State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

April 29-30, 2010

Panel A	April 29	8:00 a.m. - 10:00 a.m.
Panel B	April 29	8:00 a.m. - 10:00 a.m.
Enforcement Committee	April 29	10:00 a.m. - 10:45 a.m.
Application Review Committee	April 29	10:45 a.m. - 11:00 a.m.
Presentation to Full Board	April 29	11:00 a.m. - 12:00 p.m.
Lunch	April 29	12:00 p.m. - 12:30 p.m.
Licensing Committee	April 29	12:30 p.m. - 2:15 p.m.
Advisory Committee on Physician Responsibility in Supervision	April 29	2:15 p.m. - 3:30 p.m.
Executive Committee	April 29	3:30 p.m. - 4:00 p.m.
Full Board	April 29	4:00 p.m. - 5:30 p.m.
Full Board	April 30	9:00 a.m. - 4:00 p.m.

MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

Sheraton Gateway Los Angeles
6101 West Century Blvd.
Los Angeles, CA 90045

April 29-30, 2010

Thursday, April 29

- **8:00 a.m. – 10:00 a.m.** — **Panel A – Gateway Ballroom**
  (Members: Duruisseau, Salomonson, Carreon, Chin, Yaroslavsky, Zerunyan)
- **8:00 a.m. – 10:00 a.m.** — **Panel B – Grand Ballroom**
  (Members: Chang, Moran, Levine, Low, Schipske)
- **10:00 a.m. – 10:45 a.m.** — **Enforcement Committee – Gateway Ballroom**
  (Members: Low, Chin, Levine, Schipske)
- **10:45 a.m. – 11:00 a.m.** — **Application Review Committee – Gateway Ballroom**
  (Gitnick, Low, Schipske)
- **11:00 a.m. – 12:00 p.m.** — **Lunch Presentation – Gateway Ballroom**
  (All Members)
- **12:00 p.m. – 12:30 p.m.** — **Lunch**
- **12:30 p.m. – 2:15 p.m.** — **Licensing Committee - Gateway Ballroom**
  (Members: Salomonson, Carreon, Chang, Gitnick, Low, Schipske, Levine)
- **2:15 p.m. – 3:30 p.m.** — **Advisory Committee on Physician Responsibility in the Supervision of Affiliated Health Care Professionals – Gateway Ballroom**
  (Members: Moran, Bruner, Grivett, Kilmer, Narurkar, Newman, Phinney, Robbins, Salomonson, Schipske)
- **3:30 p.m. – 4:00 p.m.** — **Executive Committee – Gateway Ballroom**
  (Members: Yaroslavsky, Chang, Gitnick, Salomonson, Zerunyan)
- **4:00 p.m. – 5:30 p.m.** — **Full Board – Gateway Ballroom**
  (All Members)

Friday, April 30

- **9:00 a.m. – 4:00 p.m.** — **Full Board Meeting – Gateway Ballroom**
  (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

April 29-30, 2010

Sheraton Gateway Los Angeles
Gateway Ballroom
6101 West Century Blvd.
Los Angeles, CA 90045
310-642-1111

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

AGENDA

Thursday, April 29, 2010
4:00 p.m. – 5:30 p.m.
(or upon conclusion of the Executive Committee)

Friday, April 30, 2010
9:00 a.m. – 4:00 p.m.

ORDER OF ITEMS IS SUBJECT TO CHANGE

Thursday, April 29, 2010, 4:00 p.m. or upon conclusion of Executive Committee

1. Call to Order / Roll Call

2. Public Comment on Items not on the Agenda
Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125, 11125.7(a)]

3. Approval of Minutes from the January 28-29, 2010 meeting

4. Executive Committee Report and Consideration of Committee Recommendations on Filling Executive Director Position
   A. Consideration of Appointment of Executive Director, if Necessary--Closed Session pursuant to Govt. Code Section 11126(a)

5. Presentation on Medical Marijuana – Ms. Zack-Simon and Mr. Mercer

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. Licensing Committee Update and Consideration of Committee Recommendations – Dr. Salomonson

7. Physician Responsibility in the Supervision of Affiliated Health Care Professionals Advisory Committee Update and Consideration of Committee Recommendations – Dr. Moran

8. Wellness Committee Update – Dr. Duruisseau

9. Adjournment

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Friday, April 30, 2010, 9:00 a.m. or upon conclusion of the Application Review Committee

10. Call to Order / Roll Call

11. 9:00 a.m. REGULATIONS – PUBLIC HEARING – Ms. Pellegrini and Ms. Scuri
Acceptable Written Examinations Regulations: (CCR, Title 16, Section 1328). This proposal amends the combination of written examinations that satisfy the statutory obligations for the Board to issue a physician's and surgeon's certificate.

12. Public Comment on Items not on the Agenda
Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125, 11125.7(a)]

13. Board Member Communications with Interested Parties – Ms. Yaroslavsky

14. President's Report - Ms. Yaroslavsky
    A. Appointment to Special Faculty Permit Review Committee effective (date)
    B. Appointment to Wellness Committee

15. Federation of State Medical Boards Update - Ms. Chang and Ms. Yaroslavsky

16. Executive Director's Report – Ms. Whitney
    A. Budget Overview
    B. Staffing Update
    C. Strategic Plan: Consideration of 2011 Update
    D. Board Meeting Dates and Locations
    E. Board Evaluation Update
    F. Bureau of State Audits Evaluation

17. Legislation – Ms. Whitney
    A. Status of Regulatory Action – Mr. Schunke
    B. 2010 Legislation
        1. MBC Bills: AB 1767, SB 1031, SB 1489
        2. DCA CPEI – SB 1111
        3. Other Legislation

18. Licensing Outreach Report – Mr. Schunke

19. Licensing Chief's Report – Ms. Pellegrini
    A. Licensing Program Update
    B. Midwifery Advisory Council Update and Consideration of Council Recommendations– Ms. Ehrlich

20. Approval of Maternidad La Luz Midwifery Challenge Program Modification – Ms. Pellegrini

21. Approval of Proposed Resolution of Written Examination Passing Scores – Ms. Scuri and Mr. Heppler

22. Update on Special Task Force on International Medical School Recognition – Dr. Low

23. Proposed Amendments to Regulations for SB 1441 – Ms. Whitney and Ms. Kirchmeyer

24. Enforcement Committee Update and Consideration of Committee Recommendations – Dr. Low

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

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

27. Physician Assistant Committee Update – Dr. Low

28. Department of Consumer Affairs Update – Ms. Kirchmeyer
    A. Board Member Training
    B. DCA Strategic Plan –Ms. Augustine

29. Agenda Items for July 29-30, 2010 Meeting in Sacramento, CA

30. Adjournment

IMMIGRANT DOCS FOR IMMIGRANT PATIENTS

An Innovative Bi-National approach to Increase the Number of Hispanic Family Physicians in California

Department of Family Medicine
David Geffen School of Medicine at UCLA
University of California, Los Angeles

Summary Points
April 2010

1. California faces a shortfall of **17,000** physicians by 2015; it has been predicted that US faces of shortfall of up to 150,000 by 2020 including some 40,000 primary care physicians, primarily for adults..

2. With a population of over 14.35 million, **Hispanics** represent **37%** of California's 36.9 million people; however only **4.2%** of the 92,000 practicing physicians in the state are Hispanics. The Institute of Medicine has documented large and significant disparities in health care received by minority populations and noted that a direct link exists between poorer health outcomes and the lack of underrepresented minority physicians. Much of this is directly related to **linguistic and cultural barriers** to care. According to the US Census, there are 6.5 million Californians with limited English proficiency (LEP) which means they cannot speak , write or read English. Of this number 4.45 million (76%) are mono-lingual Spanish speaking.

3. One of every four **(25%)** of the 830,000 practicing physicians in the U.S.(>200,000) is a international medical graduate **(IMG)**, defined as a graduate of a medical school outside of the U.S., Canada or Puerto Rico (These schools are all accredited by Liaison Commission for Medical Education) Approximately 24% of the 82,000 physicians in California are IMGs.

4. California has 10 total medical schools—8 allopathic and 2 osteopathic-- of which 5 are University of California schools. The 10 schools graduate approximately 1320 physicians a year of which approximately 110-15 or 8.5-9.0% **are Hispanic**.

5. The U.S. has 25,000 first year Graduate Medical Education (GME) training positions and a total of 102,000 graduate medical education **(GME)** residency positions in teaching hospitals. These are hospital training positions (interns and residents) for graduates of medical schools. They are referred to as 'residency

training programs' and are of 3-7 years in duration. They are necessary to refine, increase and improve clinical skills to qualify for medical licensure and to sit for specialty board certification.

6. Each year there are approximately 19,500 graduates of U.S. medical schools who compete in a national "MATCH" process for one of the 25,000 first year **GME** positions. Because the nation has more GME positions than U.S. medical school graduates approximately 5,500 IMGs or 25 % of the total, enter residency training in the US every year. Last year more than 14,000 IMGs applied for these 5,500 training spots. Up to 98% of the 5,500 international physicians who complete residency training yearly stay on to practice in the US. By practicing in an underserved area for 3 years these IMGs can obtain a waiver for a permanent visa.

7. To be eligible for a GME position in the US, an IMG must pass the same licensing board exams as US Medical school graduates which includes Step 1 of the US Medical Licensing Exam (USMLE) which tests for basic sciences and Step 2 USMLE which includes two distinct tests--Clinical Knowledge and Clinical Skills.

8. Hispanics represent the largest minority population in the US comprising 15.4% of the 304 million Americans (2008) More than 38 million people residing in the US are foreign born; of that number over 51% are Hispanics, with approximately 2/3rds from Mexico. In spite of this **not 1 of the 10 top countries of citizenship** of the more than 200, 000 IMG physicians practicing in this country or of the 26,000 IMGs currently in GME residency training positions in the US is a Latin American country. The top countries of origin include India, Pakistan, Philippines, China and Russia.

9. Mexico graduates approximately **12,000 physicians a year but has only 4,500 GME positions for residency training**. As such, the majority of Mexican medical graduates do not obtain any residency training other than an internship which is part of the 6 year medical school curriculum. This relative shortage of residency training positions is true for most nations with the exception of the US, Canada, England among others. There are approximately 175, 000 MDs in Mexico. Many cannot find work in medicine.

10. Between **400 and 2,500 unlicensed Hispanic physicians (IMGs) legally reside and work in Southern California**. Since they lack a license they cannot practice here. Many work in a variety of health roles such as ultrasound technician, health educator, interpreter; a few have been re-trained as nurses (RNs).

11. The UCLA Department of Family Medicine developed a program of up to 16-18 months duration to assist promising bilingual unlicensed Hispanic IMGs who legally reside in California to pass steps 1 and 2 of the USMLE and be competitive for 3 year residency training position in one of the 30+ Family Medicine residency training programs in California. **Upon completion of their**

training they will be required to practice in an underserved community in the state for up to 3 years. The program includes the Kaplan review course for Step 1 and clinical review on the wards and clinics of UCLA Family Medicine for the two Step 2 USMLE board tests. This is followed by additional time at UCLA on the wards as observers to insure they understand the culture of US medicine. The program averages 50 hours a week over the 16-18 months, thus the reason stipend. Those who are successful will obtain assistance with the application process. for a residency position via the national process know as the "Match" and most importantly will get a letter of endorsement of their clinical skills from UCLA

12. The program was approved by Gerald S. Levey, MD Dean of the David Geffen School of Medicine at UCLA and the University of California VP for Health Affairs in December 2006 with the proviso that no state funding would be available and that private funding would need to be raised by the Dept. of Family Medicine.

OUTCOMES

13. As of March 2010 the program has placed a total of 19 graduates into Family Medicine residencies; another 11 graduates of the program we be commencing in Family Medicine residency programs in California beginning July 2010. As such we have placed **30** bilingual bicultural Hispanic IMGs in Family Medicine programs, 29 of which are in California.

14. It costs an average US allopathic Medical school at least $280K and 4 years to produce a medical graduate who is eligible for residency training and licensure. This UCLA Program costs approximately $53 K per graduate and takes 16-18 months to prepare Physician's for IMG training. Of this $53 K approximately ½ is for the stipend, Kaplan tuition and other educational resources and learning materials.

15. Upon completion of residency training the **IMG will be required to spend up to 3 years working in an underserved community in the state.** At present the state has over 225 federally designated health professional shortage areas for primary care. Less than 20% of the entire state population resides in underserved areas; for Hispanics it is 32%. There are over 6500 federally designated Health Professional Shortages Areas (HPSAs) for primary care in the country.

16. We view this as an adjunct to vigorous 'pipeline" programs in the state to increase the number of minority students matriculating into medical school. Given the gap between the percent of Hispanics in the state (36%) and the physician workforce (4%), it will take a very long time to address this neeed. This process is further compounded by the 49% drop out rate of Hispanic high school students.

17. **Other facts:** The UCLA IMG program is the only such program in the U.S. One of every ten people born in Mexico alive today currently lives in the U.S (11 million). Based on that alone 10% of the Mexican born physicians, or approximately 17,000, should be practicing in the US. The actual number is a

small fraction of this. The Ministry of Health of Mexico is aware of this unique UCLA program and endorses it. They believe that they have a sufficient supply of physicians and know that many emigrate to the U.S. They are concerned about the lack of access and care for Mexican immigrants in the U.S. and believe that this program could help address that need. They concur with our belief **that the inclusion of well trained immigrant family physicians in the provision of care to immigrants of the same background will enhance compliance, satisfaction, and access while reducing disparities.**

18. To date more than $2 million has been raised from private funds. Leading funding sources included The California Endowment, the UniHealth Foundation, tke Kaiser Permanente Community Benefit Fund and the Molina Family Foundation.

On October 12, 2007 a delegation of 25 people who were attending the 7th annual U.S. - Latin American Bi-national Forum on Health and Migration which was held in Los Angeles came to UCLA to learn of this program. There was very significant interest in the program. One prominent health official from Mexico thought that the Mexican government might be interested in providing some funding. We are not clear how that would work. The world-wide financial crisis put on damper on that for now.

For additional information see web site at;

http://fm.mednet.ucla.edu/IMG/img_program.asp. Or search for "UCLA IMG program"

Thank you

Michelle Anne Bholat MD, MPH
Vice Chair and Executive Program Director UCLA IMG Program
mbholat@mednet.ucla.edu

Patrick T. Dowling MD, MPH
Chair, Dept of Family Medicine
Associate Director of UCLA IMG program
The Kaiser Permanente Professor of Community Medicine
David Geffen School of Medicine at UCLA
10833 Le Conte CHS 50-078
Los Angeles, CA 90095-1683
310 825 8234
pdowling@mednet.ucla.edu
Dated: April 5, 2010

United States Medical Licensing Examinations (USMLE):

- **DO NOT** take any of the USMLE's without first achieving at least three minimum scores of 500 on the National Board of Medical Examination (NBME) practice tests. **Residency programs will receive ALL your USMLE attempts and scores.**

NBME link:http://www.nbme.org/

English as Second Language (ESL):

- Regardless of your English language fluency, we recommend that you enroll in an ESL course. If you are in the LA area, we highly recommend the English for Health Professionals' course tailored to IMGs and taught by UCLA faculty member Darren Kelley,MFA .
Email: dmkny71@yahoo.com

Basic Science Preparatory Course:

- If you are in the LA area, we highly recommend our Pre-Program A course taught by Dr. Luis Cazal. This 14-week basic science review prepares you to effectively study for the USMLE Step 1 examination.
Email: LYCazal@mednet.ucla.edu

Program Core Faculty

David Wallenstein, MD
Assistant Clinical Professor,
UCLA Department of Family Medicine

Ravi Dave, MD
Associate Clinical Professor
UCLA Department of Medicine

Dr. Luis Cazal
Basic Sciences

Darren Kelley, MFA
English for Health Professionals

Sponsors

The program is funded solely by private sources including the Kaiser Community Benefit Foundation, UniHealth Foundation, Molina Family Foundation, The California Endowment and New America Alliance. No state funds are used.

For Additional Information About the Program Visit :

http://fm.mednet.ucla.edu/IMG/about/benefits.asp

Mail Application to:
UCLA Family Health Center
International Medical Graduate Program
c/o Celina Diaz, MPA
1920 Colorado Avenue
Santa Monica, CA 90404
Phone: 310-319-4709 ext 282
Fax: 310-453-5676
Email: ckdiaz@mednet.ucla.edu

UCLA International Medical Graduate Program

A Program for International Medical Graduates (IMGs) from Latin America or Spanish–speaking countries who are interested in obtaining residency training in Family Medicine and a medical license to practice in California.

PROGRAM DIRECTORS

Michelle Anne Bholat, MD, MPH
Co-Founder
Executive Director
Associate Professor and Vice-Chair
UCLA Dept. of Family Medicine

Patrick T. Dowling, MD, MPH
Co-Founder
Associate Director
Professor and Chair
UCLA Dept. of Family Medicine

Key Eligibility Criteria

- **Please see Eligibility Criteria At-A Glance:** http://fm.mednet.ucla.edu/IMG/download/UCLA%20IMGP%20Applicant%20Eligibility%20Grid.xls
- US Citizenship or Permanent Resident or Refugee Status.
  The program CANNOT assist you in obtaining the required immigration visa.
- **F-1 Visa holders MUST possess a Social Security number.** Applications will be reviewed on a case-by-case basis.
- Live in the Los Angeles area if selected as an IMG scholar in Program B or C.
- **Professional FLUENCY** of written and oral English and Spanish languages, bi-cultural competency in U.S. American/ Latin-American cultures.
- Medical school appears on the Medical Board of California website. http://www.medbd.ca.gov/applicant/schools_recognized.html
- Meet all requirements to obtain the Post-Graduate Training Authorization Letter (PTAL) aka the California Letter . Please refer to the following website http://www.medbd.ca.gov/applicant/application_international.pdf

Program Rationale

FACTS: Only 5.2 % of the physician workforce in California is Hispanic compared to 36% of the state's population. Further, almost 35% of California's 13 million Hispanics reside in medically underserved areas (MUAs) compared to 20% of the total population.

SOLUTION: The UCLA Department of Family Medicine has developed an innovative program to address the state's changing demographics and existing shortage of bilingual (English/Spanish) and bicultural physicians.

HOW: This UCLA program provides bilingual English/Spanish IMGs, who are committed to the care of our state's underserved populations, with a comprehensive program to pass the USMLE Step 1, USMLE Step 2 CK, USMLE Step 2 CS and compete for a Family Medicine residency training program position in the state. The program provides educational stipends which help offset the cost of participating in this full-time program.

OBJECTIVE: The UCLA IMG pre-residency training program goal is to increase the number of bilingual and bicultural Hispanic family physicians practicing in California's underserved communities.

CURRICULUM:
It is comprised of three programs and is sequential: A- (Basic Science)
B-(Clinical Science) and C (Clinical Observership). However, point of entry into either Programs B, or C, is contingent on USMLE and English diagnostic examination scores.

Application Process

How to Obtain Application:

Visit the program website at: http://fm.mednet.ucla.edu/img_program.asp to obtain and download an initial application **(you will need your medical school transcripts).**

IMPORTANT: Review Eligibility At-A-Glance **before submitting initial application:** http://fm.mednet.ucla.edu/IMG/download/UCLA%20IMGP%20Applicant%20Eligibility%20Grid.xls

Initial applications will be reviewed by an advisory committee throughout the year. Applicants will be notified if they are selected to complete a secondary application.

Participants Responsibility

Fulfillment of UCLA's IMG Contract and Mission: Agree to apply only to a California Family Medicine residency training program whether rural or urban. All residents receive a salary.

Obligation of Service Months: For IMGs entering Program A and B, the minimum service commitment is 36 months of post-residency employment in a California health care facility and providing services in a designated underserved area. For those IMGs entering Program C, the minimum service commitment is 18-months of post-residency employment in health care facilities serving vulnerable populations. Physicians receive salaries commensurate with other physicians in the health center.

MEDICAL BOARD OF CALIFORNIA
Executive Office

Medical Board of California
Embassy Suites San Francisco Airport
150 Anza Boulevard
Burlingame, CA 94010

January 28-29, 2010

MINUTES

In order to remain consistent with the record, the agenda items presented in these minutes are listed in the order discussed at the January 28-29, 2010 meeting.

Agenda Item 1 Call to Order/ Roll Call
Ms. Yaroslavsky called the meeting of the Medical Board of California (Board) to order on January 28, 2010 at 4:15p.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.
Staff Present:
Brian Ansay, Investigator
Susan Cady, Enforcement Manager
Candis Cohen, Public Information Officer
Janie Cordray, Research Specialist
Abbie French, Telemedicine Manager
Kurt Heppler, Legal Counsel
Teri Hunley, Business Services Manager
Barb Johnston, Executive Director
Ross Locke, Business Services Office

DRAFT

Armando Melendez, Business Services Office
Cindi Oseto, Licensing Special Programs Analyst
Deborah Pellegrini, Chief of Licensing
Regina Rao, Business Services Office
Paulette Romero, Enforcement Manager
Kevin Schunke, Regulation Coordinator
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Susan Thadani, Senior Investigator
Cheryl Thompson, Executive Assistant
Renee Threadgill, Chief of Enforcement
Linda Whitney, Chief of Legislation

Members of the Audience:

Bill Barnaby, Sr., California Society of Anesthesiologists (CSA)
Bill Barnaby, Jr., California Society of Anesthesiologists (CSA)
Yvonne Choong, California Medical Association (CMA)
Jim Conway, Pacific Assistance Group
Betsy Crouch, Center for Public Interest Law (CPIL)
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)
James Hay, M.D., California Medical Association (CMA)
Brett Michelin, California Medical Association (CMA)
Joy Mobley, Member of the Public
Margaret Montgomery, Kaiser Permanente
Gary Nye, M.D., Alameda / Contra Costa Medical Association
Nancy Peverini, Consumer Attorneys of California
Carlos Ramirez, Senior Assistant Attorney General
Greg Santiago, Department of Consumer Affairs (DCA)
Rehan Sheikh, Member of the Public

Agenda Item 2 Telemedicine Presentation: Delivery Methods and Legal Issues

Dr. Marcin, UC Davis, spoke on the use of real time video conferencing for telemedicine. He noted that while 25% of the nation's population lives in rural communities, only 5% of doctors live or work in rural areas. Telemedicine allows clinicians to reach underserved populations that would otherwise have no or limited access to care and reduces disparities in the level of care by linking remote sites to regional medical centers, specialists, and subspecialists.

Dr. Goldyne, private dermatology practitioner in San Francisco, presented on the use of store and forward telemedicine and teledermatology. In teledermatology, referral sites send images of the skin condition, the patient's history and medications in an encrypted email to the specialist. The specialist evaluates the images and the electronic medical record and then emails back a consult providing diagnostic and therapeutic assistance. This consult transcript then becomes part of the patient's medical record. Studies have shown the clinical outcomes of store and forward telemedicine were equivalent to those done via in person visits.

Ms. Orlowski, UC Davis Legal Department, discussed legal implications for telemedicine providers. Telemedicine is defined as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data or education using interactive audio, video, or data communications where a patient is at a site remote from the provider. Telemedicine is *not* a

telephone or facsimile transmission or internet prescribing. California law has very specific restrictions on internet prescribing, stating one may not provide prescription medication to a patient without a prior examination and a medical indication. A telemedicine visit does constitute a proper medical indication; the provision of good medical care does not require a face to face visit. For telemedicine visits, state law requires an informed consent form be completed; the primary care or referring physician with ultimate authority over the patient must obtain this consent. California statutes are also specific that any information that is transmitted as part of the telemedicine consult must be made part of the medical record.

With regard to licensure, Ms. Orlowski noted every state's rules vary for permitting out of state practitioners to provide telemedicine services in their state without a license, ranging from no exception (must be fully licensed in state) to full exception (state license not required). California falls under the "consultative" model which allows out of state practitioners who are duly licensed in their state to provide consultations to patients, but they may not have any ultimate authority over the patient, may not see the patient in California, may not receive calls from patients while in California, and may not give orders. Unless the telemedicine provider obtains a California license, they must act purely as a consultant. The provider must also possess professional liability insurance.

California has a statute recognizing telemedicine as appropriate health care and prohibits health care service plans from requiring a face to face visit with a patient in order to qualify as a reimbursable service under private payer contracts.

Jose Guerrero, Supervising Deputy from the Attorney General's Office (AG), spoke on a recent case brought against an out of state physician for internet prescribing without a good faith medical examination with a patient. He noted that existing laws in the Medical Practices Act and the standard Disciplinary Guidelines must be adhered to in order to protect California consumers.

There was no public comment and Ms. Yaroslavsky adjourned the meeting at 4:35 p.m.

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Agenda Item 3 Call to Order/ Roll Call

Ms. Yaroslavsky called the meeting of the Medical Board of California (Board) to order on January 29, 2010 at 9:10 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.

Staff Present:

Susan Cady, Enforcement Manager
Candis Cohen, Public Information Officer
Janie Cordray, Research Specialist
Kurt Heppler, Legal Counsel
Teri Hunley, Business Services Manager
Barb Johnston, Executive Director
Robin Jones, Midwifery Analyst
Ross Locke, Business Services Office
Armando Melendez, Business Services Office
Kelly Nelson, Legislative Analyst
Cindi Oseto, Licensing Special Programs Analyst
Pat Park, Application Review Analyst
Deborah Pellegrini, Chief of Licensing
Regina Rao, Business Services Office
Paulette Romero, Enforcement Manager
Kevin Schunke, Regulation Coordinator
Dennis Scully, Investigator
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Kathryn Taylor, Licensing Program Manager
Susan Thadani, Senior Investigator
Cheryl Thompson, Executive Assistant
Renee Threadgill, Chief of Enforcement
Linda Whitney, Chief of Legislation

Members of the Audience:

Chloe Angelis, Permanente Medical Group
Leo A. Baca, Beverly Radiology Group
Bill Barnaby, Sr., CSA
Bill Barnaby, Jr., CSA
Richard Bell, M.D., Member of the Public
Richard Boxer, M.D., Member of the Public
Claudia Breglia, California Association of Midwives
Yvonne Choong, CMA
Jim Conway, Pacific Assistance Group
Betsy Crouch, CPIL
Patricia Dailey, M.D., CSA
Karen Ehrlich, Midwifery Advisory Council (MAC)
Julie D'Angelo Fellmeth, CPIL
Janis Fodran –Keeney, Member of the Public
Jauna Foster, Member of the Public
Ben Frank, Benjamin Frank Management Consultants
Faith Gibson, MAC
Kele Griffiths, Johnson & Johnson

DRAFT

Beth Grivett, P.A., California Academy of Physician Assistants (CAPA)
James Hay, M.D., CMA
Marla Hicks, Nizhoni Institute
Kimberly Kirchmeyer, Department of Consumer Affairs (DCA)
Brett Michelin, CMA
Joy Mobley, Member of the Public
Margaret Montgomery, Permanente Medical Group
Gary Nye, M.D., Alameda / Contra Costa Medical Association
Nancy Peverini, Consumer Attorneys of California
Rosielyn Pulmano, Senate Business and Professions (Senate B&P)
Carlos Ramirez, Senior Assistant Attorney General
Paul Riches, DCA
Greg Santiago, DCA
Rehan Sheikh, Member of the Public
Taryn Smith, Senate Office of Research

Agenda Item 5 Approval of Minutes from the October 30, 2009 Meeting
Mr. Zerunyan moved to approve the minutes from the October 30, 2009 meeting; s/Moran; motion carried.

Agenda Item 6 Public Comment on Items Not on the Agenda
No public comment was offered.

Agenda Item 7 Board Member Communications with Interested Parties
No communications were reported by Members.

Agenda Item 8 President's Report
Ms. Yaroslavsky expressed the Board's appreciation to staff for their efforts in eliminating the licensing backlog by the end of December 2009. She also stated she was pleased with the work of the various committees and their collaboration with interested parties to address important issues and achieve mutual goals.

She announced the Executive Director, Barb Johnston, has accepted a job offer in the private sector in the field of telemedicine and extended the Board's best wishes to Ms. Johnston.

Ms. Johnston thanked the Board. Ms. Yaroslavsky presented Ms. Johnston with a plaque in appreciation of her service.

Ms. Yaroslavsky reported she, Ms. Johnston and Ms. Whitney attended a meeting on December 16, 2009 with Paul Phinney, CMA Board Chair, Alfred Gilchrist, CMA CEO, and CMA Staff Brett Michelin and Yvonne Choong to discuss the Board's priorities for the coming year.

Agenda Item 9 Executive Director's Report
Ms. Johnston presented an overview of the budget. She noted that savings and expenditures for the Office of Administrative Hearings have provided sufficient funds to cover the $111,000 in overtime. All staff overtime has been stopped for now and staff has been asked to look for ways to significantly decrease temporary help.

DCA requested Board staff to submit a plan to reflect the Administration's request for an additional 5% salary savings in budget year 2010/11. The budget for next year currently expects a salary savings of $908,000; the Board was required to provide a plan for an additional 5%, or $915,000, for a total of $1.8 million in salary savings in 2010/11. DCA requested that staff submit one plan that did not include the new FTEs for the Enforcement BCP and another plan that does include these positions.

DCA also asked staff to complete a survey that would identify staff and resources required to improve services of the Licensing Program, focusing on what was required to reduce licensing timeframes.

Ms. Johnston reported the staffing vacancy rate was positive, with a 10% vacancy rate in Enforcement and a 4% rate in Licensing.

Dr. Gitnick asked about the level of the Board's current reserves and whether this was within the guidelines established by the Legislature. Ms. Johnston reported the reserve fund balance currently exceeds the guidelines. She noted staff will be reviewing which BCPs need to be submitted this year to fund the positions authorized last year, including six full time positions for the Operation Safe Medicine (OSM) program, 5 positions for Probation, and 7.8 for Licensing. These BCPs, if they go forward, should put the Board in compliance, though this cannot be guaranteed until the next budget report which will reflect additional funds spent on overtime.

Agenda Item 10 Legislation

A. Status of Regulatory Action

Ms. Whitney reported the CME Audits and the Re-review of International Medical School regulations took effect in early January 2010. She noted the Notice to Consumers by Physicians is still pending at the Department of Finance. The Disciplinary Guidelines are still at the Medical Board being finalized before forwarding to the DCA. The 2010 calendar for proposed regulations will be submitted to the Office of Administrative Law in mid-February.

B. 2009 Legislation and Implementation Plans

AB 501 (Emmerson) Licensing: Limited License, Use of M.D., Fee/Fund

This Board-sponsored bill addresses an initial limited license, the use of M.D. by individuals in medical training, and allows the Board to have a four month fund reserve instead of two. Information regarding changes in the use of M.D. has been detailed in the Board's newsletter; a mailing notifying medical schools, hospitals and training programs of the new requirements will be forthcoming.

The implementation of the limited license will require regulatory action. It will not require setting any new fee, though revisions to the current application must be made and procedures must be written on how to handle limited license requests.

Ms. Whitney stated she did not provide an analysis of the fund condition due to the various 2010/11 initiatives that have arisen and the new salary savings drill since these must be incorporated into the analysis. A more complete projection of the fund condition will be available at the April meeting which may allow the Members to have an informed discussion on

a possible reduction in fees. This analysis will include the $22 credit that will be returned to those renewing a license in FY 2010/2011 as part of the required fee reduction for the elimination of the diversion program.

AB 1070 (Hill) Enforcement Enhancements: reporting, public reprimand
This Board-sponsored bill carried the Board's enforcement enhancements. Many of the provisions of this bill have already been implemented by Enforcement staff. Still outstanding is the establishment of a team building plan between the Board and the Health Quality Enforcement Section of the Attorney General's Office.

SB 132 (Denham) Polysomnographic Technologists
The implementation of the Polysomnographic Technologists Licensing bill is dependent upon the hiring of an analyst to head the program. The sponsor and the interested parties are ready to assist the Board by providing expertise, history, and qualification materials in order to swiftly draft the regulations and move them forward to hearing. Applications are currently being solicited for the analyst position and timelines will be adjusted after the position is filled.

The application, licensing, and renewal fees will be set in regulation to be cost neutral, but will likely start at the maximum amount permitted in law. As the licensure program is implemented, an assessment will be made to determine if these fees are excessive or insufficient and adjustments will be made. Levels of required supervision not already determined by law will be set in regulation for technologist, technicians and assistant technicians.

C. Consideration of 2010 Proposed Legislation
Ms. Whitney directed Members to the "2010 Legislative Proposals" section of their Legislative Packets.

The Board sponsored enforcement proposals come from the November 2009 Quarterly Meeting:

1. Representation of Board Obtained Expert Witness for Enforcement Cases: Language has been drafted and presented to Assembly Member Hill who has agreed to carry the bill this year. Additional enforcement enhancements may be added to the bill.
2. Up Front Specialty Reviews: This proposal was forwarded to the Enforcement Committee for future discussion.
3. Default Decisions: It is hoped that this proposal will be addressed in the DCA enforcement bill.
4. Posting of PC 23 Orders: This proposal will likely appear in either the DCA enforcement bill or in another bill carried by the chair of the Senate Business & Professions Committee (B&P).
5. Omnibus – Various Sections: These provisions have been submitted to the Senate B&P Committee. The item to clarify a subsection of B&P 805 will not be included in the omnibus bill, but in a possible bill carried by Senator Negrete-McLeod related to peer review.

The licensing legislative proposals consist of:

1. Minor amendment to B&P 2184: submitted for review in the omnibus bill.
2. Midwifery provision: technical clean up of the reporting language to be included in the omnibus bill.
3. Licensing enhancements: will go forward in 2011.

4. Omnibus – Various Sections: technical cleanup.

Overall legislative proposals that affect the full Board:

1. Malpractice Coverage for Volunteer Physicians: see report from the Access to Care Committee.
2. Biennial Program Audit of the Board: Discussions have occurred with Senate B&P on a biennial audit of the Board. The Board has a sunset review scheduled in 2012; a full evaluation of the Board will occur in late 2011 for the sunset review, hence, it is unclear whether the Board should go forward with a legislative amendment this year for an audit or should put the proposal in a sunset bill that would make it continuous. Dr. Gitnick requested at the October 2009 meeting that the Board's audit be similar to that which is required of the State Bar and would require all aspects of the Board's activity (not limited to just the Enforcement and Licensing Programs).

Ms. Whitney reported the following concepts have originated from other sources; some may require action by the Board:

1. Physician Assistant Statute of Limitations.
2. Physician Assistant Sign and Attest Per Delegation of Services Agreement
3. Letter of Request from Assembly Member Carter to Sponsor New Version of AB 252: A similar version of this bill, which addresses patient safety in cosmetic medical procedures, was vetoed by the Governor as being duplicative of existing law.

   Ms. Chang moved to decline Assembly Member Carter's request to sponsor the bill, but to notify her that the Board would be support the bill if it was introduced; s/Zerunyan; motion carried.

