of any procedure, or presents "before" and "after" views of a patient, without specifying in a prominent location in easily readable type size what procedures were performed on that patient is a violation of subdivision (a).

Any "before" and "after" views (i) shall be comparable in presentation so that the results are not distorted by favorable poses, lighting, or other features of presentation, and (ii) shall contain a statement that the same "before" and "after" results may not occur for all patients.

(4) Relates to fees, other than a standard consultation fee or a range of fees for specific types of services, without fully and specifically disclosing all variables and other material factors.

(5) Contains other representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.

(6) Makes a claim either of professional superiority or of performing services in a superior manner, unless that claim is relevant to the service being performed and can be substantiated with objective scientific evidence.

(7) Makes a scientific claim that cannot be substantiated by reliable, peer reviewed, published scientific studies.

(8) Includes any statement, endorsement, or testimonial that is likely to mislead or deceive because of a failure to disclose material facts.

(c) Any price advertisement shall be exact, without the use of phrases, including, but not limited to, "as low as," "and up," "lowest prices," or words or phrases of similar import. Any advertisement that refers to services, or costs for services, and that uses words of comparison shall be based on verifiable data substantiating the comparison. Any person so advertising shall be prepared to provide information sufficient to establish the accuracy of that comparison. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discount, premiums, gifts, or any statements of a similar nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

(d) Any person so licensed shall not compensate or give anything of value to a representative of the press, radio, television, or other communication medium in anticipation of, or in return for, professional publicity unless the fact of compensation is made known in that publicity.

(e) Any person so licensed may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

(f) Any person so licensed who violates this section is guilty of a misdemeanor. A bona fide mistake of fact shall be a defense to this subdivision, but only to this subdivision.

(g) Any violation of this section by a person so licensed shall constitute good cause for revocation or suspension of his or her license or other disciplinary action.

(h) Advertising by any person so licensed may include the following:

(1) A statement of the name of the practitioner.

(2) A statement of addresses and telephone numbers of the offices maintained by the practitioner.

(3) A statement of office hours regularly maintained by the practitioner.

(4) A statement of languages, other than English, fluently spoken by the practitioner or a person in the practitioner's office.

(5) (A) A statement that the practitioner is certified by a private or public board or agency or a statement that the practitioner limits his or her practice to specific fields.

(i) For the purposes of this section, a dentist licensed under Chapter 4 (commencing with Section 1600) may not hold himself or herself out as a specialist, or advertise membership in or specialty recognition by an accrediting organization, unless the practitioner has completed a specialty education program approved by the American Dental Association and the Commission on Dental Accreditation, is eligible for examination by a national specialty board recognized by the American Dental Association, or is a diplomate of a national specialty board recognized by the American Dental Association.

(ii) A dentist licensed under Chapter 4 (commencing with Section 1600) shall not represent to the public or advertise accreditation either in a specialty area of practice or by a board not meeting the requirements of clause (i) unless the dentist has attained membership in or otherwise been credentialed by an accrediting organization that is recognized by the board as a bona

fide organization for that area of dental practice. In order to be recognized by the board as a bona fide accrediting organization for a specific area of dental practice other than a specialty area of dentistry authorized under clause (i), the organization shall condition membership or credentialing of its members upon all of the following:

(I) Successful completion of a formal, full-time advanced education program that is affiliated with or sponsored by a university based dental school and is beyond the dental degree at a graduate or postgraduate level.

(II) Prior didactic training and clinical experience in the specific area of dentistry that is greater than that of other dentists.

(III) Successful completion of oral and written examinations based on psychometric principles.

(iii) Notwithstanding the requirements of clauses (i) and (ii), a dentist who lacks membership in or certification, diplomate status, other similar credentials, or completed advanced training approved as bona fide either by an American Dental Association recognized accrediting organization or by the board, may announce a practice emphasis in any other area of dental practice only if the dentist incorporates in capital letters or some other manner clearly distinguishable from the rest of the announcement, solicitation, or advertisement that he or she is a general dentist.

(iv) A statement of certification by a practitioner licensed under Chapter 7 (commencing with Section 3000) shall only include a statement that he or she is certified or eligible for certification by a private or public board or parent association recognized by that practitioner's licensing board.

(B) A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she limits his or her practice to specific fields, but shall not include a statement that he or she is certified or eligible for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, unless that board or association is (i) an American Board of Medical Specialties member board, (ii) a board or association with equivalent requirements approved by that physician and surgeon's licensing board, or (iii) a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training

program that provides complete training in that specialty or subspecialty. A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification, unless the physician and surgeon is also licensed under Chapter 4 (commencing with Section 1600) and the use of the term "board certified" in reference to that certification is in accordance with subparagraph (A). A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the Medical Board of California, for certifying medical doctors and other health care professionals that is based on the applicant's education, training, and experience.

For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is an American Board of Medical Specialties member board, an organization with equivalent requirements approved by a physician and surgeon's licensing board, or an organization with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in a specialty or subspecialty.

The Medical Board of California shall adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition pursuant to this subparagraph. The fee shall not exceed the cost of administering this subparagraph. Notwithstanding Section 2 of Chapter 1660 of the Statutes of 1990, this subparagraph shall become operative July 1, 1993. However, an administrative agency or accrediting organization may take any action contemplated by this subparagraph relating to the establishment or approval of specialist requirements on and after January 1, 1991.

(C) A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she is certified or eligible or qualified for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, if that board or association meets one of the following requirements: (i) is approved by the Council on Podiatric Medical Education, (ii) is a board or association with equivalent requirements approved by the California Board of Podiatric Medicine, or (iii) is a board or association with the Council on Podiatric Medical Education approved postgraduate training programs that provide training in podiatric medicine and podiatric surgery. A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement. A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the California Board of Podiatric Medicine, for certifying doctors of podiatric medicine that is based on the applicant's education, training, and experience. For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is a Council on Podiatric Medical Education approved board, an organization with equivalent requirements approved by the California Board of Podiatric Medicine, or an organization with a Council on Podiatric Medical Education approved postgraduate training program that provides training in podiatric medicine and podiatric surgery.

The California Board of Podiatric Medicine shall adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition pursuant to this

subparagraph, to be deposited in the State Treasury in the Podiatry Fund, pursuant to Section 2499. The fee shall not exceed the cost of administering this subparagraph.

(6) A statement that the practitioner provides services under a specified private or public insurance plan or health care plan.

(7) A statement of names of schools and postgraduate clinical training programs from which the practitioner has graduated, together with the degrees received.

(8) A statement of publications authored by the practitioner.

(9) A statement of teaching positions currently or formerly held by the practitioner, together with pertinent dates.

(10) A statement of his or her affiliations with hospitals or clinics.

(11) A statement of the charges or fees for services or commodities offered by the practitioner.

(12) A statement that the practitioner regularly accepts installment payments of fees.

(13) Otherwise lawful images of a practitioner, his or her physical facilities, or of a commodity to be advertised.

(14) A statement of the manufacturer, designer, style, make, trade name, brand name, color, size, or type of commodities advertised.

(15) An advertisement of a registered dispensing optician may include statements in addition to those specified in paragraphs (1) to (14), inclusive, provided that any statement shall not violate subdivision (a), (b), (c), or (e) or any other section of this code.

(16) A statement, or statements, providing public health information encouraging preventative or corrective care.

(17) Any other item of factual information that is not false, fraudulent, misleading, or likely to deceive.

(i) (1) Advertising by the following licensees shall include the designations as follows:

(A) Advertising by a chiropractor licensed under Chapter 2 (commencing with Section 1000) shall include the designation "DC" or the word "chiropractor" immediately following the chiropractor's name.

(B) Advertising by a dentist licensed under Chapter 4 (commencing with Section 1600) shall include the designation "DDS" or "DMD" immediately following the dentist's name.

(C) Advertising by a physician and surgeon licensed under Chapter 5 (commencing with Section 2000) shall include the designation "MD" immediately following the physician and surgeon's name.

(D) Advertising by an osteopathic physician and surgeon certified under Article 21 (commencing with Section 2450) shall include the designation "DO" immediately following the osteopathic physician and surgeon's name.

(E) Advertising by a podiatrist certified under Article 22 (commencing with Section 2460) of Chapter 5 shall include the designation "DPM" immediately following the podiatrist's name.

(F) Advertising by a registered nurse licensed under Chapter 6 (commencing with Section 2700) shall include the designation "RN" immediately following the registered nurse's name.

(G) Advertising by a licensed vocational nurse under Chapter 6.5 (commencing with Section 2840) shall include the designation "LVN" immediately following the licensed vocational nurse's name.

(H) Advertising by a psychologist licensed under Chapter 6.6 (commencing with Section 2900) shall include the designation "Ph.D." immediately following the psychologist's name.

(I) Advertising by an optometrist licensed under Chapter 7 (commencing with Section 3000) shall include the applicable designation or word described in Section 3098 immediately following the optometrist's name.

(J) Advertising by a physician assistant licensed under Chapter 7.7 (commencing with Section 3500) shall include the designation "PA" immediately following the physician assistant's name.

(K) Advertising by a naturopathic doctor licensed under Chapter 8.2 (commencing with Section 3610) shall include the designation "ND" immediately following the naturopathic doctor's name. However, if the naturopathic doctor uses the term or designation "Dr." in an advertisement, he or she shall further identify himself by any of the terms listed in Section 3661.

(2) For purposes of this subdivision, "advertisement" includes communication by means of mail, television, radio, motion picture, newspaper, book, directory, Internet, or other electronic communication.

(3) Advertisements do not include any of the following:

(A) A medical directory released by a health care service plan or a health insurer.

(B) A billing statement from a health care practitioner to a patient.

(C) An appointment reminder from a health care practitioner to a patient.

(4) This subdivision shall not apply until January 1, 2011, to any advertisement that is published annually and prior to July 1, 2010.

(5) This subdivision shall not apply to any advertisement or business card disseminated by a health care service plan that is subject to the requirements of Section 1367.26 of the Health and Safety Code.

(j) Each of the healing arts boards and examining committees within Division 2 shall adopt appropriate regulations to enforce this section in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

Each of the healing arts boards and committees and examining committees within Division 2 shall, by regulation, define those efficacious services to be advertised by businesses or professions under their jurisdiction for the purpose of determining whether advertisements are false or misleading. Until a definition for that service has been issued, no advertisement for that service shall be disseminated. However, if a definition of a service has not been issued by a board or committee within 120 days of receipt of a request from a licensee, all those holding the license may advertise the service. Those boards and committees shall adopt or modify regulations defining what services may be advertised, the manner in which defined services may be advertised, and restricting advertising that would promote the inappropriate or excessive use of health services or commodities. A board or committee shall not, by regulation, unreasonably prevent truthful, nondeceptive price or otherwise lawful forms of advertising of services or commodities, by either outright prohibition or imposition of onerous disclosure requirements. However, any member of a board or committee acting in good faith in the adoption or enforcement of any regulation shall be deemed to be acting as an agent of the state.

(k) The Attorney General shall commence legal proceedings in the appropriate forum to enjoin advertisements disseminated or about to be disseminated in violation of this section and seek other appropriate relief to enforce this section. Notwithstanding any other provision of law, the costs of enforcing this section to the respective licensing boards or committees may be awarded against any licensee found to be in violation of any provision of this section. This shall not diminish the power of district attorneys, county counsels, or city attorneys pursuant to existing law to seek appropriate relief.

(*l*) A physician and surgeon or doctor of podiatric medicine licensed pursuant to Chapter 5 (commencing with Section 2000) by the Medical Board of California who knowingly and intentionally violates this section may be cited and assessed an administrative fine not to exceed ten thousand dollars ($10,000) per event. Section 125.9 shall govern the issuance of this citation and fine except that the fine limitations prescribed in paragraph (3) of subdivision (b) of Section 125.9 shall not apply to a fine under this subdivision.

SEC. 2. Section 2023.5 of the Business and Professions Code is amended to read:

2023.5. (a) The board, in conjunction with the Board of Registered Nursing, and in consultation with the Physician Assistant Committee and professionals in the field, shall review issues and problems surrounding the use of laser or intense light pulse devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants. The review shall include, but need not be limited to, all of the following:

(1) The appropriate level of physician supervision needed.

(2) The appropriate level of training to ensure competency.

(3) Guidelines for standardized procedures and protocols that address, at a minimum, all of the following:

(A) Patient selection.

(B) Patient education, instruction, and informed consent.

(C) Use of topical agents.

(D) Procedures to be followed in the event of complications or side effects from the treatment.

(E) Procedures governing emergency and urgent care situations.

(b) On or before January 1, 2009, the board and the Board of Registered Nursing shall promulgate regulations to implement

changes determined to be necessary with regard to the use of laser or intense pulse light devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants.

(c) On or before January 1, 2011, the board shall adopt regulations regarding the appropriate level of physician availability needed within clinics or other settings using laser or intense pulse light devices for elective cosmetic procedures. However, these regulations shall not apply to laser or intense pulse light devices approved by the federal Food and Drug Administration for over-the-counter use by a health care practitioner or by an unlicensed person on himself or herself.

(d) Nothing in this section shall be construed to modify the prohibition against the unlicensed practice of medicine.

SEC. 3. Section 2027.5 is added to the Business and Professions Code, to read:

2027.5. The board shall post on its Internet Web site an easy-to-understand factsheet to educate the public about cosmetic surgery and procedures, including their risks. Included with the factsheet shall be a comprehensive list of questions for patients to ask their physician and surgeon regarding cosmetic surgery.

SEC. 4. Section 1248 of the Health and Safety Code is amended to read:

1248. For purposes of this chapter, the following definitions shall apply:

(a) "Division" means the Medical Board of California. All references in this chapter to the division, the Division of Licensing of the Medical Board of California, or the Division of Medical Quality shall be deemed to refer to the Medical Board of California pursuant to Section 2002 of the Business and Professions Code.

(b) (1) "Outpatient setting" means any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Section 1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.

(2) "Outpatient setting" also means facilities that offer in vitro fertilization, as defined in subdivision (b) of Section 1374.55.

(3) "Outpatient setting" does not include, among other settings, any setting where anxiolytics and analgesics are administered, when done so in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

(c) "Accreditation agency" means a public or private organization that is approved to issue certificates of accreditation to outpatient settings by the board pursuant to Sections 1248.15 and 1248.4.

SEC. 5. Section 1248.15 of the Health and Safety Code is amended to read:

1248.15. (a) The board shall adopt standards for accreditation and, in approving accreditation agencies to perform accreditation of outpatient settings, shall ensure that the certification program shall, at a minimum, include standards for the following aspects of the settings' operations:

(1) Outpatient setting allied health staff shall be licensed or certified to the extent required by state or federal law.

(2) (A) Outpatient settings shall have a system for facility safety and emergency training requirements.

(B) There shall be onsite equipment, medication, and trained personnel to facilitate handling of services sought or provided and to facilitate handling of any medical emergency that may arise in connection with services sought or provided.

(C) In order for procedures to be performed in an outpatient setting as defined in Section 1248, the outpatient setting shall do one of the following:

(i) Have a written transfer agreement with a local accredited or licensed acute care hospital, approved by the facility's medical staff.

(ii) Permit surgery only by a licensee who has admitting privileges at a local accredited or licensed acute care hospital, with the exception that licensees who may be precluded from having admitting privileges by their professional classification or other administrative limitations, shall have a written transfer agreement with licensees who have admitting privileges at local accredited or licensed acute care hospitals.

(D) The outpatient setting shall submit for approval by an accrediting agency a detailed procedural plan for handling medical

emergencies that shall be reviewed at the time of accreditation. No reasonable plan shall be disapproved by the accrediting agency.

(E) The outpatient setting shall submit for approval by an accreditation agency at the time accreditation of a detailed plan, standardized procedures, and protocols to be followed in the event of serious complications or side effects from surgery that would place a patient at high risk for injury or harm and to govern emergency and urgent care situations.

(F) All physicians and surgeons transferring patients from an outpatient setting shall agree to cooperate with the medical staff peer review process on the transferred case, the results of which shall be referred back to the outpatient setting, if deemed appropriate by the medical staff peer review committee. If the medical staff of the acute care facility determines that inappropriate care was delivered at the outpatient setting, the acute care facility's peer review outcome shall be reported, as appropriate, to the accrediting body, the Health Care Financing Administration, the State Department of Public Health, and the appropriate licensing authority.

(3) The outpatient setting shall permit surgery by a dentist acting within his or her scope of practice under Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code or physician and surgeon, osteopathic physician and surgeon, or podiatrist acting within his or her scope of practice under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act. The outpatient setting may, in its discretion, permit anesthesia service by a certified registered nurse anesthetist acting within his or her scope of practice under Article 7 (commencing with Section 2825) of Chapter 6 of Division 2 of the Business and Professions Code.

(4) Outpatient settings shall have a system for maintaining clinical records.

(5) Outpatient settings shall have a system for patient care and monitoring procedures.

(6) (A) Outpatient settings shall have a system for quality assessment and improvement.

(B) Members of the medical staff and other practitioners who are granted clinical privileges shall be professionally qualified and appropriately credentialed for the performance of privileges

granted. The outpatient setting shall grant privileges in accordance with recommendations from qualified health professionals, and credentialing standards established by the outpatient setting.

(C) Clinical privileges shall be periodically reappraised by the outpatient setting. The scope of procedures performed in the outpatient setting shall be periodically reviewed and amended as appropriate.

(7) Outpatient settings regulated by this chapter that have multiple service locations governed by the same standards may elect to have all service sites surveyed on any accreditation survey. Organizations that do not elect to have all sites surveyed shall have a sample, not to exceed 20 percent of all service sites, surveyed. The actual sample size shall be determined by the board. The accreditation agency shall determine the location of the sites to be surveyed. Outpatient settings that have five or fewer sites shall have at least one site surveyed. When an organization that elects to have a sample of sites surveyed is approved for accreditation, all of the organizations' sites shall be automatically accredited.

(8) Outpatient settings shall post the certificate of accreditation in a location readily visible to patients and staff.

(9) Outpatient settings shall post the name and telephone number of the accrediting agency with instructions on the submission of complaints in a location readily visible to patients and staff.

(10) Outpatient settings shall have a written discharge criteria.

(b) Outpatient settings shall have a minimum of two staff persons on the premises, one of whom shall either be a licensed physician and surgeon or a licensed health care professional with current certification in advanced cardiac life support (ACLS), as long as a patient is present who has not been discharged from supervised care. Transfer to an unlicensed setting of a patient who does not meet the discharge criteria adopted pursuant to paragraph (10) of subdivision (a) shall constitute unprofessional conduct.

(c) An accreditation agency may include additional standards in its determination to accredit outpatient settings if these are approved by the board to protect the public health and safety.

(d) No accreditation standard adopted or approved by the board, and no standard included in any certification program of any accreditation agency approved by the board, shall serve to limit the ability of any allied health care practitioner to provide services within his or her full scope of practice. Notwithstanding this or

any other provision of law, each outpatient setting may limit the privileges, or determine the privileges, within the appropriate scope of practice, that will be afforded to physicians and allied health care practitioners who practice at the facility, in accordance with credentialing standards established by the outpatient setting in compliance with this chapter. Privileges may not be arbitrarily restricted based on category of licensure.

(e) The board shall adopt standards that it deems necessary for outpatient settings that offer in vitro fertilization.

SEC. 6. Section 1248.2 of the Health and Safety Code is amended to read:

1248.2. (a) Any outpatient setting may apply to an accreditation agency for a certificate of accreditation. Accreditation shall be issued by the accreditation agency solely on the basis of compliance with its standards as approved by the board under this chapter.

(b) The board shall obtain and maintain a list of all accredited, certified, and licensed outpatient settings from the information provided by the accreditation, certification, and licensing agencies approved by the board, and shall notify the public whether a setting is accredited, certified, or licensed, or the setting's accreditation, certification, or license has been revoked, suspended, or placed on probation, or the setting has received a reprimand by the accreditation agency.

SEC. 7. Section 1248.25 of the Health and Safety Code is amended to read:

1248.25. If an outpatient setting does not meet the standards approved by the board, accreditation shall be denied by the accreditation agency, which shall provide the outpatient setting notification of the reasons for the denial. An outpatient setting may reapply for accreditation at any time after receiving notification of the denial. The accreditation agency shall immediately report to the board if the outpatient setting's certificate for accreditation has been denied.

SEC. 8. Section 1248.35 of the Health and Safety Code is amended to read:

1248.35. (a) Every outpatient setting which is accredited shall be inspected by the accreditation agency and may also be inspected by the Medical Board of California. The Medical Board of

California shall ensure that accreditation agencies inspect outpatient settings.

(b) Unless otherwise specified, the following requirements apply to inspections described in subdivision (a).

(1) The frequency of inspection shall depend upon the type and complexity of the outpatient setting to be inspected.

(2) Inspections shall be conducted no less often than once every three years by the accreditation agency and as often as necessary by the Medical Board of California to ensure the quality of care provided.

(3) The Medical Board of California or the accreditation agency may enter and inspect any outpatient setting that is accredited by an accreditation agency at any reasonable time to ensure compliance with, or investigate an alleged violation of, any standard of the accreditation agency or any provision of this chapter.

(c) If an accreditation agency determines, as a result of its inspection, that an outpatient setting is not in compliance with the standards under which it was approved, the accreditation agency may do any of the following:

(1) Issue a reprimand.

(2) Place the outpatient setting on probation, during which time the setting shall successfully institute and complete a plan of correction, approved by the board or the accreditation agency, to correct the deficiencies.

(3) Suspend or revoke the outpatient setting's certification of accreditation.

(d) Except as is otherwise provided in this subdivision, before suspending or revoking a certificate of accreditation under this chapter, the accreditation agency shall provide the outpatient setting with notice of any deficiencies and the outpatient setting shall agree with the accreditation agency on a plan of correction that shall give the outpatient setting reasonable time to supply information demonstrating compliance with the standards of the accreditation agency in compliance with this chapter, as well as the opportunity for a hearing on the matter upon the request of the outpatient center. During that allotted time, a list of deficiencies and the plan of correction shall be conspicuously posted in a clinic location accessible to public view. The accreditation agency may immediately suspend the certificate of accreditation before

providing notice and an opportunity to be heard, but only when failure to take the action may result in imminent danger to the health of an individual. In such cases, the accreditation agency shall provide subsequent notice and an opportunity to be heard.

(e) If the board determines that deficiencies found during an inspection suggests that the accreditation agency does not comply with the standards approved by the board, the board may conduct inspections, as described in this section, of other settings accredited by the accreditation agency to determine if the agency is accrediting settings in accordance with Section 1248.15.

(f) Reports on the results of any inspection conducted pursuant to subdivision (a) shall be kept on file with the board or the accreditation agency along with the plan of correction and the outpatient setting comments. The inspection report may include a recommendation for reinspection. All inspection reports, lists of deficiencies, and plans of correction shall be public records open to public inspection.

(g) The accreditation agency shall immediately report to the board if the outpatient setting has been issued a reprimand or if the outpatient setting's certification of accreditation has been suspended or revoked or if the outpatient setting has been placed on probation.

SEC. 9. Section 1248.5 of the Health and Safety Code is amended to read:

1248.5. The board shall evaluate the performance of an approved accreditation agency no less than every three years, or in response to complaints against an agency, or complaints against one or more outpatient settings accreditation by an agency that indicates noncompliance by the agency with the standards approved by the board.

SEC. 10. Section 1248.55 of the Health and Safety Code is amended to read:

1248.55. (a) If the accreditation agency is not meeting the criteria set by the board, the board may terminate approval of the agency or may issue a citation to the agency in accordance with the system established under subdivision (b).

(b) The board may establish, by regulation, a system for the issuance of a citation to an accreditation agency that is not meeting the criteria set by the board. This system shall meet the

requirements of Section 125.9 of the Business and Professions Code, as applicable, except that both of the following shall apply:

(1) Failure of an agency to pay an administrative fine assessed pursuant to a citation within 30 days of the date of the assessment, unless the citation is being appealed, may result in the board's termination of approval of the agency. Where a citation is not contested and a fine is not paid, the full amount of the assessed fine shall be added to the renewal fee established under Section 1248.6. Approval of an agency shall not be renewed without payment of the renewal fee and fine.

(2) Administrative fines collected pursuant to the system shall be deposited in the Outpatient Setting Fund of the Medical Board of California established under Section 1248.6.

(c) Before terminating approval of an accreditation agency, the board shall provide the accreditation agency with notice of any deficiencies and reasonable time to supply information demonstrating compliance with the requirements of this chapter, as well as the opportunity for a hearing on the matter in compliance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) (1) If approval of the accreditation agency is terminated by the board, outpatient settings accredited by that agency shall be notified by the board and, except as provided in paragraph (2), shall be authorized to continue to operate for a period of 12 months in order to seek accreditation through an approved accreditation agency, unless the time is extended by the board for good cause.

(2) The board may require that an outpatient setting, that has been accredited by an accreditation agency whose approval has been terminated by the board, cease operations immediately if the board is in possession of information indicating that continued operation poses an imminent risk of harm to the health of an individual. In such cases, the board shall provide the outpatient setting with notice of its action, the reason underlying it, and a subsequent opportunity for a hearing on the matter. An outpatient setting that is ordered to cease operations under this paragraph may reapply for a certificate of accreditation after six months and shall notify the board promptly of its reapplication.