4. SB 1441 Task Force Recommendations: Discussion was deferred to Item 11.
5. DCA sponsored Enforcement Enhancements:
   Kim Kirchmeyer, Deputy Director of Board Relations for the DCA, presented on the Consumer Protection Enforcement Initiative (CPEI). The Department assembled a working group to put together the proposed initiative to improve the enforcement process by reducing the length of time it takes from the date a complaint is received until it is finalized from the current three years down to twelve to eighteen months.

   The initiative focuses on three main areas: administrative improvements, staffing and IT resources, and legislative changes. A Deputy Director for Enforcement and Compliance, Paul Riches, was hired by the Department to review and monitor the improvements happening at each board. Performance agreements are being established with several other state agencies, including the Attorney General's Office and the Office of Administrative Hearings in order to set timelines.

   A global BCP was put forward for additional staffing resources for the enforcement processes for all the healing arts boards; the BCP has been supported by the Administration and is in the Governor's budget. For the Board, the BCP would add 20 additional enforcement positions; this could have a significant impact on the Board's fund reserve.

   The implementation of a new IT process is also a part of the CPEI. The former Complaint Resolution Information Management System (CRIMS) project has been

transitioned into a Department-wide project called BreEZe. A Request for Proposal (RFP) is being assembled; it is hoped in December 2012 the first group of healing arts boards will move forward to implement the system. The BreEZe system will encompass both enforcement and licensing processes.

DCA is also seeking legislative changes including the ability to suspend a license in a more timely manner, the removal of the gag clause in any civil settlements, the delegation of approval for stipulated surrenders in default decisions. A number of the changes reflect regulations the Board already has in place. Ms. Kirchmeyer requested that the Board ask staff to meet with legal counsel and the Department to make minor amendments to the bill to ensure the Board would approve the draft document that will be going forward. Currently, the document is at legislative council; a bill will be forthcoming and DCA requests the Board to work with them on this legislation.

Dr. Duruisseau made a motion to have the Board work with the Department to improve the language of specific parts of the proposal and work together, generally, on the Consumer Protection Enforcement Initiative; s/Moran.

Mr. Zerunyan asked how the initiative fits with Vertical Enforcement (VE). Ms. Kirchmeyer responded the initiative should not affect VE, allows the other healing arts boards the option of doing VE, and develops a timeframe for the AG's Office to file an accusation and serve it. The twelve to eighteen month timeframe goal *includes* the time the Attorney General's Office will be involved in a complaint.

Mr. Zerunyan and Dr. Gitnick expressed their concern with the Board's ability to control the AG Offices' timeframes. Dr. Gitnick stated the Board has no real authority to hold the AG's Office to the timeframes, thus these timeframes must be firmly established in law.

Dr. Levine asked for clarification on CPEI's future amendment to eliminate the authority of boards to adopt or non-adopt decisions. Ms. Kirchmeyer stated this was not in the actual proposal and noted she is aware the Board has not been supportive of this position in the past. The DCA has not taken a position on this issue yet.

Rosielynn Pulmano, Senate B&P staff, reported Senator Negrete-McLeod will author this bill that DCA is sponsoring. Senate B&P will work with the stakeholders on the issues raised in the proposal. She reported another proposal would allow Board members to actually hear non-controversial cases (such as cite and fine cases). Senate B&P would work with the Board on the non-adopt issue.

Mr. Zerunyan suggested the CPEI team look at the Trial Reduction Act in the Los Angeles Superior Court system as a model for reducing time in a judicial system or format.

Dr. Salomonson asked whether the Board should formalize it's preference to continue to be able to vote on Administrative LawJudge decisions. Ms. Yaroslavsky suggested the Enforcement Committee should consider this.

Ms. Pulmano indicated the bill be introduced in mid-February; hearings on the bill in

Senate B&P will occur in April.
Ms. Yaroslavsky called for a vote on the motion; motion carried.

Ms. Yaroslavsky directed staff to call an interim Enforcement Committee meeting once the Enforcement Committee is officially established. In addition, she directed staff to call an interim Executive Committee meeting where the Enforcement Committee will present its findings and recommendations on the CPEI.

6. Peer Review: The DCA will be convening a stakeholders group per the Governor's veto.
7. Radiologist Assistant Practice Act under the Medical Board: Ms. Whitney recommended the Board take no action at this time until a bill is actually introduced.

During public comment, Laura Foster noted Registered Radiologist Assistants (RRAs) and Radiology Practitioner Assistants (RPAs) perform similar functions, though they are certified by two separate entities. Janis Fodran-Keeney reported twenty seven states already have laws regarding the profession's practice. Ms. Keeney, Ms. Foster, and Leo Baca spoke in support of amending the proposed Act to also include RPAs in the proposal.

D. 2010 Legislation

AB 977 (Skinner) Pharmacists: immunization protocols with physicians
Ms. Whitney reported this bill would allow a pharmacist, in consultation with a physician, to administer influenza immunizations to any person 18 years of age or older. Dr. Salomonson and Dr. Low voiced their concerns with the bill.

Dr. Moran noted the practice of pharmacists administering immunizations, which is common in other states, is used as a tool to provide increased access to care.

Dr. Gitnick asked if CMA supports this bill. Brett Michelin, CMA, reported they have taken a neutral position on the bill.

Dr. Moran made a motion to support the bill; s/Zerunyan; motion carried (1 abstention).

Agenda Item 11 SB 1441 Guidelines and Discussion of Possible Legislative and Regulatory Action the Board May Need to Take for Implementation
Mr. Riches reported he is responsible for establishing an oversight system.

Ms. Whitney directed Members to the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees. Mr. Riches indicated DCA will sponsor legislation to implement any needed statutory changes.

Standard #1 states any licensee on probation who the board has reasonable suspicion has a substance abuse problem shall be required to undergo a clinical diagnostic evaluation at the licensee's expense. This standard is consistent with the Board's disciplinary guidelines. Staff will be reviewing the standard to make sure it coincides with all the Board's procedures.

Standard #2 addresses practice restrictions. The standard would require placing licensees on inactive status if they are found to be abusing substances. This will require a revision to the Medical Practice Act or general provisions.

Standard #3 deals with specific requirements that govern the ability of the licensing board to communicate with the licensee's employer about the licensee's status or condition. This standard can be implemented by including it in a stipulation or order as long as the definition of "worksite" is resolved.

Standard #4 addresses drug testing standards and would require 104 random drug tests per year; currently the Board orders 52 tests. Ms. Whitney stated this standard presents policy, cost, resource, and necessity issues for the Board. Ms. Scuri added the mandatory number of testings has the potential to reduce the number of stipulations that licensees are willing to enter into; this impact should be considered.

Mr. Riches reported the standards, once developed, would be *mandatory* for *all* healing arts boards. This includes 104 drug tests in the first year only; in subsequent years the number of tests is reduced to 50 consistent with the Board's current practices.

Dr. Gitnick noted when the Board established 52 drug test per year as its standard, the decision was not based on scientific research or the advice of experts; he recalls it was an arbitrary decision. He felt, if the Board questions the 104 drug tests, it should be based on scientific evidence and advice.

Jim Conway, Pacific Assistance Group, stated 104 drug tests per year is not evidenced based and does not reflect national standards. He reported the Federation of State Physician Health Program's standard is four or more tests per month, as needed. He indicated the impact of the number of required tests can be economically devastating for health care professionals.

Julie D'Angelo Fellmeth, CPIL, noted no scientific evidence on the frequency of drug testing was presented at SB 1441 Committee meeting she attended. The recommended frequency of the testing varied significantly. She felt the higher number of required tests offers greater public protection.

Standards #5 and #6 do not apply to the Medical Board.

Standard #7 addresses worksite monitors. The Board's procedures may need to be revised.

Standard #8 focuses on the procedures to be followed when a licensee tests positive for a banned substance. The standard calls for placing the licensee's license on inactive status which will require legislation.

Standard #9 does not apply to the Board as it is already a part of the Board's evaluation of a major violation.

Standard #10 deals with the specific consequences for major and minor violations. To implement the consequences included in the standard, the authority for inactivation of a license would need to be placed in law. Since the Board does not have a diversion program, the remainder of the consequences does not apply.

Standard #11 addresses the criteria that a licensee must meet in order to petition for return to practice on a full time basis. The Board would need the statutory authority for the practitioner to

return to practice at the same time it obtains authority to remove the licensee from practice, as previously mentioned in Standards #2, #8, and #10.

Standard #12 lists the criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license. These criteria are already in existing law; the Board would generally follow this same process since it already exists. It appears the standard is looking at two different processes; the Board may need a statutory requirement to address the second process.

Standards #13, #14, and #15 do not apply to the Board.

Standard #16 addresses measurable criteria and standards to determine whether the Board's method of dealing with substance-abusing licensees protects patients from harm. The Board would need to develop a reporting mechanism to provide all of the specified data to DCA.

Ms. Kirchmeyer requested that any standards that will require regulatory changes be addressed at the Board's next meeting, any standards that can be implemented by policy be done so immediately, and the implementation of the standards appear as a regular item on the Board's meeting agenda to check on progress.

During public comment, Mr. Conway expressed his concern the standards would lead to a decline in voluntary referrals by licensees into diversion programs since information would appear on the website which will be a barrier to employment and practice.

Once the legislation is written and regulatory language and proposals are developed, staff will bring the issue before the Board for discussion and voting. Staff will move ahead with any required changes at the policy level in order to implement the standards as requested by DCA.

Agenda Item 12 Discussion on Physician Supervision of Nurse Anesthetists

Ms. Cordray read the Summary from the Staff Report on the Governor's decision to "opt-out" of physician supervision of California Registered Nurse Anesthetists (CRNAs) for Medicare and Medicaid (MediCal) services.

It is questionable whether California may not opt-out of the requirement that CRNAs be supervised by physicians, as this would not be consistent with California law. Staff asked members to choose one of the following options:

1. Take no action; allowing the legal community and the professional associations to grapple with the issues surrounding the Governor's action;
2. Write the Governor and ask that he reconsider his decision in light of the Legislative Counsel's opinion;
3. Direct the Board's Advisory Committee on the Physician Responsibility in the Supervision of Allied Health Professionals to further study the issues and report their findings back to the Board.

Bill Barnaby, CMA, introduced Patricia Dailey, M.D., California Society of Anesthesiologists (CSA). Dr. Dailey spoke on the policy and patient protection implications of the Governor's action. CSA urged the Board to choose option #2.

Dr. Gitnick stated the Governor's opt-out decision was based on his concern for patients in underserved areas of the state who have little or no access to anesthesia care. He noted the decision came down to a question of whether the patients were better off with no anesthesia or with anesthesia provided by an unsupervised CRNA. If the Board chooses option #2, he would like to offer the Governor a plan to provide the necessary physicians who are willing to oversee CRNAs in underserved areas, with CMA and CSA taking the lead on providing such a plan.

Mr. Barnaby stated physicians are obligated under the law to order the administration of a medication by an RN or a CRNA and to direct the administration of a controlled substance or a dangerous drug. He asserted it is up to the physician community, specifically surgeons and obstetricians, to exercise those obligations they presently have.

Dr. Salomonson noted the difference in training between an anesthesiologist and a CRNA was significant and expressed her concern over the CRNAs ability to handle emergencies. Dr. Salomonson said the issue should be taken up by the Access to Care Committee working in conjunction with the anesthesiologists to come up with creative solutions for specialty coverage in underserved areas while holding to the patient safety standard of physician supervision of CRNAs.

Yvonne Choong reported CMA supports option #2.

Richard Bell, M.D., stated the data from studies quantifying the difference in patient outcomes in cases performed by CRNAs versus anesthesiologists shows for the low risk patient, there is no difference in outcomes. He noted the opt-out does not *require* hospitals to allow CRNAs to practice unsupervised; hospitals may still require supervision in their rules and regulations. However, in communities with a shortage of anesthesiologists, anesthesia would still be available via an unsupervised CRNA. Dr. Bell noted fourteen other states have opted out of the physician supervision of CRNAs over the past ten years and there have not been a large number of adverse outcomes. He urged the Board to adopt option #1.

Ms. Yaroslavsky suggested referring the issue to a joint taskforce of the Access to Care and the Physician Responsibility in the Supervision of Affiliated Health Care Professions Committees in order to work with interested parties to explore options and present their recommendations back to the Full Board.

Dr. Moran made a motion that, in the interest of patient safety, a letter should first be written to the Governor asking that he reconsider his action and then the Board should go into committee to craft solutions to the issue; s/Salomonson.

After considerable discussion, ***Dr. Moran amended her motion to write a letter to the Governor asking him to reconsider his decision in light of concerns about consumer safety and explain that it is the Board's intention to work diligently to develop solutions to the problem of access to care.***

Ms. Chang, Dr. Low, Dr. Chin, and Dr. Gitnick indicated, in light of the complexity of the issue, they would prefer the committees work with stakeholders to craft solutions *before* writing a letter to the Governor.

Ms. Yaroslavsky called for the vote; the motion failed (2-yes, 7-no, 1 abstention).

Dr. Carreon made a motion to create a taskforce with stakeholders that will meet as soon as practically possible in order to craft solutions to the issue that will then be addressed to the Governor in a letter; s/Duruisseau.

Dr. Levine suggested that representatives from the hospitals be included in the task force and information on the size of the gap in physician supervision of CRNAs from county to county should be assembled in order to match excess supply to unmet demand.

Dr. Salomonson expressed her concern that the Board was setting a precedent that if a specialty cannot provide complete coverage in all areas, then the educational requirement will be lowered. She felt this would mandate each specialty to provide complete coverage in order to be the provider of services.

Ms. Yaroslavsky called for a vote on Dr. Carreon's motion; motion carried (8–yes, 2-no).

Agenda Item 4 Executive Director Position
Pursuant to Government Code Section 1126(e)(2)(A), the Board went into closed session at approximately 12:15 p.m. to discuss the appointment of an Interim Executive Director and the search for a new Executive Director.

Open Session:
The Board reconvened in open session at approximately 1:15 p.m.

B. Appointment of Interim Executive Director
Ms. Yaroslavsky announced the appointment of Linda K. Whitney as the Interim Executive Director and administered the Oath of Office.

C. Search for New Executive Director
Ms. Yaroslavsky asked Ms. Whitney to provide a plan for the search for a new Executive Director at the April 2010 meeting.

Agenda Item 21 Special Faculty Permit Review Committee Recommendations
Dr. Gitnick reported the Special Faculty Permit Review Committee met on December 17, 2009 where they reviewed and discussed the application of a highly qualified radiologist for the UC Irvine School of Medicine. The Committee unanimously recommended his approval for a 2168 certificate.

Dr. Moran made a motion to adopt the Committee's recommendation; s/Duruisseau; motion carried.

Agenda Item 22 Access to Care Committee Update and Consideration of Committee Recommendations
Dr. Gitnick reported, per AB 2342 (Nakanishi), the Committee has been studying options for providing malpractice insurance for physicians who provide voluntary, uncompensated healthcare. A Malpractice Task Force, established at the October 2009 Board meeting, met in mid-January 2010. Members include Mr. Zerunyan (chair), two members of the Access to Care

Committee (Dr. Carreon and Mr. Zerunyan), and representatives from CMA, the California Hospital Association (CHA), and liability insurers. Dr. Gitnick reported the task force participants were interested in further pursuing the sovereign immunity model under which the physicians are considered "state actors" or state employees (used in Florida). However, they wanted to consider an alternative funding model. At the recommendation of the task force, the Access to Care Committee would like to move forward with what they have labeled the "California model". A review of California law as it relates to this model will need to be done.

Mr. Zerunyan made a motion that the Board adopt the Access to Care Committee's recommendation that the Medical Board either sponsor, or seek others with whom to co-sponsor, legislation to enact a state actor or sovereign immunity model similar that which is used in Florida; s/Carreon.

The Access to Care Committee also requested that interested parties share their supporting ideas and make their concerns known to the Board regarding the following elements: funding, administration of the proposed program, operational issues, claimant issues, and coverage. Beth Grivett, CAPA, requested that physician assistants be included the discussion as PA volunteers encounter similar barriers.

Ms. Choong reported CMA is looking for authors to sponsor the legislation and is putting together the draft language.

Dr. Levine stated IRS taxation issues will also need to be included in any review; if the model envisions physicians as state employees, there may be imputed income on the value of the indemnification that would create a tax liability for the physician.

Karen Ehrlich, MAC, urged the Board to consider expanding any legislation to include all healthcare providers who are volunteers.

Ms. Yaroslavsky called for a vote; motion carried.

Agenda Item 23 Physician Supervision Advisory Committee Update and Consideration of Committee Recommendations

Dr. Moran reported the Committee was established to examine physician supervision and availability for the affiliated healing arts staff. The Committee will study the current real world practices, laws and regulations, and will look for solutions to any deficiencies in patient protection. The impetus for the Committee is a growing concern about physician oversight of physician extenders and perceived and potential lapses in that oversight. The Committee has a mandate from Business and Professions Section 2023.5 which directs the Board to look specifically at lasers and light treatment of patients being done by physician extenders and, more recently, from Senator Negrete-McLeod who sponsored SB 674. The Committee has the ability to weigh in on issues other than cosmetic procedures, such as the CRNA issue previously discussed, though this is the most blatant area of violation with regard to physician oversight concerns. Dr. Moran invited other interested parties to be involved with the Committee and attend their meetings to participate in discussions.

The Committee consists of: Jack Bruner, M.D., California Society of Plastic Surgeons, Beth Grivett, P.A., California Academy of Physician Assistants, Suzanne Kilmer, M.D., American Society of Dermatologic Surgery, Victor Narurkar, M.D., California Society of Dermatology and

Dermatologic Surgery, James Newman, M.D., California Society of Facial Plastic Surgery, Paul Phinney, M.D., CMA, and Harrison Robbins, M.D., California Academy of Cosmetic Surgery.

Dr. Moran made a motion to approve the appointment of the members named; s/Low. The motion carried.

Agenda Item 13 Licensing Chief's Report

A. Licensing Program Update

Ms. Pellegrini reported the physician and surgeon licensing backlog was successfully eliminated by December 23, 2009. Since June of 2008, significant improvements in the Licensing Program have been made including the development of a policy and procedure manual, creation of automated reports to track licensing trends and data, use of electronic communication to inform applicants of the status of their applications (WAAS), and the addition of staff via a budget change proposal (BCP) to address persistent staffing shortages in the Licensing Program. The BPR report provides recommendations to further improve the program.

The total number of un-reviewed applications, within the regulatory timeframe, continues to decrease. Review timelines for US applications is currently at 76 days, international applications for licensure is at 71 days, and international applications for post graduate training authorization letters (PTAL) is at 63 days. Ms. Pellegrini stated it is very important that the Licensing Program continue to work the application caseload down to 60 days in preparation for the annual influx of applications from residents and fellows needing licensure by July 1, 2010. With the cessation of all overtime, as noted by Ms. Johnston in the Executive Director's report, the ability to retain the 16 temporary staff is critical.

At the request of Ms. Yaroslavsky, Ms. Pellegrini provided information on Senior Level 2 Reviews (SR2); these reviews are for problem applications and take a significant amount of staff time to research. Cindi Oseto, Licensing Program Senior Analyst, reported the oldest un-reviewed SR2 file is from November 1, 2009; reviewed files awaiting additional information or the assessment of an applicant date back to the summer of 2009. Applicants requiring evaluations are not given a deadline but may obtain the evaluation at a time convenient for them; this often leads to a delay.

Ms. Yaroslavsky asked that the Licensing Committee members receive a copy of the Licensing Manual or an overview of the licensing application process.

Ms. Pellegrini reported Mr. Schunke has been working with the Licensing Program and the GME programs and teaching hospitals; to date, there are 875 names on the list of residents requiring licensure by July 1, 2010. Information will be provided back to the schools on a monthly basis whether their residents requiring licensure have or have not yet submitted an application and whether the individual has been licensed.

Dr. Levine noted the surge in applicants requiring licensure by July 1 was not limited to residents in teaching hospitals; most of the physicians going into practice who are working in hospitals are generally hired as of July 1. This makes the surge even larger. Further, some of the smaller hospitals and communities are dependent upon these physicians being licensed by July 1, making these applications a priority as well.

Dr. Salomonson asked if all hospitals could receive the information provided to teaching hospitals so they, too, could track the status of an applicant they are seeking to hire.

Ms. Whitney reported that Mr. Schunke has been setting up meetings with recruiters from the valley hospitals so he can speak to them about the licensing process and provide advice on the best time to hire since July 1 is historically a very busy time for licensure.

Ms. Yaroslavsky requested a plan for the reduction of temporary staff before the next meeting, stating the Licensing program should not be relying on temporary help to perform its function. Ms. Pellegrini reported it is her intent to keep the temporary staff in place until the July 1 surge has passed. The four additional permanent staff to be hired from the BCP will reduce the need for temporary help, but these individuals will need time to be trained. Ms. Yaroslavsky suggested that an additional BCP may be necessary.

B. Licensing Consultant's Report

Ms. Chang suggested tabling this agenda item until there was more time to review the BPR report and an opportunity for the Interim Executive Director to meet with Ms. Pellegrini to discuss the report.

Ms. Chang made a motion to refer the BPR report to the Licensing Committee who would then present their recommendations to the Board; s/Moran; motion carried.

C. Midwifery Advisory Council Update

Ms. Pellegrini reported a discussion took place at the January 7, 2010 Midwifery Advisory Council (MAC) meeting regarding clarification in the language in Business and Professions Code Section 2516 dealing with reporting requirements. These technical amendments clarify the dates of the report and clarify "demise and/or death" to include morbidity *and* mortality. These changes will be brought to the Board as a legislative proposal.

Ms. Yaroslvasky made a motion to approve the proposal to amend this section of law; s/Levine; motion carried.

A task force was formed within the MAC to study terms and conditions for remedial training of licensed midwives in quality of care cases. The task force made three recommendations: (1)Continuing education authored by any organization listed in Title 16, California Code of Regulations, Section 1379.26; (2)Examination (oral or written exam, or clinical evaluation similar to the challenge mechanism); and (3)Practice monitor (similar to that for physicians).

Dr. Levine made a motion to approve the MAC's recommendations for remedial training; s/Low; motion carried (1 abstention).

Faith Gibson stated there was a statistically improbable number of maternal demise or deaths reported in the most recent midwifery survey that was provided to the Legislature. OSHPD investigated and discovered there was a high level of error or misunderstanding in the reporting, in part due to the survey design. New data was collected from these midwives. The redesigned survey will be mandatory and will be done on-line to allow pop-up screens to provide clarification on some of the definitions. In addition, Robin Jones will provide in-service education on completing the survey at four different locations throughout the state. Ms. Gibson suggested a notation be included in the report to the Legislature that the data includes

information from midwives who are licensed in California but are currently practicing out of state or in other countries. Ms. Yaroslavsky suggested that all the members receive a copy of the survey form for future reference.

Agenda Item 14 Proposed Amendments to Section 1328 of Title 16 CCR (Acceptable Written Examinations)

This section enumerates the combination of written examinations that are acceptable to the Board for the issuance of an initial physician and surgeon's license. Staff is recommending the regulation be amended to included USMLE steps 1 and 2 combined with NBME part 3 as an acceptable combination of examinations for licensure and that a regulatory hearing be scheduled at the April 2010 Board meeting.

Dr. Low made a motion to approve staff's recommendation; s/Chang; motion carried.

Agenda Item 15 Midwifery Advisory Council Nominations and Approval

The MAC consists of six positions: three California licensed midwives in good standing and three public members, two of which are obstetrician/gynecologists and one is a member of the Board. There are currently two vacancies on the MAC. Staff is asking the Board to reappoint Faith Gibson and Ruth Haskins, M.D. to three-year terms on the MAC.

Ms. Yaroslavsky made a motion to reappoint Faith Gibson to a three-year term; s/Chang; motion carried. Ms. Yaroslavsky made a motion to reappoint Dr. Ruth Haskins to a three-year term; s/Duruisseau; motion carried.

Agenda Item 16 Approval of Nizhoni Midwifery Institute

Ms. Pellegrini reported the Board received an application for recognition from the Nizhoni Midwifery Institute in San Diego. Robin Jones conducted an evaluation of the program and its compliance with requirements in law. Staff recommends the recognition of the Nizhoni Midwifery Institute.

Dr. Moran made a motion to approve staff's recommendation and that the recognition of the Nizhoni Midwifery Institute be retroactive to the date of the achievement of the pre-accreditation status from the Midwifery Education Accreditation Council (MEAC) of July 2, 2009; s/Duruisseau; motion carried.

Agenda Item 17 Enforcement Chief's Report

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

Ms. Threadgill requested approval of 13 Orders Restoring License Following Satisfactory Completion of Probation, 16 Orders Issuing Public Letters of Reprimands, and 3 Orders for License Surrender During Probation.

Dr. Low made the motion; s/Moran; motion carried.

B. Expert Utilization Report

Ms. Threadgill directed members to page 129 of the packets for a chart reflecting the use of experts by specialty during the past quarter. She reported the list of active experts has increased from 11,038 to 11,052 since the last report. She reported Ms. Choong and Brett Michelin, CMA, have indicated they will continue to assist the Board in obtaining additional experts and in improving the quality of these experts by encouraging the local medical societies to allow Board representatives to attend their meetings and provide training.

C. Enforcement Program Update

Ms. Threadgill reported the Enforcement Program has an overall vacancy rate of 10%; this does not include vacant positions that have candidates identified and moving through the selection process. The Probation Program currently has no vacancies.

In April 2010 the Operation Safe Medicine (OSM) Unit is scheduled to move into office space in San Dimas along with the Diamond Bar District Office and Probation staff. Currently, OSM has more than forty unlicensed practice cases under investigation.

The Complaint Unit has successfully implemented a transition to the utilization of electronic medical records whenever possible which should expedite cases.

The Enforcement Program will soon be able to provide investigators with desk access to CLETS, a law enforcement tracking system. This will allow them to obtain accurate information more quickly, as they will be able to run their own searches.

Last year, the Enforcement Program pursued the purchase of videoconferencing equipment, however, the contracts were suspended. Enforcement will resurrect this issue and once again attempt to obtain a contract for purchase in order to increase efficiency and reduce travel costs.

The CRIMS project has transitioned into the Department's BreEZe project. Staff will remain involved in the project to ensure the Board's requirements are fulfilled.

Enforcement continues to review older cases in its Age Case Council. Since starting the Council, the number of cases older than 600 days has been reduced by fifty percent. In December 2009, the San Diego District Office was able to clear seventeen cases that resulted in administrative or criminal findings.

The Probation Office is currently monitoring 107 probationers that have biological testing requirements; thirty-two of these probationers are out of state and are pended (not currently being tested). There were twenty-eight positive tests in the last quarter of 2009; these will be handled with probation violations.

In 2004 there were 392 decisions, stipulations, Public Letters of Reprimand, Petitions to Compel Exams, Petitions for Reconsideration, and other items sent to panel members for a vote; in 2005 there were 356; in 2006 there were 340; in 2007 there were 373; in 2008 there were 238; and in 2009 there were 274. The drops in the past two years are attributed to defaults and surrenders that are signed off by the Executive Director and no longer require a vote by members.

Ms. Threadgill reported a presentation on medical marijuana will be given at the April 2010 meeting.

D. Request to Establish an Enforcement Committee to Assist Staff

Ms. Threadgill requested the Board to establish an Enforcement Committee to review issues such as the upfront specialty reviewer timelines and the Board's current medical marijuana guidelines.

Ms. Chang made a motion to establish and Enforcement Committee; s/Duruisseau; motion carried.

Ms. Yaroslavsky asked Dr. Low to chair the Enforcement Committee and Dr. Chin and Ms. Schipske to serve on the Committee. She invited other members to notify her if they were also interested in serving on the Committee.

Agenda Item 18 Vertical Enforcement Program Report

Ms. Threadgill directed members to page 134 of their packets for statistics on the Vertical Enforcement (VE) Program. Senior Enforcement staff continues to meet quarterly with Carlos Ramirez and supervising deputy attorney generals from the Health Quality Enforcement Section. At the most recent meeting, an agreement to engage in joint training was reached. Mr. Ramirez reported training modules will be developed on record acquisition, physician interviewing, and expert witness selection and performance at hearings.

Agenda Item 19 Licensing Committee Update and Consideration of Committee Recommendations

Dr. Salomonson reported the Committee reviewed a statutory amendment on the validity of test scores with a simple change in the language. Regulatory issues discussed included the timeline for an application being considered "open", the implementation of a limited license, issues surrounding the PTAL, and oversight of sleep technologists. Future agenda items include a review of the Licensing Program BPR Study, prioritization of applications, an audit of the Licensing Program, and the aforementioned regulations.

Agenda Item 20 Special Task Force on International Medical School Recognition – Consideration of Recommendations

Dr. Low reported the Special Task Force on International Medical School Recognition was formed this month with Dr. Gitnick and himself as the two members. The purpose of the Task Force is to review the procedures the Board uses to review international medical schools. B&P Code Section 2084 authorizes the Division of Licensing to approve the medical schools that comply with the medical education requirements in Section 2089 and 2089.5 of the Code. Medical schools located in the US, Canada and Puerto Rico are deemed approved by the Division of Licensing through their accreditation by the Liaison Committee on Medical Education (LCME). All other medical schools are subject to the Division's individual review and approval and must demonstrate that they offer a resident course of professional instruction that is equivalent to that provided in LCME accredited medical schools.

Dr. Low provided historical information on the emergence of international medical schools and the need for a task force to review and approve these programs. He reported there is currently a backlog of four international medical schools with pending applications dating back to March 2008; the most recent application was submitted in November 2009. There are also three international medical schools requiring a seven year re-evaluation for 2010 that includes a site visit. Historically, there have been two consultants to review these applications: Dr. Simon and

Dr. Nuovo. The reviews have been interrupted by a freeze imposed by the Governor from July through November of 2008, the illness of one of the consultants and the unavailability of the other consultant due to teaching responsibilities.

Ms. Pellegrini and Pat Park have developed a solution that requires the hiring of two additional consultants to assist in the review process to resolve the backlog problem and keep reviews current. Dr. Joe Silva, former dean of the UC Davis School of Medicine, has been hired as one of the consultants. Dr. Simon will be providing in-depth training to Dr. Silva. The Board is in the process of recruiting a second consultant.

Ms. Yaroslavsky asked about the status of one of the schools with a pending application. Dr. Low indicated that institutions opening a second campus are only required to submit paperwork for review; a site visit is typically not required. Once staff is satisfied that the program has met all requirements the consultant will make a recommendation to the Board to require a site visit, approve, or deny the application for recognition.

Dr. Salomonson expressed her concerns over the depth of review that could be provided by the Board.

Agenda Item 24 Wellness Committee Update and Consideration of Committee Recommendations

Dr. Duruisseau summarized the findings from the Committee's survey to identify wellness resources throughout the state. There was great variability in the availability of wellness programs in hospitals and physician groups. Most respondents indicated they would utilize additional wellness resources if they were made available by the Board. A difference of opinion emerged on whether wellness education should be mandated as part of CME requirements or incentivized. Dr. Gregg was asked to work with staff to identify the next steps the Committee should pursue and report back to the Committee.

The feasibility of creating a "best practices" manual for the wellness programs was discussed. Staff was asked to set up a meeting with interested parties to explore this idea. An update on the collaboration between UC Davis and the Board was provided at the Committee meeting. The Committee has no recommendations to the Board at this time.

Agenda Item 25 Physician Assistant Committee Update

Dr. Low reported the Physician Assistant Committee (PAC) adopted a new Strategic Plan at the November 5 meeting. A regulatory hearing will be held at the PAC's next meeting on February 18, 2010 on the proposal to require that licensees who are mandated to participate in the diversion program as a condition of probation pay the full amount of the monthly participation fee charged by the contractor. Licensees voluntarily enrolled in the program would be required to pay 75% of the monthly participation fee charged by the contractor.

The PAC website has been enhanced: a Career page has been added to provide information about the PA profession and additional reports are now included for the Diversion, Licensing and Enforcement statistics.

Agenda Item 26 Federation of State Medical Boards Update
Ms. Chang reported FSMB has provided the Board with a copy of its Maintenance of Licensure (MOL) initiative and has asked the Board to provide comments. The Federation has opened an advocacy office in Washington DC to lobby for public protection and access to care.

Agenda Item 27 Strategic Plan Update
Ms. Yaroslavsky directed members to review the Strategic Plan included in their packets. Ms. Yaroslavsky and Ms. Whitney will work during the next quarter to review and update the Strategic Plan.

Agenda Item 28 Agenda Items for April 29-30, 2010 Meeting
Ms. Yaroslavsky asked for a possible lunch presentation to the Board by Dr. Dowling, head of family medicine at UCLA, on facilitating the entry of physicians trained in World Health Organization hospitals into healthcare positions after passing the first level of the USMLE.

Ms. Yaroslavsky requested a discussion be held on the issues surrounding the loss of family medicine residency programs from non-university teaching hospitals.

Agenda Item 22 Adjournment
There being no further business, the meeting was adjourned at 4:00 p.m.

_____
Barbara Yaroslavsky, President

_____
Hedy Chang, Secretary

_____
Linda K. Whitney, Interim Executive Director

DRAFT

Medical Marijuana

This statement was adopted by the full Medical Board on May 7, 2004. For more information, please see our news release dated May 13, 2004.

On November 5, 1996, the people of California passed Proposition 215. Through this Initiative Measure, Section 11362.5 was added to the Health & Safety Code, and is also known as the Compassionate Use Act of 1996. The purposes of the Act include, in part:

> "(A) To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where the medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief; and
>
> (B) To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction."

Furthermore, Health & Safety Code section 11362.5(c) provides strong protection for physicians who choose to participate in the implementation of the Act. - "Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes."

The Medical Board of California developed this statement since medical marijuana is an emerging treatment modality. The Medical Board wants to assure physicians who choose to recommend medical marijuana to their patients, as part of their regular practice of medicine, that they WILL NOT be subject to investigation or disciplinary action by the MBC if they arrive at the decision to make this recommendation in accordance with accepted standards of medical responsibility. The mere receipt of a complaint that the physician is recommending medical marijuana will not generate an investigation absent additional information indicating that the physician is not adhering to accepted medical standards.

These accepted standards are the same as any reasonable and prudent physician would follow when recommending or approving any other medication, and include the following:

1. History and good faith examination of the patient.
2. Development of a treatment plan with objectives.
3. Provision of informed consent including discussion of side effects.
4. Periodic review of the treatment's efficacy.
5. Consultation, as necessary.
6. Proper record keeping that supports the decision to recommend the use of medical marijuana.

In other words, if physicians use the same care in recommending medical marijuana to patients as they would recommending or approving any other medication, they have nothing to fear from the Medical Board.