SEC. 11. Section 1279 of the Health and Safety Code is amended to read:

1279. (a) Every health facility for which a license or special permit has been issued shall be periodically inspected by the department, or by another governmental entity under contract with the department. The frequency of inspections shall vary, depending upon the type and complexity of the health facility or special service to be inspected, unless otherwise specified by state or federal law or regulation. The inspection shall include participation by the California Medical Association consistent with the manner in which it participated in inspections, as provided in Section 1282 prior to September 15, 1992.

(b) Except as provided in subdivision (c), inspections shall be conducted no less than once every two years and as often as necessary to ensure the quality of care being provided.

(c) For a health facility specified in subdivision (a), (b), or (f) of Section 1250, inspections shall be conducted no less than once every three years, and as often as necessary to ensure the quality of care being provided.

(d) During the inspection, the representative or representatives shall offer such advice and assistance to the health facility as they deem appropriate.

(e) For acute care hospitals of 100 beds or more, the inspection team shall include at least a physician, registered nurse, and persons experienced in hospital administration and sanitary inspections. During the inspection, the team shall offer advice and assistance to the hospital as it deems appropriate.

(f) The department shall ensure that a periodic inspection conducted pursuant to this section is not announced in advance of the date of inspection. An inspection may be conducted jointly with inspections by entities specified in Section 1282. However, if the department conducts an inspection jointly with an entity specified in Section 1282 that provides notice in advance of the periodic inspection, the department shall conduct an additional periodic inspection that is not announced or noticed to the health facility.

(g) Notwithstanding any other provision of law, the department shall inspect for compliance with provisions of state law and regulations during a state periodic inspection or at the same time as a federal periodic inspection, including, but not limited to, an inspection required under this section. If the department inspects for compliance with state law and regulations at the same time as

a federal periodic inspection, the inspection shall be done consistent with the guidance of the federal Centers for Medicare and Medicaid Services for the federal portion of the inspection.

(h) The department shall emphasize consistency across the state and in its district offices when conducting licensing and certification surveys and complaint investigations, including the selection of state or federal enforcement remedies in accordance with Section 1423. The department may issue federal deficiencies and recommend federal enforcement actions in those circumstances where they provide more rigorous enforcement action.

(i) It is the intent of the Legislature that the department, pursuant to its existing regulations, inspect the peer review process utilized by acute care hospitals as part of its periodic inspection of those hospitals pursuant to this section.

SEC. 12. 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.

SB 726

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 726
Author: Ashburn
Bill Date: August 20, 2009, amended
Subject: Pilot Program Authorizing Acute Care Hospitals to Employ Physicians
Sponsor: Author
Board Position: Support

STATUS OF BILL:

This bill is currently on the Assembly Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill makes revisions to a current pilot program administered by the Medical Board of California (Board), relating to the direct employment of physicians by certain hospitals.

This bill was amended July 15th to set forth specific definitions for "qualified health care district," to add and define "qualified rural hospital," and to specify the requirements for each to employ physicians under the pilot project. The analysis in bold below describes the changes in this bill.

Amendments taken August 20, 2009 make minor technical changes to the bill's provisions.

ANALYSIS:

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

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

SB 376 was sponsored by the Association of California Healthcare Districts to enable qualified district hospitals to recruit, hire and employ physicians as full-time paid staff in a

rural or underserved community meeting the criteria contained in the bill. Support for this bill was premised upon the belief that the employment of physicians could improve the ability of district hospitals to attract the physicians required to meet the needs of those communities and also help to ensure the continued survival of healthcare district hospitals in rural and underserved communities, without any cost to the state.

Although it was anticipated that this pilot program would bring about significant improvement in access to healthcare in these areas, only five hospitals throughout all of California have participated, employing a total of six physicians. The last date for physicians to enter into or renew a written employment contract with the qualified district hospital was December 31, 2006, and for a term not in excess of four years.

Current law required the Board to evaluate the program and to issue a report to the Legislature no later than October 1, 2008. In March, 2008, staff sent letters to the six physicians and five hospital administrators participating in the program, asking each to define the successes, problems, if any, and overall effectiveness of this program for the hospital and on consumer protection. Additional input was sought as to how the program could be strengthened, and the participating physicians were asked to share thoughts on how the program impacted them personally.

The Board was challenged in evaluating the program and preparing the required report because the low number of participants did not afford us sufficient information to prepare a valid analysis of the pilot. In summary, while the Board supports the ban on the corporate practice of medicine, it also believes there may be justification to extend the pilot so that a better evaluation can be made. However, until there is sufficient data to perform a full analysis of an expanded pilot, the Board's position as spelled out in the report to the Legislature (September 10, 2008) was that the statutes governing the corporate practice of medicine should not be amended as a solution to solve the problem of access to healthcare.

The pilot provided safeguards and limitations. That program provided for the direct employment of no more than 20 physicians in California by qualified district hospitals at any time and limited the total number of physicians employed by such a hospital to no more than two at a time. The Medical Board was notified of any physicians hired under the pilot, and the contracts were limited to four years of service. Further, per the current pilot program: 1) the hospital must be located in smaller counties (a population of less than 750,000); 2) the hospital must provide a majority of care to underserved populations; 3) the hospital must notify the Board.

This bill revises the existing pilot program by:

- Allowing any general acute care hospital (instead of only certain district hospitals) to participate so long as the hospital is located in a medically underserved population, a medically underserved area, or a health professional shortage area.
- Removing the statewide limit of 20 physicians who may participate in the pilot.
- Increasing the number of physicians who may be employed at any hospital from two to five.

- Requiring physicians and hospitals to enter into a written contract, not in excess of four years, by December 31, 2011. This document, together with other information, shall be submitted to the Board for approval, and the Board must provide written confirmation to the hospital within five working days.
- Requiring the Board to submit a report to the Legislature by October 1, 2013.
- Repealing the pilot effective on January 1, 2016 unless deleted or extended by subsequent legislation.

The author's office reports that there are 69 rural hospitals, of which 31 are owned and operated by Health Care Districts. There are then 15 District hospitals that are non-rural that would be included in the most recent amendments to this bill. It total, there are 84 hospitals statewide that would be included.

It also remains unclear what impact, if any, would be realized by removing the current limit of 20 physicians statewide or by increasing the number of physicians at each hospital from two to five. As SB 376 was being debated before the Legislature, the Board discussed the potential impact of the bill with the author's office. While recognizing that the limitations of the pilot (a statewide total of 20 participants with no more than two physicians at any one hospital) would make only a small first-step towards increasing access to healthcare, the Board anticipated that all 20 slots soon would be filled. After the Governor signed the bill and the law took effect on January 1, 2004, staff was prepared to promptly process the applications as they were submitted. The Board recognized that to have an adequate base of physicians to use in preparing a valid analysis of the pilot, as many as possible of the 20 positions would need to be filled. However, such a significant response failed to materialize. Unexpectedly, the first application was not received until six months after the pilot became operational, and that hospital elected to hire a physician for only three years instead of the four years allowed by the pilot. Further, during the years that the pilot was operational, only six physicians were hired by five eligible hospitals. So, unless there is an unexpected groundswell of interest in the revised pilot, this workload could be accomplished within existing resources. Again, expanding the pool of available positions to be filled could increase access to health care.

One issue of importance with bill is the implementation dates. If the bill is signed, the law would not become effective until January 2010. Hospitals would only have 24 months during which to hire physicians—for contracts up to four years. However, the report would be due to the Legislature only 21 months thereafter. This limited time for the pilot to be operational and for the Board to collect information is not practical for conducting a full and valuable evaluation.

Recent amendments to this bill add a definition for "qualified health care district" and sets forth requirements for a qualified health care district to employ physicians. Qualified health care district is defined as a health care district organized and governed under the Local Health Care District Law. This may include clinics and hospitals but only the district is authorized to hire. A qualified health care district is eligible to employ physicians if:

1. **It is operated by the district itself and not by another entity;**

2. **It is located within a medically underserved population or area;**

3. **The chief executive officer of the district provides certification to the board that the district has been unsuccessful in recruiting a physician to provide services for at least twelve months. This was revised from a specific 12 month period to any 12 month period prior to hiring;**

4. **The chief executive officer certifies to the board that the hiring of physicians shall not supplant current physicians with privileges and contracts at the hospital. This was added to address concerns that new physicians would not come into the area, that hires would not be made by robbing from the existing pool of physicians;**

5. **The district hires the physicians before December 31, 2017 for a term of not more than ten years;**

6. **The district employs no more than two physicians at one time. The Board can authorize up to three more additional hires if the hospital shows a need for more.**

7. **The district notifies the Board in writing that it plans to hire a licensee and the Board confirms that the district is eligible to hire (does not have more than two). The district cannot actively recruit a physician who is already employed with a federally qualified health center, a rural health center, or other community clinic not affiliated with the district.**

This removes the affirmative vote needed from the medical staff and the elected trustees of the hospital that each physician's employment is in the best interests of the communities served by the hospital.

Per the sponsor, there are 46 health care district hospitals which could equate to 92 employed physicians prior to Board approval.

This bill adds and defines "qualified rural hospital" as a general acute care hospital located in an area designated as nonurban by the United States Census Bureau, a general acute care hospital located in a rural-urban commuting area code of four or greater as designated by the United States Department of Agriculture, or a rural hospital located within a medically underserved population or medically underserved area, so designated by the federal government as a Health Professional Shortage Area. A qualified rural hospital is eligible to employ physicians if:

1. **The chief executive officer of the hospital provides certification to the board that the district has been unsuccessful in recruiting a physician to provide services for at least twelve continuous months (same requirement as with the districts);**

2. **The chief executive officer certifies to the board that the hiring of physicians shall not supplant current physicians with privileges and contracts at the hospital (same requirement as with the districts);**

3. **The district hires the physicians before December 31, 2017 for a term of not more than ten years (same requirement as with the districts);**

4. **The district employs no more than two physicians at one time. The Board can authorize additional hires up to three more if the hospital shows a need for more. This provision is very different from AB 648 that addressed rural hospitals. That bill allowed for 10 physician hires per hospital.**

5. **The district notifies the Board in writing that it plans to hire a licensee and the Board confirms that the district is eligible to hire (does not have more than two). The district cannot actively recruit a physician who is already employed with a federally qualified health center, a rural health center, or other community clinic not affiliated with the district.**

This removes the affirmative vote needed from the medical staff and the elected trustees of the hospital that each physician's employment is in the best interests of the communities served by the hospital.

Per the sponsor, there are 38 rural hospitals that are not district hospitals. This could equate to 76 employed physicians prior to Board approval.

This bill was also amended to require the Board to include in the final report evaluating the effectiveness of the pilot project an analysis of the impact of the pilot project on the ability of nonprofit community clinics and health centers located in close proximity to participating health care district facilities and participating rural hospitals to recruit and retain physicians. This report is due to the Legislature no later than July 1, 2016.

The Board supported the concept of expanding the pilot program in some manner in one of the three bills pending in the 2009 session. This keeps the pilot reasonably small with potentially enough physicians to fully evaluate the impact of the direct employment of physicians by both district hospitals and rural hospitals.

FISCAL: Within existing resources to monitor the program, potentially $50,000 to do the evaluation study in 2016.

POSITION: Support

September 28, 2009

AMENDED IN ASSEMBLY AUGUST 20, 2009

AMENDED IN ASSEMBLY JULY 15, 2009

AMENDED IN SENATE MAY 6, 2009

AMENDED IN SENATE APRIL 23, 2009

SENATE BILL No. 726

Introduced by Senator Ashburn
(Principal coauthors: Assembly Members Chesbro and Swanson)
(Coauthors: Senators Cox and Ducheny)

February 27, 2009

An act to amend Sections 2401 and 2401.1 of the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

SB 726, as amended, Ashburn. Health care districts: rural hospitals: employment of physicians and surgeons.

Existing law, the Medical Practice Act, restricts the employment of licensed physicians and surgeons and podiatrists by a corporation or other artificial legal entity, subject to specified exemptions. Existing law establishes, until January 1, 2011, a pilot project to allow qualified district hospitals to employ a physician and surgeon if certain conditions are satisfied. The pilot project authorizes the direct employment of a total of 20 physicians and surgeons by those hospitals, and specifies that each qualified district hospital may employ up to 2 physicians and surgeons, subject to certain requirements. The pilot project requires that the term of a contract with a licensee not exceed 4 years. Existing law requires the Medical Board of California to report to the Legislature not later than October 1, 2008, on the effectiveness of the pilot project.

This bill would revise the pilot project to authorize the direct employment by qualified health care districts and qualified rural hospitals, as defined, of an unlimited number of physicians and surgeons under the pilot project, and would authorize such a district or hospital to employ up to 5 physicians and surgeons at a time if certain requirements are met. The bill would require that the term of a contract with a physician and surgeon not exceed 10 years and would extend the pilot project until January 1, 2018. The bill would require the board to provide a preliminary report to the Legislature not later than July 1, 2013, and a final report not later than July 1, 2016, evaluating the effectiveness of the pilot project, and would make conforming changes.

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

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

1 SECTION 1. Section 2401 of the Business and Professions
2 Code is amended to read:
3 2401. (a) Notwithstanding Section 2400, a clinic operated
4 primarily for the purpose of medical education by a public or
5 private nonprofit university medical school, which is approved by
6 the Division of Licensing or the Osteopathic Medical Board of
7 California, may charge for professional services rendered to
8 teaching patients by licensees who hold academic appointments
9 on the faculty of the university, if the charges are approved by the
10 physician and surgeon in whose name the charges are made.
11 (b) Notwithstanding Section 2400, a clinic operated under
12 subdivision (p) of Section 1206 of the Health and Safety Code
13 may employ licensees and charge for professional services rendered
14 by those licensees. However, the clinic shall not interfere with,
15 control, or otherwise direct the professional judgment of a
16 physician and surgeon in a manner prohibited by Section 2400 or
17 any other provision of law.
18 (c) Notwithstanding Section 2400, a narcotic treatment program
19 operated under Section 11876 of the Health and Safety Code and
20 regulated by the State Department of Alcohol and Drug Programs,
21 may employ licensees and charge for professional services rendered
22 by those licensees. However, the narcotic treatment program shall
23 not interfere with, control, or otherwise direct the professional

judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.

(d) Notwithstanding Section 2400, a qualified health care district organized and governed pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code or a qualified rural hospital may employ a licensee pursuant to Section 2401.1, and may charge for professional services rendered by the licensee, if the physician and surgeon in whose name the charges are made approves the charges. However, the district or hospital shall not interfere with, control, or otherwise direct the physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other provision of law.

SEC. 2. Section 2401.1 of the Business and Professions Code is amended to read:

2401.1. (a) The Legislature finds and declares as follows:

(1) Due to the large number of uninsured and underinsured Californians, a number of California communities are having great difficulty recruiting and retaining physicians and surgeons.

(2) In order to recruit physicians and surgeons to provide medically necessary services in rural and medically underserved communities, many qualified health care districts and qualified rural hospitals have no viable alternative but to directly employ physicians and surgeons in order to provide economic security adequate for a physician and surgeon to relocate and reside in their communities.

(3) The Legislature intends that a qualified health care district or qualified rural hospital meeting the conditions set forth in this section be able to employ physicians and surgeons directly, and to charge for their professional services.

(4) The Legislature reaffirms that Section 2400 provides an increasingly important protection for patients and physicians and surgeons from inappropriate intrusions into the practice of medicine, and further intends that a qualified health care district or qualified rural hospital not interfere with, control, or otherwise direct a physician and surgeon's professional judgment.

(b) A pilot project to provide for the direct employment of physicians and surgeons by qualified health care districts and qualified rural hospitals is hereby established in order to improve the recruitment and retention of physicians and surgeons in rural and other medically underserved areas.

(c) For purposes of this section, "qualified health care district" means a health care district organized and governed pursuant to the Local Health Care District Law (Division 23 (commencing with Section 32000) of the Health and Safety Code). A qualified health care district shall be eligible to employ physicians and surgeons pursuant to this section if all of the following requirements are met:

(1) The district health care facility at which the physician and surgeon will provide services meets both of the following requirements:

(A) Is operated by the district itself, and not by another entity.

(B) Is located within a medically underserved population or medically underserved area, so designated by the federal government pursuant to Section 254b or 254c-14 of Title 42 of the United States Code, or within a federally designated Health Professional Shortage Area.

(2) The chief executive officer of the district has provided certification to the board that the district has been unsuccessful, using commercially reasonable efforts, in recruiting a physician and surgeon to provide services at the facility described in paragraph (1) for at least 12 continuous months beginning on or after July 1, 2008. This certification shall specify the commercially reasonable efforts~~, including, but not limited to, recruitment payments or other incentives,~~ used to recruit a physician and surgeon that were unsuccessful and shall specify the reason for the lack of success, if known. *In providing a certification pursuant to this paragraph, the chief executive officer need not provide confidential information regarding specific contract offers or individualized recruitment incentives.*

(3) The chief executive officer of the district certifies to the board that the hiring of a physician and surgeon pursuant to this section shall not supplant physicians and surgeons with current privileges or contracts with the facility described in paragraph (1).

(4) The district enters into or renews a written employment contract with the physician and surgeon prior to December 31, 2017, for a term not in excess of 10 years. The contract shall provide for mandatory dispute resolution under the auspices of the board for disputes directly relating to the physician and surgeon's clinical practice.

(5) The total number of physicians and surgeons employed by the district does not exceed two at any time. However, the board shall authorize the district to hire no more than three additional physicians and surgeons if the district makes a showing of clear need in the community following a public hearing duly noticed to all interested parties, including, but not limited to, those involved in the delivery of medical care.

(6) The district notifies the board in writing that the district plans to enter into a written contract with the physician and surgeon, and the board has confirmed that the physician and surgeon's employment is within the maximum number permitted by this section. The board shall provide written confirmation to the district within five working days of receipt of the written notification to the board.

(7) The chief executive officer of the district certifies to the board that the district did not actively recruit ~~or employ~~ a physician and surgeon who, at the time, was employed by a federally qualified health center, a rural health center, or other community clinic not affiliated with the district.

(d) (1) For purposes of this section, "qualified rural hospital" means any of the following:

(A) A general acute care hospital located in an area designated as nonurban by the United States Census Bureau.

(B) A general acute care hospital located in a rural-urban commuting area code of four or greater as designated by the United States Department of Agriculture.

(C) A small and rural hospital as defined in Section 124840 of the Health and Safety Code.

~~(C)~~

(D) A rural hospital located within a medically underserved population or medically underserved area, so designated by the federal government pursuant to Section 254b or 254c-14 of Title 42 of the United States Code, or within a federally designated Health Professional Shortage Area.

(2) To be eligible to employ physicians and surgeons pursuant to this section, a qualified rural hospital shall meet all of the following requirements:

(A) The chief executive officer of the hospital has provided certification to the board that the hospital has been unsuccessful, using commercially reasonable efforts, in recruiting a physician

and surgeon for at least 12 continuous months beginning on or after July 1, 2008. This certification shall specify the commercially reasonable efforts~~, including, but not limited to, recruitment payments or other incentives,~~ used to recruit a physician and surgeon that were unsuccessful and shall specify the reason for the lack of success, if known. *In providing a certification pursuant to this subparagraph, the chief executive officer need not provide confidential information regarding specific contract offers or individualized recruitment incentives.*

(B) The chief executive officer of the hospital certifies to the board that the hiring of a physician and surgeon pursuant to this section shall not supplant physicians and surgeons with current privileges or contracts with the hospital.

(C) The hospital enters into or renews a written employment contract with the physician and surgeon prior to December 31, 2017, for a term not in excess of 10 years. The contract shall provide for mandatory dispute resolution under the auspices of the board for disputes directly relating to the physician and surgeon's clinical practice.

(D) The total number of physicians and surgeons employed by the hospital does not exceed two at any time. However, the board shall authorize the hospital to hire no more than three additional physicians and surgeons if the hospital makes a showing of clear need in the community following a public hearing duly noticed to all interested parties, including, but not limited to, those involved in the delivery of medical care.

(E) The hospital notifies the board in writing that the hospital plans to enter into a written contract with the physician and surgeon, and the board has confirmed that the physician's and surgeon's employment is within the maximum number permitted by this section. The board shall provide written confirmation to the hospital within five working days of receipt of the written notification to the board.

(F) The chief executive officer of the hospital certifies to the board that the hospital did not actively recruit~~ or employ~~ a physician and surgeon who, at the time, was employed by a federally qualified health center, a rural health center, or other community clinic not affiliated with the hospital.

(e) The board shall provide a preliminary report to the Legislature not later than July 1, 2013, and a final report not later

than July 1, 2016, evaluating the effectiveness of the pilot project in improving access to health care in rural and medically underserved areas and the project's impact on consumer protection as it relates to intrusions into the practice of medicine. The board shall include in the report an analysis of the impact of the pilot project on the ability of nonprofit community clinics and health centers located in close proximity to participating health care district facilities and participating rural hospitals to recruit and retain physicians and surgeons.

(f) Nothing in this section shall exempt a qualified health care district or qualified rural hospital from any reporting requirements or affect the board's authority to take action against a physician and surgeon's license.

(g) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2018, deletes or extends that date.

O

SB 819

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 819
Author: Committee on Business, Professions, and Economic Development
Chapter: #308
Subject: Omnibus
Sponsor: Committee
Board Position: Support MBC Provisions

DESCRIPTION OF LEGISLATION:

This bill is 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. The provisions in this bill were those previously carried in SB 1779 (2008), which was vetoed.

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):

- 2089.5 – Specifying the type of residency programs; and technical changes.
- 2096 – Specifying the type of residency programs; and technical changes.
- 2102 – Since the Federation of State Medical Boards (FSMB) will not test anyone without a state license, this eliminates this option and makes technical changes.
- 2107 – Technical changes.
- 2135 – Technical changes as follows:
  - *Subdivision (a)(1)* – Specifying degree of Medical Doctor to clarify and ensure understanding.
  - *Subdivision (d)* – Maintaining consistency among all licensing pathways.
- 2168.4 & 2169 – 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 – Requiring the Board to maintain examination records until June 1, 2070.

- 2221 – Making the process by which an applicant's probationary certificate can be modified or terminated consistent with the process that a licensee on probation must follow to modify or terminate probation.

- 2307 – Specify that recommendations for reinstatement 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. Our amendments add 10 days to the 90-day period by which provisions and proposed decisions must be issued by the Board. This provision will make the requirements consistent with the Administrative Procedures Act.

<u>IMPLEMENTATION</u>:

- Newsletter Article
- Notify Board Staff
- Work with Licensing and Enforcement staff to complete updates for these technical changes.

October 19, 2009

Senate Bill No. 819

CHAPTER 308

An act to amend Sections 27, 101, 128.5, 144, 146, 149, 683, 733, 800, 801, 803, 1907, 2089.5, 2096, 2102, 2107, 2135, 2168.4, 2175, 2221, 2307, 2335, 2486, 2488, 2570.5, 2570.6, 2570.7, 2570.185, 2760.1, 3503, 3517, 3518, 3635, 3636, 3753.5, 4022.5, 4027, 4040, 4051, 4059.5, 4060, 4062, 4076, 4081, 4110, 4111, 4126.5, 4161, 4174, 4231, 4301, 4305, 4329, 4330, 4857, 4980.30, 4980.43, 4996.2, 4996.17, 4996.18, 5092, 5093, 5801, 6534, 6536, 6561, 7616, 7629, 8030.2, 8740, and 8746 of, to add Sections 2169, 2570.36, 2835.7, 4036.5, 4980.04, 4990.09, and 5094.6 to, to add and repeal Sections 5094.5 and 5094.7 of, to repeal Sections 2172, 2173, 2174, 4981, 4994.1, 4996.20, 4996.21, 5096.11, and 6761 of, and to repeal and amend Section 5094 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.

[Approved by Governor October 11, 2009. Filed with Secretary of State October 11, 2009.]

LEGISLATIVE COUNSEL'S DIGEST

SB 819, Yee. 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, any of a list of specified state regulatory agencies 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.

Existing law requires specified healing arts boards to report to the State Department of Health Care Services the name and license number of a person whose license has been revoked, suspended, surrendered, made inactive, or otherwise restricted, and requires specified healing arts boards to create and maintain a central file of the names of all persons who hold a

* ONLY THE SECTIONS THAT PERTAIN TO THE BOARD ARE ATTACHED.

1907. The following functions may be performed by a registered dental hygienist, in addition to those authorized pursuant to Sections 1908 to 1914, inclusive:

(a) All functions that may be performed by a registered dental assistant.

(b) All persons holding a license as a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions as of December 31, 2005, are authorized to perform the duties of a registered dental assistant specified in this chapter. All persons issued a license as a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions on or after January 1, 2006, shall qualify for and receive a registered dental assistant license prior to performance of the duties of a registered dental assistant specified in this chapter.

SEC. 12. 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. 13. 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 the 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. 14. 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. 15. 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. 16. 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. 17. 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. 18. 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. 19. Section 2172 of the Business and Professions Code is repealed.

SEC. 20. Section 2173 of the Business and Professions Code is repealed.

SEC. 21. Section 2174 of the Business and Professions Code is repealed.

SEC. 22. 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, 2070. 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. 23. 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. 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. 25. 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 calendar 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. 26. 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.

(e) The applicant has committed no acts or crimes constituting grounds for denial of a certificate under Division 1.5 (commencing with Section 475).

(f) The board determines that no disciplinary action has been taken against the applicant by any podiatric licensing authority and that the applicant has not been the subject of adverse judgments or settlements resulting from the practice of podiatric medicine that the board determines constitutes evidence of a pattern of negligence or incompetence.

SB 820

BILL NUMBER: SB 820
VETOED DATE: 10/12/2009

To the Members of the California State Senate:

I am returning Senate Bill 820 without my signature.

Peer review is an extremely important part of assuring the integrity and quality of care provided in our California hospitals. Unfortunately, the peer review process has also been criticized over the years because it increases litigious behavior, and lacks transparency and responsiveness. While perhaps well-intentioned, this bill does not provide a solution to the problem, but rather, jeopardizes the entire process by narrowing the reporting element to "serious" cases of incompetence involving only patients. How is this good policy? For example, what about a physician that engages in egregious behavior against hospital staff or even other physicians – how does this serve the public by keeping these reports from the Medical Board?

This bill also fails to align with recent Joint Commission requirements that hospitals adopt a "zero tolerance" policy towards physicians engaging in disruptive behavior in their interactions with nurses and other hospital staff. A peer review body should not be limited from acting on this type of behavior and in fact, should be encouraged to act more swiftly.

I believe the peer review process is worth preserving. It does however, deserve to be thoroughly reviewed and reworked to ensure that inappropriate behavior of any kind is immediately acted upon. I would ask that the author and interested stakeholders work with my Department of Consumer Affairs to streamline and improve the peer review process in order to increase its effectiveness in taking action against providers that jeopardize quality or safety measures.

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

Sincerely,

Arnold Schwarzenegger

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 820
Author: Negrete McLeod and Aanestad
Chapter: VETOED (see attached veto message)
Subject: Peer Review
Sponsor: Authors
Board Position: Support

DESCRIPTION OF LEGISLATION:

This bill was gutted and amended to carry many of the provisions regarding peer review that were originally contained in SB 700 (Negrete McLeod).

Business and Professions Code section 800 – Central File

1. Allows the physician to submit into the central file exculpatory or explanatory statements related to an 805 report and any court findings that an 805 report was submitted in bad faith. This provision allows physicians to have in his or her central file, maintained by the Board, additional information explaining the physician's or court's point of view.

Business and Professions Code section 803.1 – Disclosure of Information

1. 805 reports for termination or revocation are disclosable. This provision adds that any exculpatory or explanatory statements submitted by the licensee will also be disclosed.

2. If a court finds that the peer review resulting in disciplinary action was conducted in bad faith and the licensee notifies the board of that finding, the 805 report and any accompanying exculpatory or explanatory statements will no longer be disclosed.

Business and Professions Code section 805 – Peer Review

1. Adds a definition of what peer review is by specifying that it is the process in which the basic qualifications, staff privileges, employment, outcomes and conduct of licentiates are reviewed to determine if licensees may continue to practice in the facility and if so, under any parameters. This bill clarifies that the definition of a peer review body includes any clinic specified in the Health and Safety Code. This clarification is needed in order to makes clear all the entities and individuals who are required to conduct peer review.

2. Rewrites for clarity the section that requires an 805 report to be filed within 15

days from the date when a physician, after receiving notice of a pending investigation:

a. resigns or takes a leave of absence from staff privileges, membership or employment;
b. withdraws or abandons his or her application for staff privileges, membership, or employment;
c. withdraws or abandons his or her request for renewal of staff privileges, membership, or employment.

Business and Professions Code section 805.01 – New Required Peer Review Reports

1. This section requires, in addition to reports required under section 805, the filing of a report after a formal investigation and prior to an 809.2 hearing if a physician is accused of any of the following:

   a. Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represent a danger to the public.
   b. Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.
   c. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without good faith effort prior examination of the patient and medical reason.
   d. Sexual misconduct with one or more patients during a course of treatment or an examination.

2. This section authorizes the board to inspect and copy the following documents in the record of any informal investigation:

   a. Any statement of charges.
   b. Any document, medical chart, or exhibit.
   c. Any opinions, findings, or conclusions.
   d. Certified medical records.

Business and Professions Code section 805.5 – Granting and Renewing Staff Privileges

1. Adds that any additional information furnished by a licensee related to an 805 shall be provided by the board to the agency granting or renewing staff privileges.

2. The board shall not send a copy of an 805 report is a court finds that the peer review resulting in disciplinary action was conducted in bad faith and the licensee notifies the board of that finding.

Business and Professions Code section 2027 – Posting on the Web

1. Adds that hospital disciplinary actions that are posted on the web shall provide a link to any exculpatory or explanatory statements submitted by the licensee.

2. If a court finds that the peer review resulting in disciplinary action was conducted in bad faith and the licensee notifies the board of that finding, the posting shall be immediately removed from the web.

IMPLEMENTATION:

None

CHAPTER _____

An act to amend Sections 800, 803.1, 805, 805.1, 805.5, 821.5, and 2027 of, to add Sections 805.01 and 821.4 to, and to repeal Section 821.6 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 820, Negrete McLeod. Healing arts: peer review.

Existing law provides for the professional review of specified healing arts licentiates through a peer review process.

This bill would define the term "peer review" for purposes of those provisions.

Under existing law, specified persons are required to file a report, designated as an "805 report," with a licensing board within 15 days after a specified action is taken against a person licensed by that board.

This bill would also require specified persons to file a report with a licensing board within 15 days after a peer review body makes a decision or recommendation regarding the disciplinary action to be taken against a licentiate of that board based on the peer review body's determination, following formal investigation, that the licentiate may have engaged in various acts, including incompetence, substance abuse, excessive prescribing or furnishing of controlled substances, or sexual misconduct, among other things. The bill would authorize the board to inspect and copy certain documents in the record of that investigation.

Existing law requires the board to maintain an 805 report for a period of 3 years after receipt.

This bill would require the board to maintain the report electronically.

Existing law authorizes the Medical Board of California, the Osteopathic Medical Board of California, and the Dental Board of California to inspect and copy certain documents in the record of any disciplinary proceeding resulting in action that is required to be reported in an 805 report.

This bill would specify that the boards have the authority to also inspect, as permitted by other applicable law, any certified copy of medical records in the record of the disciplinary proceeding.

Existing law requires specified healing arts boards to maintain a central file of their licensees containing, among other things, disciplinary information reported through 805 reports.

Under this bill, if a court finds, in a final judgment, that the peer review resulting in the 805 report was conducted in bad faith and the licensee who is the subject of the report notifies the board of that finding, the board would be required to include that finding in the licensee's central file.

Existing law requires the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine to disclose an 805 report to specified health care entities and to disclose certain hospital disciplinary actions to inquiring members of the public. Existing law also requires the Medical Board of California to post hospital disciplinary actions regarding its licensees on the Internet.

This bill would prohibit those disclosures, and would require the Medical Board of California to remove certain information posted on the Internet, if a court finds, in a final judgment, that the peer review resulting in the 805 report or the hospital disciplinary action was conducted in bad faith and the licensee notifies the board of that finding. The bill would also require the Medical Board of California to include certain exculpatory or explanatory statements in those disclosures or postings and would require the board to post on the Internet a factsheet that explains and provides information on the 805 reporting requirements.

Existing law also requires the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine to disclose to an inquiring member of the public information regarding enforcement actions taken against a licensee by the board or by another state or jurisdiction.

This bill would also require those boards to make those disclosures regarding enforcement actions taken against former licensees.

Existing law requires a peer review body that reviews physicians and surgeons to, under specified circumstances, report certain information to an obsolete diversion program within the Medical Board of California.

This bill would instead require the report to be made directly to the executive director of the board and would make other conforming changes.

The bill would make related nonsubstantive changes.

The bill would also provide that it shall become operative only if AB 120 is also enacted and becomes operative.

The bill would incorporate additional changes to Section 800 of the Business and Professions Code, proposed by SB 819, to be operative only if both bills are chaptered and become effective on or before January 1, 2010, and this bill is chaptered last.

The bill would incorporate additional changes to Section 805 of the Business and Professions Code, proposed by SB 821, to be operative only if both bills are chaptered and become effective on or before January 1, 2010, and this bill is chaptered last.

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

SECTION 1. Section 800 of the Business and Professions Code is amended to read:

800. (a) The Medical Board of California, the Board of Psychology, the Dental Board of California, the Osteopathic Medical Board of California, the State Board of Chiropractic Examiners, the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians, the State Board of Optometry, the Veterinary Medical Board, the Board of Behavioral Sciences, the Physical Therapy Board of California, the California State Board of Pharmacy, and the Speech-Language Pathology and Audiology Board shall each separately create and maintain a central file of the names of all persons who hold a license, certificate, or similar authority from that board. Each central file shall be created and maintained to provide an individual historical record for each licensee with respect to the following information:

(1) Any conviction of a crime in this or any other state that constitutes unprofessional conduct pursuant to the reporting requirements of Section 803.

(2) Any judgment or settlement requiring the licensee or his or her insurer to pay any amount of damages in excess of three thousand dollars ($3,000) for any claim that injury or death was proximately caused by the licensee's negligence, error or omission

in practice, or by rendering unauthorized professional services, pursuant to the reporting requirements of Section 801 or 802.

(3) Any public complaints for which provision is made pursuant to subdivision (b).

(4) Disciplinary information reported pursuant to Section 805, including any additional exculpatory or explanatory statements submitted by the licentiate pursuant to subdivision (f) of Section 805. If a court finds, in a final judgment, that the peer review resulting in the 805 report was conducted in bad faith and the licensee who is the subject of the report notifies the board of that finding, the board shall include that finding in the central file. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(5) Information reported pursuant to Section 805.01, including any explanatory or exculpatory information submitted by the licensee pursuant to subdivision (b) of Section 805.01.

(b) Each board shall prescribe and promulgate forms on which members of the public and other licensees or certificate holders may file written complaints to the board alleging any act of misconduct in, or connected with, the performance of professional services by the licensee.

If a board, or division thereof, a committee, or a panel has failed to act upon a complaint or report within five years, or has found that the complaint or report is without merit, the central file shall be purged of information relating to the complaint or report.

Notwithstanding this subdivision, the Board of Psychology, the Board of Behavioral Sciences, and the Respiratory Care Board of California shall maintain complaints or reports as long as each board deems necessary.

(c) The contents of any central file that are not public records under any other provision of law shall be confidential except that the licensee involved, or his or her counsel or representative, shall have the right to inspect and have copies made of his or her complete file except for the provision that may disclose the identity of an information source. For the purposes of this section, a board may protect an information source by providing a copy of the material with only those deletions necessary to protect the identity of the source or by providing a comprehensive summary of the substance of the material. Whichever method is used, the board shall ensure that full disclosure is made to the subject of any

personal information that could reasonably in any way reflect or convey anything detrimental, disparaging, or threatening to a licensee's reputation, rights, benefits, privileges, or qualifications, or be used by a board to make a determination that would affect a licensee's rights, benefits, privileges, or qualifications. The information required to be disclosed pursuant to Section 803.1 shall not be considered among the contents of a central file for the purposes of this subdivision.

The licensee may, but is not required to, submit any additional exculpatory or explanatory statement or other information that the board shall include in the central file.

Each board may permit any law enforcement or regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes to inspect and have copies made of that licensee's file, unless the disclosure is otherwise prohibited by law.

These disclosures shall effect no change in the confidential status of these records.

SEC. 1.5. Section 800 of the Business and Professions Code is amended to read:

800. (a) The Medical Board of California, the Board of Psychology, the Dental Board of California, the Osteopathic Medical Board of California, the State Board of Chiropractic Examiners, the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians, the State Board of Optometry, the Veterinary Medical Board, the Board of Behavioral Sciences, the Physical Therapy Board of California, the California State Board of Pharmacy, the Speech-Language Pathology and Audiology Board, the California Board of Occupational Therapy, and the Acupuncture Board shall each separately create and maintain a central file of the names of all persons who hold a license, certificate, or similar authority from that board. Each central file shall be created and maintained to provide an individual historical record for each licensee with respect to the following information:

(1) Any conviction of a crime in this or any other state that constitutes unprofessional conduct pursuant to the reporting requirements of Section 803.

(2) Any judgment or settlement requiring the licensee or his or her insurer to pay any amount of damages in excess of three

thousand dollars ($3,000) for any claim that injury or death was proximately caused by the licensee's negligence, error or omission in practice, or by rendering unauthorized professional services, pursuant to the reporting requirements of Section 801 or 802.

(3) Any public complaints for which provision is made pursuant to subdivision (b).

(4) Disciplinary information reported pursuant to Section 805, including any additional exculpatory or explanatory statements submitted by the licentiate pursuant to subdivision (f) of Section 805. If a court finds, in a final judgment, that the peer review resulting in the 805 report was conducted in bad faith and the licensee who is the subject of the report notifies the board of that finding, the board shall include that finding in the central file. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(5) Information reported pursuant to Section 805.01, including any explanatory or exculpatory information submitted by the licensee pursuant to subdivision (b) of Section 805.01.

(b) Each board shall prescribe and promulgate forms on which members of the public and other licensees or certificate holders may file written complaints to the board alleging any act of misconduct in, or connected with, the performance of professional services by the licensee.

If a board, or division thereof, a committee, or a panel has failed to act upon a complaint or report within five years, or has found that the complaint or report is without merit, the central file shall be purged of information relating to the complaint or report.

Notwithstanding this subdivision, the Board of Psychology, the Board of Behavioral Sciences, and the Respiratory Care Board of California shall maintain complaints or reports as long as each board deems necessary.

(c) The contents of any central file that are not public records under any other provision of law shall be confidential except that the licensee involved, or his or her counsel or representative, shall have the right to inspect and have copies made of his or her complete file except for the provision that may disclose the identity of an information source. For the purposes of this section, a board may protect an information source by providing a copy of the material with only those deletions necessary to protect the identity of the source or by providing a comprehensive summary of the

substance of the material. Whichever method is used, the board shall ensure that full disclosure is made to the subject of any personal information that could reasonably in any way reflect or convey anything detrimental, disparaging, or threatening to a licensee's reputation, rights, benefits, privileges, or qualifications, or be used by a board to make a determination that would affect a licensee's rights, benefits, privileges, or qualifications. The information required to be disclosed pursuant to Section 803.1 shall not be considered among the contents of a central file for the purposes of this subdivision.

The licensee may, but is not required to, submit any additional exculpatory or explanatory statement or other information that the board shall include in the central file.

Each board may permit any law enforcement or regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes to inspect and have copies made of that licensee's file, unless the disclosure is otherwise prohibited by law.

These disclosures shall effect no change in the confidential status of these records.

SEC. 2. Section 803.1 of the Business and Professions Code is amended to read:

803.1. (a) Notwithstanding any other provision of law, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall disclose to an inquiring member of the public information regarding any enforcement actions taken against a licensee, including a former licensee, by the board or by another state or jurisdiction, including all of the following:

(1) Temporary restraining orders issued.

(2) Interim suspension orders issued.

(3) Revocations, suspensions, probations, or limitations on practice ordered by the board, including those made part of a probationary order or stipulated agreement.

(4) Public letters of reprimand issued.

(5) Infractions, citations, or fines imposed.

(b) Notwithstanding any other provision of law, in addition to the information provided in subdivision (a), the Medical Board of California, the Osteopathic Medical Board of California, and the

California Board of Podiatric Medicine shall disclose to an inquiring member of the public all of the following:

(1) Civil judgments in any amount, whether or not vacated by a settlement after entry of the judgment, that were not reversed on appeal and arbitration awards in any amount of a claim or action for damages for death or personal injury caused by the physician and surgeon's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services.

(2) (A) All settlements in the possession, custody, or control of the board shall be disclosed for a licensee in the low-risk category if there are three or more settlements for that licensee within the last 10 years, except for settlements by a licensee regardless of the amount paid where (i) the settlement is made as a part of the settlement of a class claim, (ii) the licensee paid in settlement of the class claim the same amount as the other licensees in the same class or similarly situated licensees in the same class, and (iii) the settlement was paid in the context of a case where the complaint that alleged class liability on behalf of the licensee also alleged a products liability class action cause of action. All settlements in the possession, custody, or control of the board shall be disclosed for a licensee in the high-risk category if there are four or more settlements for that licensee within the last 10 years except for settlements by a licensee regardless of the amount paid where (i) the settlement is made as a part of the settlement of a class claim, (ii) the licensee paid in settlement of the class claim the same amount as the other licensees in the same class or similarly situated licensees in the same class, and (iii) the settlement was paid in the context of a case where the complaint that alleged class liability on behalf of the licensee also alleged a products liability class action cause of action. Classification of a licensee in either a "high-risk category" or a "low-risk category" depends upon the specialty or subspecialty practiced by the licensee and the designation assigned to that specialty or subspecialty by the Medical Board of California, as described in subdivision (f). For the purposes of this paragraph, "settlement" means a settlement of an action described in paragraph (1) entered into by the licensee on or after January 1, 2003, in an amount of thirty thousand dollars ($30,000) or more.

(B) The board shall not disclose the actual dollar amount of a settlement but shall put the number and amount of the settlement in context by doing the following:

(i) Comparing the settlement amount to the experience of other licensees within the same specialty or subspecialty, indicating if it is below average, average, or above average for the most recent 10-year period.

(ii) Reporting the number of years the licensee has been in practice.

(iii) Reporting the total number of licensees in that specialty or subspecialty, the number of those who have entered into a settlement agreement, and the percentage that number represents of the total number of licensees in the specialty or subspecialty.

(3) Current American Board of Medical Specialty certification or board equivalent as certified by the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine.

(4) Approved postgraduate training.

(5) Status of the license of a licensee. By January 1, 2004, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall adopt regulations defining the status of a licensee. The board shall employ this definition when disclosing the status of a licensee pursuant to Section 2027.

(6) Any summaries of hospital disciplinary actions that result in the termination or revocation of a licensee's staff privileges for medical disciplinary cause or reason, unless a court finds, in a final judgment, that the peer review resulting in the disciplinary action was conducted in bad faith and the licensee notifies the board of that finding. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805. In addition, any exculpatory or explanatory statements submitted by the licentiate electronically pursuant to subdivision (f) of Section 805 shall be disclosed.

(c) Notwithstanding any other provision of law, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall disclose to an inquiring member of the public information received regarding felony convictions of a physician and surgeon or doctor of podiatric medicine.

(d) The Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine may formulate appropriate disclaimers or explanatory statements to be included with any information released, and may by regulation establish categories of information that need not be disclosed to an inquiring member of the public because that information is unreliable or not sufficiently related to the licensee's professional practice. The Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall include the following statement when disclosing information concerning a settlement:

"Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the State of California believes that consumers should have access to malpractice information. In these profiles, the State of California has given you information about both the malpractice settlement history for the doctor's specialty and the doctor's history of settlement payments only if in the last 10 years, the doctor, if in a low-risk specialty, has three or more settlements or the doctor, if in a high-risk specialty, has four or more settlements. The State of California has excluded some class action lawsuits because those cases are commonly related to systems issues such as product liability, rather than questions of individual professional competence and because they are brought on a class basis where the economic incentive for settlement is great. The State of California has placed payment amounts into three statistical categories: below average, average, and above average compared to others in the doctor's specialty. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high-quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make an individual doctor's history more meaningful.

This report reflects data only for settlements made on or after January 1, 2003. Moreover, it includes information concerning those settlements for a 10-year period only. Therefore, you should

know that a doctor may have made settlements in the 10 years immediately preceding January 1, 2003, that are not included in this report. After January 1, 2013, for doctors practicing less than 10 years, the data covers their total years of practice. You should take into account the effective date of settlement disclosure as well as how long the doctor has been in practice when considering malpractice averages.

The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to settle. Some doctors work primarily with high-risk patients. These doctors may have malpractice settlement histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the doctor. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information in this report and the general issue of malpractice with your doctor."

(e) The Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall, by regulation, develop standard terminology that accurately describes the different types of disciplinary filings and actions to take against a licensee as described in paragraphs (1) to (5), inclusive, of subdivision (a). In providing the public with information about a licensee via the Internet pursuant to Section 2027, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall not use the terms "enforcement," "discipline," or similar language implying a sanction unless the physician and surgeon has been the subject of one of the actions described in paragraphs (1) to (5), inclusive, of subdivision (a).

(f) The Medical Board of California shall adopt regulations no later than July 1, 2003, designating each specialty and subspecialty practice area as either high risk or low risk. In promulgating these regulations, the board shall consult with commercial underwriters of medical malpractice insurance companies, health care systems that self-insure physicians and surgeons, and representatives of

the California medical specialty societies. The board shall utilize the carriers' statewide data to establish the two risk categories and the averages required by subparagraph (B) of paragraph (2) of subdivision (b). Prior to issuing regulations, the board shall convene public meetings with the medical malpractice carriers, self-insurers, and specialty representatives.

(g) The Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall provide each licensee, including a former licensee under subdivision (a), with a copy of the text of any proposed public disclosure authorized by this section prior to release of the disclosure to the public. The licensee shall have 10 working days from the date the board provides the copy of the proposed public disclosure to propose corrections of factual inaccuracies. Nothing in this section shall prevent the board from disclosing information to the public prior to the expiration of the 10-day period.

(h) Pursuant to subparagraph (A) of paragraph (2) of subdivision (b), the specialty or subspecialty information required by this section shall group physicians by specialty board recognized pursuant to paragraph (5) of subdivision (h) of Section 651 unless a different grouping would be more valid and the board, in its statement of reasons for its regulations, explains why the validity of the grouping would be more valid.

SEC. 3. Section 805 of the Business and Professions Code is amended to read:

805. (a) As used in this section, the following terms have the following definitions:

(1) (A) "Peer review" means both of the following:

(i) A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following:

(I) Determine whether a licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, to determine the parameters of that practice.

(II) Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services.

(ii) Any other activities of a peer review body as specified in subparagraph (B).

(B) "Peer review body" includes:

(i) A medical or professional staff of any health care 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.

(ii) A health care service plan licensed 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.

(iii) 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.

(iv) 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.

(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.

(3) "Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates listed in paragraph (2).

(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.

(7) "805 report" means the written report required under subdivision (b).

(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 health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body:

(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.

(c) If a licentiate undertakes any action listed in paragraph (1), (2), or (3) after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that his or her application for membership or staff privileges is denied or will be denied for a medical disciplinary cause or reason, 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 health care facility or clinic where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges or membership, or sought the renewal thereof, shall file an 805 report with the relevant agency within 15 days after the licentiate undertakes the action:

(1) Resigns or takes a leave of absence from membership, staff privileges, or employment.

(2) Withdraws or abandons his or her application for membership or staff privileges.

(3) Withdraws or abandons his or her request for renewal of membership or staff privileges.

(d) For purposes of filing an 805 report, the signature of at least one of the individuals indicated in subdivision (b) or (c) on the completed form shall constitute compliance with the requirement to file the report.

(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.

(f) A copy of the 805 report, and a notice advising the licentiate of his or her right to submit additional statements or other information, electronically or otherwise, pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report. The notice shall also advise the licentiate that information submitted electronically will be publicly disclosed to those who request the information. The information to be reported in an 805 report shall include the name and license number of the licentiate involved, a description of the facts and circumstances of the medical disciplinary cause or reason, and any other relevant information deemed appropriate by the reporter.

A supplemental report shall also be made within 30 days following the date the licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action by the reporting peer review body. In performing its dissemination functions required by Section 805.5, the agency shall include a copy of a supplemental report, if any, whenever it furnishes a copy of the original 805 report.

If another peer review body is required to file an 805 report, a health care service plan is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason. If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

(g) The reporting required by this section shall not act as a waiver of confidentiality of medical records and committee reports.

The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800 and Sections 803.1 and 2027, provided that a copy of the report containing the information required by this section may be disclosed as required by Section 805.5 with respect to reports received on or after January 1, 1976.

(h) The Medical Board of California, the Osteopathic Medical Board of California, and the Dental Board of California shall disclose reports as required by Section 805.5.

(i) An 805 report shall be maintained electronically by an agency for dissemination purposes for a period of three years after receipt.

(j) No person shall incur any civil or criminal liability as the result of making any report required by this section.

(k) A willful failure to file an 805 report by any person who is designated or otherwise required by law to file an 805 report is punishable by a fine not to exceed one hundred thousand dollars ($100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licentiate. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, "willful" means a voluntary and intentional violation of a known legal duty.

(*l*) Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that under no circumstances shall exceed fifty thousand dollars ($50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and

surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code.

(m) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that negotiates and enters into a contract with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code, when determining participation with the plan or insurer, shall evaluate, on a case-by-case basis, licentiates who are the subject of an 805 report, and not automatically exclude or deselect these licentiates.

SEC. 3.5. Section 805 of the Business and Professions Code is amended to read:

805. (a) As used in this section, the following terms have the following definitions:

(b) (A) "Peer review" means both of the following:

(i) A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following:

(I) Determine whether a licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, to determine the parameters of that practice.

(II) Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services.

(ii) Any other activities of a peer review body as specified in subparagraph (B).

(B) "Peer review body" includes:

(i) A medical or professional staff of any health care 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.

(ii) A health care service plan licensed 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.

(iii) 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.

(iv) 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.

(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 or 2168.

(3) "Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates listed in paragraph (2).

(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.

(7) "805 report" means the written report required under subdivision (b).

(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 health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body:

(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.

(c) If a licentiate undertakes any action listed in paragraph (1), (2), or (3) after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that his or her application for membership or staff privileges is denied or will be denied for a medical disciplinary cause or reason, 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 health care facility or clinic where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges or membership, or sought the renewal thereof, shall file an 805 report with the relevant agency within 15 days after the licentiate undertakes the action:

(1) Resigns or takes a leave of absence from membership, staff privileges, or employment.