Here are some important points to consider when recommending medical marijuana:

1. Although it could trigger federal action, making a recommendation in writing to the patient will not trigger action by the Medical Board of California.
2. A patient need not have failed on all standard medications, in order for a physician to recommend or approve the use of medical marijuana.
3. The physician should determine that medical marijuana use is not masking an acute or treatable progressive condition, or that such use will lead to a worsening of the patient's condition.
4. The Act names certain medical conditions for which medical marijuana may be useful, although physicians are not limited in their recommendations to those specific conditions. In all cases, the physician should base his/her determination on the results of clinical trials, if available, medical literature and reports, or on experience of that physician or other physicians, or on credible patient reports. In all cases, the physician must determine that the risk/benefit ratio of medical marijuana is as good, or better, than other medications that could be used for that individual patient.
5. A physician who is not the primary treating physician may still recommend medical marijuana for a patient's symptoms. However, it is incumbent upon that physician to consult with the patient's primary treating physician or obtain the appropriate patient records to confirm the patient's underlying diagnosis and prior treatment history.
6. The initial examination for the condition for which medical marijuana is being recommended must be in-person.
7. Recommendations should be limited to the time necessary to appropriately monitor the patient. Periodic reviews should occur and be documented at least annually or more frequently as warranted.
8. If a physician recommends or approves the use of medical marijuana for a minor, the parents or legal guardians must be fully informed of the risks and benefits of such use and must consent to that use.

Physicians may wish to refer to CMA's ON-CALL Document #1315 titled "The Compassionate Use Act of 1996", updated annually for additional information and guidance (http://www.cmanet.org/bookstore/freeoncall2.cfm/CMAOnCall1315.pdf?call_number=1315&CFID=745764&CFTOKEN=27566287).

Although the Compassionate Use Act allows the use of medical marijuana by a patient upon the recommendation or approval of a physician, California physicians should bear in mind that marijuana is listed in Schedule I of the federal Controlled Substances Act, which means that it has no accepted medical use under federal law. However, in Conant v. Walters (9th Cir.2002) F.3d 629 the United States Court of Appeals recognized that physicians have a constitutionally-protected right to discuss medical marijuana as a treatment option with their patients and make oral or written recommendation for medical marijuana. However, the court cautioned that physicians could exceed the scope of this constitutional protection if they conspire with, or aid and abet, their patients in obtaining medical marijuana.

MEDICAL BOARD OF CALIFORNIA

Medical Board Reaffirms its Commitment to Physicians Who Recommend Medical Marijuana

Board adopts statement clarifying implementation of California's Compassionate Use Act to insure California's physicians and consumers receive appropriate guidance under the law

SACRAMENTO—The Medical Board of California marked a milestone for California consumers and physicians by adopting a statement clarifying that the recommendation of medical marijuana by physicians in their medical practice will not have any effect against their physician's license if they follow good medical practice.

"The intent of the statement is to clearly and succinctly reassure physicians that if they use the same proper care in recommending medical marijuana to their patients as they would any other medication or treatment, their activity will be viewed by the Medical Board just as any other appropriate medical intervention," said Hazem Chehabi, M.D., immediate past president of the board. "This is consistent with the board's mission to protect and advance the interests of California patients."

In November 1996, the voters of California passed Proposition 215, the "Compassionate Use Act of 1996." The purposes of the act were "to ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where the medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana....and to ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction."

In January 1997 the Medical Board published standards for physicians when recommending medical marijuana. According to the board's new statement, consultation should include:

- History and good faith examination of the patient
- Development of a treatment plan with objectives
- Provision of informed consent including discussion of side effects
- Periodic review of the treatment's efficacy
- Consultation, as necessary
- Proper record keeping that supports the decision to recommend the use of medical marijuana

"The clarification of the guidelines regarding the recommendation for the use of medical marijuana assists both physicians and patients," said Dr. Chehabi. "Establishing clearly defined guidelines will allow the medical community to concentrate on the important medical needs of the patient and end the confusion about when recommendation of medical marijuana is appropriate."

According to testimony received by the board at its hearing on this issue last week, the author of the Act, Dennis Peron, supported the board's efforts to implement the law and assist California's physicians and their patients who receive a recommendation for the use of medical marijuana. "The Medical Board is in a unique position to guide physicians and patients on the proper standards for medical intervention for those who can benefit from treatment using medical marijuana," stated Mr. Peron. "I applaud the board's efforts and hope their action puts an end to the controversy that has surrounded this issue since California citizens voted to support the Compassionate Use Act."

For a copy of the Medical Board's statement, please contact the board's information officer, Candis Cohen, at (916) 263-2394.

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

If you have a question or complaint about the healthcare you are receiving, the Board encourages you to visit its Web site at www.caldocinfo.ca.gov or for questions call the Consumer Information Line at (916) 263-2382, or with complaints call (800) 633-2322

CALIFORNIA HEALTH & SAFETY CODE

§11362.5 – 11362.83

MEDICAL MARIJUANA PROGRAM

CAL. HSC. CODE § 11362.5

(a) This section shall be known and may be cited as the Compassionate Use Act of 1996.

(b) (1) The people of the State of California hereby find and declare that the purposes of the Compassionate Use Act of 1996 are as follows:

(A) To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief.

(B) To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction.

(C) To encourage the federal and state governments to implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana.

(2) Nothing in this section shall be construed to supersede legislation prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes.

(c) Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes.

(d) Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient's primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician.

(e) For the purposes of this section, "primary caregiver" means the individual designated by the person exempted under this section who has consistently assumed responsibility for the housing, health, or safety of that person.

CAL. HSC. CODE § 11362.7

For purposes of this article, the following definitions shall apply:

(a) "Attending physician" means an individual who possesses a license in good standing to practice medicine or osteopathy issued by the Medical Board of California or the Osteopathic Medical Board of California and who has taken responsibility for an aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient and who has conducted a medical examination of that patient before recording in the patient's medical record the physician's assessment of whether the patient has a serious medical condition and whether the medical use of marijuana is appropriate.

(b) "Department" means the State Department of Health Services.

(c) "Person with an identification card" means an individual who is a qualified patient who has applied for and received a valid identification card pursuant to this article.

(d) "Primary caregiver" means the individual, designated by a qualified patient or by a person with an identification card, who has consistently assumed responsibility for the housing, health, or safety of that patient or person, and may include any of the following:

(1) In any case in which a qualified patient or person with an identification card receives medical care or supportive services, or both, from a clinic licensed pursuant to Chapter 1 (commencing with Section 1200) of Division 2, a health care facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, a residential care facility for persons with chronic life-threatening illness licensed pursuant to Chapter 3.01 (commencing with Section 1568.01) of Division 2, a residential care facility for the elderly licensed pursuant to Chapter 3.2 (commencing with Section 1569) of Division 2, a hospice, or a home health agency licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2, the owner or operator, or no more than three employees who are designated by the owner or operator, of the clinic, facility, hospice, or home health agency, if designated as a primary caregiver by that qualified patient or person with an identification card.

(2) An individual who has been designated as a primary caregiver by more than one qualified patient or person with an identification card, if every qualified patient or person with an identification card who has designated that individual as a primary caregiver resides in the same city or county as the primary caregiver.

(3) An individual who has been designated as a primary caregiver by a qualified patient or person with an identification card who resides in a city or county other than that of the primary caregiver, if the individual has not been designated as a primary caregiver by any other qualified patient or person with an identification card.

(e) A primary caregiver shall be at least 18 years of age, unless the primary caregiver is the parent of a minor child who is a qualified patient or a person with an identification card or the primary caregiver is a person otherwise entitled to make medical decisions under state law pursuant to Sections 6922, 7002, 7050, or 7120 of the Family Code.

(f) "Qualified patient" means a person who is entitled to the protections of Section 11362.5, but who does not have an identification card issued pursuant to this article.

(g) "Identification card" means a document issued by the State Department of Health Services that document identifies a person authorized to engage in the medical use of marijuana and the person's designated primary caregiver, if any.

(h) "Serious medical condition" means all of the following medical conditions:

(1) Acquired immune deficiency syndrome (AIDS).

(2) Anorexia.

(3) Arthritis.

(4) Cachexia.

(5) Cancer.

(6) Chronic pain.

(7) Glaucoma.

(8) Migraine.

(9) Persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis.

(10) Seizures, including, but not limited to, seizures associated with epilepsy.

(11) Severe nausea.

(12) Any other chronic or persistent medical symptom that either:

(A) Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336).

(B) If not alleviated, may cause serious harm to the patient's safety or physical or mental health.

(i) "Written documentation" means accurate reproductions of those portions of a patient's medical records that have been created by the attending physician, that contain the information required by paragraph (2) of subdivision (a) of Section 11362.715, and that the patient may submit to a county health department or the county's designee as part of an application for an identification card.

CAL. HSC. CODE § 11362.71

(a) (1) The department shall establish and maintain a voluntary program for the issuance of identification cards to qualified patients who satisfy the requirements of this article and voluntarily apply to the identification card program.

(2) The department shall establish and maintain a 24-hour, toll-free telephone number that will enable state and local law enforcement officers to have immediate access to information

necessary to verify the validity of an identification card issued by the department, until a cost-effective Internet Web-based system can be developed for this purpose.

(b) Every county health department, or the county's designee, shall do all of the following:

(1) Provide applications upon request to individuals seeking to join the identification card program.

(2) Receive and process completed applications in accordance with Section 11362.72.

(3) Maintain records of identification card programs.

(4) Utilize protocols developed by the department pursuant to paragraph (1) of subdivision (d).

(5) Issue identification cards developed by the department to approved applicants and designated primary caregivers.

(c) The county board of supervisors may designate another health-related governmental or nongovernmental entity or organization to perform the functions described in subdivision (b), except for an entity or organization that cultivates or distributes marijuana.

(d) The department shall develop all of the following:

(1) Protocols that shall be used by a county health department or the county's designee to implement the responsibilities described in subdivision (b), including, but not limited to, protocols to confirm the accuracy of information contained in an application and to protect the confidentiality of program records.

(2) Application forms that shall be issued to requesting applicants.

(3) An identification card that identifies a person authorized to engage in the medical use of marijuana and an identification card that identifies the person's designated primary caregiver, if any. The two identification cards developed pursuant to this paragraph shall be easily distinguishable from each other.

(e) No person or designated primary caregiver in possession of a valid identification card shall be subject to arrest for possession, transportation, delivery, or cultivation of medical marijuana in an amount established pursuant to this article, unless there is reasonable cause to believe that the information contained in the card is false or falsified, the card has been obtained by means of fraud, or the person is otherwise in violation of the provisions of this article.

(f) It shall not be necessary for a person to obtain an identification card in order to claim the protections of Section 11362.5.

CAL. HSC. CODE § 11362.715

(a) A person who seeks an identification card shall pay the fee, as provided in Section 11362.755, and provide all of the following to the county health department or the county's designee on a form developed and provided by the department:

(1) The name of the person, and proof of his or her residency within the county.

(2) Written documentation by the attending physician in the person's medical records stating that the person has been diagnosed with a serious medical condition and that the medical use of marijuana is appropriate.

(3) The name, office address, office telephone number, and California medical license number of the person's attending physician.

(4) The name and the duties of the primary caregiver.

(5) A government-issued photo identification card of the person and of the designated primary caregiver, if any. If the applicant is a person under 18 years of age, a certified copy of a birth certificate shall be deemed sufficient proof of identity.

(b) If the person applying for an identification card lacks the capacity to make medical decisions, the application may be made by the person's legal representative, including, but not limited to, any of the following:

(1) A conservator with authority to make medical decisions.

(2) An attorney-in-fact under a durable power of attorney for health care or surrogate decisionmaker authorized under another advanced health care directive.

(3) Any other individual authorized by statutory or decisional law to make medical decisions for the person.

(c) The legal representative described in subdivision (b) may also designate in the application an individual, including himself or herself, to serve as a primary caregiver for the person, provided that the individual meets the definition of a primary caregiver.

(d) The person or legal representative submitting the written information and documentation described in subdivision (a) shall retain a copy thereof.

CAL. HSC. CODE § 11362.72

(a) Within 30 days of receipt of an application for an identification card, a county health department or the county's designee shall do all of the following:

(1) For purposes of processing the application, verify that the information contained in the application is accurate. If the person is less than 18 years of age, the county health department or its designee shall also contact the parent with legal authority to make medical decisions, legal guardian, or other person or entity with legal authority to make medical decisions, to verify the information.

(2) Verify with the Medical Board of California or the Osteopathic Medical Board of California that the attending physician has a license in good standing to practice medicine or osteopathy in the state.

(3) Contact the attending physician by facsimile, telephone, or mail to confirm that the medical records submitted by the patient are a true and correct copy of those contained in the physician's office records. When contacted by a county health department or the county's designee, the attending physician shall confirm or deny that the contents of the medical records are accurate.

(4) Take a photograph or otherwise obtain an electronically transmissible image of the applicant and of the designated primary caregiver, if any.

(5) Approve or deny the application. If an applicant who meets the requirements of Section 11362.715 can establish that an identification card is needed on an emergency basis, the county or its designee shall issue a temporary identification card that shall be valid for 30 days from the date of issuance. The county, or its designee, may extend the temporary identification card for no more than 30 days at a time, so long as the applicant continues to meet the requirements of this paragraph.

(b) If the county health department or the county's designee approves the application, it shall, within 24 hours, or by the end of the next working day of approving the application, electronically transmit the following information to the department:

(1) A unique user identification number of the applicant.

(2) The date of expiration of the identification card.

(3) The name and telephone number of the county health department or the county's designee that has approved the application.

(c) The county health department or the county's designee shall issue an identification card to the applicant and to his or her designated primary caregiver, if any, within five working days of approving the application.

(d) In any case involving an incomplete application, the applicant shall assume responsibility for rectifying the deficiency. The county shall have 14 days from the receipt of information from the applicant pursuant to this subdivision to approve or deny the application.

CAL. HSC. CODE § 11362.735

(a) An identification card issued by the county health department shall be serially numbered and shall contain all of the following:

(1) A unique user identification number of the cardholder.

(2) The date of expiration of the identification card.

(3) The name and telephone number of the county health department or the county's designee that has approved the application.

(4) A 24-hour, toll-free telephone number, to be maintained by the department, that will enable state and local law enforcement officers to have immediate access to information necessary to verify the validity of the card.

(5) Photo identification of the cardholder.

(b) A separate identification card shall be issued to the person's designated primary caregiver, if any, and shall include a photo identification of the caregiver.

CAL. HSC. CODE § 11362.74

(a) The county health department or the county's designee may deny an application only for any of the following reasons:

(1) The applicant did not provide the information required by Section 11362.715, and upon notice of the deficiency pursuant to subdivision (d) of Section 11362.72, did not provide the information within 30 days.

(2) The county health department or the county's designee determines that the information provided was false.

(3) The applicant does not meet the criteria set forth in this article.

(b) Any person whose application has been denied pursuant to subdivision (a) may not reapply for six months from the date of denial unless otherwise authorized by the county health department or the county's designee or by a court of competent jurisdiction.

(c) Any person whose application has been denied pursuant to subdivision (a) may appeal that decision to the department. The county health department or the county's designee shall make available a telephone number or address to which the denied applicant can direct an appeal.

CAL. HSC. CODE § 11362.745

(a) An identification card shall be valid for a period of one year.

(b) Upon annual renewal of an identification card, the county health department or its designee shall verify all new information and may verify any other information that has not changed.

(c) The county health department or the county's designee shall transmit its determination of approval or denial of a renewal to the department.

CAL. HSC. CODE § 11362.755

(a) The department shall establish application and renewal fees for persons seeking to obtain or renew identification cards that are sufficient to cover the expenses incurred by the department, including the startup cost, the cost of reduced fees for Medi-Cal beneficiaries in accordance with subdivision (b), the cost of identifying and developing a cost-effective Internet Web-based system, and the cost of maintaining the 24-hour toll-free telephone number. Each county health department or the county's designee may charge an additional fee for all costs incurred by the county or the county's designee for administering the program pursuant to this article.

(b) Upon satisfactory proof of participation and eligibility in the Medi-Cal program, a Medi-Cal beneficiary shall receive a 50 percent reduction in the fees established pursuant to this section.

CAL. HSC. CODE § 11362.76

(a) A person who possesses an identification card shall:

(1) Within seven days, notify the county health department or the county's designee of any change in the person's attending physician or designated primary caregiver, if any.

(2) Annually submit to the county health department or the county's designee the following:

(A) Updated written documentation of the person's serious medical condition.

(B) The name and duties of the person's designated primary caregiver, if any, for the forthcoming year.

(b) If a person who possesses an identification card fails to comply with this section, the card shall be deemed expired. If an identification card expires, the identification card of any designated primary caregiver of the person shall also expire.

(c) If the designated primary caregiver has been changed, the previous primary caregiver shall return his or her identification card to the department or to the county health department or the county's designee.

(d) If the owner or operator or an employee of the owner or operator of a provider has been designated as a primary caregiver pursuant to paragraph (1) of subdivision (d) of Section 11362.7, of the qualified patient or person with an identification card, the owner or operator shall notify the county health department or the county's designee, pursuant to Section 11362.715, if a change in the designated primary caregiver has occurred.

CAL. HSC. CODE § 11362.765

(a) Subject to the requirements of this article, the individuals specified in subdivision (b) shall not be subject, on that sole basis, to criminal liability under Section 11357, 11358, 11359, 11360, 11366, 11366.5, or 11570. However, nothing in this section shall authorize the individual to smoke or otherwise consume marijuana unless otherwise authorized by this article, nor shall anything in this section authorize any individual or group to cultivate or distribute marijuana for profit.

(b) Subdivision (a) shall apply to all of the following:

(1) A qualified patient or a person with an identification card who transports or processes marijuana for his or her own personal medical use.

(2) A designated primary caregiver who transports, processes, administers, delivers, or gives away marijuana for medical purposes, in amounts not exceeding those established in subdivision (a) of Section 11362.77, only to the qualified patient of the primary caregiver, or to the person with an identification card who has designated the individual as a primary caregiver.

(3) Any individual who provides assistance to a qualified patient or a person with an identification card, or his or her designated primary caregiver, in administering medical

marijuana to the qualified patient or person or acquiring the skills necessary to cultivate or administer marijuana for medical purposes to the qualified patient or person.

(c) A primary caregiver who receives compensation for actual expenses, including reasonable compensation incurred for services provided to an eligible qualified patient or person with an identification card to enable that person to use marijuana under this article, or for payment for out-of-pocket expenses incurred in providing those services, or both, shall not, on the sole basis of that fact, be subject to prosecution or punishment under Section 11359 or 11360.

CAL. HSC. CODE § 11362.77

(a) A qualified patient or primary caregiver may possess no more than eight ounces of dried marijuana per qualified patient. In addition, a qualified patient or primary caregiver may also maintain no more than six mature or 12 immature marijuana plants per qualified patient.

(b) If a qualified patient or primary caregiver has a doctor's recommendation that this quantity does not meet the qualified patient's medical needs, the qualified patient or primary caregiver may possess an amount of marijuana consistent with the patient's needs.

(c) Counties and cities may retain or enact medical marijuana guidelines allowing qualified patients or primary caregivers to exceed the state limits set forth in subdivision (a).

(d) Only the dried mature processed flowers of female cannabis plant or the plant conversion shall be considered when determining allowable quantities of marijuana under this section.

(e) The Attorney General may recommend modifications to the possession or cultivation limits set forth in this section. These recommendations, if any, shall be made to the Legislature no later than December 1, 2005, and may be made only after public comment and consultation with interested organizations, including, but not limited to, patients, health care professionals, researchers, law enforcement, and local governments. Any recommended modification shall be consistent with the intent of this article and shall be based on currently available scientific research.

(f) A qualified patient or a person holding a valid identification card, or the designated primary caregiver of that qualified patient or person, may possess amounts of marijuana consistent with this article.

CAL. HSC. CODE § 11362.775

Qualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients and persons with identification cards, who associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions under Section 11357, 11358, 11359, 11360, 11366, 11366.5, or 11570.

CAL. HSC. CODE § 11362.78

A state or local law enforcement agency or officer shall not refuse to accept an identification card issued by the department unless the state or local law enforcement agency or officer has

reasonable cause to believe that the information contained in the card is false or fraudulent, or the card is being used fraudulently.

CAL. HSC. CODE § 11362.785

(a) Nothing in this article shall require any accommodation of any medical use of marijuana on the property or premises of any place of employment or during the hours of employment or on the property or premises of any jail, correctional facility, or other type of penal institution in which prisoners reside or persons under arrest are detained.

(b) Notwithstanding subdivision (a), a person shall not be prohibited or prevented from obtaining and submitting the written information and documentation necessary to apply for an identification card on the basis that the person is incarcerated in a jail, correctional facility, or other penal institution in which prisoners reside or persons under arrest are detained.

(c) Nothing in this article shall prohibit a jail, correctional facility, or other penal institution in which prisoners reside or persons under arrest are detained, from permitting a prisoner or a person under arrest who has an identification card, to use marijuana for medical purposes under circumstances that will not endanger the health or safety of other prisoners or the security of the facility.

(d) Nothing in this article shall require a governmental, private, or any other health insurance provider or health care service plan to be liable for any claim for reimbursement for the medical use of marijuana.

CAL. HSC. CODE § 11362.79

Nothing in this article shall authorize a qualified patient or person with an identification card to engage in the smoking of medical marijuana under any of the following circumstances:

(a) In any place where smoking is prohibited by law.

(b) In or within 1,000 feet of the grounds of a school, recreation center, or youth center, unless the medical use occurs within a residence.

(c) On a schoolbus.

(d) While in a motor vehicle that is being operated.

(e) While operating a boat.

CAL. HSC. CODE § 11362.795

(a) (1) Any criminal defendant who is eligible to use marijuana pursuant to Section 11362.5 may request that the court confirm that he or she is allowed to use medical marijuana while he or she is on probation or released on bail.

(2) The court's decision and the reasons for the decision shall be stated on the record and an entry stating those reasons shall be made in the minutes of the court.

(3) During the period of probation or release on bail, if a physician recommends that the probationer or defendant use medical marijuana, the probationer or defendant may request a modification of the conditions of probation or bail to authorize the use of medical marijuana.

(4) The court's consideration of the modification request authorized by this subdivision shall comply with the requirements of this section.

(b) (1) Any person who is to be released on parole from a jail, state prison, school, road camp, or other state or local institution of confinement and who is eligible to use medical marijuana pursuant to Section 11362.5 may request that he or she be allowed to use medical marijuana during the period he or she is released on parole. A parolee's written conditions of parole shall reflect whether or not a request for a modification of the conditions of his or her parole to use medical marijuana was made, and whether the request was granted or denied.

(2) During the period of the parole, where a physician recommends that the parolee use medical marijuana, the parolee may request a modification of the conditions of the parole to authorize the use of medical marijuana.

(3) Any parolee whose request to use medical marijuana while on parole was denied may pursue an administrative appeal of the decision. Any decision on the appeal shall be in writing and shall reflect the reasons for the decision.

(4) The administrative consideration of the modification request authorized by this subdivision shall comply with the requirements of this section.

CAL. HSC. CODE § 11362.8

No professional licensing board may impose a civil penalty or take other disciplinary action against a licensee based solely on the fact that the licensee has performed acts that are necessary or appropriate to carry out the licensee's role as a designated primary caregiver to a person who is a qualified patient or who possesses a lawful identification card issued pursuant to Section 11362.72. However, this section shall not apply to acts performed by a physician relating to the discussion or recommendation of the medical use of marijuana to a patient. These discussions or recommendations, or both, shall be governed by Section 11362.5.

CAL. HSC. CODE § 11362.81

(a) A person specified in subdivision (b) shall be subject to the following penalties:

(1) For the first offense, imprisonment in the county jail for no more than six months or a fine not to exceed one thousand dollars ($1,000), or both.

(2) For a second or subsequent offense, imprisonment in the county jail for no more than one year, or a fine not to exceed one thousand dollars ($1,000), or both.

(b) Subdivision (a) applies to any of the following:

(1) A person who fraudulently represents a medical condition or fraudulently provides any material misinformation to a physician, county health department or the county's designee, or

state or local law enforcement agency or officer, for the purpose of falsely obtaining an identification card.

(2) A person who steals or fraudulently uses any person's identification card in order to acquire, possess, cultivate, transport, use, produce, or distribute marijuana.

(3) A person who counterfeits, tampers with, or fraudulently produces an identification card.

(4) A person who breaches the confidentiality requirements of this article to information provided to, or contained in the records of, the department or of a county health department or the county's designee pertaining to an identification card program.

(c) In addition to the penalties prescribed in subdivision (a), any person described in subdivision (b) may be precluded from attempting to obtain, or obtaining or using, an identification card for a period of up to six months at the discretion of the court.

(d) In addition to the requirements of this article, the Attorney General shall develop and adopt appropriate guidelines to ensure the security and nondiversion of marijuana grown for medical use by patients qualified under the Compassionate Use Act of 1996.

CAL. HSC. CODE § 11362.82

If any section, subdivision, sentence, clause, phrase, or portion of this article is for any reason held invalid or unconstitutional by any court of competent jurisdiction, that portion shall be deemed a separate, distinct, and independent provision, and that holding shall not affect the validity of the remaining portion thereof.

CAL. HSC. CODE § 11362.83

Nothing in this article shall prevent a city or other local governing body from adopting and enforcing laws consistent with this article

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	OAH No. N2002110020
TOD H. MIKURIYA, M.D.	)	MBC Case No. 12-1999-98783
Physician's and Surgeon's Certificate No. G 9124	)	PRECEDENTIAL DECISION No. MBC-2007-02-Q
Respondent.	)	

DESIGNATION AS A PRECEDENTIAL DECISION

Pursuant to Government Code section 11425.60 and Title 16 CCR 1364.40, the Division of Medical Quality, Medical Board of California, hereby designates as precedential Decision No. MBC-2007-02-Q the decision in the Matter of the Accusation Against Tod H. Mikuriya, M.D.

This precedential designation shall be effective July 27, 2007.

Cesar A. Aristeiguieta, M.D., F.AC.E.P.,
President
Division of Medical Quality
Medical Board of California

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: TOD H. MIKURIYA, M.D. 1168 Sterling Avenue Berkeley, California 94708 Physician's and Surgeon's Certificate No. G-9124 Respondent.	Case No. 12-1999-98783 OAH No. N2002110020

AMENDED DECISION AFTER REMAND FROM SUPERIOR COURT

This matter was heard before Administrative Law Judge Jonathan Lew, State of California, Office of Administrative Hearings on September 3, 4, 5, 8, 9 and 24, 2003, in Oakland, California.

Complainant Ron Joseph was represented by Deputy Attorneys General Lawrence A. Mercer and Jane Zack Simon.

Respondent Tod H. Mikuriya, M.D. was present and represented by John L. Fleer, Esq., Susan J. Lea, Esq. and William M Simpich, Esq.

Submission of the matter was deferred pending receipt of closing argument. Complainant's Closing Argument and Reply Brief were received on November 7 and 20, 2003, and marked respectively as Exhibits 26 and 27 for identification. Respondent's Closing Brief and Reply Brief were received on November 7 and 21, 2003, and marked respectively as Exhibits AA and BB for identification. The case was submitted for decision on November 21, 2003[1]

[1] On December 26, 2003, respondent also submitted an Amicus Curiae Brief filed by the California Medical Association in a matter before the California Court of Appeal that respondent believes directly concerns the facts in this case. Respondent requests that judicial notice be taken of that brief. Complainant filed an Objection to Request for Judicial Notice on December 26, 2003, and such objection is sustained.

On January 30, 2004, the administrative law judge submitted his proposed decision to the Medical Board of California. The board adopted that decision on March 18, 2004, to become effective on April 19, 2004.

Thereafter, respondent filed a Petition for Writ of Mandate in Sacramento County Superior Court, Case No. 04CS00477. On November 2, 2006, the court issued its Order in the matter, granting the peremptory writ of administrative mandamus solely to the extent that the board based its decision on a finding of unprofessional conduct based on a violation of section 2242 and denying the Petition on all other grounds.

The Superior Court of the State of California, pursuant to its Judgment and Order dated November 2, 2006, commanded this board to reconsider its Decision in light of the court's finding.

Having reconsidered its Decision pursuant to the court's direction in the Judgment and Order, the board now makes a modified decision in compliance with the Judgment and Order dated November 2, 2006. A copy of the Judgment and Order is attached as Exhibit "A" and incorporated herein by reference.

FACTUAL FINDINGS

1. Ron Joseph (complainant) is the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs. He brought the Accusation, First and Second Amended Accusations solely in his official capacity.

2. On October 16, 1963, the Board issued Physician's and Surgeon's Certificate Number G-9124 to Tod Hiro Mikuriya, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times pertinent to this case.

3. On July 25, 2003, a Second Amended Accusation was filed against respondent alleging unprofessional conduct, gross negligence, negligence and incompetence arising out of his care and treatment of sixteen patients. In each case he recommended marijuana for medical purposes. Complainant alleges that respondent's medical records for these patients were inadequate in that they routinely lacked adequate documentation of physical examination, clinical findings, vital signs, mental status examination, laboratory tests, follow-up and treatment plans. Complainant contends such matters are relevant and necessary to an evaluation and diagnosis of each patient's condition, or to support the recommendation or prescription of any medication. Complainant further alleges that respondent prescribed, dispensed or furnished marijuana, a controlled substance, without conducting a prior good-faith examination and/or without medical indication. Finally, complainant contends that respondent committed unprofessional conduct and/or was grossly negligent, negligent, incompetent or committed acts of dishonesty or corruption in his interactions with and care and treatment of an undercover narcotics officer.

Respondent's Background

4. Respondent has been a licensed California physician for 40 years. He is recognized as an expert on the use of marijuana for medical purposes and he has conducted research and has numerous publications on the topic of medical marijuana. He founded California Cannabis Research Medical Group to facilitate shared cannabis research. Respondent has been actively involved in the efforts to legalize marijuana for medical purposes.

Respondent attended Temple University School of Medicine before completing psychiatric residencies at Oregon State Hospital in Salem, Oregon, and Mendocino State Hospital in Talmage, California. He has served as Director, Drug Addiction Treatment Center, New Jersey NeuroPsychiatric Institute, Princeton, New Jersey (1966-67); Consulting Research Psychiatrist, National Institute of Mental Health Center for Narcotics and Drug Abuse Studies (1967); Consulting Psychiatrist, Alameda County Alcoholism Clinic, Oakland (1968-69); Consulting Psychiatrist, Alameda County Health Department Drug Abuse Project (1969); Attending Staff Psychiatrist, Gladman Hospital, Oakland (1969-92); Consultant, National Commission on Marihuana and Drug Abuse (1972); Chair, Department of Psychiatry, Eden Hospital, Castro Valley (1993-94); and Psychiatric Consultant, Fairmont Hospital, San Leandro (1991-95).

He is currently an attending psychiatrist at Eden Medical Center, Castro Valley; Vencor Hospital, San Leandro; San Leandro Hospital, San Leandro; and St. Anthony's, Park View Convalescent, Clinton Village. He describes his private practice in Berkeley as all about medicinal cannabis consultations and this includes activities in his role as Medical Coordinator of California Cannabis Centers (Oakland Cannabis Buyers Cooperative, Hayward Hempery, CHAMP, San Francisco and the Humboldt Cannabis Center, Arcata).

Respondent is a member of professional organizations including the California Medical Association, Alameda-Contra Costa Medical Association (Chemical Addictions Committee), American Psychiatric Association, Northern California Psychiatric Society, East Bay Psychiatric Association, American Society of Addiction Medicine and the California Society of Addiction Medicine (CSAM). He has been on CSAM's Medical Marijuana Task Force since April 1997.

The Compassionate Use Act

5. On November 5, 1996, the voters of California passed Proposition 215, the Compassionate Use Act of 1996, also known as the Medical Marijuana Initiative. (Health & Saf. Code, § 11362.5.) The Compassionate Use Act provides that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana. The Act makes specific provision for the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief. One of the Act's purposes

is to ensure that seriously ill Californians have the right to obtain and use marijuana for "medical purposes" and "where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana." (*Ibid.*)

The Act also expressly affirms public policy against conduct that endangers others or the diversion of marijuana for non-medical purposes. It is left for the physician, as gatekeeper, to ensure that marijuana is used for "medical purposes" to benefit the seriously ill[2]. Under these circumstances it is presumed that physicians who recommend marijuana under the Act will follow accepted medical practice standards and make good faith recommendations based on honest medical judgments. (*Conant* v. *McCaffrey* (2000 WL 1281174.) The parties agree that good faith recommendations based on honest medical judgments must be made in every case. Where they differ, and rather markedly so, is on what constitute accepted medical practice standards to be followed in making such a recommendation.

Standard of Practice Issues

6. Complainant sees no need to articulate a new standard of practice to assist physicians in recommending marijuana, believing that the standard of practice in the area of medical marijuana is not new at all, but the same as pertains to recommending any treatment or prescribing any other medication – namely history, physical examination and appropriate treatment plan. Where marijuana is being recommended for a psychiatric condition, complainant believes the examination would entail a mental status examination to establish a psychiatric diagnosis, and might either not include a physical examination or might only include a limited physical examination appropriate to the clinical situation. Complainant relies heavily upon a policy statement issued by the Board to all California physicians in its January 1997 Action Report. This statement came on the heels of Proposition 215 and recognized that there was at that time "a great deal of confusion concerning the role of physicians under this law." The policy statement specifies:

> While the status of marijuana as a Schedule I drug means that no objective standard exists for evaluating the medical rationale for its use, there are certain standards that always apply to a physician's practice that may be applied. In this area, the Board would expect that any physician who recommends the use of marijuana by a patient should have arrived at that decision in accordance with accepted standards of medical responsibility; i.e., history and physical examination of the patient; development of a treatment plan with objectives; provision of informed consent, including discussion of side effects; periodic

[2] In *Conant* v. *Walters* (2002) 309 F.3d 629, Justice Kozinski described the key role of physicians anticipated under the Act: "The state law in question does not legalize use of marijuana by anyone who believes he has a medical need for it. Rather, state law is closely calibrated to exempt from regulation only patients who have consulted a physician. And the physician may only recommend marijuana when he has made an individualized and bona fide determination that the patient is within the small group that may benefit from its use."

review of the treatment's efficacy and, of critical importance especially during this time of uncertainty, proper record keeping that supports the decision to recommend the use of marijuana.

In spring of 1997, CSAM issued a position statement regarding the recommendation of marijuana, in which it stated that marijuana is a mood-altering drug capable of producing dependency, urging the Board to formally adopt the standards set forth in the January 1997 Action Report, and further suggesting that the Board's statement be expanded to include a requirement for notation of a diagnosis or differential diagnosis.

7. Respondent notes that there are only a handful of physicians, less than twenty, who consult on medical cannabis issues as a primary part of their practice and among whom there is no uniform agreement and few guidelines on practice standards. Physicians consulting in this way are not "treating physicians" and patients who are seen are primarily self-referred and come with a single question in mind – "Do I qualify for a medical cannabis recommendation?" These patients typically are already using cannabis for their medical condition and claim a benefit from so doing. In seeking a physician's recommendation their main consideration is avoiding involvement with the criminal justice system. Most physicians are very reluctant to become involved in making such recommendations. They are afraid to say anything to patients about medical cannabis for fear that they will become targets of law enforcement themselves. The Compassionate Use Act does provide that no physician shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes. (Health and Saf. Code, § 11362.5, subd. (c).) However, as even the Board recognized early on, this language offers no protection from federal prosecution, including threat of criminal prosecution of physicians, revocation of DEA registration and exclusion from participation in the Medicare and Medicaid program for having made such recommendations.[3]

Given this history and climate respondent believes this case has been motivated politically, directed both by federal government officials and California State officials opposed to Proposition 215, and conducted from the outset in bad faith. Yet, in considering this case, every effort has been made to remain squarely focused on determining what practice standards govern medical cannabis recommendations. That is the primary issue and therefore evidence proffered on the history, motivation and other matters underlying or relating to the investigation and prosecution of this case, though considered, have been largely disregarded.[4]

8. Respondent urges as the standard of practice a more focused medical cannabis consultation model consisting of a good faith examination designed to gain needed information, no more and no less. The needed information would be limited to that sought in

[3] January 17, 1997 Memorandum to Board Members from Ron Joseph regarding Proposition 215, Use of Marijuana for Medicinal Purposes.

[4] Respondent submitted an Offer of Proof on remaining Exhibits P – W. These exhibits have been received into evidence as marked. Objections to relevancy go largely to the weight attached, and in most cases this was very marginal

answering the simple question whether a patient is eligible for inclusion under the Compassionate Use Act. Respondent believes a physician would primarily be concerned with determining if there is medical evidence supporting eligibility. There would also be a future obligation to monitor patients using medical marijuana. Respondent proposes as minimum practice standards that physicians conduct an initial face to face interview, obtain identifying information, make a diagnosis and arrange for follow-up examinations that allow for incorporation of fax, e-mail or telephone exchanges of patient information. Respondent notes that while there have been uniform guidelines recommended and submitted to the California Medical Association (CMA), practice guidelines have yet to be adopted by the CMA or by the Board. Respondent views the protocols followed in making a Proposition 215 recommendation as quite different from those followed by a physician in making a prescription. He also believes that any treatment plan should address only the medical use of cannabis and not the patient's entire medical profile/condition. Respondent believes that the relevant practice standard should not require him to fully evaluate or treat every symptom present or suspected at the time the patient is evaluated.

This generally summarizes what the parties believe to be the correct practice models in making medical cannabis recommendations. In determining which governs, the appropriateness of the two models is best evaluated by considering the medical expert opinions offered in this case. The opinions relate directly to respondent's management of the sixteen patients referenced in the Second Amended Accusation and, accordingly, patient summaries and respondent's actions with respect to each patient are briefly outlined below.

A discussion of appropriate practice standards and whether or not respondent complied with them is incorporated within these discussions of each patient.

Patient R.A.

9. Patient R.A. was seen by respondent on March 5, 1997. Medical records include a Registration Form completed by Patient R.A., but two of the five pages from that form are missing. No other documentation reflects respondent's initial evaluation of this patient. There are no records reflecting the patient's medical complaints/health problems, medical/psychiatric history, physical/mental status examination or what advice was given by respondent. A Physician's Statement dated March 5, 1997, was issued indicating that Patient R.A. was under respondent's "medical care and supervision for the treatment of medical condition(s): Anxiety Disorder Gastritis." It also indicated that respondent had discussed the medical risks and benefits of cannabis use as a treatment and that he condoned the use of cannabis.

Patient R.A. completed a "Cannabis Patient Follow Up Visit Questionnaire" dated November 6, 1998. It indicated that marijuana had been used by him for treatment of gastritis/anxiety disorder. No psychiatric history, medical history, physical/mental status examination is recorded. Respondent noted "irritation from low potency" and "recounts stressors of arrest & case & involvement & insomnia" and that he discussed the effects on the patient's life. A Physician's Statement dated November 18, 1998, confirmed that Patient

R.A. was under respondent's "medical care and supervision" for "Gastritis Anxiety Disorder." Respondent also noted that Patient R.A. "Must return by 12-2-98 for follow up."

Patient R.A. completed a follow up questionnaire dated August 5, 1999, which reported treating complaints of anxiety disorder, gastritis and irritable bowel syndrome with marijuana, 15 to 38 grams/week. An "Illness status" category on the questionnaire was checked as "Stable". There were follow up visits on April 28, 2000, and on January 4, 2001. A progress note for April 28, 2000, noted increased anxiety and insomnia. The January 4, 2001 follow up questionnaire listed gastritis and anxiety as symptoms/conditions treated with cannabis and Patient R.A.'s illness status was marked as "Stable". Respondent noted that Patient R.A. planned on relocating to Holland secondary to his fear of continuing prosecution. R.A. did leave the country and respondent maintained contact with him. On March 12, 2001, respondent consulted with Patient R.A. by telephone. He reported increased anxiety, bowel symptoms/constipation, lumbosacral back pain and a 20 pound weight loss.

10. Complainant contends that respondent committed errors and omissions in the care and treatment of Patient R.A. by: 1) failing to evaluate his anxiety and insomnia complaints by means of a standard psychiatric history, medical history, physical examination and mental status examination; 2) failing to evaluate gastrointestinal complaints to rule out serious and perhaps life threatening illness while recommending palliative treatment; 3) failing to follow up on complaints and using a questionnaire that inappropriately lumped multiple complaints into a single illness category; 4) falsely and unethically representing that Patient R.A. was under his care and supervision for treatment of serious medical conditions; maintaining medical records that lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, laboratory tests, follow-up and treatment plans necessary to an evaluation and diagnosis of the patient's condition, or to support the recommendation/prescription of any medication; and 6) furnishing marijuana without conducting a prior good faith examination and/or without medical indication.

11. Laura Duskin, M.D. testified as an expert witness on behalf of complainant. She is a psychiatrist with Kaiser Permanente, Adult Psychiatry Department, and a senior physician specialist, psychiatry with the San Francisco Department of Public Health, Community Clinics. Dr. Duskin is an Assistant Clinical Professor, UCSF School of Medicine. Her responsibilities there include teaching interviewing skills and diagnosis/treatment of psychiatric conditions to interns and residents at the medical school. Dr. Duskin is a Diplomate, American Board of Psychiatry and Neurology in Psychiatry (unlimited) and Geriatric Psychiatry. She has practiced psychiatry since 1983.

Dr. Duskin is familiar with the standard of practice for psychiatrists in both treating and consulting capacities. In terms of the initial patient evaluation she opines that the standard of practice is essentially the same, regardless of whether the physician is acting as a treating physician or as a consultant. She believes the standard of practice for recommending marijuana is identical to that governing any medication – mainly that the physician does an evaluation of the patient's complaints, formulates a differential diagnosis, discusses treatment options with the patient including the risks and benefits of medications, and

develops a treatment plan with provision for future monitoring. There is always an initial evaluation, some more comprehensive than others depending upon the status of the patient. When marijuana is being recommended for a psychiatric condition, the examination would include a mental status examination. This is basically an assessment of the patient's behavior, speech, reported mood, coherency, short term memory, impaired insight or judgment, thoughts of suicide or harming others, obsessive thoughts, etc. In some cases formal testing is required.

Where a psychiatrist is called upon to treat a condition that is non-psychiatric in nature the standard of practice is the same as that followed by any other physician, namely history, physical examination, differential diagnosis, appropriate treatment plan and plans for follow-up and responsibility for management of the problem unless it can be referred to the patient's primary care physician. Dr. Duskin emphasizes that this is really very basic, something all physicians learn as part of their medical school education. She makes specific reference to the Board's 1997 Action Report and to CSAM's policy statement (Finding 6) noting that they both merely confirm existing and accepted medical standards for treatment or prescribing of any medication.

Dr. Duskin notes that the standard of practice when treating patients in follow-up is to reevaluate the problem(s), the efficacy or problems with treatment, and to appropriately address any new concerns. If more than one condition is the focus of treatment, each condition is evaluated independently even if the same drug is being used to treat all of the conditions. Where referral for further evaluation and follow-up is warranted, a psychiatrist is responsible for making this referral and documenting this in the medical record. The standard of practice for medical records is for the psychiatrist to keep all records pertaining to the treatment of the patient, including prescriptions or certificates, and where copies of any portions of the medical records are provided to others, the psychiatrist retains the originals and sends copies only.

12. Dr. Duskin believes that respondent's treatment of Patient R.A. represented an extreme departure from the standard of practice in numerous areas of concern. The patient records contain no adequate initial evaluation note, no psychiatric or medical history, no mental status examination and no differential diagnosis. She notes that such lack of documentation for a patient for whom a psychoactive drug was being recommended was an extreme departure from the standard of care.

Dr. Duskin is critical of respondent's failure to document the history and make an appropriate follow-up plan for the patient's potentially serious gastrointestinal complaints. She is particularly concerned that "gastrointestinal cancer or other disease manifest with symptoms as described by this patient, and without appropriate medical evaluation the cannabis, if symptomatically effective, might only mask the problem until the disease progressed to a life threatening degree." There is no indication from the records that Patient R.A. was receiving ongoing treatment from another physician, important information that should be ascertained. If a physician is offering pain management or palliative treatment the physician is also responsible for making sure that the underlying problem is being addressed,

or that the patient is refusing to have that problem addressed. If such occurred in this case it was not documented and there is no indication that respondent discussed Patient R.A.'s medical or psychiatric treatment with any other health care provider.

Respondent used a patient questionnaire that allowed for illness status to be described in single word categories such as "stable", "improved" or "worse" and that grouped multiple conditions into a single evaluation category. Thus, on August 5, 1999, in reference to anxiety disorder, gastritis and irritable bowel syndrome that were being treated with cannabis, the reevaluation of the conditions consisted of the single word "stable". Dr. Duskin notes that when a symptom or condition is the focus of treatment, a one word description of the clinical situation is grossly inadequate, and that no competent clinician would lump multiple conditions into an illness category and evaluate them together as one.

In follow-up evaluations it was noted that the patient had increased anxiety and insomnia on April 28, 2000, and on March 12, 2001. No evaluation of these symptoms was documented and no treatment plan other than to recommend cannabis was made. Dr. Duskin allows that cannabis may have been efficacious for these problems but given the ongoing nature of the problems "further evaluation and consideration of supplemental treatment with other medications, other treatment modalities or a complete change in treatment for these conditions was clearly in order." Dr. Duskin is also critical of the length of time between follow-up contacts and the lack of an interval history of the progress of the patient's conditions between contacts.

Dr. Duskin has additional concerns that respondent provided a certification indicating that the patient was under his "care and supervision," something she characterizes as false and misleading. She notes, for example, that the patient's gastritis was not being followed in any way in a manner that would be expected if he was under respondent's care and supervision for that condition.

13. Respondent did not view himself as R.A.'s primary care physician and avers that he only rendered a diagnosis sufficient for the purpose of determining that R.A. had a serious and chronic condition that was helped by marijuana. He contends that R.A. was under his care and treatment because he had seen him frequently and stayed in telephone contact and followed his condition even after he left the country. He believes that he conducted a bona fide examination in determining that R.A.'s condition was both serious, chronic and helped by cannabis. He attributes R.A.'s symptoms (psycho-physiologic gastrointestinal dysfunction) to R.A.'s anxiety related to law enforcement. He disagrees that he failed to evaluate R.A.'s gastrointestinal complaints to rule out more serious disease, dismissing the notion that marijuana was palliative treatment at all.

14. Philip Andrew Denney, M.D. testified as an expert witness on behalf of respondent. He attended the University of Southern California School of Medicine and has been in medical practice since 1976. Recent professional activities include positions as the Facility Medical Director of Meridian Occupational medicine Group, Sacramento (1996-97); Facility Medical Director of Healthsouth Medical Clinic, Rocklin (1997-99); Medical

Director, Marshall Center for Occupational Health (1999-2000); and Occupational and Legal Medicine (2000 – present). From 1999 his medical legal practice has included medical cannabis recommendations. Dr. Denney's membership in professional societies includes the American College of Occupational and Environmental Medicine and the California Cannabis Research Medical Group. He remains informed about medical cannabis from the small universe of practitioners in this field who exchange information informally or through organized conferences. He describes one of respondent's publications as an authoritative and seminal work that introduces western physicians to appropriate citations in medical literature in this field. Although he believes thousands of doctors give cannabis recommendations, Dr. Denney notes that fewer than twenty consult on medical cannabis issues as a primary part of their practice. He falls within this category.

Dr. Denney views respondent's role as that of a consultant, and not as that of a treating physician. Because cannabis cannot be prescribed he notes that the physician is not involved in treatment at all, rather the patient is engaged in self treatment of a medical condition. The physician's role is that of recommending the cannabis for a medical condition. The physician is not saying that this is the sole treatment, it may be only one small part. Dr. Denney believes that the good faith examination required in these cases is only that which is necessary to gain the information needed. He considers the Board's 1997 Action Report to be advisory in nature and not the standard of practice.

With regard to Patient R.A., Dr. Denney opines that cannabis has salutary effects on gastritis but would not mask a more serious condition. He describes its effects as very mild compared to other prescription drugs, opiates for example. He has no criticism of respondent's medical records or lack thereof. Dr. Denney notes that it is not uncommon to have cursory, largely unintelligible and useless information contained in medical records. In making a sincere medical judgment he believes physicians rely more on actual observations and face to face contact with patients, and not upon medical records or other written documents provided by the patient.

15. Dr. Denney acknowledges obtaining a patient's history and performing physical examinations in his own practice, including medical cannabis consultations. He explains that he does so primarily for administrative and legal reasons yet he has consistently taken this examination approach for patients over his entire career in an effort to practice "excellent medicine." During medical cannabis evaluations he investigates complaints raised by the patient and if warranted he advises patients to seek follow-up care. He documents such discussions in his medical records. Dr. Denney opines that respondent is a superb physician whose medical cannabis practices were both appropriate and within the standard of care. Yet Dr. Denney's own practices are very different from respondent's and his practices are entirely consistent with the Board's 1997 Action Report policy statement. In conducting his medical cannabis evaluation Dr. Denney obtains a medication history and reviews the reason for using cannabis. He discusses medical cannabis and any problems with its use with the patient, reviews any available records and tries to determine whether the patient is being truthful. He conducts a "head to toe" physical examination and evaluates the presenting complaint for each patient. Dr. Denney notes that if a patient raises a complaint of

importance he would "certainly" advise the patient to seek follow-up care with a physician. He acknowledges that it is important to keep medical records documenting the medical evaluation, and that such records might be important to subsequent treating physicians.

Essentially, the good faith examination Dr. Denney performs to support a recommendation for medical marijuana is no different than what he follows in any other medical evaluation.[5] It is also consistent with the standards articulated by Dr. Duskin.

16. The above matters having been considered, it does appear that the standard of practice for conducting a medical cannabis evaluation is identical to that followed by physicians in recommending any other treatment or medication. The standard applies regardless of whether the physician is acting as a treating or as a consulting physician. The medical cannabis evaluation is certainly focused on the patient's complaints, but it does not disregard accepted standards of medical responsibility. These standards include history and physical examination of the patient; development of a treatment plan with objectives; provision of informed consent; periodic review of the treatment's efficacy and proper record keeping. When a cannabis recommendation is being made for a psychiatric condition the examination would additionally entail a mental status examination to establish a psychiatric diagnosis and severity of the condition. In such cases a physical examination might not be included, or might only include a limited physical examination appropriate to the clinical situation. In sum, the standard of practice for a physician recommending marijuana to a patient is the same as pertains to recommending any other treatment or medication.

Respondent contends that consulting physicians would be unreasonably burdened with conducting a complete work up on each conceivable diagnosis or symptom presented or suspected and that he would have to maintain extensive notes on every item of communication between physician and patient. He is also concerned that he would be responsible for referring patients out for additional medical care if not provided personally and that patients would be required to return for further evaluations and extensive testing to independently verify medical diagnoses or symptoms.

A physician must obviously exercise some discretion in making clinical judgments and it would be unreasonable to require a comprehensive physical/mental examination in every case. Complainant's major criticism of respondent is that he failed to perform any work up on each patient's chief presenting complaint and that he failed to conduct even the most cursory of physical or mental status examinations. Dr. Denney's practice is instructive because, like respondent, he also performs numerous medical cannabis evaluations. Yet he incorporates traditional elements of a medical evaluation and the examination that he

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[5] Dr. Denney acknowledged in prior testimony that he makes a determination of whether a patient should be given a prescription or some kind of treatment as follows: "I take a medical history. I examine the patient. I do a physical examination. I base my opinion on those things, on records if they're available, on my opinion as to the patient's truthfulness, etc." When asked what is a recommendation for cannabis he answered: "A recommendation is an opinion based upon history and physical exam and experience that says that the patient has a condition which in the physician's opinion will benefit from cannabis use." (*People* v. *Urziceneau*, Sacramento Superior Court No. 00F06296.)

undertakes is the same that he performs on all his patients. The model is not as rigid or as burdensome as respondent suggests. Dr. Duskin allows for flexibility, noting for example that no physical examination or only a limited physical examination may be appropriate in cases where medical marijuana is recommended for a psychiatric condition. When warranted, it hardly seems burdensome at all to refer a patient out for additional evaluation or care if one is not the treating physician and a serious condition is suspected or confirmed. Failure to do so is an extreme departure from the standard of care.

17. It was established that respondent committed errors and omissions in his care of Patient R.A. in the following respects:

a. Respondent failed to evaluate R.A.'s gastrointestinal complaints, anxiety, and insomnia by means of a standard medical history, physical examination and mental status examination. Medical records for R.A. lacked adequate documentation of physical examination, clinical findings, vital signs, mental status examination, test results and treatment plan. Such failures constituted an extreme departure from the standard of care.

b. Respondent failed to evaluate or refer R.A. out for evaluation of gastrointestinal complaints to rule out serious and perhaps life threatening illness and such constituted an extreme departure from the standard of care.

c. Respondent failed to follow-up on R.A.'s complaints and used an inadequate check box questionnaire that lumped multiple complaints together into a single illness category. It was designed to be completed by the patient. The lumping of multiple complaints into a single illness category is a matter of poor questionnaire design, a departure from the standard of care.

d. Respondent falsely represented that R.A. was under his care and supervision for treatment of a serious medical condition. The choice of language on respondent's Physician Statement was intended to assist the patient in certifying eligibility under Proposition 215, no more. It was boilerplate and the form was designed by respondent at a time when there was little guidance on appropriate language to be used. Under these circumstances it reflected a departure from the standard of care.

Patient S.A.

18. Patient S.A., a 20 year old male, was seen by respondent on May 20, 1996. He reported a history of nausea, vomiting, motion sickness and anorexia. Medical records indicated that he had previously been worked up by physicians with an upper GI exam showing "probable small duodenal ulcer." Respondent's medical records for S.A. contain no

documentation that he elicited a history of other medical conditions, that he took vital signs or that he performed a physical/mental status examination. No treatment plan was formulated and there was no plan for follow-up of the patient's continuing gastrointestinal problems. Respondent did prescribe Marinol, a pharmaceutical containing the active ingredient in marijuana, for the patient's symptoms.

On November 10, 1997, respondent noted that the Marinol provided less relief than crude marijuana and based upon the patient's statement that he was "doing well with symptom control" respondent issued a Physician Statement indicating that S.A. was under his medical care and supervision for the serious medical condition of gastritis and that respondent recommended marijuana for this condition.

On May 12, 1998, S.A. requested a renewal of his Marinol prescription. The communication was characterized as a "televisit" and the patient's gastritis was described by a box checked "stable." A note on the form indicates that the certificate was mailed to the patient.

On October 16, 1999, the patient again requested a "renewal of cannabis recommendation." The communication was not in person, but was conducted via fax transmittal of a "Cannabis Patient Follow Up Visit Questionnaire." The form contains the patient's assessment that his gastritis was "stable" and his nausea was "better." S.A. also checked the box indicating that he found the treatment to be "very effective" and answered "no" to the question whether he experienced adverse effects. He issued the cannabis recommendation after he received the follow-up questionnaire and requested fee.

19. Dr. Duskin notes that S.A. was first seen by respondent approximately three years after he was diagnosed with a possible duodenal ulcer and that it was incumbent upon him to obtain an interim history to determine whether disease progression or some other gastrointestinal problem could account for current symptoms. Vital signs, frequency of vomiting, loss of blood and weight loss would all have been basic parts of a medical evaluation in this case. No vital signs or patient weight were recorded by respondent. On the basis of the patient's verbal reports, respondent justified a diagnosis of "gastritis, rule out peptic ulcer." Respondent prescribed Marinol without documenting informed consent and there is no indication that he referred S.A. back to his gastroenterologist or primary care provider for further evaluation. During his initial visit respondent noted that S.A.'s chemistry panel was within normal limits.

Two of the three follow-up visits were not face to face meetings. The standard of practice for follow-up visits is for the physician to reevaluate the clinical complaint(s) and any new problems. This entails an interval history of the symptoms or condition. A one word statement ("Stable") checked on a form by the patient is not sufficient information upon which to make a clinical decision to continue Marinol. A medication renewal to treat gastritis, nausea and motion sickness would necessitate a clinical evaluation of the patient or documentation that an appropriate clinical evaluation was done by another practitioner prior to renewing the medication. A doctor might renew a prescription for a brief period without

seeing a patient if the patient had been seen recently, but in this case respondent issued a cannabis recommendation on October 29, 1999, more than seventeen months after his previous evaluation. It appears that respondent issued the cannabis recommendation only after he received the follow-up questionnaire and requested fee. Dr. Duskin opines that "to charge for what amounts to a medication renewal without reevaluating the patient is unethical and grossly inappropriate. Likewise, this action would constitute an extreme departure from the standard of practice from a clinical standpoint."

Respondent signed a statement indicating that S.A. was under his "medical care and supervision" for the treatment of gastritis. If this were the case respondent would have been coordinating the ongoing evaluation and treatment of this condition with the patient's gastroenterologist or other medical practitioner and this was not the case.

20. Respondent notes that he evaluated S.A. only for a medical marijuana recommendation and that for purposes of follow-up, telephone contact and questionnaire were sufficient. He did not see himself as the primary care physician, noting that S.A. was self treating with cannabis before he saw respondent. Respondent believes that he performed a bona fide examination on the initial as well as on follow-up evaluations. He acknowledges that he did nothing to rule out peptic ulcer or to work up the gastritis. His focus was on determining eligibility under the Compassionate Use Act. When asked if he would be concerned if S.A. did not have a physician he answered in the negative, noting that it was not his responsibility and that it was beyond the scope of a consultative exam.

21. It was established that respondent committed errors and omission in the care and treatment of Patient S.A. in the following respects:

a. Respondent failed to evaluate S.A.'s gastrointestinal complaints by means of a standard medical history, physical examination. Medical records for S.A. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan. He prescribed Marinol without ruling out progression of the previously suspected duodenal ulcer. Such failures constituted extreme departures from the standard of care.

b. Respondent failed to re-evaluate or refer S.A. out for evaluation of gastrointestinal complaints to rule out serious illness and such constituted an extreme departure from the standard of care.

c. Respondent renewed S.A.'s recommendation in 1998 and 1999 without an interval history of the patient's condition and with the last examination not having been performed since November 1997.

d. Respondent charged S.A. for medication renewal without conducting an examination, an extreme departure from the standard of practice.

Patient J.B.

22. Patient J.B., a 40 year old female, was seen by respondent only once, on August 9, 1997. She presented with a ten year history of chronic depression and anxiety.

He diagnosed her with dysthymic disorder and Post Traumatic Stress Disorder (PTSD).

Dr. Duskin opines that respondent's treatment represented an extreme departure from the standard of practice when he failed to evaluate her symptoms of anxiety, depression and panic attacks. Respondent did not obtain the requisite history of the onset and duration of the patient's complaints, nor did he determine whether the patient had ever been hospitalized or ever been suicidal. He conducted a mental status examination that Dr. Duskin believes was deficient because it provided information only about the patient's current state and nothing about her history. Further, he did not offer her standard treatment for these diagnosed conditions when many effective treatments are available for both PTSD and dysthymia. The medical records contain no documentation that he offered standard treatment for these conditions or that if he did that the patient refused. Dr. Duskin also opines that he inappropriately instructed her to follow-up with him as needed instead of establishing a follow-up plan given the severity of her psychiatric conditions. Dr. Duskin has no quarrel with the cannabis recommendation, only with respondent's failure to do more. She emphasizes that a treatment plan in this case would need a number of elements – life circumstances needed to be addressed, and consideration given to behavioral interventions and perhaps adjunctive medications. Respondent issued a statement indicating that J.B. was under his "medical care and supervision" for dysthymic disorder and PTSD and this simply was not the case.

Respondent views his role in this case as that of providing J.B. with medicinal justification and protection from law enforcement His understanding is that a clinical evaluation is a visit where a clinical decision is made and he believes he conducted a bona fide examination in this case. He avers that he spent over an hour with this patient. He does not know if J.B. had another physician and notes that she was opposed to taking pharmaceuticals making treatment options and interventions limited. He did not refer her to therapy or to another physician. Respondent believes the scope of the consultative evaluation was to issue her a certificate even though he felt that she needed much more.

23. It was established that respondent committed errors and omissions in the care and treatment of J.B. in the following respects:

a. Respondent conducted an inadequate evaluation of her symptoms of depression, anxiety and panic attacks.

b. Respondent arrived at a diagnosis of PTSD and dysthymic disorder without conducting a documented clinical evaluation.

c. Respondent failed to offer or refer J.B. out for standard psychiatric treatment for her conditions.

d. Respondent failed to provide follow up care for J.B.'s complaints.

Respondent's overall treatment of J.B. as above described represented an extreme departure from the standard of care.

Patient J.M.B.

24. On December 30, 1998, Patient J.M.B., a 26 year old male, consulted respondent for complaints of chronic pain that he attributed to spinal injuries sustained in prior automobile accidents. Respondent's records contain no vital signs physical examination or other medical evaluation of the patient's spinal complaints. Respondent issued a physician's certificate stating that J.M.B. was under his medical care and supervision for the treatment of intervertebral disc disease. A physician evaluating a patient with chronic orthopedic complaints is required to perform a physical examination, to obtain a history of the patient's condition, to assess any decrease in range of motion and limitations in daily activities. Respondent did none of these things.

On June 22, 1999, respondent issued a physician's statement to J.M.B. reiterating that he remained under respondent's care and supervision for the treatment of intervertebral disc disease. There is no record that respondent re-evaluated J.M.B. on this date, nor is there any evidence that respondent obtained an interval history.

Respondent believes he performed a bona fide examination for purposes of recommending medical cannabis. When asked whether a physical examination might have assisted in verifying complaint he explains that in most cases he takes what a patient says to be true and accurate.

25. It was established that respondent committed errors and omissions in the care and treatment of J.M.B. in the following respects:

a. Respondent failed to evaluate J.M.B. for intervertebral disc disease and arrived at a diagnosis without performing appropriate medical work up. Such failure constituted an extreme departure from the standard of care.

b. Respondent renewed the patient's recommendation without interval history or re-evaluation, an extreme departure from the standard of care.

c. Respondent's statement that J.M.B. was under his medical care and supervision for intervertebral disc disease was false, a departure from the standard of care.

Patient R.B.

26. Respondent saw R.B., a 27 year old male, on May 21, 1999. R.B. presented with complaints of nausea and dizziness and respondent made diagnoses of nausea and alcohol-related gastritis. In doing so he recorded no vital signs and ordered no laboratory tests. Medical records do not document any history, physical examination or other appropriate methods by which respondent arrived at a diagnosis. Dr. Duskin opines that respondent's treatment of R.B. "represented an extreme departure from the standard of practice when he made two diagnoses without obtaining an adequate medical history e.g. review of the onset, course of illness, alleviating and exacerbating factors in enough detail to make an accurate diagnoses."

R.B. did bring medical and other records, 40 pages worth, with him to his examination with respondent along with his medications. He had a primary care physician with Kaiser and had undergone extensive medical work-up and treatment prior to being seen by respondent. R.B. indicated that he was told that Kaiser would not permit its doctors to sign Proposition 215 recommendations and that was why he sought out respondent.

Respondent notes that he reviewed the records that R.B. brought with him and that he examined him. This included a family and past medical history, present illness, treatment plan and a review of cannabis use pattern. Respondent believes vital signs and laboratory tests were irrelevant in that they have nothing to do with the specific question of whether medical cannabis is appropriate. He acknowledges that he does not take vital signs, including blood pressure, for any of his patients. He notes that he conducted a bona fide examination of R.B.

27. It was established that respondent diagnosed R.B. with nausea and gastritis without performing a physical evaluation, recording vital signs or ordering laboratory tests.

Medical records for R.B. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan. Such failures constituted extreme departures from the standard of care. It was not established that respondent failed to take an adequate history given the information that R.B. provided to him via patient records and clinical interview.

Patient D.B.

28. Respondent saw D.B. on June 26, 1998, with complaints of cerebral palsy and post-traumatic arthritis. No physical examination and no vital signs were recorded. On June 27, 1998, respondent issued a recommendation for the patient's medical cannabis use and indicating that D.B. was under his medical care and supervision for the treatment of cerebral palsy and post-traumatic arthritis. There were no treatment goals and no baseline data upon which progress could be measured. By the time of a follow-up evaluation on January 21, 2000, there were still no records of any kind, nor any type of appropriate referral for medical reevaluation of the physical condition of concern. D.B. was charged $100 for "confirming

status" without any apparent examination. Dr. Duskin notes that even though cannabis was reportedly beneficial to the patient "other adjunctive treatments would need to be explored including possible medication, physical therapy, occupational therapy for assistive or corrective devices, etc." Just addressing the cannabis portion of treatment did not amount to "medical care and supervision."

It was established that respondent committed errors and omissions in the care and treatment of D.B. in the following respects:

a. Respondent recommended treatment to D.B. without conducting a physical examination. Medical records for D.B. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to provide follow up or referral for the patient's complaints.

c. Respondent charged for renewal of the patient's recommendation even though no examination was performed.

d. Respondent's statement that D.B. was under his medical care and supervision for cerebral palsy and traumatic arthritis was false.

Respondent's overall treatment of D.B. as above described represented an extreme departure from the standard of care.

Patient K.J.B.

29. Respondent first saw K.J.B., a 42 year old male with complaints of muscle spasm and lumbosacral pain, on August 24, 1998. There is no record of a physical examination of the patient, nor is there a proposed treatment plan or plan for follow-up. Respondent issued a physician statement indicating that K.J.B. was under his medical care and supervision for the treatment of Lumbosacral Disease. On September 20, 1999, K.J.B. again contacted respondent and on that occasion he provided respondent with a Beck Inventory, a self-administered questionnaire that is used to measure the degree of a patient's depression. K.J.B. endorsed a number of items and multiple statements indicating a significant level of depression. K.J.B. also completed a form indicating that he suffered from depression, insomnia, weight loss, cannabis addiction and back pain. There is no recorded assessment by respondent of the patient's multiple complaints and there was no plan for treatment or follow-up for the patient's depression and back pain except for a box indicating follow-up in 6 – 12 months.

The standard of practice for treating musculoskeletal pain and muscle spasm is to take an adequate history, do a pertinent physical examination, obtain old records when available, make or confirm the diagnosis, and develop a treatment plan presenting all reasonable

treatment options and making referrals as appropriate. The same standard applies to treating depression except that the examination would consist of a mental status examination and pertinent parts of the physical examination. In this case there was not an adequate evaluation of either the psychiatric or the musculoskeletal complaints.

K.J.B. believed that respondent was his treating psychiatrist and was the "best" in the field and it is therefore troubling that respondent indicates that he did not perform a formal mental status examination and that K.J.B. was mistaken if he believed that he was his psychiatrist. Dr. Duskin notes that though cannabis may have helped in the patient's depression, there are many effective treatments for depression including both antidepressants and psychotherapy, treatments that respondent failed to provide or refer out for. Respondent avers that he did not suggest therapy or standard treatment for K.J.B. because he believed K.J.B. was not the sort of person who would be accepting of therapy.

30. It was established that respondent committed errors and omissions in the care and treatment of K.J.B. in the following respects:

a. Respondent failed to conduct a physical examination of K.J.B. before recommending treatment. Medical records for K.J.B. lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to conduct an evaluation of the patient's depression.

c. Respondent failed to reevaluate the patient in light of the patient's continuing depression or to consider alternative treatments for the patient's recurrent depression.

d. Respondent's statement that K.J.B. was under his medical care and supervision for lumbosacral disease was false.

Respondent's overall treatment of K.J.B. as above described represented an extreme departure from the standard of care.

Patient J.C.

31. Respondent saw J.C., an 18 year old female, on December 11, 1998. She complained of anorexia and stated that she was 6 months pregnant and had used marijuana to keep food down. Donnatal and over-the-counter medications were apparently ineffective. Dr. Duskin opines that such complaints in pregnant patients are potentially serious for the patient and for the fetus. The standard of care requires that a physician evaluate, first, the type of anorexia that is being addressed and include a description of the patient, her weight, vital signs and a detailed history. Respondent failed to record the patient's height, weight or vital signs and no history relevant to the patient's anorexia is documented, nor is a history documented with regard to his diagnosis of prolonged traumatic stress disorder. There is no

record of discussion of the relative risks and benefits of marijuana use. Dr. Duskin believes the failures above described were simple departures from the standard of care, but given the multiple simple departures represented an extreme departure.

J.C. and her mother both testified. As soon as J.C. began using cannabis she began to gain weight and her pregnancy was a healthy one. She provided a substantial number of patient records to respondent that he reviewed at the time of his evaluation. Respondent is criticized for his failure to contact J.C.'s treating obstetrician, but he explains that J.C.'s mother told him that the obstetrician approved of her daughter receiving cannabis but was afraid to provide a written recommendation. Under the circumstances respondent believed it unnecessary to contact this physician. Respondent also recommended cannabis instead of Marinol because he believed that J.C.'s stomach would be too sensitive and that through vaporization technique J.C. would be able to inhale therapeutic resins without other contaminants.

32. It was established that respondent committed errors and omissions in the care and treatment of J.C. in the following respects:

a. The medical records for J.C. lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, test results and treatment plan.

b. He failed to work up J.C. prior to arriving at a diagnosis of prolonged traumatic stress disorder.