(2) Withdraws or abandons his or her application for membership or staff privileges.

(3) Withdraws or abandons his or her request for renewal of membership or staff privileges.

(d) For purposes of filing an 805 report, the signature of at least one of the individuals indicated in subdivision (b) or (c) on the completed form shall constitute compliance with the requirement to file the report.

(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.

(f) A copy of the 805 report, and a notice advising the licentiate of his or her right to submit additional statements or other information, electronically or otherwise, pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report. The notice shall also advise the licentiate that information submitted electronically will be publicly disclosed to those who request the information. The information to be reported in an 805 report shall include the name and license number of the licentiate involved, a description of the facts and circumstances of the medical disciplinary cause or reason, and any other relevant information deemed appropriate by the reporter.

A supplemental report shall also be made within 30 days following the date the licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action by the reporting peer review body. In performing its dissemination functions required by Section 805.5, the agency shall include a copy of a supplemental report, if any, whenever it furnishes a copy of the original 805 report.

If another peer review body is required to file an 805 report, a health care service plan is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason. If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

(g) The reporting required by this section shall not act as a waiver of confidentiality of medical records and committee reports. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800 and Sections 803.1 and 2027, provided that a copy of the report containing the information required by this section may be disclosed as required by Section 805.5 with respect to reports received on or after January 1, 1976.

(h) The Medical Board of California, the Osteopathic Medical Board of California, and the Dental Board of California shall disclose reports as required by Section 805.5.

(i) An 805 report shall be maintained electronically by an agency for dissemination purposes for a period of three years after receipt.

(j) No person shall incur any civil or criminal liability as the result of making any report required by this section.

(k) A willful failure to file an 805 report by any person who is designated or otherwise required by law to file an 805 report is punishable by a fine not to exceed one hundred thousand dollars ($100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licentiate. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, "willful" means a voluntary and intentional violation of a known legal duty.

(*l*) Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that under no circumstances shall exceed fifty thousand dollars ($50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report

was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code.

(m) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that negotiates and enters into a contract with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code, when determining participation with the plan or insurer, shall evaluate, on a case-by-case basis, licentiates who are the subject of an 805 report, and not automatically exclude or deselect these licentiates.

SEC. 4. Section 805.01 is added to the Business and Professions Code, to read:

805.01. (a) As used in this section, the following terms have the following definitions:

(1) "Agency" has the same meaning as defined in Section 805.

(2) "Formal investigation" means an investigation performed by a peer review body based on an allegation that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) occurred.

(3) "Licentiate" has the same meaning as defined in Section 805.

(4) "Peer review body" has the same meaning as defined in Section 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 health care facility or clinic shall file a report with the relevant agency within 15 days after a peer review body makes a final decision or recommendation regarding the disciplinary action, as specified in subdivision (b) of Section 805, resulting in a final proposed action to be taken against a licentiate based on the peer review body's determination, following formal investigation of the licentiate, that any of the acts listed in paragraphs (1) to (4), inclusive, may have occurred, regardless of whether a hearing is held pursuant to Section 809.2. The licentiate shall receive a notice of the proposed action as set forth in Section 809.1, which shall also include a notice advising the licentiate of the right to submit additional explanatory or exculpatory statements electronically or otherwise.

(1) Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, such that the physician and surgeon poses a risk to patient safety. This paragraph shall not be construed to affect or require the imposition of immediate suspension pursuant to Section 809.5.

(2) Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without good faith effort prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Sexual misconduct with one or more patients during a course of treatment or an examination.

(c) The relevant agency shall be entitled to inspect and copy the following documents in the record of any formal investigation required to be reported pursuant to subdivision (b):

(1) Any statement of charges.

(2) Any document, medical chart, or exhibit.

(3) Any opinions, findings, or conclusions.

(4) Any certified copy of medical records, as permitted by other applicable law.

(d) The report provided pursuant to subdivision (b) and the information disclosed pursuant to subdivision (c) shall be kept confidential and shall not be subject to discovery, except that the information may be reviewed as provided in subdivision (c) of Section 800 and may be disclosed in any subsequent disciplinary hearing conducted pursuant to the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

(e) The report required under this section shall be in addition to any report required under Section 805.

(f) A peer review body shall not be required to make a report pursuant to this section if that body does not make a final decision or recommendation regarding the disciplinary action to be taken against a licentiate based on the body's determination that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) may have occurred.

SEC. 5. Section 805.1 of the Business and Professions Code is amended to read:

805.1. (a) The Medical Board of California, the Osteopathic Medical Board of California, and the Dental Board of California shall be entitled to inspect and copy the following documents in the record of any disciplinary proceeding resulting in action that is required to be reported pursuant to Section 805:

(1) Any statement of charges.

(2) Any document, medical chart, or exhibits in evidence.

(3) Any opinion, findings, or conclusions.

(4) Any certified copy of medical records, as permitted by other applicable law.

(b) The information so disclosed shall be kept confidential and not subject to discovery, in accordance with Section 800, except that it may be reviewed, as provided in subdivision (c) of Section 800, and may be disclosed in any subsequent disciplinary hearing conducted pursuant to the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 6. Section 805.5 of the Business and Professions Code is amended to read:

805.5. (a) Prior to granting or renewing staff privileges for any physician and surgeon, psychologist, podiatrist, or dentist, any health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code, or any health care service plan or medical care foundation, or the medical staff of the institution shall request a report from the Medical Board of California, the Board of Psychology, the Osteopathic Medical Board of California, or the Dental Board of California to determine if any report has been made pursuant to Section 805 indicating that the applying physician and surgeon, psychologist, podiatrist, or dentist has been denied staff privileges, been removed from a medical staff, or had his or her staff privileges restricted as provided in Section 805. The request shall include the name and California license number of the physician and surgeon, psychologist, podiatrist, or dentist. Furnishing of a copy of the 805 report shall not cause the 805 report to be a public record.

(b) Upon a request made by, or on behalf of, an institution described in subdivision (a) or its medical staff, the board shall furnish a copy of any report made pursuant to Section 805 as well as any additional exculpatory or explanatory information submitted electronically to the board by the licensee pursuant to subdivision (f) of Section 805. However, the board shall not send a copy of a report (1) if the denial, removal, or restriction was imposed solely because of the failure to complete medical records, (2) if the board has found the information reported is without merit, (3) if a court finds, in a final judgment, that the peer review, as defined in Section 805, resulting in the report was conducted in bad faith and the licensee who is the subject of the report notifies the board of that finding, or (4) if a period of three years has elapsed since the report was submitted. This three-year period shall be tolled during any period the licentiate has obtained a judicial order precluding disclosure of the report, unless the board is finally and permanently precluded by judicial order from disclosing the report. If a request is received by the board while the board is subject to a judicial order limiting or precluding disclosure, the board shall provide a disclosure to any qualified requesting party as soon as practicable after the judicial order is no longer in force.

If the board fails to advise the institution within 30 working days following its request for a report required by this section, the institution may grant or renew staff privileges for the physician and surgeon, psychologist, podiatrist, or dentist.

(c) Any institution described in subdivision (a) or its medical staff that violates subdivision (a) is guilty of a misdemeanor and shall be punished by a fine of not less than two hundred dollars ($200) nor more than one thousand two hundred dollars ($1,200).

SEC. 7. Section 821.4 is added to the Business and Professions Code, to read:

821.4. (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 executive director of the 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 executive director of the board under this section shall also notify the executive director of the board when it has completed or closed an investigation.

(b) The executive director of the board, 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 executive director of the board shall contact the peer review body periodically thereafter to monitor the progress of the investigation. At any time, if the executive director of the board determines that the progress of the investigation is not adequate to protect the public, the executive director shall notify the chief of enforcement of the board, who shall promptly conduct an investigation of the matter. Concurrently with notifying the chief of enforcement, the executive director of the board 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, "board" means the Medical Board of California.

(d) 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.

(e) 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.

(f) Information received by the executive director of the board pursuant to this section shall be governed by, and shall be deemed confidential to the same extent as records under, subdivision (d) of Section 805.01. The records shall not be further disclosed by the executive director of the board, except as provided in subdivision (b).

(g) 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 executive director of the board shall purge and destroy all records in his or her possession pertaining to the investigation unless the executive director has referred the matter to the chief of enforcement pursuant to subdivision (b).

(h) 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 (f).

(i) The report required by this section shall be submitted on a short form developed by the board. The contents of the short form shall reflect the requirement of this section.

(j) Nothing in this section shall exempt a peer review body from submitting a report required under Section 805 or 805.01.

SEC. 8. Section 821.5 of the Business and Professions Code is amended to read:

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 executive director of the 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 executive director of the board under this section shall also notify the executive director of the board when it has completed or closed an investigation.

(b) The executive director of the board, 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 executive director of the board shall contact the peer review body periodically thereafter to monitor the progress of the investigation. At any time, if the executive director of the board determines that the progress of the investigation is not adequate to protect the public, the executive director shall notify the chief of enforcement of the board, who shall promptly conduct an investigation of the matter. Concurrently with notifying the chief of enforcement, the executive director of the board 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, "board" means the Medical Board of California.

(d) 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.

(e) 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.

(f) Information received by the executive director of the board pursuant to this section shall be governed by, and shall be deemed confidential to the same extent as records under, subdivision (d) of Section 805.01. The records shall not be further disclosed by the executive director of the board, except as provided in subdivision (b).

(g) 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 executive director of the board shall purge and destroy all records in his or her possession pertaining to the investigation unless the executive director has referred the matter to the chief of enforcement pursuant to subdivision (b).

(h) 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 (f).

(i) The report required by this section shall be submitted on a short form developed by the board. The contents of the short form shall reflect the requirements of this section.

(j) Nothing in this section shall exempt a peer review body from submitting a report required under Section 805 or 805.01.

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

SEC. 10. Section 2027 of the Business and Professions Code is amended to read:

2027. (a) 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. The posting shall also provide a link to any additional explanatory or exculpatory information submitted electronically by the licensee pursuant to subdivision (f) of Section 805.

(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.

(3) Notwithstanding paragraph (2) and except as provided in paragraph (4), 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.

(4) Notwithstanding paragraph (2), if a court finds, in a final judgment, that peer review resulting in a hospital disciplinary action was conducted in bad faith and the licensee notifies the board of that finding, the information concerning that hospital disciplinary action posted pursuant to paragraph (6) of subdivision (a) shall be immediately removed from the board's Internet Web site. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(c) The board shall also post on the Internet a fact sheet that explains and provides information on the reporting requirements under Section 805.

(d) 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 health care 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.

SEC. 11. Section 1.5 of this bill incorporates amendments to Section 800 of the Business and Professions Code proposed by both this bill and SB 819. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2010, but SB 819 becomes operative first, (2) each bill amends Section 800 of the Business and Professions Code, and (3) this bill is enacted after SB 819, in which case Section 800 of the Business and Professions Code, as amended by SB 819, shall remain operative only until the operative date of this bill, at which time Section 1.5 of this bill shall become operative and Section 1 of this bill shall not become operative.

SEC. 12. (a) Section 3.5 of this bill incorporates amendments to Section 805 of the Business and Professions Code proposed by both this bill and SB 821. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2010, (2) both bills amend Section 805 of the Business and Professions Code, and (3) this bill is enacted after SB 821, in which case Section 3 of this bill shall not become operative.

SEC. 13. This act shall only become operative if Assembly Bill 120 of the 2009–10 Regular Session is also enacted and becomes operative.

SEC. 14. In addition to the contingency described in Section 13 of this bill, all of the following shall apply:

(a) Section 7 of this bill shall only become operative if Senate Bill 821 of the 2009–10 Regular Session is also enacted and becomes operative and repeals Section 821.5 of the Business and Professions Code.

(b) Section 8 of this bill shall not become operative if Senate Bill 821 of the 2009–10 Regular Session is also enacted and becomes operative and repeals Section 821.5 of the Business and Professions Code.

(c) Section 9 of this bill shall not become operative if Senate Bill 821 of the 2009–10 Regular Session is also enacted and becomes operative and repeals Section 821.6 of the Business and Professions Code.

SB 821

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 821
Author: Committee on Business, Professions, and Economic Development
Chapter: #307
Subject: Omnibus
Sponsor: Committee
Board Position: Support MBC provisions

DESCRIPTION OF LEGISLATION:

This bill is 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.

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):

- **805(a)(2)** – Add the category of Special Faculty Permit holders to the definition of "Licentiate" so that they are subject to the same reporting requirements as all other licensees.
- **821.5** – Repeal, board no longer needs the reporting coming to the diversion program administrator due to the sunset of the program. All reports now come to the Board under B&P Code section 805.
- **821.6** – Repeal, board no longer needs the reporting coming to the diversion program administrator due to the sunset of the program.

IMPLEMENTATION:

- Newsletter Article
- Notify Board staff

October 15, 2009

Senate Bill No. 821

CHAPTER 307

An act to amend Sections 139, 805, 1632.5, 1634.2, 2493, 2530.2, 2532.2, 2532.7, 2570.2, 2570.3, 2570.4, 2570.5, 2570.6, 2570.7, 2570.9, 2570.10, 2570.13, 2570.16, 2570.18, 2570.20, 2570.26, 2570.28, 2571, 2872.2, 3357, 3362, 3366, 3456, 3740, 3750.5, 3773, 4101, 4112, 4113, 4160, 4196, 4200.3, 4200.4, 4510.1, 4933, 4938, 4980.45, 4980.48, 4982, 4982.2, 4989.22, 4989.54, 4992.1, 4992.3, 4996.23, 4996.28, 4996.5, 4999.2, 5016, 5021, 5022, 5023, 5651, 7028.7, 7044, 7159, 7159.5, 7159.14, 7303.2, 7500.1, 7505.5, 7507.9, 7507.12, 7606, 7616, 7641, 7643, 7646, 7647, 7662, 7665, 7666, 7671, 7725.5, 7729, 9884.2, 9889.3, and 10146 of, to add Sections 2532.25, 2570.17, 4013, 4146, 4989.49, 4992.2, 4996.24, 7044.01, and 7507.115 to, to repeal Sections 821.5 and 821.6 of, and to repeal and add Section 7108.5 of, the Business and Professions Code, to amend Sections 44014.2, 44017.3, 44072.1, 44072.2, 44095, and 123105 of the Health and Safety Code, to amend Sections 28, 5201, and 24603 of the Vehicle Code, and to amend Section 3 of Chapter 294 of the Statutes of 2004, relating to consumer affairs.

[Approved by Governor October 11, 2009. Filed with Secretary of State October 11, 2009.]

LEGISLATIVE COUNSEL'S DIGEST

SB 821, Committee on Business, Professions and Economic Development. Consumer affairs: 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 that certain examinations for licensure be developed by, or in consultation, with the Office of Examination Resources in the department, as specified.

This bill would rename that office the Office of Professional Examination Services.

(2) Existing law provides for the professional review of specified healing arts licentiates through a peer review process, and requires the peer review body to report to the relevant agency upon certain circumstances, including circumstances related to an obsolete diversion program.

This bill would include within the definition "licentiate" a holder of a special faculty permit to practice medicine within a medical school. The bill would also delete the peer review provisions related to the obsolete diversion program.

(3) Existing law, the Bagley-Keene Open Meeting Act, requires a state body, as defined, to provide prescribed notice of its meetings to any person who requests that notice in writing. Existing law provides for the licensure

* ONLY THE SECTIONS THAT PERTAIN TO THE BOARD ARE ATTACHED.

~~of a licensing~~ examination pursuant to contract with a public or private entity may ~~rely on an~~ occupational analysis or item analysis conducted by that entity. The ~~department shall~~ compile this information, along with a schedule specifying when ~~examination~~ validations and occupational analyses shall be performed, and submit it to the ~~appropriate~~ fiscal, policy, and sunset review committees of the Legislature by ~~September 30~~ of each year. It is the intent of the Legislature that the method specified ~~in this~~ report be consistent with the policy developed by the department ~~pursuant~~ to subdivision (b).

SEC. 2. Section 805 of the Business and Professions Code is amended to read:

805. (a) As used in this section, the following terms have the following definitions:

(1) "Peer review body" includes:

(A) A medical or professional staff of any health care 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 health care 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.

(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 or 2168.

(3) "Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates listed in paragraph (2).

(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.

(7) "805 report" means the written report required under subdivision (b).

(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 health care 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:

(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.

(c) 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 health care facility or clinic shall file an 805 report with the relevant agency 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:

(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.

(d) For purposes of filing an 805 report, the signature of at least one of the individuals indicated in subdivision (b) or (c) on the completed form shall constitute compliance with the requirement to file the report.

(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.

(f) A copy of the 805 report, and a notice advising the licentiate of his or her right to submit additional statements or other information pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report.

The information to be reported in an 805 report shall include the name and license number of the licentiate involved, a description of the facts and

circumstances of the medical disciplinary cause or reason, and any other relevant information deemed appropriate by the reporter.

A supplemental report shall also be made within 30 days following the date the licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action by the reporting peer review body. In performing its dissemination functions required by Section 805.5, the agency shall include a copy of a supplemental report, if any, whenever it furnishes a copy of the original 805 report.

If another peer review body is required to file an 805 report, a health care service plan is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason. If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

(g) The reporting required by this section shall not act as a waiver of confidentiality of medical records and committee reports. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800 and Sections 803.1 and 2027, provided that a copy of the report containing the information required by this section may be disclosed as required by Section 805.5 with respect to reports received on or after January 1, 1976.

(h) The Medical Board of California, the Osteopathic Medical Board of California, and the Dental Board of California shall disclose reports as required by Section 805.5.

(i) An 805 report shall be maintained by an agency for dissemination purposes for a period of three years after receipt.

(j) No person shall incur any civil or criminal liability as the result of making any report required by this section.

(k) A willful failure to file an 805 report by any person who is designated or otherwise required by law to file an 805 report is punishable by a fine not to exceed one hundred thousand dollars ($100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licentiate. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, "willful" means a voluntary and intentional violation of a known legal duty.

(*l*) Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a

fine that under no circumstances shall exceed fifty thousand dollars ($50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code.

(m) A health care 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 negotiates and enters into a contract with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code, when determining participation with the plan or insurer, shall evaluate, on a case-by-case basis, licentiates who are the subject of an 805 report, and not automatically exclude or deselect these licentiates.

SEC. 3. Section 821.5 of the Business and Professions Code is repealed.

SEC. 4. Section 821.6 of the Business and Professions Code is repealed.

SEC. 5. Section 1632.5 of the Business and Professions Code is amended to read:

1632.5. (a) Prior to implementation of paragraph (2) of subdivision (c) of Section 1632, the department's Office of Professional Examination Services shall review the Western Regional Examining Board examination to ensure compliance with the requirements of Section 139 and to certify that the examination process meets those standards. If the department determines that the examination process fails to meet those standards, paragraph (2) of subdivision (c) of Section 1632 shall not be implemented. The review of the Western Regional Examining Board examination shall be conducted during or after the Dental Board of California's occupational analysis scheduled for the 2004–05 fiscal year, but not later than September 30, 2005. However, an applicant who successfully completes the Western Regional Examining Board examination on or after January 1, 2005, shall be deemed to have met the requirements of subdivision (c) of Section 1632 if the department certifies that the Western Regional Examining Board examination meets the standards set forth in this subdivision.

TRACKER II

Medical Board of California
2009 Tracker II - Legislative Bills
10/21/2009

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 52	Portantino	Unbilical Cord Blood Collection Program	Sen. Health	06/24/09
AB 82	Evans	Dependent Children: psychotropic medications	Vetoed	09/02/09
AB 159	Nava	Perinatal Mood and Anxiety Disorders: task force	2-year bill	03/25/09
AB 259	Skinner	Health Care Coverage: certified nurse-midwives: direct access	2-year bill	
AB 361	Lowenthal	Workers' Compensation: treatment authorization	Chapter #436	09/02/09
AB 417	Beall	Medi-Cal Drug Treatment Program: buprenorphine	Sen. Approps. - susp	07/23/09
AB 445	Salas	Use of X-ray Equipment: prohibition: exemptions	2-year bill	
AB 452	Yamada	In-home Supportive Services: CA Independence Act of 2009	2-year bill	
AB 456	Emmerson	State Agencies: period review	Sen. B&P	05/28/09
AB 497	Block	Vehicles: HOV lanes: used by physicians	Sen. T&H	05/14/09
AB 520	Carter	Public Records: limiting requests	2-year bill	
AB 542	Feuer	Adverse Medical Events: expanding reporting	Sen. Health	06/18/09
AB 657	Hernandez	Health Professions Workforce: task force	Vetoed	09/01/09
AB 681	Hernandez	Confidentiality of Medical Information: psychotherapy	Chapter #464	08/24/09
AB 718	Emmerson	Electronic Prescribing Pilot Program	Sen. Rules	09/01/09
AB 721	Nava	Physical Therapists: scope of practice	2-year bill	04/13/09
AB 830	Cook	Drugs and Devices	Chapter #479	08/25/09
AB 832	Jones	Ambulatory surgical clinics: workgroup	2-year bill	05/05/09
AB 834	Solorio	Health Care Practitioners: peer review	2-year bill	04/14/09
AB 867	Nava	California State University: Doctor of Nursing Practice Degree	Sen. Approps. - susp	07/23/09
AB 877	Emmerson	Healing Arts: DCA Director to appoint committee	2-year bill	04/14/09
AB 931	Fletcher	Emergency Supplies: increase amount	Chapter #491	06/17/09

Medical Board of California
2009 Tracker II - Legislative Bills
10/21/2009

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 950	Hernandez	Hospice Providers: licensed hospice facilities	Sen. Health	06/02/09
AB 977	Skinner	Pharmacists: immunization protocols with physicians	2-year bill	04/23/09
AB 995	Block	Tissue bank licensing	Chapter #497	07/23/09
AB 1005	Block	CA Board of Accountancy: live broadcast of board meetings	Chapter #378	07/16/09
AB 1083	Perez	Health Facilities: security plans	Chapter #506	06/17/09
AB 1094	Conway	Disposal of Personal Information	Chapter #134	06/30/09
AB 1113	Lowenthal	Prisoners: professional mental health providers: MFTs	Chapter #135	05/14/09
AB 1140	Niello	Healing Arts (spot)	Sen. Health	04/14/09
AB 1152	Anderson	Professional Corporations: licensed physical therapists	Sen. B&P	07/08/09
AB 1162	Carter	Health Facilities: licensure	2-year bill	
AB 1168	Carter	Professions and Vocations (spot)	2-year bill	
AB 1194	Strickland	State Agency Internet Web Sites: information	2-year bill	
AB 1317	Block	Assisted Oocute Production: advertisment	Chapter #523	08/19/09
AB 1397	Hill	Health and Safety Code: tissue donation	Vetoed	08/17/09
AB 1458	Davis	Drugs: adverse effects: reporting	2-year bill	05/05/09
AB 1478	Ammiano	Written Acknowledgment: medical nutrition therapy	2-year bill	
AB 1518	Anderson	State Government: Boards, Commissions, Committees, repeal	2-year bill	05/11/09
AB 1535	Jones	Audiologists: hearing aids	Chapter #309	09/04/09
AB 1540	Health Comm.	Health	Chapter #298	09/03/09
AB 1542	Health Comm.	Medical Records: centralized location	Sen. Health	07/01/09
AB 1544	Health Comm.	Health Facilities: licensure	Chapter #543	09/04/09

Medical Board of California
2009 Tracker II - Legislative Bills
10/21/2009

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 26	Simitian	Home-generated Pharmaceutical Waste	2-year bill	04/15/09
SB 33	Correa	Marriage and Family Therapy: licensure and registration	Chapter #26	06/08/09
SB 39	Benoit	Torts: personal liability immunity	Chapter #27	06/26/09
SB 58	Aanestad	Physicians and Surgeons: peer review	2-year bill	05/19/09
SB 92	Aanestad	Health care reform	2-year bill	03/11/09
SB 112	Oropeza	Hemodialysis Technicians	Chapter #559	08/27/09
SB 158	Wiggins	Health Care Coverage: human papillomavirus vaccination	Vetoed	08/31/09
SB 171	Pavley	Certified Employees: physician assistants: medical certificates	Chapter #34	06/17/09
SB 186	DeSaulnier	Workers' Compensation: treatment: predesignationof physician	Chapter #565	
SB 238	Calderon	Medical Information: prescription refil requirements	2-year bill	04/23/09
SB 303	Alquist	Nursing Facility Residents: informed consent	Vetoed	09/02/09
SB 341	DeSaulnier	Pharmaceuticals: adverse drug reactions	2-year bill	05/14/09
SB 368	Maldonado	Confidential Medical Information: unlawful disclsure	2-year bill	04/01/09
SB 374	Calderon	Health Care Providers: resonable disclosure: reproductive choices	Asm. Approps. - susp	06/24/09
SB 395	Wyland	Medical Practice	2-year bill	
SB 442	Ducheny	Clinic Corporation: licensing	2-year bill	05/06/09
SB 482	Padilla	Healing Arts: Medical Practice	2-year bill	04/14/09
SB 484	Wright	Ephedrine and Pseudoephedrine: classification as Schedule V	Asm. Approps.	05/12/09
SB 502	Walters	State Agency Web Sites: information posting: expenditures	2-year bill	
SB 599	Negrete McLeod	Licensing Boards: disciplinary actions: posting	Enrolled	09/02/09
SB 606	Ducheny	Physicians and Surgeons: loan repayment	Chapter #600	06/18/09
SB 620	Wiggins	Healing Arts: osteopaths	Chapter #602	06/23/09
SB 630	Steinberg	Health Care Coverage: reconstructive surgery: dental	Chapter #604	09/04/09

Medical Board of California
2009 Tracker II - Legislative Bills
10/21/2009

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 638	Negrete McLeod	Regulatory boards: operations	2-year bill	
SB 700	Negrete McLeod	Healing Arts: peer review	Sen. Inactive	05/20/09
SB 719	Huff	State Agency Internet Web Sites: information searchability	2-year bill	
SB 743	Health Comm.	Health Facilities: psychiatric patient release	Chapter #612	06/01/09
SB 744	Strickland	Clinical Laboratories: public health labs	Chapter #201	07/14/09
SB 761	Aanestad	Health Manpower Pilot Projects	Asm. Health	05/06/09
SB 762	Aanestad	Professions and Vocations: healing arts	Chapter #16	05/05/09
SB 788	Wyland	Licensed Professional Clinical Counselors	Chapter #619	09/03/09
SB 810	Leno	Single-Payer Health Care Coverage	2-year bill	04/23/09
SJR 14	Leno	Medical Marijuana	Asm. Health	
SJR 15	Leno	Public Health Laboratories	Asm. Health	08/17/09

Proposed Legislation

LEGISLATIVE PROPOSALS FOR 2010

Public Disclosure – Amend the law regarding disclosure and posting to include PC 23's, court orders to place practice restrictions on an individual when there are pending criminal proceedings. These restrictions need to be publically disclosed and posted in order to inform healthcare consumers of the practice restrictions imposed by the court. (B&P 803.1 & 2027)

Default Decisions – Amend current law to authorize the Executive Director to adopt stipulations to surrender a license when the law requires a mandatory revocation. (B&P 2224)

Peer Review - Amends to the 805 sections were vetoed in 2009. We will work with the authors and interested parties on proposals they have and request technical and other amendments as appropriate, but will not sponsor amends unless there are none moving forward.

Expedite Complaint Process - Remove the need for a upfront specialty expert to review complaints prior to the complaint being sent to the field. This would allow for a general practice medical consultant to review the medical records, statements from the physician, and the standard of care, then to make the recommendation to close or forward to the field for investigation. This will expedite the complaint triage process, reducing the amount of processing time needed to make the decision to close or forward the complaint to the field. (B&P 2220.08)

Licensing - The program has suggested a variety of clean up or changes that would enhance the licensing program and expedite licensure. In addition, there may be changes/enhancements that need to be made to laws related to the other licensees/registrations. These have not been fully developed due to backlog priorities, thus will be fully reviewed and discussed at the January meeting of the Medical Board.

Web Applicant Access System - Application Information Page

ATS ID: 1
Applicant Name: DOE, JOHN
Date Application and Fees Received: 07/28/2009
Application Status: Application Pending

Requirement	Status	Comments
APPLICATION, FORM L1A-L1E	Received/Not Reviewed	L1E received 08/18/09
VALID ECFMG CERTIFICATE	Received/Not Reviewed	received 8/13/09
WRITTEN EXAM TRANSCRIPT	Not Received	
CERTIFICATE OF MEDICAL EDUCATION, FORM L2	Received/Not Reviewed	GRN01 received 8/6/09
MEDICAL SCHOOL TRANSCRIPTS	Received/Not Reviewed	GRN01 received 8/6/09
DIPLOMA (MEDICAL DEGREE)	Not Received	GRN01 received 8/6/09
LETTERS OF GOOD STANDING	Not Received	
CERT OF COMPLETION OF ACGME TRAINING, FORM L3A/B	Not Received	
UNDERGRADUATE CLINICAL ROTATIONS, FORM L5	Received/Not Reviewed	
DOJ CLEARANCE	Approved	
FBI CLEARANCE	Deficient	
REDUCED LICENSING FEE	Not Received	
INITIAL LICENSURE FEE	N/A	

Information is current as of: 8/14/2009 12:00:00 AM PST

The Web Applicant Access System provides applicants the ability to check whether or not the Board has received documents required as part of an application for a Postgraduate Training Authorization Letter or Physician's and Surgeon's license. The status of each document will be noted as either:

- **Not Received** (item has not been received by the Board);
- **Received/Not Reviewed** (item has been received by the Board and is pending review);
- **Approved** (item was received, reviewed, and determined to satisfy the requirement);
- **Deficient** (item does not satisfy the requirement or additional information is required); or
- **N/A** (item not required).

Please note: Applicants will be notified in writing by the Board regarding Deficient items. The Board will update the Web Applicant Access System within 10 days of receipt of any documentation in support of your application.

Logout

DRAFT

State of California
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, Ca 95815
www.mbc.ca.gov

Memorandum

Date: October 15, 2009

To: Board Members

From: Deborah Pellegrini
Chief, Licensing Program

Subject: Licensing Program Report

On October 1, 2009, I presented to the Board's Executive Committee the Licensing Program Plan to eliminate the physician and surgeon application backlog and revamp the Licensing program (Attachment 1). Since that presentation, we have accelerated the workoff of the Licensing backlog such that we intend to completely eliminate the backlog by the end of 2009. This more aggressive target due date is possible in large part to the strong collaboration across the Medical Board of California, starting with Ms. Johnston and her Executive Team. We are deploying additional resources required to eliminate the backlog as well as addressing the underlying problems behind it. The following is an update to the October 1, 2009 Licensing Program Plan.

Eliminating the Licensing Backlog

Hiring and training additional staff: The major focus in October has been hiring and training new staff.

- Trained six newly hired college students to conduct initial reviews of US/Canadian applications. Six additional Board employees were identified to also receive training to conduct initial US/Canadian application reviews. All 12 employees completed their initial training and are currently reviewing applications to evaluate if the files are ready for licensure or prepare deficiency letters that request missing and/or incomplete documents. A Senior Licensing Analyst conducted the training and is reviewing these employees' work. We anticipate completing additional training and mentoring of these employees by October 26.
- Conducted interviews and hired six new licensing analysts for international medical school (IMG) applications. Two of these hires are due to filling behind staff who announced their retirement. The remaining four hires are two-year limited term positions. We anticipate starting all six employees by November 2. As stated in the October 1 Licensing Program Report, after a three-week training period, these employees will be assigned IMG application caseload.
- Other Board employees have been volunteering to work after hours and on weekends to assist the Licensing Program and are receiving training to assist with the licensing process, thus allowing the analysts more time to review applications for licensure. Examples of the functions other Board staff are performing include setting up new application files, logging

incoming documents into the Application Tracking System, returning applicants' email, and filing newly arriving documents in application files.

- A senior level manager was assigned to the Licensing Program temporarily for the next several months allowing effective and efficient management by the current management team for the larger staff as well as more time to continually improve the productivity of the resources deployed.

Key milestones to review applications and documents and eliminate the backlog

The new accelerated Plan uses a phased-in approach to reduce the backlog. This first phase starts with an initial round of training so the new resources will be as productive as possible on the US/CAN applications. The largest backlog now exists with the US/CAN applications. Part of the new workforce will be deployed to the IMG applications once they have received additional training. However, IMG applications are more difficult to process and thus require more skilled reviewers.

The approximate times to review an application from time of receipt to licensure are listed below.

- A US medical school graduate application that is submitted complete (all required submitted documents are correct with no identified problems/issues) takes approximately 4 hours and 50 minutes. (Less than 2 percent of all US applications are submitted complete.)

- An IMG medical school graduate application that is submitted complete (all required submitted documents are correct with no identified problems/issues) takes approximately 6 hours and 5 minutes. (Less than one-half of one percent of all IMG applications are submitted complete.)

- An application with deficiencies will require an additional 90 minutes for a total processing time of 6 hours and 20 minutes for a US applicant and 7 hours and 35 minutes for IMG applicant.

- An application with a Level 1 problem (SR1) requires an additional 30 minutes for a total processing time of 6 hours and 50 minutes for a US applicant and 8 hours and 5 minutes for an IMG graduate.

- A Level 2 problem case application (SR2) with a resolution not requiring a hearing will take an additional 57 hours for a total processing time of 63 hours and 50 minutes for a US applicant and 65 hours and 5 minutes for an IMG applicant.

- A Level 2 problem case application (SR2) with a resolution requiring an administrative hearing will take an additional 48 hours and 30 minutes for a total processing time of 112 hours and 20 minutes and 113 and 35 minutes for an IMG applicant.

Based on the additional staff hired for the Licensing Program and other Board staff volunteering to assist the licensing analysts, an accelerated work plan was developed with weekly goals to eliminate the backlog by December 30, 2009. Each staff member is assigned specific work goals per person (number of files to review per week and month). The work goals are closely monitored weekly at both the individual as well as group level such that we will be able to make corrections in the Plan if issues arise.

As of September 30, to eliminate the backlog, 2,135 applications (1,287 US and 848 IMG) must be reviewed by December 30, 2009. Attachment 2 displays the physician and surgeon US/IMG workload status as of September 30, 2009. Attachment 3 displays the incoming applications, applications reviewed and licensed over the past nine months. The October 29, 2009 US/IMG

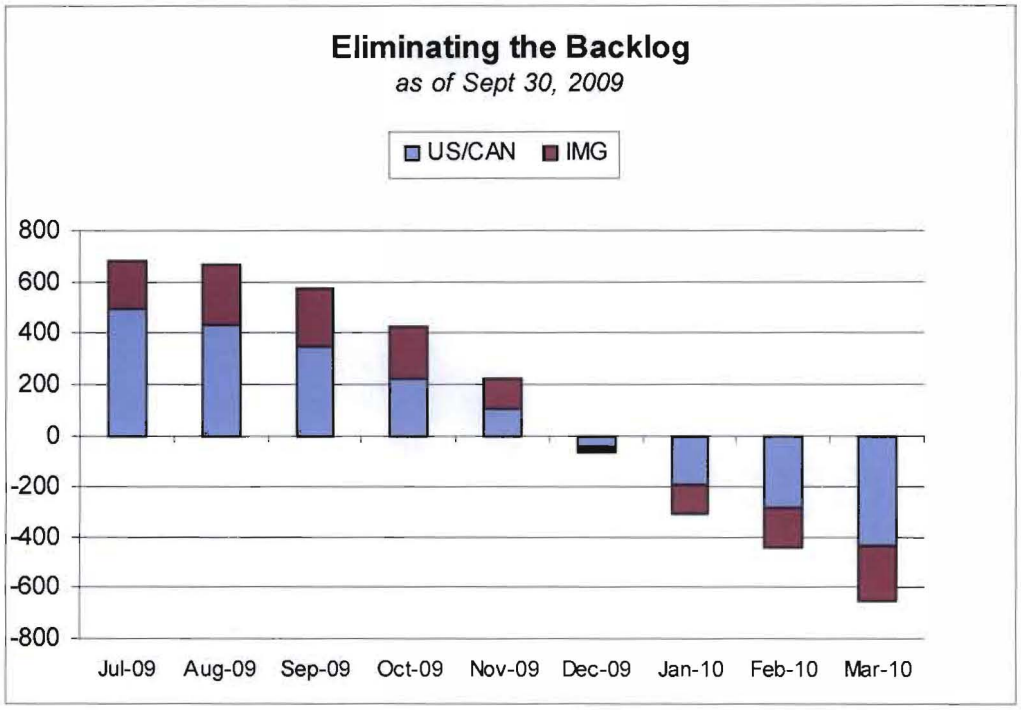
workload status is being provided as a meeting handout. The Plan to eliminate the backlog includes:

For US applications:

- By November 1, 2009, review 382 applications, reducing the application backlog by 30 percent.
- By December 1, 2009, review an additional 452 applications, reducing the application backlog by 65 percent.
- By December 30, 2009, review the remaining 453 applications, thus eliminating the backlog.
- By February 1, 2010, conduct initial application reviews within 75 calendar days.

For IMG applications:

- By November 1, 2009, review 198 applications, reducing the application backlog by 23 percent.
- By December 1, 2009, review an additional 284 applications, reducing the application backlog by 57 percent.
- By December 30, 2009, review the remaining 366 applications, thus eliminating the backlog.
- By February 1, 2010, conduct initial application reviews within 85 calendar days.



In the chart above, after the first of the year we will have a growing "negative backlog" as the staff continues to process more applications than we are receiving. By continuing the 10 additional staff hired into the Licensing Program in October and November, we anticipate continuing to decrease the number of days for an initial review, thus conducting all applications initial reviews within 60 calendar days by April 1, 2010. This is less than the regulatory time frames of 60 working days (90 calendar days).

To meet the accelerated Plan to eliminate the backlog, the focus will be on:

- Maximize the contribution of overtime to work on the backlog in light of the fact that in the next few months we will lose considerable productivity as a result of several holidays.
- Rapidly increase the skills of our expanded workforce through a combination of an effective training program, a hands-on management approach to help coach as well as provide quality control over the expanded work team.
- Re-prioritize and streamline the work of our existing staff such that we can get as many of the backlog files processed as possible without stopping other critical licensing functions.
- Continue to process "pending" application files awaiting additional documents.

Revamping the Licensing Program

The Business Process Reengineering Consultant continues to review the work processes, procedures and tools with the objective of outlining a strategic roadmap aimed at revamping the way the Licensing Program operates. They will present a draft set of recommendations in late November which will be discussed with Ms. Johnston prior to finalizing the report. From the work completed to date and discussions, one change we expect to implement is to reorganize the front end duties to maximize productivity.

The Information Systems Branch continues discussion on significantly upgrading the Licensing Program's current IT solution. This includes the Web Application Access Project and acquiring automated workload statistics. These will significantly improve staff productivity, improve communications with our applicants, and provides a much more robust management tool to manage the licensing process with real time information about the application flow. These plans will be complete in November.

In closing, by the time the Board meets again at the end of January, I plan to tell you about the successful elimination of the backlog as well as a more detailed plan for revamping the Licensing Program.

Executive Committee Meeting
October 1, 2009
Licensing Program Report

Issue for Discussion: The number of physician and surgeon applications not reviewed within the regulatory time frames has grown since first reported to the Board in July 2008. This report describes the licensing requirements, factors contributing to the backlog, and the plan to eliminate the backlog by February 2010, while simultaneously revamping the MBC licensing process.

Background: The Licensing Program promotes public protection for the health care consumer by ensuring all applicants' educational credentials and training meet statutory and regulatory requirements prior to issuing physician and surgeon licenses to practice medicine.

The Licensing Program divides the analysts reviewing applications by the type of applications received: United States and Canadian medical school graduates (US) and international medical school graduates (IMG). There are six permanent full-time analysts reviewing US applications and 10.6 permanent full-time analysts and four part-time retired annuitants reviewing IMG applications. These analysts conduct a comprehensive evaluation of the licensing application to ensure all of the requisite qualifications and educational requirements necessary for medical licensure are satisfied. For a complete physician and surgeon application, up to thirteen different types of documents are required and several requirements may require multiple documents. For example, if an applicant attended three different postgraduate training programs, three postgraduate training forms are required. Attachment 1 displays the statutory and regulatory required documents for a complete physician and surgeon application and the primary sources for the documents. Applications received are generally incomplete as necessary supporting documentation and forms must be obtained from distant medical schools, agencies, and programs, resulting in delays beyond the control of the Board.

Pursuant to Title 16, California Code of Regulations section 1319.4, the Board is required to:

(a) within 60 working (approximately 90 calendar days) of receipt of an application pursuant to Business and Professions Code section 2102, 2103, 2135, or 2151 for a license to practice medicine, the division shall inform the applicant in writing whether it is complete and accepted for filing or that it is deficient and what specific information or documentation is required to complete the applications.
(b) within 100 calendar days from the date of filing of a complete application, the division shall inform the applicant in writing of the decision regarding the application for licensure.

Once an analyst conducts an initial file review and determines the application is incomplete, a "deficiency" letter is prepared informing the applicant which documents are missing and/or information needed. The reviewed files are separated from files awaiting a review; both types of applications must be managed according to the regulations above. Once the required documents identified in the deficiency letter arrive at the Board, the analysts review each document to determine if the document is complete and acceptable. Additional deficiency letters are sent if the recently submitted documents are not acceptable. Once all documents are deemed acceptable, the application files are forwarded for a quality control review and if the file is complete and correct, the file is forwarded to the licensing desk. Licenses are issued every Tuesday and Thursday night, effective the following day.

History of Present Backlog

Nine years ago, Board management identified that the Licensing program was not operating as efficiently and effectively as possible. In 2001, the Board contracted with Cooperative Personnel Services (CPS) to conduct a study of the Licensing program to identify the specific licensing processes utilized, evaluate their effectiveness, and recommend process revisions or enhancements. CPS issued a Report and Recommendations from the Review of the Licensing Function Processes (Report) in June 2001. The Report recommended several process improvements and noted additional positions were required to implement the recommendations. As a result of the July 2001 Executive order freezing all hiring, eliminating overtime and positions, the Board failed to implement the Report's recommendations, which included adding additional staff and developing management reports.

Over the past nine years, the number of physician and surgeon applications received annually by the Medical Board has grown by almost 500 applications (from 5,687 to 6,169) without a corresponding increase in staff. See Table 1. This substantial inequity in allocated staff positions relative to the increase in the workload resulted in a "Band-Aid" approach of overtime to accommodate the required workload.

The Licensing Chief Report for the July 2008 Board meeting again reported a backlog of applications not reviewed within the 90 calendar day regulatory time frame requirements. The backlog has continued to grow over the past 15 months. Several factors contribute to this continued growth in the number of applications not reviewed within regulatory timeline and the time frame to review incoming documents from applications previously reviewed and awaiting licensure. One factor is the Governor's Executive Order that eliminated the overtime from August 1 to October 15, 2008 and the Governor's Executive Order of two furlough days per month from February through June 2009 and three furlough days effective July 1, 2009. Table 2 displays the reduction in time staff worked due to the furlough, overtime hours worked, applications received, reviewed and licenses issued.

Another factor contributing to the backlog is the complexity of applications received and the number of applications received with identified problems including criminal convictions, medical school and/or postgraduate training issues, alcohol or drug addictions, driving violations involving drugs and/or alcohol, mental health issues, discipline by other state medical boards, federal sanctions, clinical competency, and dishonesty. Table 3 displays the increase in the number of applications with problems over the past four years. These cases take more time to process due to the research, investigation and legal and medical consultants guidance needed to determine if the applicant should proceed to licensure, and/or be issued a Public Letter of Reprimand, a probationary license, or be denied. Senior Review Level 1 (SR1) is the first level of review conducted by a manager. There was a policy change in 2007 that classified more issues for the SR1 review. Those policies were reviewed and revised in 2009, providing the analysts more authority to approve minor issues such as leave of absences from medical school and postgraduate training programs. Senior Level 2 (SR2) denotes files with issues/problems that are severe, require complete research, investigation, and guidance from Legal and Executive management.

As of June 2008, only limited management reports were available from the Application Tracking System (ATS), including the number of application fees paid monthly and annually. These reports were used to project workload. To gain access to the overall application workload, the analysts started manually inventory their files in August 2008. In July 2009, the Board obtained an ATS Adhoc Reporting tool and is starting to generate reports to gain historical information and forecast workload. While these reports provide historical data, the Board lacks true

knowledge of the changes in the overall workload, such as type and complexity of applications received. Research and discussion with staff suggests trends include an increase in IMG versus US applications, more identified drug and alcohol problems, and more identified postgraduate training program problems (non-renew contract and start in another program).

The Executive Director identified licensing program problems and directed the new Licensing Chief hired in June 2008 to solve some long standing issues in the program. These include:

- Ensuring the objective enforcement of the Medical Practice Act through the vigorous screening of applicants during the licensing process.
- Evaluating licensing resources, processes and tools and creating an action plan to revamp the licensing process.
- Building a cohesive management team and determining the appropriate resource levels needed to efficiently and timely process physician and surgeon applications.
- Preparing and deploying throughout the organization the Licensing program's policy and procedure manual as a means of fostering common approaches across the Licensing program.
- Building management reporting tools to provide reports to better manage the workload.
- Improving our communication with applicants, postgraduate training programs and other stakeholders in the licensing process and maximizing the use of up-to-date tools, including the Medical Board's web presence.
- Implementing process improvements to bring the organization to acceptable application processing levels without adversely affecting public protection with the support of a consultant hired to conduct a business process reengineering study to provide analysis and make recommendations to improve efficiency in licensing processes.

Licensing Application Workload

As of September 1, 2009, the table below displays the physician and surgeon licensing workload including the total number of applications awaiting licensure and/or Postgraduate Training Authorization Letter (PTAL), the number not reviewed within the 90 calendar day regulatory time frame, the number of applications not reviewed that arrived within the last 90 calendar days, and applications reviewed but still awaiting documents. Note: many of the IMG applications reviewed have received PTALs and no staff action is needed until they complete two to three years of training.

US/IMG Apps.	Date of Oldest App.	Backlog – Apps. Not Reviewed over 90 calendar days	Apps. Not reviewed under 90 calendar days	US/IMG App. Reviewed Awaiting Documents (Pending) & IMG Apps. Issued PTAL	Total Apps. in Inventory	Date of Pending Mail for Reviewed Apps.	PTAL Issued in August	License Issued in August	Apps. Reviewed in August
US	3/12/09	437	619	853	1909	8/3/09	NA	216	278
IMG	3/2/09	216	534	4533	5283	4/1/09	141	97	129
Total	**3/2/09**	**653**	**1153**	**5386**	**7192**	**4/1/09**	**141**	**313**	**407**

Recent Licensing Accomplishments/Program Changes: In June 2008, a new licensing management team was hired. The Licensing program has had the following key accomplishments during the past fiscal year:

- Implemented quality review of license application files prior to issuance (July 2008).
- Instituted manual inventory of all license applications received at the Medical Board by each licensing analyst (August 2008).
- Redistributed application files to balance the caseload among license analysts (September 2008).
- Created electronically generated deficiency letters with over 50 standard paragraphs for the licensing analysts to use (previously each analyst created "individualized" deficiency letters) which resulted in improving quality and decreased staff time to create each letter (December 2008).
- Implemented a new Web-based Call Center receiving over 11,000 calls per month (December 2008).
- Gained statutory authority and started issuing Public Letters of Reprimand (January 2009).
- Began a workload time and motion analysis to determine work accomplished and resources needed to perform the workload timely (January 2009).
- Created two ATS generated management reports to provide the number of initial applications reviewed and number of licenses issued per analyst (February 2009).
- Began developing in September 2008, a comprehensive Policies and Procedures manual for processing US, IMG and PTAL applications and incorporated the manual into operations (March 2009).
- Determined the need for additional staff in March 2009 based on the workload time and motion analysis and submitted a proposal for 7.8 new Licensing program staff and four new staff for the call center (June 2009).
- Amended regulatory language for Continuing Medical Education in Section 1338 (Board approved May 2009) and international medical schools in Section 1314.1 (Board approved July 2009).
- Per the Executive Director's request, began developing a new online applicant licensing look up system anticipated to be available in November 2009 (July 2009).
- Provided with each new application received, a letter to the applicant informing him/her the application was received and the number of days it is taking to conduct an initial application review (August 2009).

- Provided each new licensee a congratulatory email notification, if they provided an email address, or a letter, if they did not provide an email address, informing them to log onto the Medical Board Web site for their license number to practice medicine (August 2009).

- Hired Management Consultants to conduct a business process reengineering study of licensing operations. The report is due in November 2009 for presentation at the January 2010 Board meeting (August 2009).

- In conjunction with the Board's Information Systems Branch, began evaluating potential management reports available via ATS Adhoc Reporting Tool and created two new ATS system generated management reports for the number of applications received for US and IMG licenses and PTALs and the amount of time to conduct an initial application review (September 2009).

- Added requirements to the monthly manual licensing file inventory for each analyst to count by 30-day increment applications received but not reviewed to accurately project future backlog (September 2009).

- Hired and trained one and one-half temporary IMG license analysts and reassigned caseload, thus reducing the caseloads of several IMG analysts with the largest caseloads (September 2009).

Plan to Meet Regulatory Physician and Surgeon Licensing Timeframes

Objective: By January 1, 2010, reduce the physician and surgeon application backlog for licensure and PTAL by 50 percent and eliminate the backlog by February 2010, thus meeting the regulatory physician and surgeon licensing time frames, while simultaneously transitioning the licensing organization and its capabilities into a sustainable licensing program capable of processing the entire application workload efficiently with a high level of customer and stakeholder satisfaction.

The Plan has two phases. Phase I are the immediate actions needed to reduce the backlog and Phase II includes projects to foster the transition to an effective and efficient program undertaken once the backlog is eliminated.

From the Licensing Chief to the individual licensing analyst, all share the responsibility to eliminate the licensing backlog while setting the stage for a much more robust licensing process as we move into 2010. This Plan anticipates the use of appropriate resources as well as adding new staff to supplement the existing licensing staff. Progress will be closely monitored and significant management attention will be used to oversee the implementation of each program element with the objective of ensuring the Plan is executed as planned.

Specific elements of the Plan include:

Phase I Licensing Plan

- **Hire and train additional 10 part-time and limited term licensing staff** - in the interim to fill the gap until 7.8 permanent full-time employees are hired in January, if request is approved, or July 2010.

a. By October 5, hire and start training six students who work approximately 20 hours per week to review initial US applications to assist the six US license reviewers. Complete training by October 26.

b. By November 1, hire and start training four full-time two-year limited term employees. After a three-week training period, these employees will be assigned IMG application caseloads, thus rebalancing all license reviewers' caseload. (IMG training is very complex and takes approximately six months to be fully trained and independent.)