Respondent's overall treatment of J.C. as above described represented an extreme departure from the standard of care. However, it was not established that he failed to adequately evaluate J.C.'s reported anorexia given the amount of information about her condition that was made available to him. Similarly, it was not established that he failed to consider alternatives to smoked marijuana for J.C. His decision not to prescribe Marinol was based on his reasonable clinical judgment that her stomach would not be able to tolerate this medication. Respondent also provides a reasonable explanation for his decision not to contact J.C.'s treating physician.

Patient S.F.

33. Patient S.F. was 16 when she saw respondent on March 18, 1999, complaining of migraine headaches, depression and painful menstrual cramps that had worsened following a therapeutic abortion. She had no treating physician and had received no medical work up for any of these conditions. Her reported history included stress and "flipping out" during periods of extreme anger. Respondent recorded no history regarding the headaches. No physical or mental status examination and no vital signs are documented in the records. Respondent issued a physician's statement indicating that S.F. was under his medical care and supervision for the treatment of migraine headache and premenstrual syndrome.

Dr. Duskin agrees that marijuana might be helpful for these complaints but notes that respondent took only a partial history from S.F. regarding her headaches and did not adequately assess their triggering factors, duration and progression. Regarding the complaints of persistent and severe menstrual cramping, the standard of care would require an evaluating physician to obtain a history, including cycle, where in the cycle the symptoms are occurring, whether the menses are heavy or light, as well as what has helped or aggravated the condition. Infertility issues should be considered for a patient this young with a history of therapeutic abortion and referral for gynecological examination was indicated.

S.F. reported past medical history of depression, stress and head injuries and there is no indication that respondent undertook an evaluation of these conditions. The standard of practice upon hearing that a patient has had a head injury is to do a full history and neurological examination, or arrange for same.

34. Respondent relied upon information provided to him by S.F. and her father. He believes that he did an adequate work up regarding the etiology of the headaches and he determined that the head injury had occurred some time in the distant past and that she had recovered with diminishing sequela. He made a specific recommendation for psychological evaluation to S.F. and to her father. There were significant behavior problems at issue in their home.

35. It was established that respondent committed errors and omissions in the care and treatment of S.F. in the following respects:

a. Respondent failed to adequately work up the etiology and nature of S.F.'s headaches. The medical records for S.F. lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to evaluate the patient's complaints of painful menstrual cramps and failed refer her to an obstetrician/gynecologist for further evaluation.

c. Respondent's statement that S.F was under his medical care and supervision for treatment of migraine headaches and premenstrual syndrome was false.

Respondent's overall treatment of S.F. as above described represented an extreme departure from the standard of care. However, it was not established that respondent failed to address her stress and depression or that he failed to make a counseling or psychotherapy referral. He did so. He also made a clinical determination that her head injury was not recent and that she had recovered with no ill effects.

Patient D.H.

36. Respondent saw D.H., a 36 year old female, on April 30, 1999. She complained of very painful headaches as well as neck and shoulder pain associated with stress. Respondent issued a recommendation for the patient to use marijuana for tension headaches, pruritus and anxiety disorder. Medical records for D.H. contain no record of physical examination, vital signs, mental status examination or other work up of her complaints. The records consist largely of a questionnaire completed by the patient. There is no written evaluation by respondent.

Dr. Duskin opines that respondent failed to conduct an adequate history and physical examination to make or confirm the diagnoses presented by D.H. This was particularly important for headache complaints given the different causes and the need for a physician to develop a treatment plan specific to the cause of headache symptoms.[6] D.H. brought with her to her appointment medical reports and evidence of her condition. She told him that she had benefited from the use of cannabis in that her headaches were less intense and the itching was not as bad. She had a primary physician and had also been to a chiropractor and respondent advised her to also follow what her other doctors had recommended.

37. It was established that respondent committed errors and omissions in the care and treatment of D.H. in the following respects:

a. Respondent failed to adequately work up the etiology and nature of D.H.'s headache complaints and, aside from recommending marijuana, did not develop a treatment plan for her. The medical records for D.H. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to document and evaluate D.H.'s complaints of pruritus and, aside from recommending marijuana, did not develop a treatment plan for her.

c. Respondent failed to document and evaluate D.H.'s complaints of anxiety and, aside from recommending marijuana, did not develop a treatment plan for her.

d. Respondent's statement that D.H. was under his medical care and supervision for treatment of headaches, pruritus and anxiety was false.

Respondent's overall treatment of D.H. as above described represented an extreme departure from the standard of care.

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[6] Causes may include benign conditions as tension headache, uncorrected vision problems, teeth clenching and migraine, to much more serious conditions such as carbon monoxide poisoning, subdural hematoma or even brain tumor.

Patient J.K.

38. Respondent issued a physician's statement dated July 23, 1999, indicating that J.K., a 37 year old year old male, was under his care and supervision for posttraumatic stress disorder and traumatic arthritis. J.K. completed a questionnaire dated June 27, 1999, describing his present illness as dysthymic disorder and steel pin in right leg. Respondent's records contain no record of psychiatric history, physical examination, vital signs, mental status examination or other work up of the patient's complaints. The standard of practice for a psychiatrist evaluating a patient with a history of dysthymia is to complete a psychiatric history and to perform a mental status examination to determine the degree of depression. In diagnosing PTSD the standard of practice is to determine whether the diagnosis is justified in light of symptoms and history. Dr. Duskin opines that respondent's treatment represented an extreme departure from the standard of practice when he diagnosed PTSD without specifying any of the symptoms/criteria necessary for this diagnosis.

Respondent avers that he learned sufficient medical history from this patient to indicate that he suffered from these conditions but acknowledges that documentation supporting PTSD was not present. With regard to traumatic arthritis, he believes that the fact of an indwelling pin indicates serious trauma with consequent arthritis.

39. It was established that respondent committed errors and omissions in the care and treatment of J.K. in the following respects:

a. Respondent failed to evaluate J.K.'s reported depression by obtaining a psychiatric history and mental status examination. The medical records for J.K. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent diagnosed J.K. with PTSD without specifying the symptoms or criteria requisite to that diagnosis.

c. Respondent failed to evaluate J.K. for traumatic arthritis by appropriate history and examination.

d. Respondent's statement that J.K. was under his medical care and supervision for treatment of PTSD and traumatic arthritis was false.

Respondent's overall treatment of J.K. as above described represented an extreme departure from the standard of care.

Patient D.K.

40. D.K., a 54 year old female, was seen by respondent on June 27, 1998, with a history of stroke and tobacco dependence. Respondent issued a physician's statement representing that D.K. was under his medical care and supervision for brain trauma and nicotine dependence. Other than that which was apparent through observation, respondent did not conduct an evaluation of her brain trauma nor did he evaluate her tobacco smoking addiction. Dr. Duskin opines that the standard of practice when treating symptoms associated with prior brain injury is to specifically identify the symptoms, onset, intensity, exacerbating and relieving factors, and effectiveness of past treatments. Though cannabis might be very effective for symptoms of brain trauma, other psychotropic medications may be equally or more effective and the patient needs to be made aware of therapeutic options. Dr. Duskin recognizes the value of cannabis being of assistance in a harm reduction treatment of nicotine dependence but notes that the standard of practice requires obtaining a smoking history (pack years, recent history including attempts to quit, etc.) and discussing treatment options.

Respondent notes that D.K. was specifically seeking recommendation for use of medical cannabis that she had found useful for symptoms of organic brain damage she suffered at age 21. He observed her peculiar speech patterns, that she was emotionally labile, depressed and had difficulty controlling her reactions. Cannabis helped her become less agitated and less disorganized. He felt that he was able to adequately evaluate her brain injury and determine that it was a serious chronic condition that would be helped by cannabis. His response to criticism of his practice regarding evaluation, diagnosis and treatment plans is that these were matters beyond his role as a medical cannabis consultant and that he had all the information that he needed to determine whether D.K. had a condition that would benefit from the use of marijuana. Respondent believed that she would also benefit from neuropsychological testing and possible eligibility for public rehabilitation programs. He issued a written recommendation for such testing.

D.K. returned to see respondent on July 24, 1999, and July 28, 2000, and records consist largely of a questionnaire completed by the patient indicating status by checked categories on the form that lumped multiple serious conditions together.

41. It was established that respondent committed errors and omissions in the care and treatment of D.K. in the following respects:

a. Respondent failed to evaluate D.K.'s brain injury, failed to establish a diagnosis of the patient's condition and failed to develop a treatment plan. The medical records for D.K. lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to evaluate D.K.'s nicotine dependency and to document her tobacco smoking history.

c. Respondent failed to conduct an appropriate follow-up evaluation for D.K.'s condition and charged for renewal without reexamining her.

d. Respondent's statement that D.K. was under his medical care and supervision for treatment of brain trauma and nicotine dependence was false.

Respondent's overall treatment of D.K. as above described represented an extreme departure from the standard of care.

Patient E.K.

42. Respondent saw E.K., a 49 year old male with complaints of insomnia and back pain, on February 17, 1997. He reported that he had a back pain since age 18 secondary to scoliosis and that he had been using marijuana to relieve pain symptoms. He also reported a history of hypertension. No physical examination is documented and no vital signs were recorded. Respondent prescribed Marinol.

On March 17, 1999, E.K. completed a follow-up questionnaire indicating a desire to replace Marinol with crude marijuana. He sought marijuana for conditions of "sleep, hypertension, blood pressure, blood sugar, eating." Respondent charged E.K. $120 and sent him a recommendation for the use of marijuana for anxiety disorder and persistent insomnia. E.K. contacted respondent in March 2000 and March 2001, and received recommendation renewals, all without examination. The recommendations indicated that E.K. was under his care and supervision for anxiety disorder, insomnia and essential hypertension, except that the 2001 statement omitted the reference to hypertension. No explanation is documented for this change.

Dr. Duskin notes that the standard of practice for a psychiatrist evaluating a patient with these conditions is to evaluate each condition and develop a treatment plan specific to each. She opines that his treatment of E.K. constituted an extreme departure from the standard of practice because he failed to evaluate the patient insomnia and anxiety in even a basic way – type, severity, duration, accompanying symptoms, exacerbating and alleviating factors. He also failed to evaluate the blood sugar and blood pressure complaints, not even taking a blood pressure reading or ordering or referring him for appropriate laboratory tests that are routine in the evaluation of a hypertensive patient.

Respondent explains that E.K. sought no more than a cannabis recommendation from him, that he conducted a sufficient examination, that he determined that the conditions were both serious and chronic and by E.K.'s account relieved by cannabis. He notes that E.K. is a Christian Scientist and his personal/religious beliefs precluded him from consultation with most physicians. Respondent did not believe he was being consulted for hypertension or high blood sugar and notes that they were conditions that were mentioned in passing. Yet, respondent listed hypertension as a condition for which E.K. was under his care and supervision and that cannabis was recommended for same.

43. It was established that respondent committed errors and omissions in the care and treatment of E.K. in the following respects:

a. Respondent failed to evaluate E.K.'s hypertension, fluctuating blood sugar and complaints of anxiety and insomnia. The medical records for E.K. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent's statement that E.K. was under his medical care and supervision for treatment of anxiety disorder, insomnia and essential hypertension was false.

c. Respondent dropped his diagnosis of essential hypertension without documenting normalization of the patient's blood pressure.

d. Respondent charged for renewal of recommendation without re-examining the patient.

Respondent's overall treatment of E.K. as above described represented an extreme departure from the standard of care.

Patient F.K.

44. Respondent saw F.K., on June 30, 1997, for complaints of alcohol dependency and lumbosacral radiculitis. His diagnosis for F.K. was thoracic or lumbosacral neuritis or radiculitis, unspecified and alcohol dependence syndrome, unspecified. He documented no mental status examination, no adequate medical, psychiatric or substance history, no physical examination to evaluate the lumbosacral problem and no treatment plan other than to discontinue alcohol. Respondent issued a physician's statement indicating that F.K. was under his care and treatment for lumbosacral thoracic radiculitis and alcoholism. Dr. Duskin opines that the standard of practice when diagnosing substance abuse or dependence is to document the substance abuse history, psychiatric history, perform a mental status examination and perform relevant physical examination and laboratory tests. A treatment plan addressing the problem should be stated in the medical record. She notes that respondent's evaluation seemed to consist only of references to three glasses of wine per week and this was inadequate. A mental status exam is needed to assess whether there is a primary or secondary psychiatric problem associated with the substance abuse. Simply informing a patient that he should "stop drinking" is not sufficient treatment.

Patient F.K. brought with him Veterans Administration (V.A.) medical records to his initial interview and they were reviewed by respondent. He had begun self-medicating with marijuana well before this meeting. It eased his back pain. V.A. physicians told him they could not recommend medical marijuana but also told him that respondent was an expert. F.K. prefers not to use opiates. In the past he drank a six pack and a couple of glasses of wine daily after work. He drinks a single glass per day with dinner if he is using marijuana.

Respondent believes he adequately evaluated F.K.'s drinking problem and that he engaged in thorough telephonic interviews for all follow-up evaluations. Telephone contacts were on March 5, 1998, November 24, 1998, and July 25, 2001. They typically lasted up to fifteen minutes after which a medical cannabis recommendation would be issued. Respondent charged F.K. $120 for this service.

45. It was established that respondent committed errors and omissions in the care and treatment of F.K. in the following respects:

a. Respondent failed to substantiate F.K.'s reported substance abuse problem prior to issuing a diagnosis of alcoholism and failed to formulate a treatment plan. The medical records for F.K. lacked adequate documentation of physical examination, mental status examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent charged for recommendation renewal without conducting an examination of the patient.

Respondent's overall treatment of F.K. as above described represented an extreme departure from the standard of care.

Patient R.H.

46. Respondent saw R.H., a 50 year old male with a history of alcoholism and alcohol-related cerebellar ataxia on March 26, 1998. He issued a recommendation for marijuana for the treatment of "Alcoholic encephalopathy & Recovering alcoholic Insomnia & Posttraumatic arthritis." A follow-up questionnaire dated April 16, 2001 indicated "No Change" on these three diagnoses. Though the patient specified that he drinks up to ten cups of coffee daily, there was no comment in the record regarding its relevance to the insomnia complaint. The standard of practice for a psychiatrist diagnosing and evaluating insomnia is to obtain a full history including onset, type, exacerbating and ameliorating factors, medications taken, drugs, caffeine history, etc. The treatment plan should be directed at the primary cause of the insomnia, and may include both a pharmacologic and behavioral component. Respondent issued a physician's statement on May 3, 2001, indicating that R.H. was under his medical care and supervision for treatment of the serious medical conditions insomnia, traumatic arthritis and brain injury and that he recommended and approved his use of cannabis for these conditions. The medical record contains no documentation of traumatic arthritis.

47. It was established that respondent committed errors and omissions in the care and treatment of R.H. in the following respects:

a. Respondent failed to evaluate R.H.'s complaints of insomnia or to consider standard treatments for its underlying cause. He also failed to

evaluate and document R.H.'s arthritis. The medical records for R.H. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent's statement that R.H. was under his medical care and supervision for post traumatic arthritis and chronic insomnia were false.

Respondent's overall treatment of R.H. as above described represented an extreme departure from the standard of care.

Patient W.H.

48. Respondent saw W.H., a 58 year old male with advanced multiple sclerosis, on November 1, 1998. W.H. was bedridden and under the care of a conservator who had requested respondent's services. Respondent met with the conservator and then saw W.H. for approximately 5 minutes. He obtained virtually no medical or psychiatric history from or about W.H. Medical records consist of an eligibility questionnaire partially completed by respondent, and several pages of medical records from other practitioners given to respondent by the conservator. He performed no physical and no mental status examination. He did not discuss the risks and benefits of cannabis with W.H. and documented no diagnosis or treatment plan. Respondent noted: "I looked at him and there he was lying in bed...He looked relatively comfortable...he appeared to be clean and appeared to be well-cared for, but again, I didn't lift the covers." Respondent issued a recommendation stating that W.H. was under his medical care and supervision for treatment of multiple sclerosis, and that he had discussed the medical risks and benefits of cannabis use with W.H.

Respondent avers that he briefly evaluated W.H. and observed ashtrays full of the ends of smoked joints near the bed. He opines that his condition was very serious, chronic and that he attained some relief from cannabis for muscle spasticity and depression. He avers that he got W.H. to articulate whether he knew about medical marijuana and was able to use it. Respondent believes discussion of the risks with W.H. was irrelevant because he had been using it for years. The conservator indicated to respondent that W.H. was deriving benefit from its use.

Dr. Duskin opines that though W.H. had severe difficulties with speech, and likely fatigued easily, this did not preclude a mental status examination, an evaluation of the painful muscle groups (rigidity, range of motion, etc.) and a focused evaluation of the pain intensity, duration, alleviating and exacerbating factors, efficacy of the current medication regimen, etc. If changing the dosing of existing medications (Baclofen and Ativan) had been tried in the past and was not efficacious, respondent did not document this fact and he was not in a position to recommend discontinuation or taper of either drug on a trial basis if either one or both were not helpful.

The standard of practice when a psychiatrist provides a focused consultation is to determine if follow-up is necessary, and if so to see the patient in follow-up at an appropriate

interval, depending upon the diagnosis and severity of the problem. Respondent failed to schedule a follow-up appointment at an appropriate interval. For pain management of a bedridden patient, planned follow-up in 6 – 12 months is inappropriate.

49. It was established that respondent committed errors and omissions in the care and treatment of W.H. in the following respects:

a. Respondent failed to adequately evaluate W.H.'s mental status.

b. Respondent failed to adequately evaluate W.H.'s complaints of pain and or muscle spasm. The medical records for W.H. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

c. Respondent failed to evaluate the efficacy of W.H.'s current medication regimen.

d. Respondent failed to discuss the risks associated with marijuana and alternative treatments available to W.H.

e. Respondent failed to schedule a follow-up appointment for W.H. at an appropriate interval.

f. Respondent's statement that W.H. was under his medical care and supervision for treatment of Multiple Sclerosis, and that respondent had discussed the medical risks and benefits of cannabis use with W.H. was false.

Respondent's overall treatment of W.H. as above described represented an extreme departure from the standard of care.

Undercover Officer

50. In early 2003, Detective Steve Gossett, lead investigator for the Sonoma County Narcotics Task Force, was involved in a marijuana investigation of a couple implicated in illegal cultivation. He was provided the telephone number of an Oakland clinic where they had intended to obtain a medical marijuana recommendation. Detective Gossett made a telephone call to the clinic and made an appointment for himself using the undercover name Scott Burris. He went to the clinic, but because there were so many people waiting to be seen he paid $50 for a medical priority appointment for the following week. He returned to the clinic on February 7, 2003, signed in for an appointment, paid an additional $150 and was given a blank questionnaire to complete. He was asked by the receptionist to fill out all questions except for his current condition, and was told that "Ben" would be helping everyone with this particular section.

Detective Gossett disregarded instructions and filled in "sleep, stress, shoulder" for his current medical condition. A Ben Morgan came to assist him with the form and told him that stress was not the best medical condition. When Detective Gossett told him that his shoulder hurt, Ben asked him to move his shoulder up and down and then suggested that Detective Gossett state on the form that he had a dislocated shoulder.

Detective Gossett was escorted into a separate room where respondent was sitting behind a desk. Respondent reviewed the paperwork and asked him questions about his parents' health, his current medical problems and his stress over a pending criminal case. Detective Gossett made up a story about being arrested for possession of 54 grams of marijuana. He also told respondent that he did not have a regular doctor and that he was an unemployed construction worker. Respondent did not conduct any type of physical examination. He did not ask which shoulder had been injured.

Respondent observed that Detective Gossett's complexion was coarse and somewhat puffy, suggesting to him that he had a drinking problem, although he stopped short of diagnosing alcoholism. Respondent did advise him not to drink so much alcohol and suggested physical therapy. He issued a medical cannabis recommendation that indicated that Scott Burris (Detective Gossett) was under his medical care and supervision for treatment of serious medical conditions. The entire session lasted 10 to 15 minutes. Following the visit with respondent, Detective Gossett returned to the waiting area and was told to go to the Oakland Cannabis Club to obtain an identification card and that he and others were now "all legal" and could grow marijuana for sale to the different clubs. Ben Morgan advised the group to stick around for a "special treat" and Detective Gossett was given a bag of marijuana by an unknown female.

51. Respondent contends that Detective Gossett's law enforcement bias from past participation on a DEA task force, his prior statements that respondent was a "quack", his failure to wear a wire and his inconsistent statements all combine to make him a highly biased witness whose testimony should be discredited. Respondent notes that his overwhelming observation of Detective Gossett was that of a person with a serious drinking problem whose chronic shoulder pain had benefited from his alleged cannabis use and that respondent acted sincerely after performing a good faith medical examination. He acknowledges that he did not perform a physical examination. Respondent felt that marijuana would help ease his anxiety and his abuse of alcohol could be avoided. Respondent's challenge of Detective Gossett's credibility is somewhat moot because he does not dispute what occurred during the course of the medical interview itself. Their accounts differ only in terms of the length of the evaluation, respondent recalling that it was 20 minutes.

Respondent avers that he had no role in setting up the protocols and procedures followed at the Oakland Clinic. He was not the medical director and he had no authority to hire or supervise staff. He did not own or lease the property. He characterizes his position as that of an independent contractor there for the specific purpose of performing clinical evaluations. He was paid cash, $150 per patient seen. The medical records were his and they went home with him. Respondent had no role or knowledge of Ben Morgan's role in helping

patients prepare questionnaires and he was unaware that cannabis samples were being given away on the premises. Ben Morgan had asked respondent to participate in a number of different clinics. Respondent does not know if Ben Morgan had any health or medical license and he does not know if any other physicians worked out of the clinic. Respondent made no inquiries into whether the owners of the clinic were non-physicians and he is apparently unaware of laws governing physician practice under non-physicians. He avers that he did not view the clinic as carrying out full medical functions because it was a consultative venue as opposed to a medical clinic per se.

52. It was established that respondent committed errors or omissions in the care and treatment and interaction with an undercover officer in the following respects:

a. Respondent recommended treatment to the officer without conducting a physical examination. He undertook minimal effort to determine whether the officer was in fact suffering from any physical ailment or condition. The medical records for Detective Gossett lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to provide follow-up or referral for the stated complaints.

c. Respondent's statement that the patient was under his medical care and supervision for treatment of a serious condition diagnosed after review of available records and in person medical examination was false.

Respondent's overall treatment of Detective Gossett as above described represented an extreme departure from the standard of care.

By virtue of his position as the physician practicing at the clinic, respondent assumed shared responsibility for the actions of the clinic facilitator/receptionist (Ben Morgan) in exaggerating information regarding patient medical conditions and for dispensation of marijuana on the premises. However, it was not established that respondent was aware of any of these practices. Whether respondent's license should be subject to disciplinary action for the acts of Ben Morgan is reserved for discussion in the Legal Conclusions section.

Cost Recovery

53. The Board has incurred the following costs in connection with the investigation and prosecution of this case:

Medical Board of California Investigative Services

Year	Hours[7]	Hourly Rate	Charges
1999	4	103.07	$ 412.28
2000	234	109.93	25,723.62
2001	52	110.84	5,763.68
2002	78	110.84	8,645.52

An additional 61 hours @ $100 were spent by medical experts for reviewing and evaluating case-related materials, report writing, hearing preparation and examinations. Board investigative costs total $46,645.16.

Attorney General Costs

The costs of prosecution by the Department of Justice for Deputy Attorneys General Jane Zack Simon and Lawrence A. Mercer total $23,608, and $30,884, respectively. The declarations of both have been reviewed and the time and charges are found to be in reasonable performance of tasks necessary for the prosecution of this case.[8] Investigative and prosecution costs total $101,137.

LEGAL CONCLUSIONS

Immunity

1. Respondent contends that the Compassionate Use Act of 1996 confers absolute immunity upon a licensed physician who recommends medical marijuana. He relies upon Health and Safety Code section 11362.5, subdivision (c), which provides:

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[7] Approximately 27 hours were spent conducting interviews, 53 hours for record review, 53 hours for travel, 173 hours on report writing and 62 hours on telephone, subpoena service, court, meetings with the Attorney General and Medical Consultant

[8] Though a breakout of hours for each task was not provided, cost certifications detailed tasks including 1) conducting an initial case evaluation, 2) obtaining, reading and reviewing the investigative material and requesting further investigation, as needed; 3) drafting pleadings, subpoenas, correspondence, memoranda, and other case-related documents; 4) researching relevant points of law and fact; 5) locating and interviewing witnesses and potential witnesses; 6) consulting and/or meeting with colleague deputies, supervisory staff, experts, client staff, and investigators; 7) communicating and corresponding with respondent's counsel; 8) providing and requesting discovery; 9) preparing for and attending trial setting, status, prehearing and settlement conferences, as required, and 10) preparing for hearing.

> Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes.

Respondent believes that his medical marijuana recommendations should be protected by the "absolute immunity" afforded under section 11362.5. He asserts that California law enforcement officials from various jurisdictions began bringing complaints against him to the Board based almost entirely on their own failed prosecutions of various medical marijuana patients and that no patient has initiated or joined a complaint against respondent. He suggests that this action is politically motivated by law enforcement officials who are now working in tandem with the Board to circumvent Proposition 215, along with other protections afforded him and his patients under the First Amendment and patient confidentiality laws.

Complainant characterizes this case as having "virtually nothing to do with medical marijuana" and notes that Board medical expert Dr. Duskin was not even critical of the recommendation, or use, of marijuana medicinally. Rather, complainant's criticism is leveled at respondent's alleged failure in virtually every case to examine the patient, to obtain a history, to perform an appropriate work up of the patient's symptoms and findings, or to follow up with or monitor the patients.

2. Respondent contends that by its use of the term "notwithstanding any other provision of law," a legal term of art, the Compassionate Use Act confers absolute immunity of doctors for their actions related to recommending or approving medical marijuana. He notes that conduct necessary to perform the immunized act falls within the scope of the grant of immunity and is thus not subject to Board discipline. Specifically, he argues that a doctor must always take some action attendant upon approving or recommending medical marijuana and that recognizing immunity for the approval or recommendation, but not the *approving* or *recommending*, is logically impossible, and legally unsupportable. Complainant would instead draw a clear distinction between the physician's recommendation, and the process by which that recommendation was reached.

Generally, decisions about when, where or how to carry out the immunized act is conduct that comes within the privilege because the methods of doing the immunized act are typically matters so intimately linked to the immunized act itself "that they are within the scope of the privilege." (*Katsaris* v. *Cook* (1986) 180 Cal.App.3d 256, 266-267; *Scozzafava* v. *Lieb* (1987) 190 Cal.App.3d 1575.) Both *Katsaris* and *Scozzafava* considered a statute that immunized the killing of dogs trespassing on the property of livestock owners. In *Scozzafava*, a chicken farmer's employee wounded a dog that was attacking the farmer's chickens. The dog returned to its owner, who then brought the dog to a veterinarian. The dog later bit a veterinary assistant as she was attempting to pick it up. The veterinary assistant brought a negligence action against the chicken farmer, who raised the immunity statute as a defense. In construing the immunity rather broadly to bar the claim the Court of Appeal held:

> The context of *Katsaris* makes it clear that the test of acts or conduct "necessary to the killing" is not rigidly limited to such obvious incidents as loading and aiming, but is instead generously construed so as to reach categories of specific decisions pertaining to more general areas such as employment practices, business policies, and most manner of matters concerning firearms. These are precisely the issues for which plaintiff seeks to impose liability on defendant. Just as we did in *Katsaris*, we hold that these acts and omissions constitute decisions necessary to the exercise of the privilege to kill.

(*Scozzafava* v. *Lieb*, *supra*, 190 Cal.App.3d at 1581.)

Respondent contends that every single fact relied upon by the Board refers to the methods by which he went about recommending or approving the use of marijuana, and nothing more. He believes that the Board has no jurisdiction or authority to discipline, or even investigate him for the methods by which he recommended medical marijuana because such matters are shielded by absolute immunity.

3. Immunity statutes, like privileges, are either absolute or conditional. Absolutely privileged conduct does not permit any remedy by way of a civil action, regardless of whether or not the privileged conduct was undertaken in bad faith or with malice. (*Saroyan v. Burkett* (1962) 57 Cal.2d 706, 708) A qualified or conditional privilege protects the actor only if he or she acts for the purpose of advancing or protecting the interest which the privilege seeks to protect. "Thus, under a qualified privilege an actor may be liable for conduct which he undertakes with an improper motive. Likewise a qualified privilege may be lost if the actor engages in conduct outside the scope of the privilege, thus 'abusing' it." (*Katsaris* v. *Cook*, *supra*, 180 Cal.App.3d at 265.) To determine the scope of privilege the analytical model adopted by courts in defamation cases has been applied to immunity statutes, incorporating a two step analysis. (*Id.* at p. 266.) First, what is the policy rationale which underlies the privilege? Second, does that policy justify applying the privilege to this particular conduct? (*Ibid.*; *Bradley* v. *Hartford Acc. & Indem. Co.* (1973) 30 Cal.App.3d 818, 824.)

In this case the immunity afforded physicians under Health and Safety Code section 11362.5 does appear to be conditional. The language of the Compassionate Use Act is instructive in this regard. Subdivision (b)(2) provides that "Nothing in this section shall be construed to supersede legislation prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes." One of the Act's purposes is to ensure that seriously ill Californians have the right to obtain and use marijuana for "medical purposes" and "where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana." Yet, the Act also expressly affirms public policy against conduct that endangers others or the diversion of marijuana for nonmedical purposes. It is left for the physician, as gatekeeper, to ensure that marijuana is used for "medical purposes" to benefit the seriously ill. Under these circumstances it is presumed that

physicians who recommend marijuana under the Act will follow accepted medical practice standards and make good faith recommendations based on honest medical judgments. (*Conant* v. *McCaffrey* (2000 WL 1281174) Complainant correctly notes that to hold otherwise and to extend absolute immunity to physicians would allow them to simply issue marijuana recommendations without the exercise of sound medical judgment and with no oversight.

4. The primary function of the Board is protection of the public. (Bus. & Prof. Code, § 2229, subd. (a).) The various provisions of the Medical Practice Act dealing with physician misconduct are designed to promote public safety by ensuring that the standards of practice for physicians are maintained and enforced. The language of the Compassionate Use Act does not conflict with these goals. Thus, the immunity afforded physicians who recommend marijuana to patients for medical purposes provides that they may not be punished, or denied any right or privilege, for having made that recommendation. However, it does not exempt them from standards or regulations generally applicable to physicians, including those that govern the manner or process by which the physician's recommendation was reached.[9] Judge Kozinski reached the same conclusion in contemplating the role of the physician in determining legal and illegal marijuana use under the Compassionate Use Act:

> [D]octors are performing their normal function as doctors and, in so doing, are determining who is exempt from punishment under state law. If a doctor abuses this privilege by recommending marijuana without examining the patient, without conducting tests, without considering the patient's medical history or without otherwise following standard medical procedures, he will run afoul of state as well as federal law. But doctors who recommend medical marijuana to patients after complying with accepted medical procedures are not acting as drug dealers; they are acting in their professional role in conformity with the standards of the state where they are licensed to practice medicine.

(*Conant* v. *Walters* (2002) 309 F.3d 629, 647.)

Application of Business and Professions Code Section 2242

5. Respondent contends that he did not "prescribe" marijuana and for that reason he cannot be held accountable for his failure to conduct a prior good faith examination nor for his failure to determine that a medical indication existed for treatment recommended by him. Business and Professions Code section 2242 provides that it is unprofessional conduct for a physician to prescribe, dispense or furnish drugs without a good faith prior examination and medical indication therefore. Respondent did not "prescribe" marijuana because one cannot prescribe a Schedule I controlled substance. (Health & Saf. Code, § 11054, subd. (d)(13).)

[9] That respondent also has a First Amendment right to recommend medical marijuana to his patients is undisputed. (*Conant* v. *Walters* (2002) 309 F.3d 629.) The Board has not imposed any content-based restrictions on his speech and he is able to communicate freely, candidly and meaningfully with his patients and to offer sincere medical judgments about the pros and cons of medical marijuana. For these reasons respondent's First Amendment challenge to the Board's action is overruled.

The administrative law judge found that the standard for prescribing cannot be distinguished from the standard of practice which proscribes recommending any other treatment without examination or medical work-up and the standard of practice is no different for "recommending" or "approving" marijuana than it is for prescribing any other medication.

However, in its Judgment and Order in this matter dated November 2, 2006, the Superior Court found, as a matter of law, that "a recommendation for marijuana is not a 'prescription' and as such, respondent was not subject to discipline pursuant to Business and Professions code section 2242". The board, therefore has excluded Business and Professions code section 2242 from consideration on remand.

Standard of Practice

6. The standard of practice for conducting a medical cannabis evaluation is as set forth in Finding 16. It is identical to that followed by physicians in recommending any other treatment or medication and it applies regardless of whether the physician is acting as a treating or as a consulting physician. Although focused on the patient's complaints, the evaluation does not disregard accepted standards of medical responsibility. These standards include history and physical examination of the patient; development of a treatment plan with objectives; provision of informed consent; and periodic review of the treatment's efficacy. When a cannabis recommendation is being made for a psychiatric condition the examination would additionally entail a mental status examination. In such cases a physical examination might not be included, or might only include a limited physical examination appropriate to the clinical situation. In sum, the standard of practice for a physician recommending marijuana to a patient is the same as that for recommending any other treatment or medication.

The standard of practice requires that the evaluation be supported by adequate documentation. That documentation must reflect the physician's initial history and physical/mental status exam, evaluation of each condition in question and a diagnosis and/or differential diagnosis. A physician must document pertinent physical and/or psychiatric findings, referrals, a treatment plan and follow-up. Business and Professions Code section 2266 provides that "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

Disciplinary Grounds

7. Under Business and Professions Code section 2234 the Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes gross negligence, repeated acts of negligence, incompetence and the commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions or duties of a physician and surgeon. (Bus. & Prof. Code, § 2234, subds. (b) – (e).)

8. Cause for disciplinary action exists under Business and Professions Code section 2234, subdivision (b), by reason of the matters set forth in Findings 17, 21, 23, 25, 27, 28, 30, 32, 35, 37, 39, 41, 43, 45, 47, 49 and 52. Respondent's errors and omissions in connection with his care and treatment of sixteen patients and the undercover officer constituted gross negligence.

9. Cause for disciplinary action exists under Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in Findings 17, 21, 23, 25, 27, 28, 30, 32, 35, 37, 39, 41, 43, 45, 47, 49 and 52. Respondent's errors and omissions in connection with his care and treatment of sixteen patients and the undercover officer constituted repeated negligent acts.