- **Establish key milestones to review applications and documents and eliminate the backlog.**

  For US applications, the backlog of applications not reviewed will continue to grow until:

  a. December 1, 2009, reduce the application backlog by 36 percent (437 to 276).
  b. January 1, 2010, reduce the application backlog by 61 percent (437 to 171).
  c. February 1, 2010, reduce the application backlog by 95 percent (437 to 26).
  d. March 1, 2010, eliminated the application backlog and conduct initial review for all applications within 75 calendar days.
  e. April 1, 2010, conduct all application initial reviews within 60 calendar days.

  For IMG applicants for licensure and PTAL, the backlog of applications not reviewed will continue to grow until:

  a. January 1, 2009, reduce the application backlog by 32 percent (216 to 146).
  b. February 1, 2010, reduce the application backlog by 97 percent (216 to 6).
  c. March 1, 2010, eliminated the application backlog and conduct initial review for all applications within 75 calendar days.
  d. April 1, 2010, maintain all application initial reviews within 60 calendar days.

  Implementing this plan will enable staff to be prepared for the influx of licensing residents and fellow applications needing licensure by the July 1 deadline. To meet this plan, we will actively communicate with all stakeholders that applications must be received no later than April 1 for staff to review the applications and provide the applicants' time to submit additional documentation. However, for applicants identified as having problems needing senior staff review, the Board may not be able to ensure licensure by July 1.

- **Proactive Management** – The primary management approach in the Licensing program over the past several years can best be described as reactionary with the vast majority of the resources focused on the "drill of the day". This is no longer seen as appropriate given our challenges. Our Plan includes realigning the management responsibilities to correspond to the individual's strength as well as moving to a proactive approach where the management team is focused on process improvements and quality control aimed at improving efficiencies and reducing the number of surprises. The licensing staff is a great resource and their input must be requested and utilized. As tools and other resources are identified, management must possess the ability to meet the staff's needs and make changes recommended in the management consultants' report.

- **Communication with Stakeholders** – The Web Application Access System project was established to allow applicants using their unique ID to inquire online about PTAL and license application status through the MBC Web site. It is anticipated that the increased functionality will significantly reduce the number of application status related calls from applicants (both CIU and Licensing Staff), resulting in better use of staff time. This access will benefit other stakeholders, such as postgraduate training programs and employers, as the applicants will know their application status in real time.

  The roll out of the Web Applicant Access System project is scheduled for November 2009. Critical to the success of this project is accurate and timely logging all incoming mail related to licensure and PTAL applications into the ATS data system. We plan to conduct an email blast to all current applicants informing them of the Web Application Access and how they can access this information. In addition, we will modify the instructions on the MBC Web site, as we transition to the Web Applicant Access System making it the primary communications tool between MBC and applicants. We will present the new Web Applicant Access System at the October 30, 2009 Board meeting.

- **Management Tools** - Over the past year, the Licensing program staff has spent many hours manually gathering workload (application file) information to understand the workload and work flow, staff also manually, via Excel spreadsheet, tracked over 1,200 residents and fellows to expedite their applications. This places the Licensing management in a reactionary mode. Given current technology, there are more options available that need to be identified and utilized. Support from ISB is essential to provide real time data and a method to receive applicant status reports.

  Building off of the Web Applicant Access System project, our plan anticipates the support from ISB to provide real time data and a system to automatically track resident and fellow information. We plan to make this data base/information accessible by all of the stakeholders (e.g. applicants, medical school administrators, and Medical Board staff and management) to manage their portion of the licensing process. For the staff, this means that the Web site is the place where they post updated licensing review activities as well as where they see their entire outstanding portfolio of license applications. For management, it will mean that all of the required workload management reports will be generated automatically on a real-time basis, providing the ability to see problems as they emerge and pro-actively address them. Details of this plan will be developed over the next few months and presented at the January 2010 Board meeting.

- **Business Process Reengineering (BPR) Study -** The BPR study is underway and we anticipate receiving the report to improve efficiencies and effectiveness in November 2009, which will form the basis to the Phase II activities. The Licensing Chief and consultants will present the BPR study report findings at the January 2010 Board meeting.

Phase II Licensing Plan

In addition to any other recommendations coming from the BPR Study report, the Licensing program staff identified several process improvements that will be executed as part of Phase II of this Plan: to reduce the number of application documents arriving incomplete and/or needing additional explanations/information.

- **Change the Focus of the Licensing Group** - The focus of the Licensing Group for years has been on managing the then-current crisis, with the focus today being on eliminating the backlog. The central theme of Phase II will be to more effectively manage and execute the overall workload, leading to higher MBC customer satisfaction. In order to accomplish this, the people, processes and procedures will be realigned such that the workload is anticipated in advance, allowing management to make corrective actions before problems occur (i.e., proactive versus reactive).

- **Revise the Licensing Application** - The licensing application was last revised in 2005. Staff has identified several areas of our current application that are misleading and/or confusing to the applicant and the medical schools, postgraduate training programs and other agencies completing the forms. Implementing the identified changes while simultaneously polling the staff for additional recommendations will go a long way to ensure that the correct information is submitted and accepted the first time, thus reducing the need for staff to prepare a deficiency letter identifying what is missing.

- **Issue Updated Licensing Guidelines** - Parallel to the Enforcement Program, the Licensing program will develop licensing guidelines to determine which applications receive Public Letters of Reprimand, probationary licenses with conditions, and which applications are denied. Licensing Guidelines will reduce the staff time currently used to process "problem cases" and ensure consistency. The Board's Application Review Committee will assist with this project.

- **Issue an Updated Policies and Procedures Manual -** The Policy and Procedure manual will need additional sections developed including addressing problem application cases and documentation requirements for ATS. Adequate resources to maintain the manual and a mechanism to update the manual to keep it current with policy and procedures decisions must be adopted.

- **Staff Training** – We intend to develop a training program for the staff based on the newly issued Licensing Guidelines and Policies and Procedures Manual with the goal of unifying our approach to processing physicians and surgeons and PTAL applications and improving our efficiency. This will also be a good time to address rebuilding the morale in the group which has been quite low over the last several years due to the heavy workload.

- **Management Reporting** – As an outgrowth of building more sophisticated management tools, we will obtain a much better understanding of the licensing application workflow cycles. The additional insight gained will enable us to create new automated and real time Management Reports to anticipate trends and redeploy resources as the nature of the workload changes.

- **Integrated Licensing Activities With Other Licensing Program Priorities** – We plan to expand our coordinating activities with postgraduate training programs and conduct more licensing fairs.

- **Update Medical Board Licensing Web Site**
    a. Include details and instructions regarding the Web Applicant Access System so that applicants are informed of the new inquiry capabilities offered.
    b. Cyclical reviews and updates of Web site content to ensure clear and concise information.
    c. Receive CIU's most common asked questions and continually update the Web site and/or application accordingly.

The Board will receive an updated report regarding the backlog and the Plan's implementation at future Board meetings until the backlog is eliminated.

Attachment 1

SUMMARY OF REQUIRED APPLICATION AND SUPPORTING DOCUMENTATION
U.S. AND CANADIAN MEDICAL SCHOOL GRADUATES APPLYING FOR LICENSURE

REPORTING SOURCE:		Applicant	*FCVS: Federation Credentials Verification Service The following Items *may* be provided by the FCVS	Examination Entity	Medical School	State Medical Board	Postgraduate Training Program
ITEMS:							
1	**Application, Forms L1A-L1E	X					
2	Two Fingerprint Cards/Live Scan	X					
3	Application Processing Fee $493	X					
4	Official Examination Transcript for one of the following exams: USMLE: United States Medical Licensing Examination FLEX: Federation Licensing Exam LMCC: Licentiate of the Medical Council of Canada ***State Board Written Examinations		X	X		***X	
5	Certificate of Medical Education, Form L2				X		
6	Official Medical School Transcript		X		X		
7	Certified Copy of Medical Degree		X		X		
8	Official Letters of Good Standing (Written licensure verification provided by other state licensing boards)					X	

Attachment 1

SUMMARY OF REQUIRED APPLICATION AND SUPPORTING DOCUMENTATION
U.S. AND CANADIAN MEDICAL SCHOOL GRADUATES APPLYING FOR LICENSURE

REPORTING SOURCE:		Applicant	*FCVS: Federation Credentials Verification Service The following Items *may* be provided by the FCVS	Examination Entity	Medical School	State Medical Board	Postgraduate Training Program
ITEMS Continued:							
9	**Certificate of Completion of ACGME/RCPSC Postgraduate Training, Form L3A/B** The FCVS provides a "Verification of Postgraduate Medical Education" which may be acceptable in lieu of the Form L3A/B **ACGME:** Accreditation Council for Graduate Medical Education **RCPSC:** Royal College of Physicians and Surgeons of Canada		X				X
10	**Certificate of Current Postgraduate Training Enrollment, Form L4**						X
11	**License Fee of $808 or $416.50**	X					

*FCVS materials accepted must be stamped as "Seal Verified" indicating the FCVS received direct source verification from the appropriate reporting source. Not all FCVS profiles received will contain the items noted in the above chart. FCVS profiles do not contain *board specific* documents such as the Medical Board of California's Form L2, Form L3A/B, and Form L4.

** Applicant and the appropriate reporting source must provide supporting documentation and explanations for any "Yes" responses to questions # 14 and # 17 through # 38 on Forms L1A-L1D.

The *Initial and Update Application for Physician's and Surgeon's License or Postgraduate Training Authorization Letter* is available from the Medical Board's Web site at www.mbc.ca.gov by selecting the "Applicants" tab and following the links. Applications are also available by mail by contacting the Medical Board's Consumer Information Unit at (916) 263-2382.

This chart and related information are presented for the benefit of interested parties, such as applicants, hospitals, educational institutions, and others. The information presented is generalized and may not be applicable in all circumstances and cases. This chart is a summary of the requirements contained in the Business and Professions Code and Title 16 of the California Code of Regulations. For more information, please visit the Medical Board's web site at

Attachment 1
SUMMARY OF REQUIRED APPLICATION AND SUPPORTING DOCUMENTATION
INTERNATIONAL MEDICAL SCHOOL GRADUATES APPLYING FOR LICENSURE

	REPORTING SOURCE:	Applicant	*FCVS: Federation Credentials Verification Service The following Items *may* be provided by the FCVS	Examination Entity	Medical School	State Medical Board	Postgraduate Training Program	Undergraduate Clinical Clerkship Training Hospital
	ITEMS:							
1	****Application, Forms L1A-L1E**	X						
2	**Two Fingerprint Cards/Live Scan**	X						
3	**Application Processing Fee $493**	X						
4	**Official Examination Transcript for one of the following exams:** **USMLE:** United States Medical Licensing Examination **FLEX:** Federation Licensing Exam **ECFMG:** Educational Council for Foreign Medical Graduates – English Exam **LMCC:** Licentiate of the Medical Council of Canada *****State Board Written Examinations**		X	X		***X		
5	**Certificate of Medical Education, Form L2**				X			
6	**Official Medical School Transcript**		X		X			
7	**Certified Copy of Medical Degree**		X		X			
8	**Original, Official English Translation for any Non-English Documents**	X	X					
9	**Official Letters of Good Standing** (Written licensure verification provided by other state licensing boards)					X		

Attachment 1
SUMMARY OF REQUIRED APPLICATION AND SUPPORTING DOCUMENTATION
INTERNATIONAL MEDICAL SCHOOL GRADUATES APPLYING FOR LICENSURE

REPORTING SOURCE:		Applicant	*FCVS: Federation Credentials Verification Service The following Items *may* be provided by the FCVS	Examination Entity	Medical School	State Medical Board	Postgraduate Training Program	Undergraduate Clinical Clerkship Training Hospital
ITEMS Continued:								
10	**Certificate of Completion of ACGME/RCPSC Postgraduate Training, Form L3A/B** The FCVS provides a "Verification of Postgraduate Medical Education" which may be acceptable in lieu of the Form L3A/B **ACGME:** Accreditation Council for Graduate Medical Education **RCPSC:** Royal College of Physicians and Surgeons of Canada		X				X	
11	**Certificate of Current Postgraduate Training Enrollment, Form L4**						X	
12	**Certificate of Clinical Clerkships, Form L5**				X			
13	**Certificate of Clinical Training, Form L6** **International medical school graduates who complete undergraduate clinical rotations in a hospital other than their medical school's primary teaching hospital are required to submit a Form L6 for each rotation.**	X						X
14	**License Fee of $808 or $416.50**	X						

Attachment 1
SUMMARY OF REQUIRED APPLICATION AND SUPPORTING DOCUMENTATION
INTERNATIONAL MEDICAL SCHOOL GRADUATES APPLYING FOR LICENSURE

*FCVS materials accepted must be stamped as "Seal Verified" indicating the FCVS received direct source verification from the appropriate reporting source. Not all FCVS profiles received will contain the items noted in the above chart. FCVS profiles do not contain *board specific* documents such as the Medical Board of California's Form L2, Form L3A/B, Form L4, Form L5, and Form L6.

** Applicant and the appropriate reporting source must provide supporting documentation and explanations for any "Yes" responses to questions # 14 and # 17 through # 38 on Forms L1A-L1D.

The *Initial and Update Application for Physician's and Surgeon's License or Postgraduate Training Authorization Letter* is available from the Medical Board's Web site at www.mbc.ca.gov by selecting the "Applicants" tab and following the links. Applications are also available by mail by contacting the Medical Board's Consumer Information Unit at (916) 263-2382.

This chart and related information are presented for the benefit of interested parties, such as applicants, hospitals, educational institutions, and others. The information presented is generalized and may not be applicable in all circumstances and cases. This chart is a summary of the requirements contained in the Business and Professions Code and Title 16 of the California Code of Regulations. For more information, please visit the Medical Board's web site at www.mbc.ca.gov and select "Applicants". The mention of specific licensing examination, educational program or institution or verification service does not represent an endorsement of that entity by the Medical Board of California. Applicants for a medical license are strongly encouraged to read the license application and related documents carefully.

Attachment 1
SUMMARY OF REQUIRED APPLICATION AND SUPPORTING DOCUMENTATION
INTERNATIONAL MEDICAL SCHOOL GRADUATES
APPLYING FOR A POSTGRADUATE TRAINING AUTHORIZATION LETTER (PTAL)

REPORTING SOURCE:		Applicant	Examination Entity	Medical School	Postgraduate Training Program	Undergraduate Clinical Clerkship Training Hospital
ITEMS:						
1	*Application, Forms L1A-L1E	X				
2	Two Fingerprint Cards/Live Scan	X				
3	Application Processing Fee $493	X				
4	Official Examination Transcript for one of the following exams: **USMLE:** United States Medical Licensing Examination **FLEX:** Federation Licensing Exam **LMCC:** Licentiate of the Medical Council of Canada		X			
5	Certificate of Medical Education, Form L2			X		
6	Official Medical School Transcript			X		
7	Certified Copy of Medical Degree			X		
8	Original, Official English Translation for any Non-English Documents	X				
9	Certificate of Clinical Clerkships, Form L5			X		

Attachment 1
SUMMARY OF REQUIRED APPLICATION AND SUPPORTING DOCUMENTATION
INTERNATIONAL MEDICAL SCHOOL GRADUATES
APPLYING FOR A POSTGRADUATE TRAINING AUTHORIZATION LETTER (PTAL)

* Applicant and the appropriate reporting source must provide supporting documentation and explanations for any "Yes" responses to questions # 14 and # 17 through # 38 on Forms L1A-L1D.
The *Initial and Update Application for Physician's and Surgeon's License or Postgraduate Training Authorization Letter* is available from the Medical Board's Web site at www.mbc.ca.gov by selecting the "Applicants" tab and following the links. Applications are also available by mail by contacting the Medical Board's Consumer Information Unit at (916) 263-2382.

This chart and related information are presented for the benefit of interested parties, such as applicants, hospitals, educational institutions, and others. The information presented is generalized and may not be applicable in all circumstances and cases. This chart is a summary of the requirements contained in the Business and Professions Code and Title 16 of the California Code of Regulations. For more information, please visit the Medical Board's web site at www.mbc.ca.gov and select "Applicants". The mention of specific licensing examination, educational program or institution or verification service does not represent an endorsement of that entity by the Medical Board of California. Applicants for a medical license are strongly encouraged to read the license application and related documents carefully.

Medical Board of California
Executive Committee Meeting
Physician and Surgeon US/IMG Workload Status
September 30, 2009

Type of App	PTALs issued in Sept 2009	Licenses issued in Sept 2009	Applications reviewed in Sept 2009	Backlog beyond 90 days	Aging 90-60	Aging 60-30	Aging 30- 0	Total Apps Not Reviewed	Total Apps Pending or Waiting	Total Inventory	Oldest Application Date in Backlog	Oldest Unprocessed Mail
US/CAN		218	280	347	256	335	349	1287	991	2278	4/23/09	8/18/09
IMG	122	103	167	229	203	202	214	848	4699	5547	4/7/09	7/13/09
TOTAL	***122***	***321***	***447***	***576***	***459***	***537***	***563***	***2135***	***5690***	***7825***		

Legend

Backlog - Applications not reviewed, over 90 calendar days old *(based on licensing receipt date)*, not meeting regulatory requirements.

Aging 90-60 - Applications not reviewed within 90-60 calendar days *(based on licensing receipt date)*

Aging 60-30 - Applications not reviewed within 60-30 calendar days *(based on licensing receipt date)*

Aging 30-0 - Applications not reviewed within 30-0 calendar days *(based on licensing receipt date)*

Total Apps Not Reviewed - Sum of: Backlog beyond 90 days + Aging 90-60 + Aging 60-30 + Aging 30-0

Total Apps Pending or Waiting - Sum of Applications Pending or Waiting

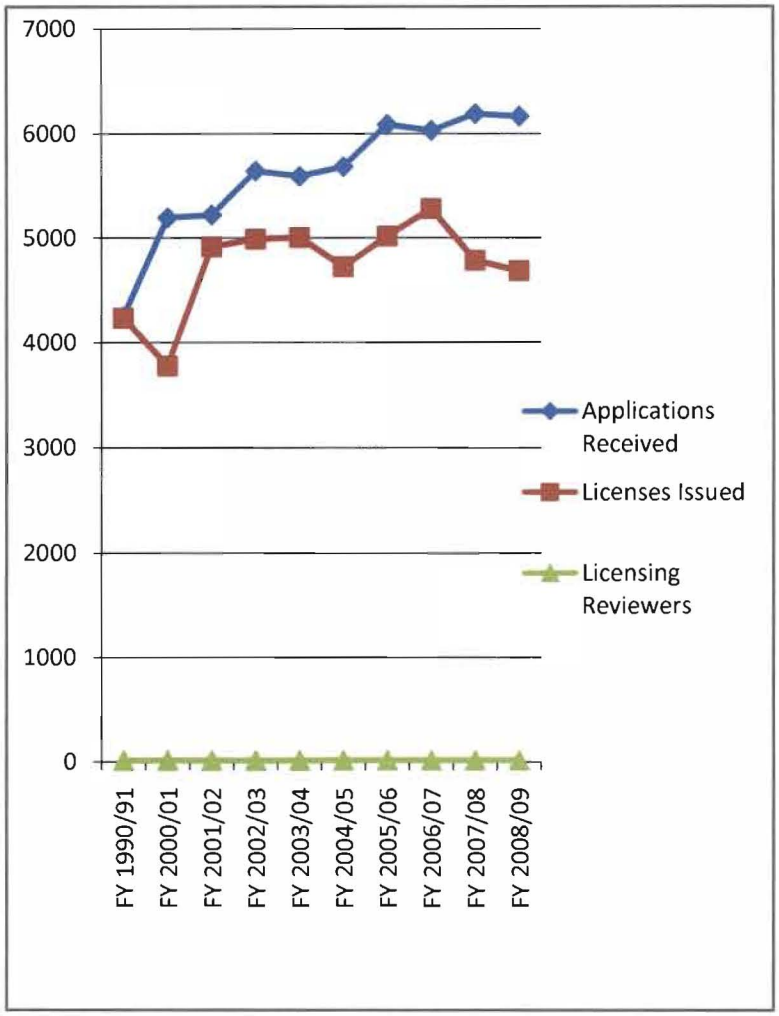
Pending - Applications reviewed and awaiting required documentation identified in a deficiency notice previously sent to applicant.
Waiting - Applications with a PTAL issued and waiting for applicant to:
(1) Complete post graduate training requirements and apply for licensure or
(2) request a new PTAL due to expiration of current PTAL

Total Inventory - Sum of: Total App Not Reviewed + Total Apps Pending or Waiting

Oldest Application Date in Backlog - Oldest receipt date of a non-reviewed new application file

Oldest unprocessed mail - Oldest receipt date for piece of mail in pending + waiting inventory of unprocessed mail associated to a Pending Application

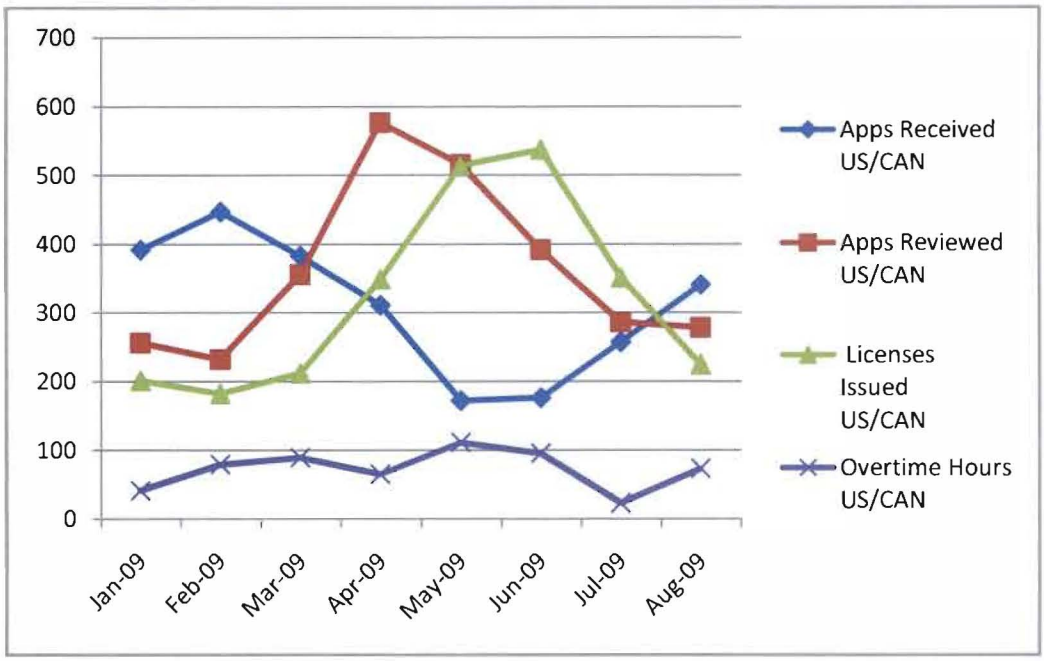
Table 1
Licensing Program Workload Trend Analysis



Date	Applications Received	Licenses Issued	Licensing Reviewers
FY 1990/91	4252	4238	15
FY 2000/01	5196	3777	16.5
FY 2001/02	5223	4920	16.5
FY 2002/03	5644	4993	15.5
FY 2003/04	5594	5008	16.5
FY 2004/05	5687	4728	18
FY 2005/06	6090	5020	17
FY 2006/07	6034	5284	18
FY 2007/08	6192	4787	18
FY 2008/09	6169	4688	18

Licensing Workload January 2009 to September 2009

US/Canada Medical School Information



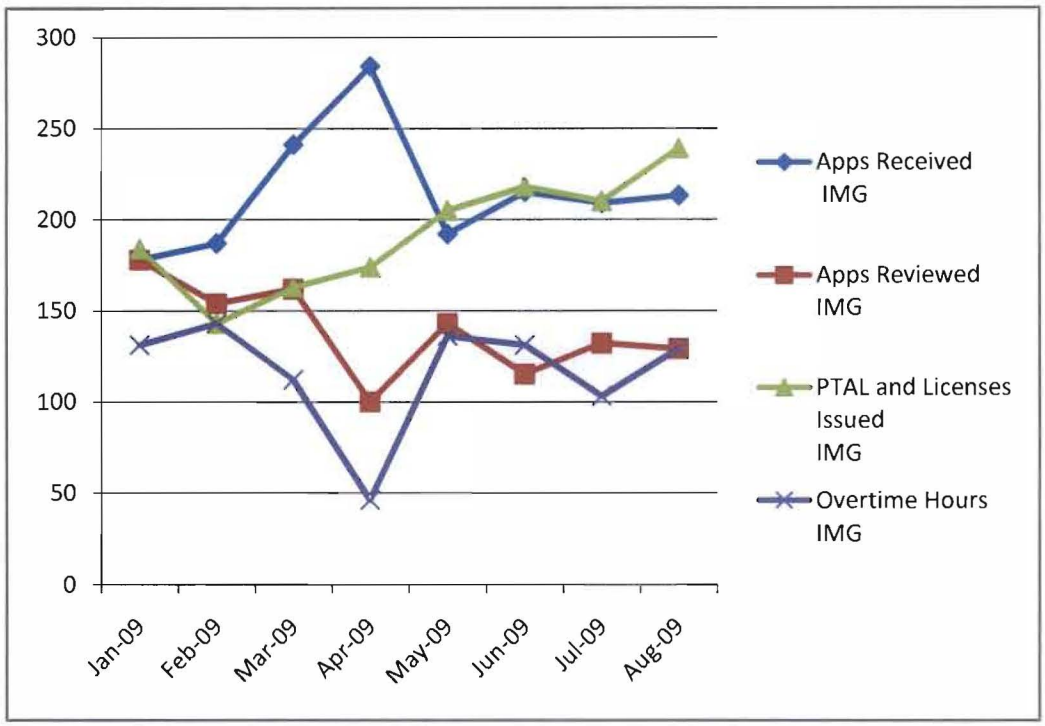
Month	Apps Received US/CAN	Apps Reviewed US/CAN	Licenses Issued US/CAN	Overtime Hours US/CAN	*Staff Hours With Furloughs US/CAN
Jan-09	392	256	201	41	1,056
Feb-09	447	232	182	79	950
Mar-09	383	356	212	89	950
Apr-09	311	577	349	65	950
May-09	172	516	514	111	950
Jun-09	176	392	537	95	950
Jul-09	257	286	351	23	897
Aug-09	341	278	224	73	897
Sep-09	399	280	218	116	897
Totals	**2,878**	**3,173**	**2,788**	**692**	****912 Hours Lost**

* Furloughs - February 2009 through June 2009 included two furlough days a month. Starting July 2009, increased to three furlough days a month.