10. No cause for disciplinary action exists under Business and Professions Code section 2234, subdivision (d), by reason of the matters set forth in Finding 54. The above described errors and omissions do not reflect respondent's incompetence, but rather choices consistent with his belief that a different standard was applicable to the evaluation of patients for purposes of medical cannabis recommendations. Incompetence generally is defined as a lack of knowledge or ability in the discharging of professional obligations and it often results from a correctable fault or defect. (*James* v. *Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109.) There are no apparent deficits in his education, knowledge, training, or skills as a physician. He is clearly capable of observing standard medical evaluation protocols for history, physical and mental status examination, development of a treatment plan, informed consent and follow up or referral. He has also demonstrated that he can maintain proper records when he chooses to do so.

11. No cause for disciplinary action exists under Business and Professions Code section 2234, subdivision (e), by reason of the matters set forth in Finding 52. It was not established that respondent had any awareness of the activities of Ben Morgan, an element necessary to a finding that he committed an act involving "dishonesty or corruption" under this particular subdivision. Generally, a licensee is responsible for the acts of agents, whether independent contractors or employees, acting in the course of the licensee's business. This is true even when the licensee does not have actual knowledge of the agent's activities. Thus, a licensee was charged with submitting false statements in MediCal billings that were done through an office manager without his review, and a pharmacist may be disciplined by the pharmacy board for the unlawful acts of his employee for illegally filling prescriptions. (*Heisenberg* v. *Myers* (1983) 148 Cal.App.3d 814, 824; *Arenstein* v. *State Board of Pharmacy* (1968) 265 Cal.App.2d 179, 192.) But even where respondent is ultimately responsible for the actions of agents, it does not also follow that he engaged in unprofessional conduct. Unprofessional conduct under section 2234, subdivision (e) contemplates more than vicarious liability for the actions of an agent and a licensee should not be found to have engaged in unprofessional conduct unless directly implicated for committing acts involving "dishonesty or corruption." A violation of this subdivision (e) should be based upon findings of respondent's own acts of dishonesty or corruption, or on

such acts by those working for him of which he had personal knowledge and which he actually ratified.[10] That is not the case here.

12. The Superior Court has found that cause for disciplinary action does not exist under Business and Professions Code section 2242.

13. Cause for disciplinary action exists under Business and Professions Code section 2266, by reason of the matters set forth in Findings 17, 21, 23, 25, 27, 28, 30, 32, 35, 37, 39, 41, 43, 45, 47, 49 and 52. Respondent failed to maintain adequate and accurate records relating to the provision of services to his patients.

14. Cost Recovery. Under Business and Professions Code section 125.3 the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case. Requested costs total $101,137. (See Finding 53.)

The Board must not assess the full costs of investigation and prosecution when to do so will unfairly penalize a licensee who has committed some misconduct, but who has used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed. The Board must consider the licensee's "subjective good faith belief in the merits of his or her position" and whether the licensee has raised a "colorable challenge" to the proposed discipline. (*Zuckerman* v. *Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45.) Such factors have been considered in this matter.

This is a case of first impression. The scope of physician immunity under Health and Safety Code section 11362.5 and other legal issues had not been considered previously and required greater time and preparation on the part of complainant. Respondent should not bear the full burden of such costs. The Board acknowledged in its own policy statement on Proposition 215 that there was "a great deal of confusion concerning the role of physicians under this law" and following passage of the Compassionate Use Act there was uncertainty over what protocols physicians should follow in making medical cannabis recommendations. Some uncertainty persisted, notwithstanding the Board's January 1997 policy statement. There was credible testimony that among the handful of physicians who consult regularly on medical cannabis issues there was no uniform agreement on practice standards. Respondent had a good faith belief in the merits of his position and he raised a colorable challenge, factually and legally, to accusation allegations. He successfully defended allegations against him based upon incompetence, dishonesty or corruption. An adjustment of approximately 25 percent would fairly and equitably accounts for these several factors. Accordingly, reasonable investigation and prosecution costs are adjusted to $75,000.

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[10] See also *James* v. *Board of Dental Examiners, supra*, 172 Cal.App.3d at 1110, where the Court of Appeal noted: "An important factor in our review is that any attack to revoke the personal license to practice dentistry of Dr. James of course must be based upon findings of his own acts of misfeasance, or on such acts by those working with him of which he had personal knowledge and which he actually ratified."

However, effective January 1, 2006, Business and Professions code section 125.3 was changed to prohibit the board from requesting or obtaining from a physician and surgeon the costs of investigation and prosecution of a disciplinary proceeding. Therefore, the board waives cost recovery in this matter.

15. Other Considerations. The protection of the public is the Board's highest priority. Yet, in determining appropriate disciplinary action and in exercising disciplinary authority the Board shall, whenever possible, "take action that is calculated to aid in the rehabilitation of the licensee." (Bus. & Prof. Code, § 2229.) This includes ordering restrictions as are indicated by the evidence. Respondent's competence was really not at issue in this case. He understands what the traditional medical examination model entails. He has applied it when patients have been evaluated for reasons outside his focused medical cannabis consultation model and indeed, when Dr. Duskin was asked to review nine of respondent's inpatient case files, she found all to be within the standard of care. In a few cases she determined his care to be excellent. He is clearly capable of observing standard medical evaluation protocols for history, physical and mental status examination, development of a treatment plan, informed consent and follow up or referral. He has also demonstrated that he can maintain proper records in such cases. Dishonesty or corruption allegations against respondent were not sustained.

Respondent strongly believed that Proposition 215 contemplated something very different than the traditional medical examination model. Such beliefs were based upon his active involvement in efforts to legalize marijuana for medical purposes and his own good faith interpretation of Proposition 215. This, combined with his practice experience as a medical cannabis consultant, resulted in rather rigid yet consistent adherence to the more focused medical cannabis consultation model. He did so even after he was on notice of the accusation allegations. The question now is whether he is willing and able to set aside these very strong views regarding the type of examination he feels is necessary to support a medical cannabis recommendation and comply with traditional medical examination standards. Complainant characterizes respondent as "obviously intransigent" and is concerned that this will impede not only his ability to successfully complete probation, but the Board's ability to adequately supervise and monitor his activities. Respondent should only be placed on probation if there is a reasonable likelihood that he will conform his practice to acceptable standards, and if he can reasonably be expected to abide by necessary practice restrictions and oversight. Respondent has certainly been a forceful advocate for his approach throughout the investigation, prosecution and hearing of this case. He has raised colorable factual and legal defenses to accusation allegations and several first impression issues were considered in this case. Importantly, he has indicated that he would be willing to conform his practices if required and it is not unreasonable to expect that he will do so.[11] He should be given that opportunity.

[11] Respondent's failure to conform his behaviors after he was on notice that the Board took issue with his evaluation process and his lack of medical documentation is troubling, but it is countered somewhat by his sincere belief that he was breaking new ground in setting standards under Proposition 215 for recommending and approving medical cannabis. He has also persisted in his belief that this case has been driven from the start by federal and state government officials opposed to Proposition 215.

It would therefore not be contrary to the public interest to place respondent on probation at this time. One of the conditions should include appointment of a practice monitor and the development of a monitoring plan. Respondent has suggested that if his practice were monitored or supervised by a physician who was not a medical cannabis consultant he would "reject" it.[12] This is a case where compliance can best be ensured through a physician monitor/supervisor approved by the Board. This physician monitor may be a medical cannabis consultant, but this is certainly not a necessary requirement. The Board normally allows licensees, in lieu of having a practice monitor, to participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education (PACE) 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. While respondent may opt to participate in program such as PACE, it remains critical that an approved practice monitor be in place to monitor his practice. Participation in PACE should not be done in lieu of having a practice monitor.

16. Reconsideration After Remand. Consistent with the Superior Court's Judgment and Order, the board has reconsidered its decision in this matter. It finds that the original Order is appropriate for the violations that remain.

Respondent has been found, by clear and convincing evidence, to have been grossly negligent and also to have committed repeated negligent acts in his care and treatment of 16 patients and 1 undercover officer. Those two types of violations, standing alone, would warrant the Order initially adopted. That Order is consistent with the board's Disciplinary Guidelines, which call for a minimum of stayed revocation and 5 years probation on terms and conditions. The board finds no reason to deviate from the Order initially imposed, given the nature and extent of respondent's misconduct and the sheer number of patients. However, for the reasons indicated in Legal Conclusion No. 14, the board has stricken cost recovery from the order.

ORDER

Physician's and Surgeon's Certificate No. G-9124 issued to respondent Tod H. Mikuriya, M.D. is revoked pursuant to Legal Conclusions 8, 9, 12 and 13, separately and for

[12] Respondent's own expert, also a medical cannabis consultant, documents all medical cannabis evaluations and conducts a good faith examination that is identical to any other medical evaluation he performs. He does so consistent with his philosophy of practicing excellent medicine in all cases. If a medical cannabis consultant such as Dr. Denney performs the same medical evaluation for all patients, then it should really make no difference whether a physician assigned to monitor respondent's practice is also a medical cannabis consultant.

all of them. However, revocation is stayed and respondent is placed on probation for five (5) years upon the following terms and conditions:

The Panel recognizes that respondent has been on probation during the course of judicial review and accordingly, time already served on probation shall be credited toward completion of the probationary period.

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

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

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

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.

2. Notification. Prior to engaging in the practice of medicine respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days. This condition shall apply to any change in hospitals, other facilities or insurance carrier.

3. Supervision of Physician Assistants. During probation, respondent is prohibited from supervising physician assistants.

4. 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.

5. Quarterly Declarations. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, 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.

6. Probation Unit Compliance. Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record,

except as allowed by Business and Professions Code section 2021(b). Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division 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.

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

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

All time spent in an intensive training program outside the State of California which has been approved by the Division 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.

9. Failure to Practice Medicine - California Resident. In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice

and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division 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.

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

11. License Surrender. Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division 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.

12. Probation Monitoring Costs. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division 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.

13. 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 completion successful of probation, respondent's certificate shall be fully restored.

This decision shall become effective at 5:00 pm on March 12, 2007

IT IS SO ORDERED this 9th day of February, 2007.

BARBARA YAROSLAVSKY
Chairperson , Panel B
Division of Medical Quality
Medical Board of California

EXHIBIT A

ORIGINAL

COPY

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Attorneys for Respondent Medical Board of California

FILED
ENDORSED
NOV - 2 2006
By FRANK TEMMERMAN
Deputy Clerk

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SACRAMENTO

TOD H. MIKURIYA, M.D., Petitioner, v. MEDICAL BOARD OF CALIFORNIA Respondent.	Case No. 04CS00477 **JUDGMENT AND ORDER RE: PETITION FOR WRIT OF ADMINISTRATIVE MANDATE**

KEYD 37

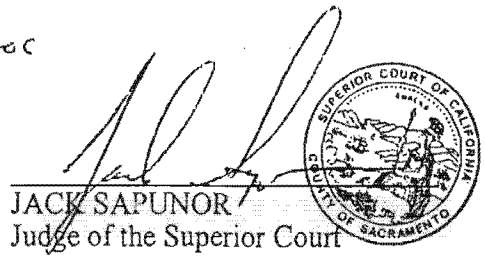
The hearing on the Petition for Writ of Administrative Mandate (the "Petition") in the above-entitled matter was heard in Department 20 on February 10, 2006, before the Honorable Jack Sapunor, Judge Presiding. Petitioner Tod Mikuriya, M.D., appeared in court, and was represented by Scott Candell, Attorney at Law; Medical Board of California, appeared by its counsel, Bill Lockyer, Attorney General of the State of California, by Lawrence A. Mercer and Jane Zack Simon, Deputy Attorneys General. The record of the administrative proceeding was received in evidence and reviewed by the Court. The Court read all the pleadings on file in the action, and the matter was orally argued and submitted.

Exercising its independent judgment, the Court therefore ORDERS, ADJUDGES AND DECREES that:

1. The Court finds that as a matter of law, a recommendation for marijuana is not a "prescription" and as such, respondent was not subject to discipline pursuant to Business and Professions Code section 2242. The petition for writ of mandate is granted solely to the extent that the Board based its Decision on a finding of unprofessional conduct based on a violation of section 2242. Accordingly, a peremptory writ of mandamus shall issue from this Court, remanding this matter to respondent for reconsideration of its Decision in light of this finding.

2. On all other grounds, the Petition is DENIED.

DATED: November 7, 2006



JACK SAPUNOR
Judge of the Superior Court

MEDICAL BOARD OF CALIFORNIA
INITIAL STATEMENT OF REASONS

Hearing Date: April 30, 2010

Subject Matter of Proposed Regulations: Written examinations

Section(s) Affected:

Amend Section 1328 in Article 8 of Chapter 1, Division 13, of Title 16.

Specific purpose of each adoption, amendment, or repeal:

Amend Section 1328 in Article 8 of Chapter 1, Division 13, relating to the Written Examinations recognized by the Board.

The Board is proposing to amend the above in order to:

1) recognize the examination combination of USMLE Steps 1 & 2 and NBME (National Board of Medical Examiners) Step 3 to meet the examination requirement for a physician and surgeon license, and;
2) make a technical change to reflect the statutorily changed structure of the Board and the elimination of the Division of Licensing, changing "Division" to "Board."(AB 253 (Eng, Chapter 678, Statutes of 2007) combined the two divisions of the Board into one board.)

CCR Title 16, section 1328, enumerates the combination of written examinations that are acceptable to the Board for the issuance of an initial physician & surgeon license. The regulations were last amended in 1999 to reflect the new USMLE steps 1, 2 and 3. At that time, the Board attempted to anticipate all of the possible legitimate combinations of examinations that future applicants would need to have recognized. Until very recently, the Board's regulation has been adequate.

Factual Basis/Rationale:

The Board has now received an application from an applicant under section 2170 of the Business & Professions Code that is unable to be licensed because examinations passed by the applicant are not included in the current regulation. Over 10 years ago, the applicant took the NBME 3 prior to taking Steps 1 & 2 of the USMLE, and two weeks prior to the Federation of State Medical Board's offering USMLE step 3.

While it would appear that this situation is rare, it is likely to occur again. The newly proposed combination of examinations are nationally recognized and are legitimate paths toward licensure. It is necessary to establish the acceptability of this combination of examinations in regulation.

Underlying Data:

The USMLE is the nationally recognized examination for physician licensure in all fifty states for first-time licensing. (Recent graduates, immigrant doctors.) Other legitimate examinations preceded the USMLE, most notably, the National Board Of Medical Examiners examination, the NBME.

Business Impact

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

This regulation only impacts persons applying to the Medical Board for a physician and surgeon license.

The proposed regulation has no business or economic impact.

Specific Technologies or Equipment:

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

Consideration of Alternatives:

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

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 Sheraton Gateway Los Angeles, 6101 West Century Blvd., Los Angeles, California, at **9:00 a.m.**, on **April 30, 2010**. Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office not later than 5:00 p.m. **on April 26, 2010** 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 of the Business and Professions Code, and to implement, interpret or make specific Sections 851, 2005, 2096, 2101, 2102, 2103, 2151, 2170, 2176 and 2183 of said Code, the Medical Board of California is considering changes to Division 13 of Title 16 of the California Code of Regulations as follows:

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Amend Section 1328 in Article 8 of Chapter 1, Division 13, relating to the Written Examinations recognized by the Board.

Existing regulations specify the types of examinations recognized by the Board. This proposal would recognize the examination combination of USMLE Steps 1 & 2 and NBME Step 3 to meet the examination requirement for a physician and surgeon license. It would also make a technical change to reflect the statutorily changed structure and elimination of the Division of Licensing.

CCR Title 16, section 1328, enumerates the combination of written examinations that are acceptable to the Board for the issuance of an initial physician & surgeon license. The regulations were last amended in 1999 to reflect the new USMLE steps 1, 2 and 3. At that time, staff and members attempted to anticipate all of the possible legitimate combinations of examinations that future applicants would need to have recognized. Until very recently, the Board's regulation has been adequate.

At present, however, the Board has received an application from a person who is unable to be licensed because the combination of examinations passed by the applicant do not meet the regulatory requirement.

FISCAL IMPACT ESTIMATES

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

Local Mandate: None

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

Business Impact:

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

There are no costs associated with the proposed regulatory action. The proposed regulation only expands the acceptable, recognized written examination combinations for physician and surgeon licensure.

Impact on Jobs/New Businesses:

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

Cost Impact on Representative Private Person or Business:

The Medical Board of California is certain that there are no cost impacts to this proposed rulemaking.

This proposed regulation only expands the acceptable, recognized written examination combinations for physician and surgeon license.

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 those applying for licensure as a physician and surgeon.

CONSIDERATION OF ALTERNATIVES

The Board must determine that no reasonable alternative it considered to the regulation or that has otherwise been identified and brought to its attention would either be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposal described in this Notice. Any interested person may present statements or arguments orally or in writing relevant to the above determinations at the above-mentioned hearing.

INITIAL STATEMENT OF REASONS AND INFORMATION

The 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:	Deborah Pellegrini, Chief of Licensing 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

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 www.mbc.ca.gov.

Medical Board of California
Written Examinations
Specific Language

1328. Written Examinations.

(a) Each of the following written examinations is recognized by the ~~division~~ **Board** as meeting the examination requirement for licensure in sections 2101, 2102, 2103, and 2170 of the code:

(1) FLEX (Federation Licensing Examination) component 1 plus FLEX component 2;

(2) NBME (National Board of Medical Examiners) parts I and II plus FLEX component 2;

(3) NBME parts I/USMLE step 2 plus FLEX component 2;

(4) USMLE (United States Medical Licensing Examination) step 1/NBME part II plus FLEX component 2;

(5) USMLE steps 1 and 2 plus FLEX component 2;

(6) NBME parts I, II, and III (U.S. and Canadian graduates only);

(7) NBME part I/USMLE step 2 plus NBME part III (U.S. and Canadian graduates only);

(8) USMLE step 1/NBME part II plus NBME part III (U.S. and Canadian graduates only);

(9) NBME part I/USMLE step 2 plus USMLE step 3;

(10) USMLE step 1/NBME part II plus USMLE step 3;

(11) NBME parts I and II plus USMLE step 3;

(12) FLEX component 1 plus USMLE step 3;

(13) USMLE steps 1, 2, and 3;

(14) Qualifying examination, Medical Council of Canada;

(15) FLEX minimum weighted average of 75 achieved in one sitting (prior to 1985);

(16) USMLE steps 1 and 2 and NBME step 3

~~(16)~~ **(17)** State board examinations administered before June 1, 1969.

(b) All parts of the examination of the LMCC (Licentiate of the Medical Council of Canada) shall qualify an applicant under section 2101 or section 2102 of the code to commence postgraduate training (clinical service) in a hospital in this state. In addition, the following written examinations are recognized by the division as qualifying international medical graduates to commence postgraduate training (clinical service) in a hospital in this state:

(1) FLEX component 1;

(2) NBME parts I and II;

(3) NBME part I and USMLE step 2;

(4) USMLE step 1 and NBME part II;

(5) USMLE steps 1 and 2.

(c) If an applicant desires to take one of the examinations referred to in this section, he or she must personally make the arrangements to do so.

(d) Candidates shall comply with the procedures for examination established by the National Board or the USMLE examination committee, where applicable.

Medical Board of California
FY 09/10
Budget Expenditure Report
(As of February 28, 2010)
(66.7% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	13,305,856	8,240,185	61.9	5,065,671
Board Members	31,500	24,300	77.1	7,200
Phy Fitness Incentive Pay	29,623	15,860	53.5	13,763
Temp Help	1,144,410	1,265,301	110.6	(120,891)
Overtime	12,142	180,888	1489.8	(168,746)
Staff Benefits	6,004,976	3,858,375	64.3	2,146,601
Salary Savings	(836,251)			(836,251)
TOTALS, PERS SERVICES	19,692,256	13,584,909	69.0	6,107,347
OPERATING EXP & EQUIP				
General Expense	139,208	169,912	122.1	(30,704)
Fingerprint Reports	361,017	181,834	50.4	179,183
Minor Equipment	291,650	4,079	1.4	287,571
Printing	733,196	520,437	71.0	212,759
Communications	504,566	213,289	42.3	291,277
Postage	496,411	104,217	21.0	392,194
Insurance	41,053	13,039	31.8	28,014
Travel In-State	394,929	140,559	35.6	254,370
Travel Out-of-State	2,031	0	0.0	2,031
Training	66,336	35,507	53.5	30,829
Facilities Operation (Rent)	2,702,140	2,095,409	77.5	606,731
Consult/Prof Services	982,594	1,327,596	135.1	(345,002)
Departmental Prorata	3,886,732	2,587,744	66.6	1,298,988
Consolidated Data Center	646,809	269,766	41.7	377,043
Data Processing	119,492	81,226	68.0	38,266
Central Admin Svcs (Statewide Prorata)	1,699,376	1,274,532	75.0	424,844
Attorney General Services	13,347,280	8,783,418	65.8	4,563,862
Office of Administrative Hearings	1,862,591	474,232	25.5	1,388,359
Evidence/Witness	1,893,439	1,009,646	53.3	883,793
Court Reporter Services	175,000	51,578	29.5	123,422
Major Equipment	333,000	27,862	8.4	305,138
Other Items of Expense	81	15,493	19,127.2	(15,412)
Vehicle Operations	261,925	174,164	66.5	87,761
TOTALS, OE&E	30,940,856	19,555,539	63.2	11,385,317
TOTALS, EXPENDITURES	50,633,112	33,140,448	65.5	17,492,664
Scheduled Reimbursements	(384,000)	(212,852)	55.4	(171,148)
Distributed Costs	(677,000)	(547,042)	80.8	(129,958)
NET TOTAL, EXPENDITURES	49,572,112	32,380,554	65.3	17,191,558
Unscheduled Reimbursements		(901,209)		
		31,479,345		

Budget Expenditure Report.xls
Date: March 30, 2010

Medical Board of California
FY 09/10
Budget Expenditure Report
With OE&E 15% Reduction
(As of February 28, 2010)
(66.7% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	13,305,856	8,240,185	61.9	5,065,671
Board Members	31,500	24,300	77.1	7,200
Phy Fitness Incentive Pay	29,623	15,860	53.5	13,763
Temp Help	1,144,410	1,265,301	110.6	(120,891)
Overtime	12,142	180,888	1489.8	(168,746)
Staff Benefits	6,004,976	3,858,375	64.3	2,146,601
Salary Savings	(836,251)			(836,251)
TOTALS, PERS SERVICES	19,692,256	13,584,909	69.0	6,107,347
OPERATING EXP & EQUIP				
General Expense	139,208	169,912	122.1	(30,704)
Fingerprint Reports	361,017	181,834	50.4	179,183
Minor Equipment	291,650	4,079	1.4	287,571
Printing	733,196	520,437	71.0	212,759
Communications	504,566	213,289	42.3	291,277
Postage	496,411	104,217	21.0	392,194
Insurance	41,053	13,039	31.8	28,014
Travel In-State	394,929	140,559	35.6	254,370
Travel Out-of-State	2,031	0	0.0	2,031
Training	66,336	35,507	53.5	30,829
Facilities Operation (Rent)	2,702,140	2,095,409	77.5	606,731
Consult/Prof Services	982,594	1,327,596	135.1	(345,002)
Departmental Prorata	3,886,732	2,587,744	66.6	1,298,988
Consolidated Data Center	646,809	269,766	41.7	377,043
Data Processing	119,492	81,226	68.0	38,266
Central Admin Svcs (Statewide Prorata)	1,699,376	1,274,532	75.0	424,844
Attorney General Services	13,347,280	8,783,418	65.8	4,563,862
Office of Administrative Hearings	1,862,591	474,232	25.5	1,388,359
Evidence/Witness	1,893,439	1,009,646	53.3	883,793
Court Reporter Services	175,000	51,578	29.5	123,422
Major Equipment	333,000	27,862	8.4	305,138
Other Items of Expense	81	15,493	19,127.2	(15,412)
Vehicle Operations	261,925	174,164	66.5	87,761
TOTALS, OE&E	30,940,856	19,555,539	63.2	11,385,317
OE & E 15% Reduction	0	469,000		(469,000)
	30,940,856	20,024,539		10,916,317
TOTALS, EXPENDITURES	50,633,112	33,609,448	66.4	17,023,664
Scheduled Reimbursements	(384,000)	(212,852)	55.4	(171,148)
Distributed Costs	(677,000)	(547,042)	80.8	(129,958)
NET TOTAL, EXPENDITURES	49,572,112	32,849,554	66.3	16,722,558
Unscheduled Reimbursements		(901,209)		
		31,948,345		

Budget Expenditure Report.xls
Date: March 30, 2010

0758 - Medical Board
Analysis of Fund Condition

(Dollars in Thousands)

	Actual 2008-09	Governor's Budget CY 2009-10	BY 2010-11	BY+1 2011-12	BY+2 2012-13
BEGINNING BALANCE	$ 23,866	$ 24,363	$ 26,586	$ 22,545	$ 17,835
Prior Year Adjustment	$ 614	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 24,480	$ 24,363	$ 26,586	$ 22,545	$ 17,835
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	$ 502	$ 422	$ 330	$ 254
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	$ 51,359	$ 50,404	$ 51,914	$ 52,230
Transfers:					
GENERAL FUND LOAN	$ (6,000)				
Totals, Revenues and Transfers	$ 45,313	$ 51,359	$ 50,404	$ 51,914	$ 52,230
Totals, Resources	$ 69,793	$ 75,722	$ 76,990	$ 74,459	$ 70,065
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	$ 18	$ 33	$ 81	$ -	$ -
8880 FSCU (State Operations)			$ 31		
Budget Act of 2009					
1110 Program Expenditures (State Operations)	$ 45,412	$ 49,572	$ 52,814	$ 53,870	$ 54,947
2009-10 BCPs:					
Probation Monitoring 1110-19		$ -	$ -	$ -	$ -
Operation Safe Medicine (OSM) 1110-17		$ -	$ -		
OE & E Savings (Approved by Agency)		$ (469)			
2010-11 BCPs:					
License Application Processing			$ -	$ -	$ -
Cal-Licensing System-BCP 1B				$ 11	$ 150
CPEI (Consumer Protection Enforcement Initiative)			$ 1,519	$ 1,714	
Potential 2011-12 BCPs				$ 1,029	$ 1,029
Totals, Disbursements	$ 45,430	$ 49,136	$ 54,445	$ 56,624	$ 56,126
FUND BALANCE					
Reserve for economic uncertainties	$ 24,363	$ 26,586	$ 22,545	$ 17,835	$ 13,939
Months in Reserve	5.9	5.9	4.8	3.8	3.0

NOTES:

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

B. INTEREST ON FUND ESTIMATED AT 2%.

C. MED BOARD'S PROB MONITORING AND OSM BCPs APPROVED WITH NO FUNDING (Prob Mon = $294,000; OSM = $510,000); OSM APPROVED FOR 2 YEARS; CONTINUATION OF OSM BEYOND 2 YEARS MUST BE AUTHORIZED VIA SUBMISSION/APPROVAL OF A BCP FOR FY 2011/12.

D. LICENSE APPLICATION PROCESSING BCP APPROVED WITH NO FUNDING BEGINNING JULY 1, 2010 ($579,000).

4/13/2010

Medical Board of California
Board Members' Expense Report
July 1, 2009 - February 28, 2010

	*Per Diem**				*Travel Expenses**	*Total Dec-Feb*	***Total FYTD***
	DEC	JAN	FEB	TOTAL			
Dr. Carreon	400	900	0	1,300	523.70	1,823.70	5,729.95
Ms. Chang	0	0	0	0	0.00	0.00	1,900.00
Dr. Chin	0	200	0	200	327.15	527.15	527.15
Dr. Duruisseau	400	1,000	500	1,900	512.80	2,412.80	6,983.95
Dr. Gitnick	0	0	0	0	406.45	406.45	1,422.13
Dr. Levine	0	0	0	0	0.00	0.00	660.94
Dr. Low	0	0	0	0	0.00	0.00	0.00
Dr. Moran	200	700	600	1,500	0.00	1,500.00	4,400.00
Dr. Salomonson	0	400	0	400	552.55	952.55	952.55
Ms. Schipske	200	400	400	1,000	0.00	1,000.00	2,438.60
Ms. Yaroslavsky	1,700	2,100	1,100	4,900	1,504.38	6,404.38	14,112.35
Mr. Zerunyan	1,100	1,700	900	3,700	595.44	4,295.44	10,028.76
BOARD TOTAL	4,000	7,400	3,500	14,900	4,422.47	19,322.47	**49,156.38**

*includes claims paid/submitted through April 2, 2010

Board Members Expense Report.xls
Date: April 8, 2010

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2009 - FEBRUARY 28, 2010

	FY 09/10 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	1,806,291	1,500,394	current
Staff Benefits	838,775	579,919	current
TOTAL PERSONAL SERVICES	2,645,066	2,080,313	
OPERATING EXPENSES & EQUIPMENT			
General Expense	5,000	10,237	1-2
Fingerprint Reports*	356,817	179,510	1
Printing	35,000	36,334	1-2
Communications	55,000	37,023	1-2
Postage	146,890	66,094	1-2
Travel In-State	25,000	10,297	1-2
Training	4,000	15	1-2
Facilities Operation	225,000	217,300	current
Consult/Professional Services	506,873	510,427	1-2
Departmental Services	334,648	222,808	current
Data Processing	1,000	6,403	1-2
Central Administrative Services	146,316	109,737	current
Attorney General	190,000	61,758	current
Evidence/Witness Fees	7,500	5,400	1-2
Court Reporter Services	0,000	185	1-2
Major Equipment	12,000	0	1-2
Minor Equipment	0	3,596	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	2,051,044	1,477,124	
SCHEDULED REIMBURSEMENTS	(384,000)	(212,852)	
DISTRIBUTED COSTS	(43,723)	(21,861)	
TOTAL BUDGET/EXPENDITURES	**4,268,387**	**3,322,724**	

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

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3/25/2010

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2009 - FEBRUARY, 2010

	FY 09/10 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	8,610,439	5,802,335	current
Staff Benefits	3,637,392	2,270,475	current
TOTAL PERSONAL SERVICES	12,247,831	8,072,810	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	48,406	72,446	1-2
Printing	326,734	344,958	1-2
Communications	278,000	126,360	1-2
Postage	105,338	37,309	1-2
Insurance	38,378	8,866	current
Travel In-State	183,139	79,670	1-2
Training	24,188	20,184	1-2
Facililties Operations	2,007,140	1,541,559	current
Consultant/Professional Services	300,000	256,348	1-2
Departmental Services	2,868,797	1,910,000	current
Data Processing	8,994	9,955	1-2
Central Administrative Services	1,254,309	940,732	current
Attorney General 1/	13,157,280	8,721,660	current
OAH	1,862,591	474,232	current
Evidence/Witness Fees	1,820,939	987,012	1-2
Court Reporter Services	175,000	51,393	1-2
Major Equipment	220,000	0	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	81	15,493	1-2
Vehicle Operations	204,425	149,041	1-2
Minor Equipment	92,000	0	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	24,975,739	15,747,218	
DISTRIBUTED COSTS	(629,942)	(523,514)	
TOTAL BUDGET/EXPENDITURES	**36,593,628**	**23,296,514**	
Unscheduled Reimbursements		(15,494)	
		23,281,020	

1/See next page for monthly billing detail

3/25/10
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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	6,660.00	170.00	1,132,200.00
	Paralegal Services	324.50	120.00	38,940.00
	Auditor/Analyst Services	92.50	99.00	9,157.50
	Cost of Suit			
				1,180,297.50
September	Attorney Services	6,498.75	170.00	1,104,787.50
	Paralegal Services	267.25	120.00	32,070.00
	Auditor/Analyst Services	93.00	99.00	9,207.00
	Cost of Suit			
				1,146,064.50
October	Attorney Services	6,615.50	170.00	1,124,635.00
	Paralegal Services	439.50	120.00	52,740.00
	Auditor/Analyst Services	99.00	99.00	9,801.00
	Cost of Suit			1,501.30
				1,188,677.30
November	Attorney Services	5,441.25	170.00	925,012.50
	Paralegal Services	279.50	120.00	33,540.00
	Auditor/Analyst	58.00	99.00	5,742.00
	Cost of Suit			
				964,294.50
December	Attorney Services	5,796.25	170.00	985,362.50
	Paralegal Services	240.75	120.00	28,890.00
	Auditor/Analyst	77.50	99.00	7,672.50
	Cost of Suit			601.26
				1,022,526.26
			July - Dec Total =	**6,678,250.06**
			09/10 FY Budget =	**13,157,280.00**

Revised 4/5/10

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

January	Attorney Services	5,695.75	170.00	968,277.50
	Paralegal Services	325.75	120.00	39,090.00
	Auditor/Analyst	77.25	99.00	7,647.75
	Cost of Suit			3,739.56
				1,018,754.81
February	Attorney Services	5,693.50	170.00	967,895.00
	Paralegal Services	369.50	120.00	44,340.00
	Auditor/Analyst	69.00	99.00	6,831.00
	Cost of Suit			5,589.47
				1,024,655.47
March	Attorney Services		170.00	0.00
	Paralegal Services		120.00	0.00
	Auditor/Analyst Services		99.00	0.00
	Cost of Suit			
				0.00
April	Attorney Services		170.00	0.00
	Paralegal Services		120.00	0.00
	Auditor/Analyst Services		99.00	0.00
	Cost of Suit			
				0.00
May	Attorney Services		170.00	0.00
	Paralegal Services		120.00	0.00
	Auditor/Analyst Services		99.00	0.00
	Cost of Suit			
				0.00
June	Attorney Services		170.00	0.00
	Paralegal Services		120.00	0.00
	Auditor/Analyst Services		99.00	0.00
	Cost of Suit			
				0.00
			09/10 FYTD Total =	**8,721,660.34**
			09/10 FY Budget =	**13,157,280.00**

Revised 4/5/10
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ENFORCEMENT/PROBATION RECEIPTS
MONTHLY PROFILE: JULY 2007 - FEBRUARY 2010

	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	44,188	1,038,981
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	61,168	1,323,475
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	1,323,475	

	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	37,530	1,008,753
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	51,080	1,176,831
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	1,176,831	

	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	1,250	740	67	1,161	7,409	11,613					27,776
Criminal Cost Recovery	0	0	0	0	0	0	0	0					0
Probation Monitoring	46,225	21,354	22,836	34,983	22,419	186,279	346,422	203,922					884,440
Exam	150	250	105	330	3,480	1,658	292	200					6,465
Cite/Fine	3,500	3,025	2,425	3,225	3,055	5,425	475	4,723					25,853
MONTHLY TOTAL	54,361	25,679	26,616	39,278	29,021	194,523	354,598	220,458	0	0	0	0	944,534
FYTD TOTAL	54,361	80,040	106,656	145,934	174,955	369,478	724,076	944,534	944,534	944,534	944,534	944,534	

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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	2,033,000	36,594,000	568,000	4,268,000	1,560,000		2,958,000	1,591,000	49,572,000
$ Spent thru 2/28 *	1,626,000	23,281,000	325,000	3,323,000	1,039,000		1,720,000	165,000	31,479,000 *
Positions Authorized	8.8	146.6	6.0	45.5	15.0		16.0	25.0	262.9

* net expenditures (includes unscheduled reimbursements)

4/8/2010

Budget Overview by Program.xls

Licensing Backlog
Overtime/Temp Help Hours Worked
October, November and December 2009

	Oct POS	Oct PO	Nov POS	Nov PO	Dec POS	Dec PO				
	Hours	Hours	Hours	Hours	Hours	Hours	Total Hours	Paid Straight	Paid Premium	TOTAL PAID
FTE - Licensing	526.20	398.85	828.00	123.25	575.25	160.50	2612.05	1929.45	682.60	$66,828.71
FTE - Other	209.25	211.50	254.75	70.25	149.50	58.00	953.25	613.50	339.75	$31,425.47
Temp Help	1050.25	0.00	988.00	0.00	1023.25	0.00	3061.50	3061.50	0.00	$47,831.84
TOTAL	1785.70	610.35	2070.75	193.50	1748.00	218.50	6626.80	5604.45	1022.35	$146,086.02

4/19/2010 11:44 AM

AGENDA ITEM 16A

Medical Board of California
Vacancy Rate per Program
as of May 1, 2010

PROGRAM	PY'S	VACANT	VACANCY RATE
Executive	8.8	2	23%
Admin	32	3	9%
Licensing	44.5	6	13%
Enforcement	152.6	15	10%
Probation	25	0	0%
TOTAL	262.9	26	10%

SWORN VACANCY RATE
as of May 1, 2010

OFFICE	PY	INVEST VACANT	# IN BACKGROUND	SUPS/MGRS PY	SUPS/MGRS VACANT	TOTAL PY'S	TOTAL VACANT
Enf HQ	2	1		5	0	7	1
Sacramento	6	0		2	0	8	0
Fresno	6	1		1	0	7	1
San Jose	6	2	4	1	0	7	2
Cerritos	6	2	2	2	0	8	2
Tustin	5	0		1	0	6	0
Valencia	6	0		1	0	7	0
San Bernardino	6	0		2	0	8	0
Diamond Bar	6	1		1	0	7	1
Pleasant Hill	6	0		1	0	7	0
Glendale	6	2	2	1	0	7	2
San Diego	6	1		1	1	7	2
Rancho Cucamonga	5	1	1	1	0	6	1
OSM	4	1	1	1	0	5	1
TOTAL	76	12	10	21	1	97	13
VACANCY RATE		16% INVESTIGATORS			5% SUPS/MGRS		13% TOTAL
VACANCY RATE (less # in background)		3%			5%		3%

4/13/2010

AGENDA ITEM 16B

Medical Board of California Strategic Plan 2008

Goal	Objective	Plan	Progress	Timeline	Staff
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.	**1.1** Assure greater compliance of CME requirements. Measure: Improve compliance with CME requirements	1. Change regulations to define the requirements and timeframes.	1. **Completed** Spring 2009	1. February 1, 2008 Hearing adoption October 2008	Licensing Staff
		2. Enhance auditing process.	2. Pending regulatory process approval.	2.Begin Fiscal Year 2008-09	
		3. Review and enhance Cite & Fine Process.	3. Pending completion of the next audit.	3.Pending completion of the next audit	
	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. **Measures**: 1) Determine impact of the Board's plan to address access to healthcare. 2) 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.	1. Establish an Access to Care Committee to make recommendations to enhance/impact on workforce shortages.	1. Access to care committee has been **established**.	1. July 2007 to meet up to quarterly	Access to Care Committee
		2. Implementation of AB 329 to plan a telemedicine/health information technology pilot project to impact access to healthcare	2. Hired and trained a Telemedicine Program Manager. Telemedicine Pilot Program in partnership with UCD Medical Center implemented July 2009. Study for Malpractice Insurance completed. A Malpractice Task force was set up to meet in January 2010 prior to the Board meeting to discuss potential for legislation and to determine goals and objectives of the task force.	2. January 2008 to 2010	
		3. Review scope of practice issues that may impact workforce shortages	3. To be discussed in committee as issues arise.	3. January 2008 to 2010	
		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.	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.	4.Fiscal Year 2008-2009	

Prepared by Barb Johnston, Executive Director, January 2010

Medical Board of California Strategic Plan 2008

Objective	Plan	Progress	Timeline	Staff
1.3 Create a plan to assist in addressing medical errors as appropriate to the Board's Mission and resources. ***Measures**: 1)* 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. 2).Educational program/link on medical errors is available on Medical Board Web Site.	1 .Establish a Medical Errors Committee to study how to reduce medical errors by physicians.	1. Medical errors committee **completed** its work by developing materials on medical errors which are available on the Board's website.	1.Summer 2007	Medical Error Committee
	2. Develop or link to educational programs regarding medical errors and their consequences and make available on Medical Board's Web Site.	2. **Completed.**	2. 2008-2010	
	3. Evaluate the feasibility of the Medical Board developing this as a CME course.	3. Committee has learned that other organizations are focused on Medical Errors and decided **not to replicate**.	3. 2008-2010	
1.4 Develop an on-line educational program on cultural and linguistic competency. ***Measures**: 1)* Determine the number of physicians using this program to enhance their skills and satisfaction with the course. 2) Cultural and Linguistic Educational program/link is available on Medical Board Web Site.	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	1. Completed	Cultural and Linguistic Committee
	2. 2. Develop and/or link to educational programs.	2. Committee to define Educational programs to link too.	2. 2008-2010	
	3. Link to resources and information related to the broader issue of cultural and language issues as relates to medical practice.	3. The Committee will determine what information needs to be posted on the web page.	3. 2008-2010	

Prepared by Barb Johnston, Executive Director, January 2010

Medical Board of California Strategic Plan 2008

Objective	Plan	Progress	Timeline	Staff
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: 1)* Site audits indicate these physicians are compliant with regulation and a decrease of complaints on this group. 2) There will be 100% compliance with requirements for all special program participants.	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.	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.	1. July 2007 and ongoing	Licensing
	2. Conduct site visits to assure compliance with requirements of these special programs.	2. Site visits to be scheduled as required. Site visit protocols are being developed.	2. July 2008 and ongoing	
1.6 Ensure international medical schools meet the Board's requirements for recognition. Measures: 1) Site inspections indicate compliance. 2) There will be 100% compliance for these programs.	1. Review established procedures within licensing to assure the Medical Board is providing adequate technical support and evaluation	1. Amended regulations regarding the international medical schools were completed at the end of 2009.	1. July 2007 with completion Dec 2009	Licensing
	2. Conduct site visits as appropriate to assure compliance.	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.	2. July 2007 and ongoing	

Prepared by Barb Johnston, Executive Director, January 2010

Medical Board of California Strategic Plan 2008

Goal	Objective	Plan	Progress	Timeline	Staff
	1.7 Promote physician wellness by providing an on-line educational programs and links to other resources. *Measure: 1)* Determine the number of physicians using these resources. 2) Track the number of participants who access information provided on the Medical Board Web site.	**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	1. Articles on Wellness have been published in the newsletter. The board's Wellness bill in 2008 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. 2. Wellness committee in 2009 began development of an online Physician Wellness education tool in collaboration with UC Davis.	1. July 2007 and ongoing 2. July 2009 and ongoing	Wellness Committee
Regulation and Enforcement Protect the public by effectively enforcing laws and standards to deter violations.	**2.1** Submit vertical enforcement report to the Legislature by December 2007 and implement the vertical enforcement model long term. ***Measure:*** *1.* Report submitted and vertical enforcement model fully integrated including implementation of fully interoperable information technology software used by the Department of Justice.	1. Develop and submit vertical enforcement report to the Legislature.	1. Report was **submitted November 2007 and July 2009**.	1. November 2007	Enforcement & Information Technology
		2. Implement the vertical enforcement model long term.	2. VE has been **fully implemented**. VE Pilot program has been extended until 2013 legislation.	2. 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.	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.	3. 2008 and ongoing	

Prepared by Barb Johnston, Executive Director, January 2010

Medical Board of California Strategic Plan 2008

Objective	Plan	Progress	Timeline	Staff
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.	1. Report by contracted vendor pursuant to Business and Professions Code section 805.2 submitted to the Legislature.	1. **Report was completed** and submitted to the Legislature July 2008.	1. July 2008	Executive
	2. Review the report and seek action as appropriate to implement recommendations.	2. Senate B&P held a hearing in 2009 on the report and its recommendations. **Legislation was introduced in 2009 session**	2. July 2008 through 2009	
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.	1. Develop budget change proposal to authorize appropriate funding and staffing to re-establish program.	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.	1. Spring 2008	Enforcement
	2. Re-establish operation safe medicine.	2. **OSM re-established July 2008.**	2. July 2008 through 2009 and ongoing	

Prepared by Barb Johnston, Executive Director, January 2010

Medical Board of California Strategic Plan 2008

Goal	Objective	Plan	Progress	Timeline	Staff
	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.	1. Reclassify investigator assistant positions to inspector positions.	1. **Re-classification done Spring 2008**.	1. Fall 2007	Enforcement
		2. Hire new manager and supervisors.	2. **New manager and supervisors employed, trained and in place 08/09**.	2. Fall 2007 through Jan 2008	
		3. Transition probation investigators to district office positions.	3. **Probation investigators transitioned** to district office positions in 08/09.	3. Fall 2007 through Spring 2008	
		4. Draft budget change proposal for additional inspector positions.	4. The BCP for **staffing was approved for fiscal year 09/10** and ongoing with funding to be absorbed.	4. Spring 2008	
Consumer Education Increase public awareness of the Board's Mission, activities and services.	**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.	1. Receive the public information study from the California Research Bureau as mandated by the legislature.	1. **Final report on Public Disclosure presented** to the board at the January 2009 Board meeting.	1. July 2008	Public Information Officer
		2. Review the report and seek action as appropriate to implement recommendations.	2. **Updated 805 summaries on the website**.	2. July 2008 through 2009.	

Prepared by Barb Johnston, Executive Director, January 2010

Medical Board of California Strategic Plan 2008

Objective	Plan	Process	Timeline	Staff
3.2 Recognition of excellence in medicine by California physicians. ***Measures:*** *1)* Ensure annual award of recognition given to recipient. 2) Board presents award to recipient at a board meeting.	1. Solicit and review nominations for the board's physician humanitarian award.	1. Nomination sought and reviewed annually.	1. August to Dec Annually	Public Information Officer
	2. The Physician Recognition Committee will select awardee.	2. Selection is done by committee.	2. December Annually	
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.	1. Increase education material on the web site.	1. Educational materials have been added to the website and staff will under direction of the Board.	1. Ongoing	
	2. Represent the Board at professional and public events statewide.	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.	2. Ongoing	
	3. Develop a public service announcement educating the public about the board.	3. High cost with low benefit/impact was determined.	3. Canceled	
	4. Issue news releases and the board's Newsletter.	4. News releases and the newsletter are widely distributed.	4. Ongoing	
	5. Contact reporters to develop stories about issues related to the board.	5. Public Information Officer is in contact with reporters across the state on a regular basis.	5. Ongoing	

Prepared by Barb Johnston, Executive Director, January 2010

Medical Board of California Strategic Plan 2008

Goal	Objective	Plan	Progress	Timeline	Staff
Organizational Relationships Improve effectiveness of relationships with related organizations to further the Board's Mission and goals.	**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.	1. Set up meetings with legislative policy and fiscal committee members to discuss annual legislative agenda and issues of mutual concern.	1. Board members remain 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	1. Fall 2007 to Spring 2008	Chief of Legislation
		2. Set up meetings with key stakeholders on issues of mutual concern.	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.	2. Fall 2007 and ongoing	
		3. Schedule members to attend legislative policy hearings on legislation sponsored by or pertaining to the board	3. Members have been scheduled to attend these meetings and will continue to do this.	3. 2008 and ongoing	
	4.2 Develop a plan for Supervising Investigators to meet with legislative staff in district offices. ***Measure***: Increases personal contact with legislative district staff.	1. Develop board informational packets for the investigative staff to deliver to legislative district staff.	1. The informational packets were developed.	1. Fall 2007	Chief of Legislation and Supervising Investigators
		2. Set up meetings with legislative district offices and investigative staff.	2. Meetings with legislative district offices and investigative staff to 120 district offices.	2. Fall 2007 and ongoing	
Organizational Effectiveness Enhance organizational	**5.1** Develop better ways of assessing Board "customer satisfaction" and implement changes that would better serve applicants, licensees and the public. ***Measures***: *1)* High levels	1. Develop an online system to allow potential licensees to access the status of their application.	1. Online system developed and launched in December 2009. Feedback will be encouraged to promote continuous improvements overtime.	1. 2008 and ongoing	All Staff

Prepared by Barb Johnston, Executive Director, January 2010

Medical Board of California Strategic Plan 2008

Goal	Objective	Plan	Progress	Timeline	Staff
effectiveness and systems to improve service to constituents.	of satisfaction reported by customers who receive services or who access information on the Board's Web site. 2) Decrease number of complaints regarding the board's processes and accessibility.	2. Establish a centralized 800-line for all consumer, applicant, and licensee inquiries to the board with customer support staff.	2. The centralized call number was developed and a consumer focused **Call center was implemented** December 2008.	2. Spring 2008	
		3. Medical Board's new headquarters will have one central public reception area to better serve physicians, applicants, the public, and other visitors.	3. Moved to new headquarters in March 2008 and central reception provided	3. Spring 2008	
	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.	1.Hire a vendor to perform an analysis of investigator classifications statewide to determine correct classification and pay for board investigators.	1. CPS awarded contract and provided initial report of analysis of investigator classifications in summer 2009. Additional work was required on report due winter 2009.	1. Summer 2008 to 2009	Chief of Enforcement
		2. Take appropriate action based upon study results.	2. Awaiting results of study.	2. 2009	

Prepared by Barb Johnston, Executive Director, January 2010

Medical Board of California Strategic Plan 2008

Objective	Plan	Progress	Timeline	Staff
5.3 Implement the restructuring of the Board to ensure greater communication and synergy between enforcement and licensing divisions of the Board. ***Measures** 1):* Implementation is completed and all board members are educated regarding all Board issues. 2) Training provided to all board members	1. Develop implementation plan of the board restructuring.	1. **Board was restructured** to operate as one unified Board January 2008.	1. December 2007	All Staff
	2. Implement plan and provide training to all board members on both licensing and enforcement programs.	2. **Training sessions** have begun and will continue to be developed. Staff continues to work with the Attorney General's office to provide training identified by Members as the highest priority.	2. 2008	
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.	1. Initiate the evaluation process.	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.	1. August 2008	Licensing Staff
	2. Conduct review and analysis.	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.	2. August 2008 t0 Sept 2009	
	3. Complete report and review recommendations for possible action.	3. Determine appropriate implementation after report received.	3. N/A	

Prepared by Barb Johnston, Executive Director, January 2010

Medical Board of California Strategic Plan 2008

Objective	Plan	Progress	Timeline	Staff
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.	1. Develop a space plan to optimize workflow	1. Space plan developed, approved and **implemented at new facility**.	1. August 2007	All Staff
	2. Reorganize record storage and retention systems by moving to online environments and eliminating wasted space.	2. **Record storage has been reorganized** to eliminate wasted space.	2. August 2007 and ongoing	
	3. Establish one central public counter and call center with a toll-free number	3. **Established public counter** in March 2008 and call center in December 2008.	3. March 2008	
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.	1. Develop online educational programs for multiple topics including but not limited to filing applications and complaints, training, and/or mandatory reporting.	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.	1. Spring 2008 and ongoing	All Staff

Prepared by Barb Johnston, Executive Director, January 2010

Medical Board of California Strategic Plan 2008

Objective	Plan	Progress	Timeline	Staff
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.	1. Evaluate existing business processes to determine those systems that could be improved by upgrading information technology (IT) environment.	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.	1. Spring 2008 and ongoing	Executive and Information Technology Staff
	2. Purchase and implement expanded and upgraded IT system to support a more efficient business environment.	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. DCA is developing a plan to replace both IT systems used by the Board with a new IT system to be sued across all DCA Boards and Bureaus. MBC staff remains on the DCA IT committees for development and implementation of this new IT system.	2. In process	

Prepared by Barb Johnston, Executive Director, January 2010

MEDICAL BOARD OF CALIFORNIA
Executive Office

SCHEDULE OF BOARD MEETING DATES FOR 2010

January 28, 29	San Francisco
April 29, 30	Los Angeles
July 29, 30* Thursday/Friday	Sacramento MBC Headquarters 2005 Evergreen Street
November 3, 4 Wednesday/Thursday	Long Beach Need to locate free government facility – if not, due diligence for least expensive option

*Possible July 27 Committee meeting

Other 2010 Dates Important to the MBC

Tuesday, May 11	Cultural Linguistic Workgroup Meeting
Thursday, May 13	Health Professions Education Foundation
Wednesday, May 26	Limited License Interested Parties Meeting
Wednesday, June 16	Polysom Interested Parties Meeting
Thursday, June 17	Specialty Faculty Permit Review Committee Meeting
Tuesday, July 28	DCA Board Member Training
Thursday, August 12	Midwifery Advisory Council Meeting
Thursday, September 30	Special Faculty Permit Review Committee Meeting
Thursday, November 18	Health Professions Education Foundation

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 (and other control agencies) for Review *	Date to OAL for Review **	Date to Sec. of State***
Notice to Consumers by Physicians	Effective June 27, 2010 (Board requested effective date 90 days after filing with Sec of State, to allow for adequate notice to licensees)	5/8/09	6/5/09	7/24/09	7/24/09	To DCA 9/1/09; approved by DCA 9/24/09; approved by Agency 10/23/09; approved by DOF 2/11/10	2/17/10	3/29/10
Disciplinary Guidelines	Pending review at DCA	7/24/09	9/11/09	10/30/09	11/30/09	To DCA on 3/18		
Written Exam for Physician licensure	Hearing set for 4/30/10	1/29/10	3/12/10	4/30/10				
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations pending Summer 2010							

* - DCA is allowed 30 calendar days for review
** - OAL is allowed 30 working days for review
*** - Regs usually take effect 30 days after filing with Sec. of State

Prepared by Kevin A. Schunke
Updated April 1, 2010
For questions, call (916) 263-2368

LEGISLATIVE PACKET

Agenda Item 17B

2010 Legislation

1. MBC Bills
2. DCA CPEI
3. Other Legislation

Will be forwarded under separate cover

Consumer Protection Enforcement Initiative Update

April 26, 2010

Dear Colleagues:

I want to take a moment to let you know that, despite a setback last week in the Legislature, our Consumer Protection Enforcement Initiative (CPEI) continues to be the department's highest priority.

Last Thursday, Senate Bill 1111, authored by Senator Negrete McLeod and sponsored by the Department, failed to make it out of committee. SB 1111 was an important component of CPEI, and we were disappointed and perplexed that the committee didn't approve it, given the clear need for legislative reform in this area. Governor Arnold Schwarzenegger also expressed his disappointment. Senator Negrete McLeod stood alone in her efforts to provide the department with the necessary authority to quickly and effectively remove from practice those licensees who have harmed patients. We are grateful for her efforts.

While this was a disappointment, it is by no means the end of our efforts. We will continue to move forward, implementing process improvement, staff development, and performance measures, and adding enforcement resources to meet our goals. We will also urge and work with our boards to adopt regulatory language that provides authority for board executive officers to quickly investigate and prosecute licensees who violate the law.

Through your willingness to change, your hard work, and your perseverance, we have already made significant progress toward reforming our enforcement programs to better protect Californians from the most dangerous health care practitioners.

We are committed to seeing this important effort through to the end. With your continued help and support, I'm confident we will overcome all obstacles and challenges to meet our goal of improving consumer protection.

As always, thank you for your efforts and your commitment to consumer protection.

Best regards,

-Brian

LEGISLATIVE PACKET

MEDICAL BOARD MEETING

APRIL 30, 2010
LOS ANGELES, CA

Medical Board of California
Tracker - Legislative Bill File
4/22/2010

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 526	Fuentes	Public Protection and Physician Health Program Act of 2009	Sen. Approps. - susp	Oppose	8/19/2009
AB 583	Hayashi	Disclosure of Education and Office Hours	Sen. Inactive	Support	7/8/2009
AB 646	Swanson	Physician employment: district hospital pilot project	Sen. B&P	Support in Concept	4/13/2010
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 977	Skinner	Pharmacists: immunizations	Sen. B&P	Support	1/25/2010
AB 1310	Hernandez	Healing Arts: database	Sen. Approps. - susp	Support	6/29/2009
AB 1767	Hill	Enforcement: expert reviewers	Asm. Floor	Sponsor/Support	
AB 2148	Tran	Personal Income Tax: charitable deductions	Asm. Rev. & Tax	Rec: Support	
AB 2566	Carter	Cosmetic surgery: employment of physicians	Asm. Approps.	Rec: Support	
AB 2600	Ma	Continuing Education Requirements	Asm. B&P	Rec: Neutral	3/25/2010
SB 700	Negrete McLeod	Peer Review	Asm. Approps.	Rec: Support	1/26/2010
SB 726	Ashburn	Hospitals: employment of physician; pilot project revision	Asm. Inact.	Support Rec: Support if amended	8/20/2009
SB 1031	Corbett	Medical Malpractice Insurance	Sen. B&P	Sponsor/Support	4/5/2010
SB 1069	Pavley	Physician Assistants	Sen. Jud.	Rec: Support	4/12/2010
SB 1111	Negrete McLeod	Regulatory Boards: CPEI	Sen. B&P	Rec: Support	4/12/2010
SB 1150	Negrete McLeod	Healing Arts: advertisements	Sen. Approps.	Rec: Support	
SB 1172	Negrete McLeod	Diversion Programs	Sen. B&P	Rec: Support	4/12/2010
SB 1410	Cedillo	Medicine: licensure examinations	Sen. Approps.	Rec: Oppose	
SB 1489	B&P Comm.	Omnibus	Sen. B&P	Rec: Support MBC Provisions	4/5/2010

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

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

April 12, 2010

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

illnesses, a physician and surgeon, certified or otherwise lawfully practicing in this state, may enter into a voluntary agreement with a physician health program. The agreement between the physician and surgeon and the physician health program shall include a jointly agreed upon treatment program and mandatory conditions and procedures to monitor compliance with the treatment program, including, but not limited to, an agreement to cease practice, as defined by the rules and regulations adopted pursuant to Section 2342. Except as provided in subdivisions (b), (c), (d), and (e), a physician and surgeon's participation in the physician health program pursuant to a voluntary agreement shall be confidential unless waived by the physician and surgeon.

(b) (1) Any voluntary agreement entered into pursuant to this section shall not be considered a disciplinary action or order by the board, shall not be disclosed to the board, and shall not be public information if all of the following are true:

(A) The voluntary agreement is the result of the physician and surgeon self-enrolling or voluntarily participating in the physician health program.

(B) The board has not 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.

(C) The physician and surgeon is in compliance with the treatment program and the conditions and procedures to monitor compliance.

(2) (A) Each participant, prior to entering into the voluntary agreement described in paragraph (1), shall 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. For those purposes, the committee shall regularly monitor recent accusations filed against physicians and surgeons and shall compare the names of physicians and surgeons subject to accusation with the names of program participants.

(B) Notwithstanding subparagraph (A), a participant who is under investigation by the board and who makes the disclosure required in subparagraph (A) may participate in, and enter into a 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

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

April 15, 2010

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: April 13, 2010, amended
Subject: Authorizing District Hospitals to Employ Physicians
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Business, Professions, and Economic Development 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

April 15, 2010

AMENDED IN SENATE APRIL 13, 2010

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,~~ Salas, Skinner, and Torres)
(Coauthors: Senators DeSaulnier ~~and Wiggins~~ *Price, Romero, Wiggins and Yee*)

February 25, 2009

An act to amend, *repeal, and add* 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~~ *50%* 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 that pilot project and would instead, *until January 1, 2021,* authorize a health care district, as defined, *and a clinic owned or operated by a health care district, as specified,* to employ physicians and surgeons if 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); *the district board conducts a public hearing and adopts a specified resolution declaring the need for the district to recruit and directly employ one or more physicians and surgeons;* 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: 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

the ~~Division of Licensing~~ *board* or the Osteopathic Medical Board of California, may charge for professional services rendered to teaching patients by licensees who hold academic appointments on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made.

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

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

(d) (1) Notwithstanding Section 2400, a health care district 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, 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), *as defined in Section 127928 of the Health and Safety Code,* 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~~

(B) The board conducts a public hearing and adopts a formal resolution declaring that a need exists for the district to recruit

and directly employ one or more physicians and surgeons to serve unmet community need.

(C) The resolution shall include all of the following findings and declarations:

(i) Patients living within the community have been forced to seek care outside of the community, or have faced extensive delays in access to care, due to the lack of physicians and surgeons.

(ii) The communities served by the district lack sufficient numbers of physicians and surgeons to meet community need or have lost or are threatened with the impending loss of one or more physicians and surgeons due to retirement, planned relocation, or other reasons.

(iii) The district has been actively working to recruit one or more physicians and surgeons to address unmet community need, or to fill an impending vacancy, for a minimum of 12 consecutive months, beginning July 1, 2008, without success.

(iv) The direct employment of one or more physicians and surgeons by the district is necessary in order to augment or preserve access to essential medical care in the communities served by the district.

(D) The resolution shall also do the following:

(i) Direct the district's executive officer to begin actively recruiting one or more physicians and surgeons, up to the limits specified in this chapter, as district employees.

(ii) Prohibit the executive officer from actively recruiting or employing a physician and surgeon who is currently employed by a federally qualified health center, rural health center, or other community clinic not affiliated with the district.

(E) Upon adoption of the resolution by the board, the executive officer shall submit 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~~ *application, adopted resolution, and all relevant documentation* of the district's inability to recruit a physician and surgeon as specified in subparagraph ~~(B)~~ *(E)* 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~~ *documentation* 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.

(6) This subdivision applies to health care districts and to any clinic owned or operated by a health care district, provided the health care district meets the criteria of, and ensures compliance with, the requirements of this subdivision.

(e) A health care district authorized to employ physicians and surgeons pursuant to subdivision (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.

(f) Nothing in subdivision (d) shall be construed to affect a primary care clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code.

(g) This section shall remain in effect only until January 1, 2021, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2021, deletes or extends that date.

SEC. 2. Section 2401 is added to the Business and Professions Code, to read:

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

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

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

(d) This section shall become operative on January 1, 2021.

~~SEC. 2.~~

SEC. 3. Section 2401.1 of the Business and Professions Code is repealed.

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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

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

April 15, 2010

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)

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

April 15, 2010

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.

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AMENDED IN ASSEMBLY JANUARY 25, 2010

AMENDED IN ASSEMBLY JANUARY 13, 2010

AMENDED IN ASSEMBLY JANUARY 6, 2010

AMENDED IN ASSEMBLY JANUARY 4, 2010

AMENDED IN ASSEMBLY APRIL 23, 2009

AMENDED IN ASSEMBLY APRIL 13, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

AB 977

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 977
Author: Skinner
Bill Date: January 13, 2010, amended
Subject: Pharmacists: immunization protocols with physicians
Sponsor: Author

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a pharmacist to administer influenza immunizations to any person 18 years of age or older.

ANALYSIS:

Current law does not allow pharmacists to administer medications. With the growing need for an increased availability of health care providers who can administer influenza immunizations, it would provide better access to care if the public could utilize their pharmacists when searching for an influenza vaccine.

This bill would require a pharmacist to complete a pharmacy-based immunization delivery training program prior to initiating or administering any immunizations. These pharmacists would also be required to complete 3 hours of immunization related continuing education coursework annually and be certified in basic life support.

A pharmacist would be required to provide patients with a Vaccine Information Statement and provide the patient and the patient's physician with documentation of having administered the immunization.

The Medical Board (Board) would be required to develop standardized protocols for the initiation and administration of influenza immunizations by pharmacists and the board may consult the Board of Pharmacy for collaboration in developing those protocols.

Amendments to this bill removed the physician consultation from the provisions.

FISCAL: Minor and absorbable

POSITION: Support

April 15, 2010

AMENDED IN ASSEMBLY JANUARY 25, 2010

AMENDED IN ASSEMBLY JANUARY 13, 2010

AMENDED IN ASSEMBLY JANUARY 6, 2010

AMENDED IN ASSEMBLY JANUARY 4, 2010

AMENDED IN ASSEMBLY APRIL 23, 2009

AMENDED IN ASSEMBLY APRIL 13, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 977

Introduced by Assembly Member Skinner

February 26, 2009

An act to add and repeal Section 4052.8 of the Business and Professions Code, relating to pharmacy.

LEGISLATIVE COUNSEL'S DIGEST

AB 977, as amended, Skinner. Pharmacists: immunization protocols ~~with physicians~~.

Existing law, the Pharmacy Law, provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy. A violation of the Pharmacy Law is a crime. Existing law, among other things, authorizes a pharmacist to administer immunizations pursuant to a protocol with a prescriber.

This bill, until January 1, 2015, would additionally authorize a pharmacist~~, in consultation with a physician and surgeon,~~ to initiate and administer influenza immunizations to any person 18 years of age or older pursuant to standardized protocols developed and approved by the Medical Board of California in consultation with public health

officers. The bill would, with respect to the development and approval of those standardized protocols, authorize the Medical Board of California to consult with the board. The bill would require a pharmacist, prior to initiating and administering those immunizations, to complete a specified pharmacy-based immunization delivery training program. The bill would also require a pharmacist initiating and administering those immunizations to complete 3 hours of immunization-related continuing education coursework annually and to be certified in basic life support. The bill would require a pharmacist, at the time of administration of that immunization, to provide the patient with a Vaccine Information Statement and to provide the patient and the patient's physician with documentation of administration of the immunization. The bill would also require a pharmacist administering that immunization to maintain a specified immunization record, provide documentation of administration to the appropriate immunization registry, report any adverse event and ensure proper storage and handling of vaccines. The bill would authorize a pharmacist initiating and administering vaccines under these provisions to initiate and administer epinephrine for severe allergic reactions.

This bill would require the board and the Medical Board of California to complete an evaluation of influenza immunizations initiated and administered under the standardized protocols authorized by the bill, and would require the board to report to the appropriate policy committees of the Legislature by January 1, 2014.

Because this bill would create new requirements under the Pharmacy Law, the violation of which would be a crime, it would impose a state-mandated local program.

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

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

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:

(a) Vaccines are a safe, effective, and efficient means to prevent sickness and death from infectious diseases as reported by the United States Department of Health and Human Services (HHS).

(b) The federal Centers for Disease Control and Prevention report that 220,000,000 persons should get the influenza vaccination annually, however, fewer than 100,000,000 do.

(c) According to the California Health Care Foundation, 6,600,000 Californians are uninsured and may not have access to immunizations.

(d) Pharmacists represent the third largest health professional group in the United States and are on the front line of preventative care.

(e) Pharmacists are trained to screen, administer, and properly deal with any adverse events that may arise from vaccines.

(f) Primary care physicians play an integral role in preventative health care for Californians. This act will provide an adjunct to that preventative health care.

(g) Therefore, in order to achieve greater access to immunization and to protect Californians, it is the intent of the Legislature to provide greater access to lifesaving vaccinations and to ensure that pharmacists may administer influenza vaccinations.

SEC. 2. Section 4052.8 is added to the Business and Professions Code, to read:

4052.8. (a) A pharmacist may~~, in consultation with a physician and surgeon,~~ initiate and administer influenza immunizations, pursuant to standardized protocols developed and approved by the Medical Board of California in consultation with public health officers, to any person 18 years of age or older. With respect to the development and approval of those standardized protocols, the Medical Board of California may consult with the board. The standardized protocols shall be consistent with protocols developed by the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention.

(b) Prior to initiating and administering immunizations, a pharmacist shall complete the American Pharmacists Association's Pharmacy-Based Immunization Delivery Certificate Training Program or another pharmacy-based immunization training certificate program endorsed by the federal Centers for Disease Control and Prevention or the Accreditation Council for Pharmaceutical Education.

(c) (1) A pharmacist initiating and administering any immunization pursuant to this section shall also complete three hours of immunization-related continuing education coursework annually.

(2) If a pharmacist fails to satisfy this requirement, he or she shall, in addition to any other applicable disciplinary action, retake the training identified in subdivision (b) and also complete the three hours of immunization-related continuing education coursework described in paragraph (1) prior to initiating and administering any further immunizations.

(3) The three hours of immunization-related continuing education may be applied toward the continuing education requirement described in Section 4231.

(d) A pharmacist initiating and administering any immunization pursuant to this section shall at all times be certified in basic life support.

(e) At the time of administration of an immunization, the pharmacist shall do all of the following:

(1) Provide the patient or the patient's agent with the appropriate Vaccine Information Statement, produced by the federal Centers for Disease Control and Prevention, for each immunization administered.

(2) Provide documentation of administration of the immunization to the patient and the patient's physician or primary care provider, if one can be identified.

(3) Provide documentation of administration of the immunization to the appropriate immunization registry.

(f) The pharmacist shall maintain an immunization administration record, which shall include, but not be limited to, the name of the vaccine, the expiration date, the date of administration, the manufacturer and lot number, the administration site and route, the Vaccine Information Statement date, and the name and title of the person administering, for 10 years from the date of administration.

(g) Any pharmacist initiating and administering vaccines may initiate and administer epinephrine by injection for severe allergic reactions.

(h) Any adverse event shall be reported to the Vaccine Adverse Event Reporting System within the United States Department of Health and Human Services.

(i) Upon receipt of a vaccine as authorized by this section, a pharmacist is responsible for ensuring that proper vaccine temperatures are maintained during subsequent storage and handling to preserve the potency of the vaccine.

(j) The board and the Medical Board of California shall evaluate the effectiveness of the initiation and administration of immunizations pursuant to this section, and the board shall report to the appropriate policy committees of the Legislature by January 1, 2014.

(k) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

~~SEC. 4.~~

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.

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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

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

April 15, 2010

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 the ~~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:

SECTION 1. Section 857 is added to the Business and Professions Code, to read:

857. (a) ~~Each~~ *Every* healing arts board specified in subdivision ~~(c) shall add and label as "mandatory" the following fields on an application for initial licensure or renewal for a person applying to that board:~~

~~(1) First name, middle name, and last name.~~

~~(2) Last four digits of social security number.~~

~~(3) Complete mailing address.~~ *(f) shall, in a manner deemed appropriate by the board, collect the following information from persons licensed, certified, registered, or otherwise subject to regulation by that board:*

~~(4)~~

(1) Educational background and training, including, but not limited to, degree, related school name and location, and year of graduation, and, as applicable, the highest professional degree obtained, related professional school name and location, and year of graduation.