** 912 hours lost February 2009 through September 2009 due to furloughs.

Licensing Workload January 2009 to September 2009

International Medical School Information



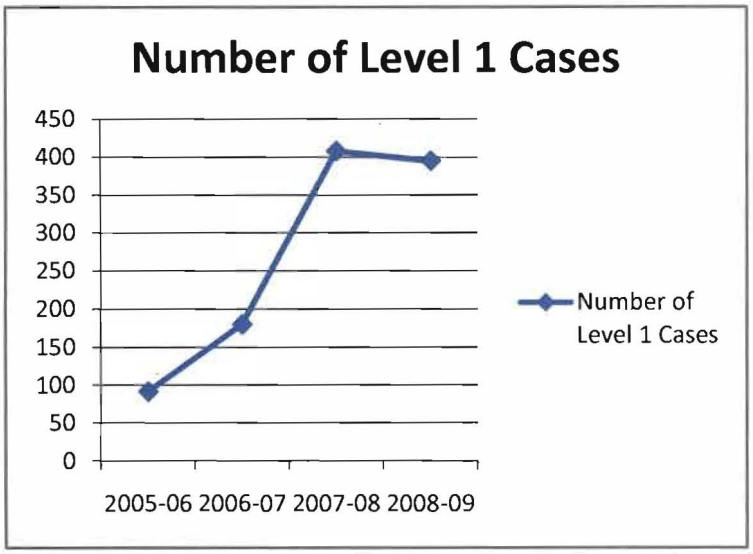
Month	Apps Received IMG	Apps Reviewed IMG	PTAL and Licenses Issued IMG	Overtime Hours IMG	* Staff Hours With Furloughs IMG
Jan-09	178	178	184	131	2112
Feb-09	187	154	143	143	1900
Mar-09	241	162	163	112	1900
Apr-09	284	100	174	46	1900
May-09	192	143	205	136	1900
Jun-09	215	115	218	131	1900
Jul-09	209	132	210	103	1795
Aug-09	213	129	239	129	1795
Sep-09	205	167	225	152	1795
Totals	**1924**	**1280**	**1761**	**1083**	****1,763 Hours Lost**

* Furloughs - February 2009 through June 2009 included two furlough days a month. Starting July 2009, increased to three furlough days a month.

** 1,763 hours lost February 2009 through September 2009 due to furloughs.

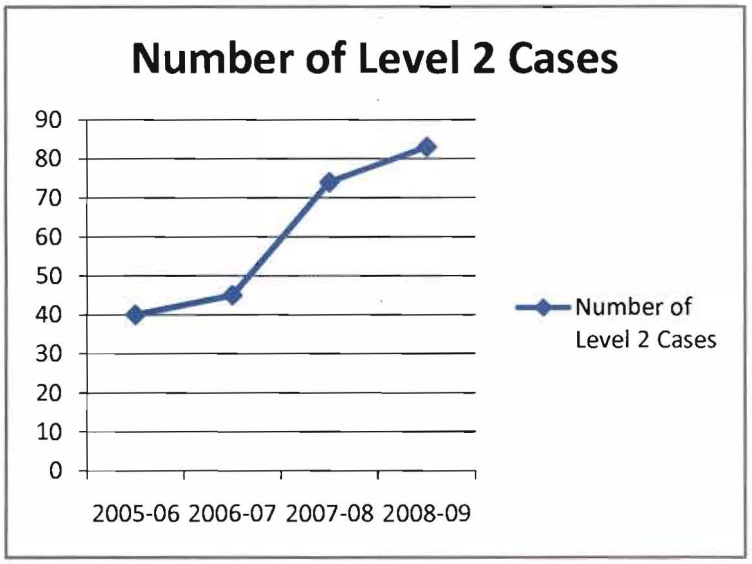
Table 3

Senior Review Files (Problem Cases)



Level 1 Cases Received

Fiscal Year	Number of Level 1 Cases
2005-06	92
2006-07	180
2007-08	408
2008-09	395



Level 2 Cases Received

Fiscal Year	Number of Level 2 Cases
2005-06	40
2006-07	45
2007-08	74
2008-09	83

Senior Review files are problem cases that include applicants with: criminal convictions, medical school and/or postgraduate training issues, alcohol or drug addiction problems, driving violations involving drugs and/or alcohol, mental health issues, discipline by other state medical boards, federal sanctions, clinical competency, and dishonesty.

SR1 - The issues are reviewed at the management level and are not as severe. The issues may be researched, addressed, and resolved in which the applicant is approved to proceed in the licensure process.

SR2 - The issues are severe, require complex research, investigation, and guidance. Files are reviewed with legal counsel, a Deputy Attorney General, the Executive Director, Licensing Chief, Licensing managers, and may require consultation with medical consultants.

LICENSING PROGRAM
CHIEF'S REPORT

FISCAL YEAR 2009-10

CONSUMER INFORMATION UNIT				
	FY 08/09	FY09/10-Q1	Q2	Q3
Total Calls Answered:	64,177	27,117		
Calls Requesting Call Back:	7,074	4,951		
Calls Abandoned:	7,875	4,967		
Address Changes Completed:	27,984	3,346		

SPECIAL PROGRAMS*										
	Applications Received		Applications Reviewed		Permits Issued		Permits Renewed		Site Visits	
	FY08/09	FY09/10-Q1	FY08/09	FY09/10-Q1	FY08/09	FY09/10-Q1	FY08/09	FY09/10-Q1	FY08/09	FY09/10-Q1
2111	44	12	29	12	38	17	29	11	0	0
2112	4	1	1	1	0	1	0	0	0	0
2113	41	5	29	5	33	13	52	11	0	0
2168	3	1	3	1	3	0	5	0	0	0
2072	0	0	0	0	0	0	0	0	0	0
1327	1	1	1	1	0	0	2	1	0	0

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS				
	Q1	Q2	Q3	Q4
New Applications Received:	0			
Applications In Consultant Review Process:	2			

*2111 - Visiting Fellow (doesn't satisfy postgraduate training required for licensure)
2112 - Hospital Fellowship Program Non-Citizen (does not satisfy postgraduate training required for licensure)
2113 - Medical School Faculty Member (may satisfy postgraduate training required for licensure)
2168 - Special Faculty Permit (academically eminent; unrestricted practice within sponsoring medical school - not eligible for licensure)
2072 - Special Faculty Permit - Correctional Facility
1327 - Special Faculty Permit - Hospital

LICENSING PROGRAM
CHIEF'S REPORT

FISCAL YEAR 2009-10

LICENSED MIDWIVES				
	Q1	Q2	Q3	Q4
Applications Received:	2			
Licenses Issued:	2			
Licenses Renewed:	18			

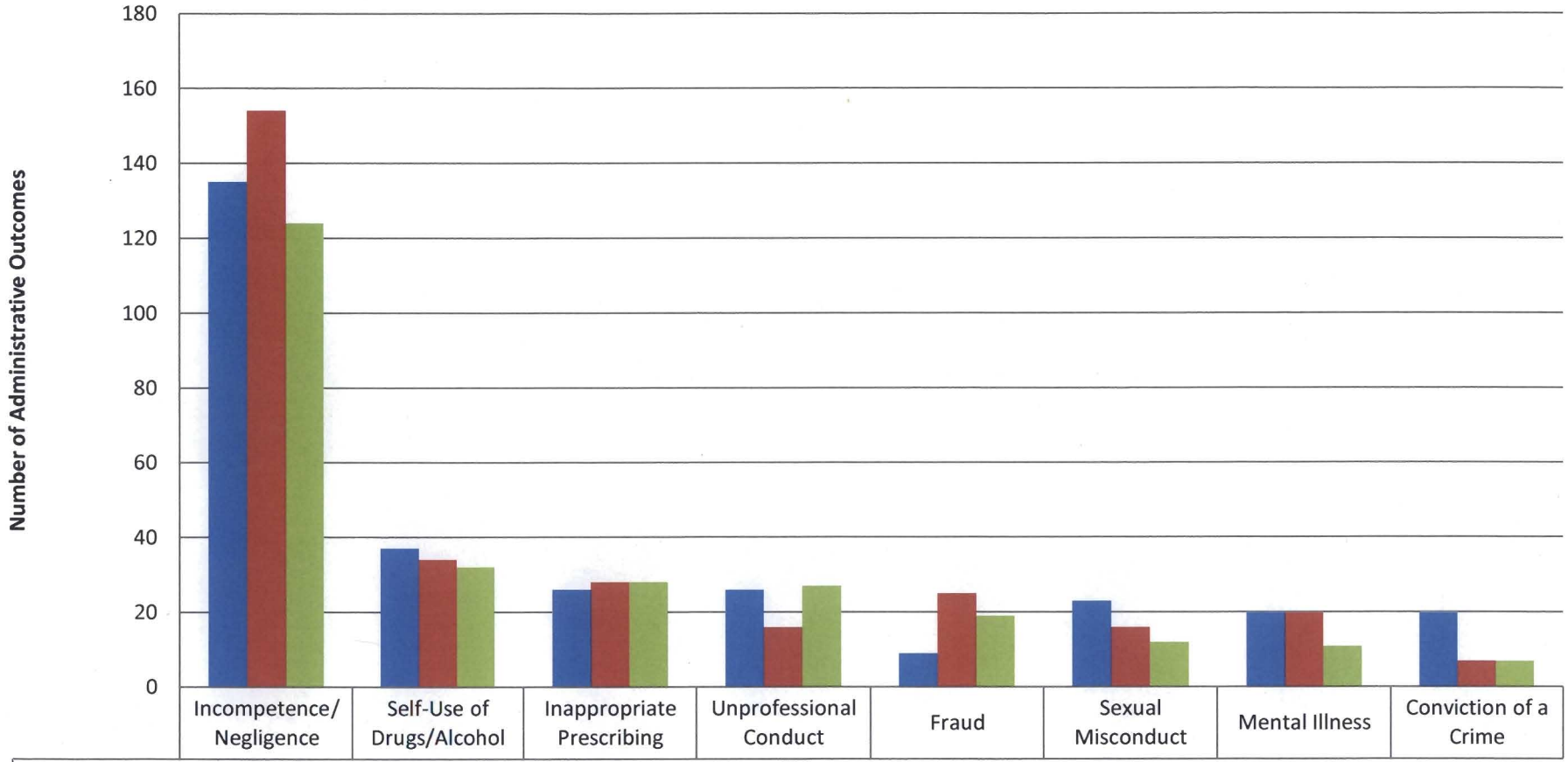
OPTICAL REGISTRATIONS				
	Q1	Q2	Q3	Q4
Business Registrations (D) Issued:	19			
Out-of-State Business Registrations (OS) Issued:	1			
Spectacle Lens Registrations (SL) Issued:	56			
Contact Lens Registrations (CL) Issued:	36			
Spectacle Lens Registrations (SL) Renewed:	214			
Contact Lens Registrations (CL) Renewed:	82			

RESEARCH PSYCHOANALYST (RP)				
	Q1	Q2	Q3	Q4
RP Applications Received:	0			
RP Licenses Issued:	0			

FICTITIOUS NAME PERMITS (FNP)				
	Q1	Q2	Q3	Q4
P&S - FNP Issued:	276			
Podiatric FNP Issued:	6			

THE TOP VIOLATIONS THAT RESULT IN PHYSICIAN DISCIPLINE

1. Incompetence/Negligence
2. Self-use of drugs/alcohol
3. Inappropriate prescribing
4. Unprofessional conduct
5. Fraud
6. Sexual misconduct
7. Mental Illness
8. Conviction of a crime



	Incompetence/ Negligence	Self-Use of Drugs/Alcohol	Inappropriate Prescribing	Unprofessional Conduct	Fraud	Sexual Misconduct	Mental Illness	Conviction of a Crime
FY 2006/2007	135	37	26	26	9	23	20	20
FY 2007/2008	154	34	28	16	25	16	20	7
FY 2008/2009	124	32	28	27	19	12	11	7

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
October 1, 2009

SPECIALTY	Number of cases reviewed/sent to Experts Jan-Sep 2009	Number of Experts used and how often utilized Jan-Sep 2009	Active List Experts Y-T-D (TOTAL=1,138⇓)
ADDICTION	10	4 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 3 CASES	13
ALLERGY & IMMUNOLOGY (A&I)			10
ANESTHESIOLOGY (Anes)	10	10 LIST EXPERTS	91 ↑
COLON & RECTAL SURGERY (CRS)	4	1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	5
COMPLEMENTARY/ALTERNATIVE MEDICINE	4	1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	14
CORRECTIONAL MEDICINE	7	5 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	16 ↑
DERMATOLOGY (D)	5	3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	13
EMERGENCY (EM)	5	5 LIST EXPERTS REVIEWED 1 CASE	59 ↓
Medical Toxicology (MT)			3
Pediatric Emergency Medicine (PEM)			4
ETHICS	1	LIST EXPERT	3
FAMILY (FM)	40	22 LIST EXPERTS REVIEWED 1 CASE 5 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES*	95 ↑
* 1 case review; 1-hearing preparation/testimony; 3 physical evaluations			
HAND SURGERY			8 ↑
HOSPICE & PALLIATIVE MEDICINE	1	LIST EXPERT	8
INTERNAL (General Internal Med)	46	25 LIST EXPERTS REVIEWED 1 CASE 9 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	219 ↓
Cardiovascular Disease (Cv) [Interventional Cardiology] [Non-Interventional Cardiology]	17 [12] [5]	6 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	33 [18] [22]
Endocrinology, Diabetes and Metabolism (EDM)	4	2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	6 ↓
Gastroenterology (Ge)	3	3 LIST EXPERTS	20
Hematology (Hem)			5
Infectious Disease (Inf)	1	LIST EXPERT	11 ↑

Interventional Cardiology (Intv Cd)	12	9 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	18
Medical Oncology (Onc)	6	3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	14
Nephrology (Nep)			12 ↑
Pulmonary Disease (Pul)	2	2 LIST EXPERTS	22 ↓
Rheumatology (Rhu)	2	1 LIST EXPERT	9
MIDWIFE REVIEWER	1	LIST EXPERT	11
MEDICAL GENETICS (MG)			1
NEUROLOGICAL SURGERY (NS)	8	2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES	16 ↓
NEUROLOGY (N)	7	4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	20
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			5
NUCLEAR MEDICINE (NuM)	1	LIST EXPERT	6
OBSTETRICS & GYNECOLOGY (ObG)	44	19 LIST EXPERTS REVIEWED 1 CASE 5 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 8 CASES*	82 ↓
* Short List of experts in this field and it's hard to find an actively practicing ob/gyn available to perform case reviews			
Gynecologic Oncology (GO)	1	LIST EXPERT	8
Maternal & Fetal Medicine (MF)	1	LIST EXPERT	10
Reproductive Endocrinology/ Infertility (RE)	1	LIST EXPERT	6 ↑
OPHTHALMOLOGY (Oph)	15	5 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES	40
ORAL & MAXILLOFACIAL SURGERY			1
ORTHOPAEDIC SURGERY (OrS)	19	10 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	47
Surgery of the Hand (HS)	1	LIST EXPERT	23
OTOLARYNGOLOGY (Oto)	5	1 LIST EXPERT REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	31
PAIN MEDICINE (PM)	19	7 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES	26 ↓
PATHOLOGY (Path)	2	2 LIST EXPERTS	11

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
(OCTOBER 1, 2009)
Page 3

PEDIATRICS (Ped)	3	3 LIST EXPERTS	61
Neonatal-Perinatal Medicine (NP)			9
Pediatric Cardiology (Cd)	1	LIST EXPERT	5
Pediatric Gastroenterology (Ge)	2	1 LIST EXPERT	4
Pediatric Hematology-Oncology (HO)			5
Pediatric Infectious Diseases (Inf)			3
PHYSICAL MEDICINE & REHABILITATION (PMR)			8 ↓
PLASTIC SURGERY (PIS)	14	5 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	52 ↓
PREVENTIVE MEDICINE (PrM) General Public Health Occupational Aerospace	1	LIST EXPERT	7
Medical Toxicology (MT)			1
Undersea & Hyperbaric Medicine (UM; UHM)			
PSYCHIATRY (Psyc)	70	19 LIST EXPERTS REVIEWED 1 CASE 6 LIST EXPERTS REVIEWED 2 CASES 4 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES* 1 LIST EXPERT REVIEWED 6 CASES** 1 LIST EXPERT REVIEWED 8 CASES***	111 ↑
*3 case reviews; 2 mental evaluations ** 1 case review; 2 hearing preparations/testimony; 3 mental evaluations *** 3 case reviews; 1 supplemental review; 4 mental evaluations			
Addiction Psychiatry (AdP)	3	3 LIST EXPERTS	22
Child & Adolescent Psychiatry (ChAP)	2	1 LIST EXPERT	21
Forensic Psychiatry (FPsy)			58
Geriatric Psychiatry (GPsyc)			22
Pain Medicine (PM)			11
Psychosomatic Medicine (PsychoMed)			12

RADIOLOGY (Rad)			38 ↑
Diagnostic Radiology (Rad DR)	9	5 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	
Radiation Oncology (Rad RO)	1	LIST EXPERT	2
Neuroradiology (NRad)			17
Vascular/Interventional Radiology (VIR)			3
SLEEP MEDICINE (S)	2	2 LIST EXPERTS	8
SPINE SURGERY (SS)			1
SURGERY (S)	19	5 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	56 ↓
Pediatric Surgery (PdS)	2	2 LIST EXPERTS	4
Pediatric Cardiothoracic Surgery			2
Vascular Surgery (VascS)	1	LIST EXPERT	9 ↑
THORACIC SURGERY (TS)	2	2 LIST EXPERTS	20 ↓
(MEDICAL) TOXICOLOGY *[Emergency]* *[Occupational]*			4 [3] [1]
UROLOGY (U)	7	3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 4 CASES	14
WORKERS' COMP/QME/IME	1	LIST EXPERT	22 ↑

/susan (10/1/09)

Medical Board of California

Investigation & Prosecution Timeframes*

	2005	2006		2007		2008		Q1 2009		Q2 2009		Q3 2009	
	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	374	358	402	402	378	374	386	386
Median	252	285	134	304	269	335	324	341	341	336	335	378	378
Record Count	827	703	192	648	539	609	588	153	153	203	202	188	188
Calendar Day Age from Request to Suspension Order Granted													
Average	51	44	4	34	38	19	19	47	28	112	112	15	15
Median	17	3	2	22	23	10	10	2	1	33	33	22	22
Record Count	24	21	11	17	13	21	17	8	7	4	4	3	3
Calendar Day Age from Request to Receipt of Medical Records													
Average	58	53	37	59	57	63	58	60	60	80	80	68	68
Median	32	31	26	31	31	28	28	36	36	41	41	17	17
Record Count	475	376	228	264	259	256	252	43	43	30	30	34	34
Calendar Day Age from Request to Physician Interview Completed													
Average	48	51	43	52	50	63	63	60	60	52	52	49	49
Median	36	42	38	37	36	41	42	40	40	37	37	37	37
Record Count	597	453	172	406	371	473	466	127	127	162	162	155	155
Calendar Day Age from Request to Receipt of Expert Opinion													
Average	51	47	35	51	43	50	50	45	45	44	44	57	57
Median	41	35	31	36	35	39	38	31	31	36	36	36	36
Record Count	519	424	82	344	270	374	359	67	66	105	104	124	124
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed													
Average	556	554	140	543	340	565	493	645	624	638	638	527	527
Median	525	504	120	523	339	541	486	634	575	719	719	488	488
Record Count	187	149	17	198	95	157	131	42	39	45	45	53	53
Calendar Day Age from Accusation Filed to Disciplinary Outcome**													
Average	608	602	85	576	188	561	243	481	345	508	349	441	323
Median	526	466	99	426	182	384	238	326	296	382	313	358	323
Record Count	212	195	3	226	29	203	80	55	39	53	36	53	37

*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	2008	Q1 2009	Q2 2009	Q3 2009
***Citations Issued**	80	81	76	109	39	29	32
Citations Issued for Failure to Produce Records	0	6	3	3	2	0	0
Civil Actions Filed	3	3	1	1	0	0	0
Civil Actions Filed for Failure to Produce Records	2	2	1	1	0	0	0

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

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: September 28, 2009
SUBJECT: Continuing Medical Education (CME) Requirements
STAFF CONTACT: Janie Cordray

RECOMMENDATIONS AND REQUESTED ACTION:

Staff is recommending and asking permission to: 1) establish an advisory committee to study CME; and 2) schedule an afternoon symposium on the subject of continuing medical education with appropriate speakers and participants, including representatives from the Federation of State Medical Boards, on Tuesday, July 27, 2010, preceding the quarterly Board meeting, or Thursday, July 29, 2010, prior to Committee meetings. This Symposium will coincide with DCA's Conference being held that week.

SUMMARY:

The Board has asked staff to study the existing continuing medical education requirements to examine if they are sufficient or useful, and to prepare the subject for study by the Board.

Currently, California physicians are required to complete 50 hours of approved continuing medical education every two years as a condition of their license renewal. The law places the responsibility with the Board to promulgate regulations to establish the specific requirements and approval of coursework.

The current literature on continuing education's usefulness or value to physician's continuing competence is voluminous, and most agree that while CME has some value, many factors affect whether or not it improves physicians' practices. Its value is dependent upon the quality of the curriculum, teacher, and student, as well as relevance to the physician's practice.

At present, the regulations are extremely broad, and grants credit for anything accredited "category 1" by approved providers. There is no requirement for external or self assessment or that coursework be specifically relevant to physicians' skill, experience or specialty.

A number of institutions and organizations have examined the subject and have published a variety of useful reports on the subject. In 2008, The Federation of State Medical Boards convened a committee on the Maintenance of Licensure. (Our Deputy Director, Kimberly Kirchmeyer, served on the committee.) Out of the committee's work, a model policy was developed, and later, the FSMB adopted a policy statement and *Guiding Principles*. While the project and adopted policies do not exclusively deal with CME, it will likely be a component in lifelong learning of physicians.

Staff has been developing a summary issue paper on the subject which will be presented to the members prior to their discussions. It is proposed that an Advisory Committee be set up to study the subject, and hold a symposium prior to the July 2010 Board meeting, inviting participants knowledgeable in continuing education, including the Federation of State Medical Boards. The following elements would be included in the discussions:

- Current California law and regulations, including the authority of the Board to set standards in regulation;
- Other states' laws and regulations;
- Other California health care practitioner licensees' laws and regulations;
- Current literature on the value of continuing medical education and best practices;
- The role of external and self-assessment in improving continuing education and continued competence;
- The Federation's work in Maintenance of Licensure and their *Guiding Principles*;
- The role of financial conflicts of interest in the delivery of continuing medical education, and;
- The role of specialty board certification and re-certification in continuing medical education requirements and ensuring continued competence.

CONCLUSION:

The subject of continuing medical education is extremely broad, and expertise outside of the Medical Board is abundant. It would be helpful for the members to participate in a discussion with experts to determine the avenue the Board should take in tackling such a vast subject. Board members may be attending the DCA Conference in Sacramento on July 28, and therefore it would be cost effective for the Board and convenient for the advisory committee to hold a 3-hour symposium coinciding with the DCA event and Board meetings. This symposium would serve as a foundation for future Board work to determine if current requirements are sufficient, and whether or not future regulations should be promulgated.

FISCAL CONSIDERATIONS:

Holding the symposium to coincide with the DCA Conference and Board meetings is cost effective, as well as being most convenient for members.

PREVIOUS MBC AND/OR COMMITTEE ACTION:

In the past, the Board, through its former Division of Licensing, has promulgated regulations to establish the hours and content of physicians' continuing medical education requirements for license renewal. In recent meetings of the Medical Board, members have expressed their desire to explore the usefulness and value of current CME requirements.

2008

Medical Board of California

Strategic Plan 2008

Barb Johnston
Annual Report
October 2009

MEDICAL BOARD OF CALIFORNIA

STRATEGIC PLAN

Developed and Approved 1/2008 *By Board Members listed below*	***Update Presented 10/2009*** *To Board Members listed below*
Richard D. Fantozzi, M.D., President **Steve Alexander** **Cesar Aristeiguieta, M.D.** **Hedy Chang** **John Chin, M.D.** **Shelton Duruisseau, Ph.D.** **Gary Gitnick, M.D.** **Reginald Low, M.D.** **Mary Lynn Moran, M.D.** **Janet Salomonson, M.D.** **Gerrie Schipske, R.N.P., J.D.** **Ronald H. Wender, M.D.** **Barbara Yaroslavsky** **Frank V. Zerunyan, J.D.** ..... **Barb Johnston, Executive Director**	**Barbara Yaroslavsky, President** **Jorge Carreon, M.D.** **Hedy Chang** **John Chin, M.D.** **Shelton Duruisseau, Ph.D.** **Gary Gitnick, M.D.** **Sharon Levine, M.D.** **Reginald Low, M.D.** **Mary Lynn Moran, M.D.** **Janet Salomonson, M.D.** **Gerrie Schipske, R.N.P., J.D.** **Frank V. Zerunyan, J.D.** ..... **Barb Johnston, Executive Director**

Protecting the Public
Promoting Wellness

INTRODUCTION

The Medical Board of California (Board) is mandated to make public protection its first priority. This mandate is articulated in Business and Professions Code Section 2001.1, which states:

> ***Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions.***

While the mandated functions of the Board generally fall into two categories, licensing and discipline, there are other, more broadly defined issues relating to healthcare that impact the protection of the public. Acknowledging that California's healthcare landscape is ever changing, that the current environment of healthcare delivery is under great strain, and that the business of medicine may contribute to preventing access to healthcare or promote substandard care, this plan addresses issues beyond the simple issuing of licenses and rendering of disciplinary actions.

MISSION

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

Item	Progress	Status
Strategic Plan 2008	Strategic plan *drafted* by Board was further developed to assure the Board's goals and objectives were clearly defined. Developed the strategic plan's work plan and identified specific and measureable goals and objectives. The new strategic plan and work plan were approved by the Board January 2008.	**Completed**
Goal 1: Professional Qualifications Promote the professional qualifications of medical practitioners by setting requirements for education, experience, and examinations, taking into account the state's need for more physicians, particularly in underserved populations; and promoting physician wellness.		
Objective 1.1 ▪ Assure greater compliance of CME requirements. *Measure:* Improve compliance with CME requirements **Plan:** 1. Change regulations to define the requirements and timeframes **February 1, 2008** **Hearing adoption October 2008** 2. Enhance auditing process **Begin Fiscal Year 2008/2009** 3. Review and enhance Cite & Fine process **Begin Fiscal Year 2008/2009** **Measure:** **20% reduction in citations issued by the Medical Board by Fiscal Year 2010-2011** **Staff:** Licensing Staff	1. Completed spring 2009. 2. Pending regulatory process approval. Anticipated completion by end of 2009. 3. Pending completion of the next audit.	**Completed** Pending Pending
Objective 1.2 ▪ Develop a plan for addressing access to care and the shortage of doctors that is appropriate to the Board's Mission and resources. *Measure:* Determine impact of the Board's plan to address access to healthcare. **Plan:**		

Item	Progress	Status
1. Establish an Access to Care Committee to make recommendations to enhance/impact on workforce shortages. **July 2007 to meet up to quarterly**	1. Access to care committee has been established.	**Completed**
2. Implementation of AB 329 to plan a telemedicine/health information technology pilot project to impact access to healthcare **January 2008 to 2010**	2. Hired and have been training Telemedicine Program Manager. Telemedicine Pilot Program in partnership with UCD Medical Center implemented July 2009. Study for Malpractice Insurance completed.	**Completed**
3. Review scope of practice issues that may impact workforce shortages **January 2008 to 2010**	3. To be discussed in committee as issues arise.	Ongoing
4. Provide funding to the Health Professions Education Foundation for the Stephen M. Thompson Loan Repayment Program to increase the number of physicians working in underserved areas. **Fiscal Year 2008-2009**	4. In 2008 Board approved $500,000 for HPEF but the Governor vetoed the bill. Board supported legislation that became effective January 2009 requiring a surcharge for licensees to provide permanent funding for HPEF for the physician loan repayment.	**Completed**
Measure: Submit report to Legislature on outcome of Telemedicine Pilot Program at the end of two-year pilot. Increased number of physicians in underserved areas as a result of repayment funding. **Staff:** Access to Care Committee		

Objective 1.3 ▪ Create a plan to assist in addressing medical errors as appropriate to the Board's Mission and resources. *Measure:* Development of an educational program to inform medical students and physicians of medical errors and consequences with a recommendation of this as curriculum or CME. **Plan:**		
1. Establish a Medical Errors Committee to study how to reduce medical errors by physicians. **Summer 2007**	1. Medical errors committee completed its work by developing materials on medical errors which are available on the Board's website.	**Completed**
2. Develop or link to educational programs regarding medical errors and their consequences and make available on Medical Board's Web Site. **2008-2010**	2. Completed.	**Completed**
3. Evaluate the feasibility of the Medical Board developing this as a CME course. **2008-2010** **Measure:** **Educational program/link on medical errors is available on Medical Board Web Site.** **Staff:** Medical Error Committee	3. Committee has learned that other organizations are focused on Medical Errors and decided not to replicate.	**Completed**
Objective 1.4 ▪ Develop an on-line educational program on cultural and linguistic competency. *Measure:* Determine the number of physicians using this program to enhance their skills and satisfaction with the course. **Plan:**		
1. Establish a Cultural and Linguistic Committee to inform physicians of the various requirements related to this issue.	1. Committee was developed and has had presentations on Cultural and Linguistic issues.	Completed

Summer 2006 2. Develop and/or link to educational programs. **2008-2010** 3. Link to resources and information related to the broader issue of cultural and language issues as relates to medical practice. **2008-2010** **Measure:** **Cultural and Linguistic Educational program/link is available on Medical Board Web Site.** **Track the number of participants accessing the educational program.** **Staff:** Cultural and Linguistic Committee	2. Educational programs to be defined. 3. The Committee will determine what information needs to be posted on the web page.	In progress In progress
Objective 1.5 ▪ Ensure that qualified internationally trained physicians are allowed to obtain license exemption under Business and Professions Code sections 2111, 2113, and 2168 through the work of the Special Programs Review Committee. *Measure:* Site audits indicate these physicians are compliant with regulation and a decrease of complaints on this group. **Plan:** 1. Review and establish procedures for licensing staff to assure the Medical Board is providing adequate education and technical support on an ongoing basis to organizations and participants interested in utilizing these programs. **July 2007 and ongoing**	1. Chief of Licensing developed the first policy and procedure manual for licensing in 2008/2009. Staff held a training session on special programs for the medical schools to educate/ answer questions on the program. Staff working on regulations revision to all special programs sections.	In Progress

2. Conduct site visits to assure compliance with requirements of these special programs. **July 2008 and ongoing** **Measure:** **There will be 100% compliance with requirements for all special program participants.** **Participants in these programs report high levels of satisfaction with these programs.** **Staff:** Licensing	2. Site visits to be scheduled as required. Site visit protocols are being developed.	In Progress
Objective 1.6 ▪ Ensure international medical schools meet the Board's requirements for recognition. *Measure:* Site inspections indicate compliance. **Plan:** 1. Review established procedures within licensing to assure the Medical Board is providing adequate technical support and evaluation. **July 2007 and ongoing** 2. Conduct site visits as appropriate to assure compliance. **July 2007 and ongoing** **Measure:** **There will be 100% compliance for these programs.** **Staff:** Licensing	1. Amended regulations regarding the international medical schools are pending regulatory process approval to be completed by the end of 2009. 2. Once regulations are completed, staff will be conducting re-evaluation of schools and site visits as required. New school site visits will be conducted as needed.	Pending In progress

Objective 1.7 ▪ Promote physician wellness by providing an on-line educational programs and links to other resources. *Measure:* Determine the number of physicians using these resources. **Plan:** 1. Develop resources related to physician wellness and make available in various forms that may include Web site, newsletter articles and/or in person meetings. **July 2007 and ongoing** **Measure:** **Track the number of participants who access information provided on the Medical Board Web site.** **Staff:** Wellness Committee	1. Articles on Wellness have been published in the newsletter. The board's Wellness bill was vetoed by the Governor. Staff has developed a webpage on Wellness with related articles and appropriate links. Staff is coordinating Wellness presentations for all medical school students and other interested parties. Wellness committee discussing development of the online education tool.	Ongoing
Goal 2: Regulation and Enforcement Protect the public by effectively enforcing laws and standards to deter violations.		
Objective 2.1 ▪ Submit vertical enforcement report to the Legislature by December 2007 and implement the vertical enforcement model long term. *Measure:* Report submitted and vertical enforcement model fully integrated including implementation of fully interoperable information technology software used by the Department of Justice. **Plan:** 1. Develop and submit vertical enforcement report to the Legislature. **November 2007** 2. Implement the vertical enforcement model long	1. Report was submitted November 2007 and July 2009. 2. VE has been fully implemented. VE Pilot program has been	**Completed** **Completed**

term. **2008 and ongoing** 3. Submit a feasibility study report and budget change proposal to authorize purchase and implementation of fully interoperable information technology software used by Department of Justice. **2008 and ongoing** **Measure:** **Vertical Enforcement Report submitted.** **Vertical Enforcement model implemented.** **Purchase of new computer system authorized.** **Staff:** Enforcement/Information Technology	extended until 2013 by legislation. 3. The feasibility study report was approved winter 2008. The budget change proposal requesting funding and staff to implement this IT enhancement was deemed premature in 2008 and has been resubmitted in 2009 for approval in budget year 10/11.	Pending

Objective 2.2 ▪ Evaluation of peer review study and address the issues identified. *Measure:* Study is completed and recommendations are provided to the Board for review and possible action. **Plan:** 1. Report by contracted vendor pursuant to Business and Professions Code section 805.2 submitted to the Legislature. **July 2008** 2. Review the report and seek action as appropriate to implement recommendations. **July 2008 through 2009** **Measure:** **Peer review study completed and recommendations presented to the board for possible action.** **Staff:** Executive	1. Report was completed and submitted to the Legislature July 2008. 2. Senate B&P held a hearing in 2009 on the report and its recommendations. Legislation has been introduced in 2009 session.	**Completed** Pending
Objective 2.3 ▪ Re-establish the Board's Operation Safe Medicine Unit to target unlicensed activity, corporate practice of medicine, and lack of supervision violations. *Measure*: Track the number of complaints and outcomes to this unit. **Plan:** 1. Develop budget change proposal to authorize appropriate funding and staffing to re-establish program. **Spring 2008** 2. Re-establish operation safe medicine. **July 2008 through 2009 and ongoing** **Measure:** **Identify, track, and reduce unlicensed activity.** **Staff:** Enforcement	1. The BCP for staffing was approved for fiscal year 09/10 with staff extension and funding to be requested for fiscal year 11/12. 2. OSM reestablished July 2009.	**Completed/ In progress** **Completed**

Objective 2.4 ▪ Restructure the Board's Probation Unit to transfer the monitoring of probations from investigators to inspectors. The investigators will be reassigned to the District Offices to decrease the length of time for investigations. *Measure*: A decrease in the length of time to conduct investigations. **Plan:** 1. Re-classify investigator assistant positions to inspector positions **Fall 2007** 2. Hire new manager and supervisors. **Fall 2007 through January 2008** 3. Transition probation investigators to district office positions. **Fall 2007 through Spring 2008** 4. Draft budget change proposal for additional inspector positions. **Spring 2008** **Measure:** **Decrease in the investigators workload and length of time to conduct investigations.** **Staff:** Enforcement	1. Re-classification done Spring 2008. 2. New manager and supervisors employed, trained and in place in 08/09. 3. Probation investigators transitioned to district office positions in 08/09. 4. The BCP for staffing was approved for fiscal year 09/10 and ongoing with the funding to be absorbed.	**Completed** **Completed** **Completed** **Completed**

Goal 3: Consumer Education Increase public awareness of the Board's Mission, activities and services.		
Objective 3.1 ▪ Complete a study of the public disclosure laws and take actions necessary to address issues identified. *Measure:* Study completed and any actions necessary have been identified. **Plan:** 1. Receive the public information study from the California Research Bureau as mandated by the legislature. **July 2008** 2. Review the report and seek action as appropriate to implement recommendations. **July 2008 through 2009** **Measure:** **Study completed and recommendations presented to the board for possible action.** **Staff:** Public Information Officer	1. Final report on Public Disclosure presented to the board at the January 2009 Board meeting. 2. Updated 805 summaries on the website.	**Completed** **Completed**
Objective 3.2 ▪ Recognition of excellence in medicine by California physicians *Measure:* Ensure annual award of recognition given to recipient. **Plan:** 1. Solicit and review nominations for the board's physician humanitarian award. **August to December Annually** 2. The Physician Recognition Committee will select awardee. **December Annually**	1. Nomination sought and reviewed annually. 2. Selection is done by committee.	Ongoing Ongoing

Measure: **Board presents award to recipient at a board meeting.** **Staff:** Public Information Officer		
Objective 3.3 ▪ Improve education about the Board and its services to consumers including obtaining information on physicians. *Measure:* High levels of satisfaction reported by consumers who access educational material and other information on the Board's Web site. **Plan:** 1. Increase educational material on the web site. **Ongoing** 2. Represent the Board at professional and public events statewide. **Ongoing** 3. Develop a public service announcement educating the public about the board. **2008 to 2009** 4. Issue news releases and the board's Newsletter. **Ongoing** 5. Contact reporters to develop stories about issues related to the board. **Ongoing** **Measure:** **Consumers who contact the board report high levels of satisfaction with the information provided.** **Staff:** Public Information Officer	1. Educational materials have been added to the website and staff will continue under direction of the Board. 2. Staff represents the Board at multiple meetings throughout the year including at all CA medical schools, the legislature, professions associations and other state agencies. 3. High cost with low benefit/impact was determined. 4. News releases and the newsletter are widely distributed. 5. Public Information Officer is in contact with reporters across the state on a regular basis.	Ongoing Ongoing Canceled Ongoing Ongoing

Goal 4: Organizational Relationships Improve effectiveness of relationships with related organizations to further the Board's Mission and goals.		
Objective 4.1 ▪ Establish a plan to include board members in meetings with legislators and other key stakeholders on various legislative proposals. *Measure:* Increase support of the Board's legislative proposals. **Plan:** 1. Set up meetings with legislative policy and fiscal committee members to discuss annual legislative agenda and issues of mutual concern. **Fall 2007 to Spring 2008** 2. Set up meetings with key stakeholders on issues of mutual concern. **Fall 2007 to Summer 2008** 3. Schedule members to attend legislative policy hearings on legislation sponsored by or pertaining to the board. **2008** **Measure:** **Passage of board-supported legislation.** **Staff:** Chief of Legislation	1. Board members remian actively involved with meetings with staff and the legislature. Board members and staff have testified several times to the legislature on Board bills and issues related to the Board. Executive staff works closely with Board Members to prepare for all meetings. 2. MBC has met with CMA, CAPG, CHA, OSPHD, CDPH, GME Offices, Latino Coalition for a Healthy California, and other relevant stakeholders such as the University of California Office of The President and the Malpractice Insurers. 3. Members have been scheduled to attend these meetings and will continue to do this.	Ongoing Ongoing Ongoing

Objective 4.2 ▪ Develop a plan for Supervising Investigators to meet with legislative staff in district offices. *Measure:* Increased awareness of the Board by legislative district offices. **Plan:** 1. Develop board informational packets for the investigative staff to deliver to legislative district staff. **Fall 2007** 2. Set up meetings with legislative district offices and investigative staff. **Fall 2007 to Summer 2008-Ongoing** **Measure:** **Increased personal contact with legislative district staff.** **Staff:** Chief of Legislation and Supervising Investigators	1. The informational packets were developed. 2. Meetings with legislative district offices and investigative staff to 120 district offices.	**Completed/ Ongoing** **Completed/ Ongoing**
Goal 5: Organizational Effectiveness		

Enhance organizational effectiveness and systems to improve service to constituents.		
Objective 5.1 ▪ Develop better ways of assessing Board "customer satisfaction" and implement changes that would better serve applicants, licensees and the public. *Measure:* High levels of satisfaction reported by customers who receive services or who access information on the Board's Web site. **Plan:**		
1. Develop an online system to allow potential licensees to access the status of their application. **2008 to 2009**	1. Online system under development to be completed January 2010.	In progress
2. Establish a centralized 800-line for all consumer, applicant, and licensee inquiries to the board with customer support staff. **Spring 2008**	2. The centralized call number was developed and a consumer focused Call center was implemented December 2008.	**Completed**
3. Medical Board's new headquarters will have one central public reception area to better serve physicians, applicants, the public, and other visitors. **Spring 2008**	3. Moved to new headquarters in March 2008 and central reception provided.	**Completed**
Measure: **Decrease number of complaints regarding the board's processes and accessibility.** **Staff:** All Staff		

Objective 5.2 ▪ Reverse loss of investigators by addressing imbalances that are contributing to investigator retention problem. Perform a study to determine the difference in work performed and pay between Board investigators and investigators from other State boards/agencies. *Measure:* Improve retention of Board investigators. **Plan:** 1. Hire a vendor to perform an analysis of investigator classifications statewide to determine correct classification and pay for board investigators. Summer **2008 to 2009** 2. Take appropriate action based upon study results. **2009** **Measure:** Investigative staff retention improves **Staff: Chief of Enforcement**	1. CPS awarded contract and provided initial report of analysis of investigator classifications in summer 2009. Additional work required on report due winter 2009. 2. Awaiting results of study.	Pending Pending
Objective 5.3 ▪ Implement the restructuring of the Board to ensure greater communication and synergy between enforcement and licensing divisions of the Board. *Measure:* Implementation is completed and all board members are educated regarding all Board issues. **Plan:** 1. Develop implementation plan of the board restructuring. **December 2007** 2. Implement plan and provide training to all board members on both licensing	1. Board was restructured to operate as one unified Board January 2008. 2. Training sessions have begun and will continue to be developed. Staff continues to work with the	**Completed** Ongoing

and enforcement programs. **2008** **Measure:** Training provided to all board members. **Staff:** All Staff	Attorney General's office to provide training identified by Members as the highest priority.	
Objective 5.4 ▪ Perform a complete evaluation of the Licensing Program to identify areas for improvement. *Measure:* Evaluation completed and any recommendations for efficiency are implemented. **Plan:** 1. Initiate the evaluation process. August **2008** 2. Conduct review and analysis. August 2008 to September 2009 3. Complete report and review recommendations for possible action. **Measure:** **Project completed and opportunities for efficiency identified.** **Staff:** Licensing Staff	1. The Board contracted with an independent entity to perform this evaluation. The contractor began August 2009. Report to be provided to Board in Jan 2010. 2. Initial staff analysis led to development of the first licensing policy and procedure manual in 08/09. This manual will require updating after independent review and report completed. 3. Determine appropriate implementation after report received.	In Progress In Progress N/A

Objective 5.5 ▪ Coordinate relocation of the Board's headquarters facilities and staff to improve operational efficiencies and to improve customer service. *Measure:* Consumers, staff and other interested parties have improved access to the Board's services. **Plan:** 1. Develop a space plan to optimize workflow. **August 2007** 2. Reorganize record storage and retention systems by moving to online environments and eliminating wasted space. **August 2007 and on going** 3. Establish one central public counter and call center with a toll-free number. **March 2008** **Measure:** **Increased accessibility to board services and records.** **Staff reports fewer complaints regarding accessibility from public.** **Staff:** All Staff	1. Space plan developed, approved and implemented at new facility. 2. Record storage has been reorganized to eliminate wasted space. 3. Established public counter in March 2008 and call center in December 2008.	**Completed** **Completed** **Completed**
Objective 5.6 ▪ Develop consumer and licensee focused educational programs made available online from the Board's Web site to provide easy access statewide. *Measure:* Determine the number of individuals using these services and satisfaction with the courses.		

Plan: 1. Develop online educational programs for multiple topics including but not limited to filing applications and complaints, training, and/or mandatory reporting. **Spring 2008 and on going** **Measure:** **Determine the number of individuals using these services and satisfaction with the courses.** **Staff:** All Staff	1. Project could not begin until move into headquarters completed due to telecommunication requirements. Draft of Licensing program content has been developed by staff. Submitted extensive plan for the purchase and implementation of a Videoconferencing system to run online content submitted February 2009. Due to Executive Order, the purchase order was denied by DCA. Will resubmit when funding is available – fiscal year 10/11.	In Progress
Objective 5.7 ▪ Improve organizational business processes through replacement of current information technology systems with state of the art user-friendly fully interoperable information technology software. *Measure:* When fully implemented staff reports significant improvement in business processes. **Plan:** 1. Evaluate existing business processes to determine those systems that could be improved by upgrading information technology (IT) environment. **Spring 2008 and on going** 2. Purchase and implement expanded and upgraded IT system to support a more efficient business environment. **Measure:** **Increased productivity, morale, and efficiency.** **Staff reports improved access to medical board information.** Staff: Executive and Information Technology Staff	1. Evaluation was completed in partnership with AGs office in Spring 2008 to assure technology could become interoperable with AGs system due to Enforcement program's VE model. 2. The feasibility study report was approved winter 2008. The budget change proposal requesting funding and staff to implement this IT enhancement was deemed premature in 2008 and has been resubmitted in 2009 for approval in budget year 10/11. Staff has continued to meet with the State CIO, Agency and DCA leadership to discuss this project.	**Completed** In Progress
Conclusion:		

This plan seeks improve the efficiency and effectiveness of the Board to assure protection of the public and provide better service to licensees and consumers. This Board is also committed to making wellness of physicians a priority for the Medical Board of California.

Major events and accomplishments during 2007 to 2008 include:

1. All Quarterly Board meetings and all related materials were organized and held on schedule.

2. Move of headquarters including 165 staff, equipment, telecommunications systems, confidential and sensitive documents to the new location required enormous planning, efforts and collaboration across all program areas and was achieved despite multiple challenges.

3. Diversion Summit January 2008; transition plan developed and implemented November 2007 to June 2008. Board President, Executive Director, and Deputy Director have presented at multiple professional organizations to explain the transition plan and end of diversion leading to need to promote a Wellness concept.

4. The Newsletters have been published and provided to all licensees and other interested parties with an unprecedented positive response to the articles this past year.

5. The Board's legislative staff organized materials for enforcement staff to get information out to the legislature in 120 regional offices across the state this past year. The goal was to inform the legislature about the Medical Board per request of the Board Members.

6. The website was completely redesigned to be in compliance with new requirements from the Governor. The website averages over 600,000 hits per month. We have continued to add more educational content on the website per recommendation of the Education committee.

7. Cooperated with the evaluation of the Enforcement Program by the Governor's office, which led to conclusion that MBC's VE program is sufficiently meeting public protection.

8. Improved relationships with AG office by establishing new and more mutually supportive relationship through regular meetings. Collaborated with the AG's senior staff to develop the first joint vertical enforcement (VE) operations manual to promote improved efficiencies and effectiveness of the program.

9. Wellness concept developed by the Board is becoming accepted as a strategy to promote healthy lifestyles and support careers of California physicians but even more importantly to promote public protection.

10. Cooperated with the evaluation of the licensing process by Agency. Staff organized several case files and presented to agency staff who were interested in the timelines and process to obtain licensure for applicants.

11. Vacancy rate estimated to be over 30% in Enforcement alone minimized to fewer than 7% through proactive recruitment and training efforts.

12. Executive Director invited to and continues to serve on Department of Public Health's Crisis Care Task Force. The main goal of this task force is to establish standards and guidelines for physicians and health facilities to transition to population based health in the event of a catastrophic event.

13. Implemented and followed all requirements of the Governor's Executive Order, which affected all aspects and functions of the Board.

14. FY 07/08 Annual Report attached.

Major events and accomplishments during 2008 to 2009 include:

1. All Quarterly Board meetings and all related materials were organized and held on schedule.

2. Telemedicine Pilot Program implemented.

3. The Newsletters have been published and provided to all licensees and other interested parties with an unprecedented positive response to the articles this past year.

4. Board determined to educate consumers on the existence and mission of the Board through requiring physicians to provide information to consumers that they are licensed and regulated by the Board.

5. Attorney General's Office has provided training sessions at several Board meetings on a variety of topics.

6. Board participated in a Senate Business and Professions Committee hearing on its enforcement model August 2009.

7. Board staff has participated in DCA's Health Roundtable summer 2009.

8. Board staff has been and continues to participate in DCA's SB1441 committee on substance abusing licensees.

9. Board staff has met with all HQES offices throughout the State to provide an update on legislation and other issues related to the enforcement program.

10. Board staff has been involved with meetings regarding ePrescribing coordinated by the California HealthCare Foundation and in partnership with the Department of Health and Human Services Deputy Director of Health Information Technology for the State of California.

11. Developed and expanded the physician profiles on the Board's website to include information self reported by the physicians on their license renewal survey.

12. Executive Director appointed by FSMB to its Executive Advisory Council and has been working with the FSMB on issues including Telemedicine, license portability, and their universal application.

13. Board members are representing California on the FSMB with one member serving as a Board member of FSMB, one member on the Nominating Committee, and one member on the Education Committee.

14. The Director of Consumer Affairs and Agency have been providing leadership for the development of a new Enforcement model for all healing art Boards. MBC staff have been actively involved with this process. MBC procedures have been provided to assist in this process.