~~(5)~~

(2) Birth date and place of birth.

~~(6)~~

(3) Sex.

~~(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

AB 1767

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1767
Author: Hill
Bill Date: February 2, 2010, introduced
Subject: Enforcement: expert reviewers
Sponsor: Medical Board of California

STATUS OF BILL:

This bill is on the Assembly Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Medical Board (Board) to provide representation to a licensed physician who provides expertise to the Board in the evaluation of the conduct of a licensee when, as a result of providing the expertise, the physician is subject to a disciplinary proceeding undertaken by a specialty board of which the physician is a member.

ANALYSIS:

The Board is currently required to provide legal representation to physicians who provide expertise to the Board if they are named as a defendant in a civil action arising out of the evaluation, opinions, or statements made while testifying on behalf of the Board.

When a professional grievance is filed with a specialty board of which the physician is a member, the Board is not able to protect the physician. This creates a disincentive for these reviewers who provide a critical consumer protection function for the Board.

This bill would give the Board a way to protect its expert witnesses in the case that their testimony for the Board brings about complaints or grievances with the specialty boards of which the physicians who participate as expert witnesses are members. This bill removes the disincentive for physicians to use their expertise to assist in the Board's enforcement cases, thus preserving the ease with which the Board is able to recruit physicians to participate as expert witnesses.

FISCAL: Unknown

POSITION: Sponsor/Support

April 15, 2010

ASSEMBLY BILL No. 1767

Introduced by Assembly Member Hill

February 9, 2010

An act to add Section 2316 to the Business and Professions Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 1767, as introduced, Hill. Physicians and surgeons: expert testimony.

Existing law requires a board under the Business and Professions Code, including the Medical Board of California, to provide legal representation to any person hired or under contract who provides expertise to the board in the evaluation of an applicant or the conduct of a licensee when that person is named as a defendant in a civil action arising out of the evaluation or any opinions rendered, statements made, or testimony given to the board. Existing law also provides immunity from civil liability to any person providing testimony to the Medical Board of California, the California Board of Podiatric Medicine, or the Department of Justice indicating that a licensee may be guilty of unprofessional conduct or may be impaired because of drug or alcohol abuse or mental illness.

This bill would require the Medical Board of California to provide representation to any licensed physician and surgeon who provides expertise to the board in the evaluation of the conduct of an applicant or a licensee when, as a result of providing that expertise, the physician and surgeon is subject to a disciplinary proceeding undertaken by a specialty board of which the physician and surgeon is a member.

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. (a) The Legislature finds and declares that
2 consumer protection is further strengthened when the Medical
3 Board of California uses board-certified physicians and surgeons
4 in the investigation of complaints and the prosecution of
5 administrative disciplinary actions. The Legislature further finds
6 and declares that the use of board-certified physicians and surgeons
7 is consistent with the requirements of Section 2220.08 of the
8 Business and Professions Code, and in conformity with existing
9 case law that requires that the standard of care and any deviations
10 from the standard of care be established by expert witnesses.
11 (b) The Legislature finds and declares that a disturbing trend
12 may be emerging whereby board-certified physicians and surgeons
13 may be subject to discipline from the very boards that certified
14 them as expert witnesses for the Medical Board of California in
15 administrative proceedings. Actual or threatened discipline against
16 board-certified physicians and surgeons may chill participation in
17 the board's expert reviewer program and may significantly impair
18 and hamper the effective and timely resolution of complaints and
19 licensure and disciplinary actions. The Legislature finds and
20 declares that the enactment of legislation is necessary to prevent
21 this occurrence and for the protection of California consumers.
22 SEC. 2. Section 2316 is added to the Business and Professions
23 Code, to read:
24 2316. If a licensed physician and surgeon who provides
25 expertise to the board in the evaluation of an applicant or a licensee
26 is, as a result of providing that expertise, the subject of a
27 disciplinary proceeding undertaken by a specialty board of which
28 the physician and surgeon is a member, the board shall provide
29 representation for the physician and surgeon in that disciplinary
30 proceeding.

O

AB 2148

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2148
Author: Tran
Bill Date: February 18, 2010, introduced
Subject: Personal Income Tax: charitable donations
Sponsor: Author

STATUS OF BILL:

This bill is in the Assembly Revenue and Tax Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a tax deduction for medical services contributed without compensation for physicians who volunteer their services in a community clinic.

ANALYSIS:

This bill is intended to encourage physicians to volunteer services where needed. The tax deduction for services provided is designed to give an incentive for physicians to provide uncompensated services in underserved communities.

This bill places limit on the maximum amount of deduction allowed per physician each year. The Franchise Tax Board estimates that, given the average rate applied to physician services, the general fund revenue losses will be $900,000 in the next fiscal year and $600,000 in following years.

FISCAL: None to the Board

POSITION: Recommendation: Support

April 15, 2010

ASSEMBLY BILL No. 2148

Introduced by Assembly Member Tran

February 18, 2010

An act to add Section 17206.2 to the Revenue and Taxation Code, relating to taxation, to take effect immediately, tax levy.

LEGISLATIVE COUNSEL'S DIGEST

AB 2148, as introduced, Tran. Personal income tax: charitable contribution deduction: physician.

The Personal Income Tax Law, in modified conformity with federal income tax laws, allows various deductions in computing the income that is subject to the taxes imposed by that law, including a deduction for a charitable contribution made by a taxpayer during the taxable year.

This bill would allow a deduction for the value of medical services contributed free of charge by a physician to a local community clinic, not to exceed specified amounts.

This bill would take effect immediately as a tax levy.

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 17206.2 is added to the Revenue and
2 Taxation Code, to read:
3 17206.2. (a) There shall be allowed as a deduction the value
4 of medical services contributed free of charge by a physician to a
5 local community clinic during the taxable year.
6 (b) For purposes of this section, all of the following apply:

1 (1) "Local community clinic" means a community clinic or free
2 clinic as defined in subdivision (a) of Section 1204 of the Health
3 and Safety Code.
4 (2) "Physician" means a person authorized to practice medicine
5 or osteopathy under the laws of any state.
6 (3) The deduction allowed to any taxpayer by this section shall
7 not exceed either of the following:
8 (A) The value of any contribution that exceeds a rate of fifty
9 dollars ($50) per hour for any medical services rendered.
10 (B) One thousand five hundred dollars ($1,500) per taxable
11 year.
12 (c) No other deduction shall be allowed by this part for any
13 contribution for which a deduction is claimed under this section.
14 SEC. 2. This act provides for a tax levy within the meaning of
15 Article IV of the Constitution and shall go into immediate effect.

O

AB 2566

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2566
Author: Carter
Bill Date: February 19, 2010, introduced
Subject: Cosmetic Surgery: employment of physicians
Sponsor: American Society for Dermatological Surgery Association

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would prohibit outpatient cosmetic surgery centers from violating the prohibition of the corporate practice of medicine. This bill defines "outpatient elective cosmetic procedures or treatments."

ANALYSIS:

The intent of this bill is to elevate the penalties of violating the corporate practice of medicine prohibition in order to prevent further offenses and to convince consumers with business models that violate this law to reconsider and revise their business practices.

This bill would enhance the penalty for corporations violating the prohibition of the corporate practice of medicine to a public offense punishable by imprisonment for up to five years and/or by a fine not exceeding $50,000. Current law states that this violation is punishable as a misdemeanor, a $1,200 fine, and imprisonment for up to 180 days.

This bill would define "outpatient elective cosmetic procedures or treatments" as medical procedures or treatments that are performed to alter or reshape normal structures of the body solely in order to improve appearance.

The Board has previously supported similar legislation such as AB 252 (Carter) in 2009 that authorized the revocation of a physician's license for knowingly practicing with an organization that is in violation of the corporate practice of medicine. This bill was vetoed for being "duplicative of existing law." In 2008 AB 2398 (Nakanishi) contained very similar provisions to AB 252 and was held in the Senate.

The author requested the Board sponsor this legislation concept. The Board declined but stated it would likely support when the bill was in print.

FISCAL: None to the Board

POSITION: Recommendation: Support

April 17, 2010

ASSEMBLY BILL No. 2566

Introduced by Assembly Member Carter
(Principal coauthor: Senator Correa)

February 19, 2010

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

LEGISLATIVE COUNSEL'S DIGEST

AB 2566, as introduced, 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 make a business organization that provides outpatient elective cosmetic medical procedures or treatments, that is owned and operated in violation of the prohibition against employment of licensed physicians and surgeons and podiatrists, and that contracts with or employs these licensees to facilitate the offer or provision of those procedures or treatments that may only be provided by these licensees, 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

1 district will be incurred because this act creates a new crime or
2 infraction, eliminates a crime or infraction, or changes the penalty
3 for a crime or infraction, within the meaning of Section 17556 of
4 the Government Code, or changes the definition of a crime within
5 the meaning of Section 6 of Article XIII B of the California
6 Constitution.

O

AB 2600

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2600
Author: Ma
Bill Date: March 25, 2010, amended
Subject: Continuing Education Requirements
Sponsor: Author

STATUS OF BILL:

This bill is in the Assembly Business and Professions Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Board to consider including a continuing education course in the diagnosis and treatment of hepatitis.

ANALYSIS:

This bill would add a provision to the section of law that sets out the various factors for the Board to consider when determining the requirements for continuing medical education for physicians, Business and Professions Code section 2191.

The Board would be required to consider including a course in the diagnosis and treatment of hepatitis to be taken by physicians whose practices may require such knowledge.

FISCAL: None to the Board

POSITION: Recommendation: Neutral

April 17, 2010

AMENDED IN ASSEMBLY MARCH 25, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 2600

Introduced by Assembly Member Ma

February 19, 2010

~~An act to amend Section 1797 of the Health and Safety Code, relating to emergency medical services.~~ *An act to amend Section 2191 of the Business and Professions Code, relating to medicine.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2600, as amended, Ma. ~~Emergency medical services.~~ *Medicine: licensing: continuing education requirements.*

Existing law requires the Medical Board of California to establish continuing education requirements for physicians and surgeons, and requires the board to consider including various courses in determining its continuing education requirements.

This bill would, in addition, require the board to consider including a continuing education course in the diagnosis and treatment of hepatitis.

~~Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, authorizes each county to designate an emergency medical services agency, for the establishment and administration of an emergency medical services program in the county. Existing law also establishes the Emergency Medical Services Authority, which, among other things, adopts regulations governing the provision of emergency medical services.~~

~~This bill would make technical, nonsubstantive changes to those provisions.~~

abused women, particularly for physicians and surgeons in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. ~~In the event the division~~ *If the board* establishes a requirement for continuing education coursework in spousal or partner abuse detection or treatment, that requirement shall be met by each licensee within no more than four years from the date the requirement is imposed.

(i) In determining its continuing education requirements, the ~~division~~ *board* shall consider including a course in the special care needs of individuals and their families facing end-of-life issues, including, but not limited to, all of the following:

(1) Pain and symptom management.

(2) The psycho-social dynamics of death.

(3) Dying and bereavement.

(4) Hospice care.

(j) In determining its ~~continuation~~ *continuing* education requirements, the ~~division~~ *board* shall give its highest priority to considering a course on pain management.

(k) In determining its continuing education requirements, the board shall consider including a course in the diagnosis and treatment of hepatitis to be taken by those licensees whose practices may require such knowledge.

~~SECTION 1. Section 1797 of the Health and Safety Code is amended to read:~~

~~1797. This division shall be known, and may be cited, as the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act.~~

O

SB 700

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 700
Author: Negrete McLeod
Bill Date: January 26, 2010, amended
Subject: Peer Review
Sponsor: Author

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill adds a definition of peer review. In addition, it adds that the peer review minutes or reports may be obtained by the Board.

ANALYSIS:

This bill focuses on enhancements to the peer review system as it relates to the Medical Board (Board) and oversight by the California Department of Public Health (DPH).

Specifically, this bill does the following:

- 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.

- Rewrites for clarity the section that requires an 805 report to be filed within 15 days from the date when;
    1. A peer review body denies or rejects a licensee's application for staff privileges or membership for a medical disciplinary cause or reason;
    2. A licensee's staff privileges, membership, or employment are revoked for a medical disciplinary cause or reason;

3. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a total of 30 days or more within any 12 month period for medical disciplinary reasons;
4. A licensee resigns or takes a leave of absence from staff privileges, membership or employment;
5. A licensee withdraws or abandons his or her application for staff privileges, membership, or employment;
6. A licensee withdraws or abandons his or her request for renewal of staff privileges, membership, or employment after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason after receiving notice that his or her application for staff privileges, membership, or employment is denied or will be denied for a medical disciplinary cause or reason.
7. A summary suspension of staff privileges, membership, or employment is imposed for a period in excess of 14 days.

This is to ensure that the Medical Board is informed as soon as possible when a physician has had restrictions imposed or is involved in an investigation regarding medical discipline.

- Requires an 805 report to be maintained electronically for dissemination for a period of three years after receipt.

- Adds that minutes or reports of a peer review are included in the documents that the Board may inspect. This will give the Board faster access to information so the Board can address issues of quality of care in an expeditious manner.

- Prohibits the Board from disclosing to the public any peer review summaries completed by a hospital if a court finds that the peer review was not conducted in good faith. This makes reporting fair for licensees who have a bogus report filed against them.

- Entitles the Board to inspect and copy specified unredacted documents relating to any disciplinary proceeding resulting in an action that is required to be reported pursuant to Section 805 without subpoena. This will give the Board faster access to information so the Board can address issues of quality of care in an expeditious manner.

- Requires the Board to remove from the Internet Website any information concerning a hospital disciplinary action that is posted if a court finds that the peer review was not done in good faith. The licensee must

notify the Board of that finding. This makes reporting fair for licensees who have a bogus report filed against them.

- Requires the Board to post a factsheet on the internet that explains and provides information on 805 reporting. The will help consumers understand the process and what this reporting means.

FISCAL: Minor and absorbable

POSITION: **Executive Committee Recommendation:** Support and direct staff to continue to work with the author to enhance consumer protections in the bill.
Recommendation: Support

AMENDED IN SENATE JANUARY 26, 2010

AMENDED IN SENATE MAY 20, 2009

AMENDED IN SENATE MAY 11, 2009

AMENDED IN SENATE APRIL 22, 2009

AMENDED IN SENATE APRIL 13, 2009

SENATE BILL No. 700

Introduced by Senator Negrete McLeod
(Coauthor: Senator Aanestad)

February 27, 2009

An act to amend Sections 800, 803.1, 805, 805.1, 805.5, and 2027 of, and to add ~~Section 805.01~~ *Sections 805.01 and 821.4* to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 700, as amended, Negrete McLeod. Healing arts: peer review.

Existing law provides for the professional review of specified healing arts licentiates through a peer review process. ~~Existing law defines the term "peer review body" as including a medical or professional staff of any health care facility or clinic licensed by the State Department of Public Health.~~

This bill would define the term "peer review" ~~and would revise the definition of the term "peer review body" to include a medical or professional staff of other specified health care facilities or clinics~~ *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~~,~~

~~including imposition of a summary suspension of staff privileges, membership, or employment if the summary suspension stays in effect for a period in excess of 14 days. 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 licentiate to request a hearing concerning that action.~~

~~This bill would specify that the 805 report must be filed within 15 days of the imposition of the summary suspension regardless of whether a hearing has occurred.~~

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 ~~departed from the standard of care, as specified, committed or was responsible for a specified adverse event, suffered from mental illness or substance abuse, or engaged in sexual misconduct~~ *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.

The bill would also require a peer review body that reviews physicians and surgeons to, under specified circumstances, report certain information to the executive director of the Medical Board of California, as specified.

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 ~~inspect those documents in unredacted form and without a subpoena and would authorize those boards to~~ also inspect ~~any peer review minutes or reports~~, *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.

The bill would make related nonsubstantive 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 800 of the Business and Professions Code*
2 *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 *and Hearing Aid Dispensers* 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 that section.

(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.

~~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. If a court finds 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.~~

~~(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 that section 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 a process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, and professional conduct of licentiates to determine whether the 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.~~

~~(B) "Peer review body" includes:~~

~~(i) A medical or professional staff of any health care facility or clinic specified 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 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.~~

~~(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 are imposed on a licentiate 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, staff privileges, or~~

~~employment 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, membership, or employment, 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, staff privileges, or employment.~~

~~(3) Withdraws or abandons his or her request for renewal of membership, staff privileges, or employment.~~

~~(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, regardless of whether a hearing has occurred pursuant to Section 809.2.~~

~~(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 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 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 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).

~~(1)~~

(B) "Peer review body" includes:

~~(A)~~

(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.

~~(B)~~

(ii) A health care service plan ~~registered~~ *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.

~~(C)~~

(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.

~~(D)~~

(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 ~~of~~ *on which* 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~~ *If a licentiate takes 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 ~~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:~~ *the licentiate takes the action.*

(1) ~~Resignation~~ *Resigns* or *takes a* leave of absence from membership, staff *privileges*, or employment.

(2) ~~The withdrawal or abandonment of a licentiate's~~ *Withdraws or abandons his or her* application for staff privileges or membership.

(3) ~~The~~ *Withdraws or abandons his or her* request for renewal of ~~those~~ *staff* 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, *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 ~~registered~~ *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, ~~occurred. A peer review body shall not await a final proposed action, as defined in Section 809.1, for purposes of filing this report.~~

~~(1) The licentiate departed from the standard of care and there was patient harm.~~

~~(2) The licentiate committed or was responsible for the occurrence of an adverse event described in paragraph (1) of subdivision (b) of Section 1279.1 of the Health and Safety Code.~~

~~(3) The licentiate suffered from mental illness or substance abuse.~~

~~(4) The licentiate engaged in sexual misconduct.~~ *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 a 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~~, without subpoena,~~ be entitled to inspect and copy the following ~~unredacted~~ 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~~, without subpoena,~~ be entitled to inspect and copy the following ~~unredacted~~ 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 peer review minutes or reports.~~

(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~~, which is received on or after January 1, 1980,~~ 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 that section.* 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 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. 7.~~

SEC. 8. 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 factsheet 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.

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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

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.

Amendments to this bill add a definition for "qualified health care district" and set 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.

Staff is working with the author's office on amendments to the sections of the bill that require mandatory dispute resolution for disputes directly relating to clinical practice. The Board does not have a dispute resolution process at this time. Implementing one would be costly. Staff is working to clarify this issue.

FISCAL: Within existing resources to monitor the program, potentially $50,000 to do the evaluation study in 2016.

POSITION: Support
Recommendation: Support if amended

April 15, 2010

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

1 than July 1, 2016, evaluating the effectiveness of the pilot project
2 in improving access to health care in rural and medically
3 underserved areas and the project's impact on consumer protection
4 as it relates to intrusions into the practice of medicine. The board
5 shall include in the report an analysis of the impact of the pilot
6 project on the ability of nonprofit community clinics and health
7 centers located in close proximity to participating health care
8 district facilities and participating rural hospitals to recruit and
9 retain physicians and surgeons.
10 (f) Nothing in this section shall exempt a qualified health care
11 district or qualified rural hospital from any reporting requirements
12 or affect the board's authority to take action against a physician
13 and surgeon's license.
14 (g) This section shall remain in effect only until January 1, 2018,
15 and as of that date is repealed, unless a later enacted statute that
16 is enacted before January 1, 2018, deletes or extends that date.

O

SB 1031

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1031
Author: Corbett
Bill Date: April 5, 2010, amended
Subject: Medical Malpractice Insurance
Sponsor: Medical Board of California
California Medical Association

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill creates the Volunteer Insured Physicians (VIP) Program to provide medical malpractice insurance to volunteer physicians for the purpose of encouraging physicians to volunteer their services in the interests of expanding access to health care.

ANALYSIS:

Currently physicians who provide uncompensated care to patients must maintain medical malpractice insurance. For these physicians who are not receiving payment for their services, the cost of medical malpractice insurance can be a disincentive to volunteering.

With the current healthcare shortage in California, volunteer physicians are invaluable to all patients, especially those in low-income, rural, and underserved areas. If maintaining medical malpractice insurance is too costly without receiving compensation, these physicians may choose not to volunteer their services.

The Board and the California Medical Association (CMA) are pursuing this legislation to create a method of providing general malpractice insurance to these physicians who would otherwise volunteer their services if the cost of maintaining malpractice insurance were not an impediment. Currently, California is one of the seven remaining states in the U.S. that does not have a program to cover physicians who provide unpaid, voluntary services.

This bill would create the Volunteer Insured Physicians (VIP) Program pursuant to the Volunteer Insured Physicians Act for the purpose of providing a licensee who would like to provide uncompensated care to patients with insurance coverage. The services provided would be general medicine or family practice level care. This bill would establish a procedure that consists of a voluntary service agreement between the licensed physician and

Board that is initiated by application to the program. This bill provides a definition for qualified healthcare entities and creates a voluntary services contract to be executed between the physician and the hospital, clinic, or health care agency. Licensees in the VIP program must hold a full and unrestricted license in California, be in good standing, and have no record of disciplinary.

The Board and CMA believe that this bill will promote an increase in access to healthcare by encouraging physicians to volunteer their services. This bill is intended to alleviate the concern many physicians have about medical malpractice liability associated with providing uncompensated care to patients.

Amendments to this bill offered by the author and taken in committee address some of the concerns raised by interested parties. Additional amendments will be developed prior to the Senate Appropriations Committee hearing. These will include: non-government operated clinics as part of the qualified healthcare entities; clarification to the definition of volunteer physician; broadening the range of patients who can receive voluntary so that it does not limit services to a limited group of low-income patients; and providing a fiscal analysis and resource.

FISCAL: Unknown

POSITION: Sponsor/Support

AMENDED IN SENATE APRIL 5, 2010

SENATE BILL **No. 1031**

Introduced by Senator Corbett

February 12, 2010

~~An act to relating to medicine.~~ *An act to add Article 17.1 (commencing with Section 2399) to Chapter 5 of Division 2 of, and to repeal Section 2399.7 of, the Business and Professions Code, relating to medicine.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1031, as amended, Corbett. Medical malpractice insurance: volunteer physicians and surgeons.

Under existing law, the Medical Practice Act, the Medical Board of California is responsible for the certification and regulation of physicians and surgeons. Existing law requires the board, in conjunction with the Health Professions Education Foundation, to study the issue of providing medical malpractice insurance to volunteer physicians and surgeons and to report its findings to the Legislature by January 1, 2008.

The bill would ~~declare the intent of the Legislature to implement the findings of that study~~ *create the Volunteer Insured Physicians Program, administered by the board, to provide specified medical malpractice insurance coverage to volunteer physicians providing uncompensated care to low-income patients pursuant to a contract with a qualified health care entity, as defined. The bill would provide unspecified funding for the program from the Contingent Fund of the Medical Board of California for a limited period of time. The bill would require annual reports to the Legislature until January 1, 2015.*

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. Article 17.1 (commencing with Section 2399) is*
2 *added to Chapter 5 of Division 2 of the Business and Professions*
3 *Code, to read:*
4
5 *Article 17.1. Volunteer Insured Physicians Program*
6
7 *2399. This article shall be known and may be cited as the*
8 *Volunteer Insured Physicians (VIP) Act, which authorizes the*
9 *creation and implementation of the Volunteer Insured Physicians*
10 *(VIP) Program.*
11 *2399.1. (a) For purposes of this article, the following*
12 *definitions shall apply:*
13 *(1) "Licensee" means the holder of a physician and surgeon's*
14 *certificate who is engaged in the professional practice authorized*
15 *by the certificate under the jurisdiction of the board.*
16 *(2) "Volunteer physician" means a licensee under this chapter*
17 *who volunteers to provide primary care medical services, as*
18 *described in Section 2399.3, to a low-income patient, with no*
19 *monetary or material compensation.*
20 *(3) "Qualified health care entity" means a county health*
21 *department, hospital district, or hospital or clinic owned and*
22 *operated by a governmental entity.*
23 *(4) "Low-income patient" means a person who is without health*
24 *care coverage and whose family income does not exceed 200*
25 *percent of the federal poverty level, as defined annually by the*
26 *federal Office of Management and Budget.*
27 *(5) "Voluntary service agreement" means an agreement*
28 *executed pursuant to this article between the board, a licensee,*
29 *and a qualified health care entity that authorizes the health care*
30 *entity to enter into a voluntary service contract with the licensee.*
31 *(6) "Voluntary service application" means the written*
32 *application developed by the board that a licensee must complete*
33 *and submit in order to be considered for participation in the VIP*
34 *Program.*
35 *(7) "Voluntary service contract" means an agreement executed*
36 *pursuant to this article between a licensee and a qualified health*
37 *care entity that authorizes the licensee to deliver health care*

services to low-income patients as an agent of the qualified health care entity on a volunteer, uncompensated basis.

2399.2. (a) A licensee who wants to provide voluntary, uncompensated care to low-income patients, but who does not have medical professional liability insurance that would include insurance coverage for premiums, defense, and indemnity costs for any claims arising from voluntary and uncompensated care, may submit a voluntary service application to the board for coverage under the VIP Program.

(b) A licensee who submits an application for a waiver of initial and renewal licensing fees under Section 2083 or 2442 and who also submits a voluntary service application shall be simultaneously assessed by the board for eligibility to receive medical professional liability insurance coverage for premiums, defense, and indemnity costs through the VIP Program.

(c) A licensee who has standard medical professional liability insurance coverage for his or her regular practice but who is not covered for volunteer service may submit a voluntary service application to participate in the VIP Program. In conjunction with the voluntary service application, the licensee shall submit verification from his or her medical professional liability insurance carrier that voluntary, uncompensated care is not covered by his or her existing medical professional liability insurance policy.

(d) The board shall review the voluntary service application to determine if the applicant meets the criteria for VIP Program participation. These criteria shall include both of the following:

(1) Holding an active license in good standing to practice medicine in the State of California.

(2) No record of disciplinary action by the board or any other regulatory board.

(e) Continued eligibility for the VIP Program shall be reassessed by the board during each license renewal cycle.

2399.3. (a) Licensees approved by the board for participation in the VIP Program may enter into a voluntary service agreement with the board and a qualified health care entity that acknowledges the terms of the VIP Program and transfers responsibility from the volunteer physician to the state for medical professional liability insurance, including premiums, defense, and indemnity costs, for voluntary, uncompensated medical care that is provided in accordance with an executed and signed voluntary service

contract between the volunteer physician and the qualified health care entity and that complies with the terms of the VIP Program.

(b) Volunteer physicians participating in the VIP Program shall agree to limit the scope of the volunteer medical care to primary care medical services.

(c) The voluntary service contract between the volunteer physician and the qualified health care entity shall include all of the following provisions:

(1) All care provided shall be both voluntary and uncompensated and shall be provided to low-income patients.

(2) Patient selection and initial referral shall be made solely by the qualified health care entity and the volunteer physician shall accept all referred patients except as otherwise allowed by law. However, the number of patients that must be accepted may be limited by the voluntary service contract and patients may not be transferred to the volunteer physician based on a violation of any antidumping provisions of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) or the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508).

(3) The qualified health care entity shall have access to the patient records of the volunteer physician delivering services under the voluntary service contract.

(4) The volunteer physician shall be subject to supervision by the qualified health care entity's standard peer review process and all related laws regarding peer review, including, but not limited to, the filing of reports pursuant to Section 805.

(5) The qualified health care entity shall utilize a quality assurance program to monitor services delivered by the volunteer physician under the voluntary services contract.

(6) The right to dismiss or terminate a volunteer physician delivering services under the voluntary service contract shall be retained by the qualified health care entity. If the volunteer services contract is terminated, the qualified health care entity shall notify the VIP Program in writing within five days.

2399.4. The fact that a volunteer physician is insured under the VIP Program in relation to particular medical services rendered shall not operate to change or affect the laws applicable to any claims arising from or related to those medical services. All laws applicable to a claim remain the same regardless of whether a licensee is insured through the VIP Program.

2399.5. If a volunteer physician covered by the VIP Program receives notice or otherwise obtains knowledge that a claim of professional medical negligence has been or may be filed, the physician shall immediately notify the VIP Program or the contracted liability carrier.

2399.6. All costs for administering the VIP Program, including the cost of medical professional liability insurance for premiums, defense, and indemnity coverage for program participants, shall be paid for from the Contingent Fund of the Medical Board of California, in an amount not to exceed ____ dollars ($____) per year.

2399.7. (a) The board shall report annually to the Legislature summarizing the efficacy of access and treatment outcomes with respect to providing health care services for low-income patients pursuant to this article. The report shall include the numbers of injuries and deaths reported, claims statistics for all care rendered under the VIP Program, including the total of all premiums paid, the number of claims made for each year of the VIP Program, the amount of all indemnity payments made, the cost of defense provided, and administration costs associated with all claims made against volunteer physicians arising from voluntary and uncompensated care provided under the VIP Program.

(b) (1) A report to be submitted pursuant to subdivision (a) shall be submitted in compliance with Section 9795 of the Government Code.

(2) Pursuant to Section 10231.5 of the Government Code, this section is repealed on January 1, 2015.

2399.8. This article shall remain operative until January 1, 2016, or until another viable source of funding is identified and adopted, whichever occurs first.

~~SECTION 1. It is the intent of the Legislature to implement the findings of the study described in Section 2023 of the Business and Professions Code, relating to providing medical malpractice insurance to physicians and surgeons who provide voluntary, unpaid services.~~

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SB 1069

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1069
Author: Pavely
Bill Date: April 12, 2010, amended
Subject: Physician Assistants
Sponsor: California Academy of Physician Assistants

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize physician assistants to perform physical examinations, order durable medical equipment, and certify disability for the purpose of unemployment insurance eligibility.

ANALYSIS:

The author and the sponsor of this bill believe that allowing physician assistants to perform physical examinations and sign all corresponding forms, order durable medical equipment, and certify disability for the purpose of unemployment insurance eligibility would expand access to health care by furthering a physician's ability to delegate specified health care tasks.

FISCAL: None

POSITION: Recommendation: Support

April 15, 2010

AMENDED IN SENATE APRIL 12, 2010

AMENDED IN SENATE APRIL 5, 2010

SENATE BILL No. 1069

Introduced by Senator Pavley
(Principal coauthor: Assembly Member Fletcher)

February 17, 2010

An act to amend Section 3501 of, and to add Sections 3502.2, 3502.3, and 3528.5 to, the Business and Professions Code, to amend Sections 44336, 49406, 49423, 49455, 87408, 87408.5, and 87408.6 of, and to add Section 49458 to, the Education Code, to amend Section 2881 of the Public Utilities Code, and to amend Section 2708 of the Unemployment Insurance Code, relating to physician assistants.

LEGISLATIVE COUNSEL'S DIGEST

SB 1069, as amended, Pavley. Physician assistants.

Existing law, the Physician Assistant Practice Act, is administered by the Physician Assistant Committee of the Medical Board of California and provides for the licensure and regulation of physician assistants. Existing law provides that a physician assistant may perform the medical services that are set forth by the regulations of the board when the services are rendered under the supervision of a licensed physician and surgeon. Existing law requires a physician assistant and his or her supervising physician ~~and surgeon~~ to establish written guidelines for the adequate supervision of the physician assistant. Existing law provides that those requirements may be satisfied by adopting protocols for some or all of the tasks performed by the physician assistant, as specified.

This bill would provide that a physician assistant *act as the agent of the supervising physician and* may perform ~~the~~ physical ~~examination~~ *examinations* and other specified medical services, as defined, and ~~may~~

sign and attest to any document evidencing ~~the physical examination~~ *those examinations* and other ~~specified medical~~ services, required pursuant to specified provisions of law. The bill would further provide that a delegation of services agreement may authorize a physician assistant to order durable medical equipment, certify disability, as specified, and make arrangements with regard to home health services or personal care services. The bill would make conforming changes to provisions in the Education Code, the Public Utilities Code, and the Unemployment Insurance Code with regard to the performance of those examinations and services and acceptance of those attestations. The bill would also authorize a physician assistant to perform a physical examination that is required for participation in an interscholastic athletic program, as specified.

Under existing law regarding administrative adjudication, a hearing to determine whether a license granted to a physician assistant shall be revoked, suspended, limited, or conditioned is initiated by filing an accusation. An accusation is a written statement of charges that sets forth in ordinary and concise language the acts or omissions with which a licensee is charged.

This bill would require an accusation against a physician assistant to be filed against the physician assistant within 3 years after the committee discovers, *as defined,* the act or omission alleged as the ground for disciplinary action, or within 7 years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first. This statute of limitation would not apply to an accusation based on the procurement of a license by fraud or misrepresentation, or upon an allegation of unprofessional conduct based on incompetence, gross negligence, or repeated negligent acts of the licensee upon proof of specified facts. The bill would toll the limitations period in certain circumstances and would also establish a different time limit for an accusation alleging sexual misconduct by a licensee, *as specified.*

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

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

1 SECTION 1. Section 3501 of the Business and Professions
2 Code is amended to read:
3 3501. As used in this chapter:
4 (a) "Board" means the Medical Board of California.

(b) "Approved program" means a program for the education of physician assistants that has been formally approved by the committee.

(c) "Trainee" means a person who is currently enrolled in an approved program.

(d) "Physician assistant" means a person who meets the requirements of this chapter and is licensed by the committee.

(e) "Supervising physician" means a physician and surgeon licensed by the board or by the Osteopathic Medical Board of California who supervises one or more physician assistants, who possesses a current valid license to practice medicine, and who is not currently on disciplinary probation for improper use of a physician assistant.

(f) "Supervision" means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant.

(g) "Committee" or "examining committee" means the Physician Assistant Committee.

(h) "Regulations" means the rules and regulations as contained in Chapter 13.8 (commencing with Section 1399.500) of Title 16 of the California Code of Regulations.

(i) "Routine visual screening" means uninvasive nonpharmacological simple testing for visual acuity, visual field defects, color blindness, and depth perception.

(j) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

(k) "Delegation of services agreement" means the writing that delegates to a physician assistant from a supervising physician the medical services the physician assistant is authorized to perform consistent with subdivision (a) of Section 1399.540 of Title 16 of the California Code of Regulations.

(*l*) "Other specified medical services" means tests or examinations performed or ordered by a physician assistant practicing in compliance with this chapter or regulations of the board promulgated under this chapter.

(m) A physician assistant acts as an agent of the supervising physician when performing any activity authorized by this chapter or regulations promulgated by the board under this chapter.

SEC. 2. Section 3502.2 is added to the Business and Professions Code, to read:

3502.2. Notwithstanding any other provision of law, a physician assistant may perform the physical examination and any other specified medical services *that are required pursuant to Section 2881 of the Public Utilities Code and Sections 44336, 49406, 49423, 49455, 87408, 87408.5, and 87408.6 of the Education Code, practicing in compliance with this chapter*, and may sign and attest to any certificate, card, form, or other documentation evidencing the examination or other specified medical services ~~that are required pursuant to Section 2881 of the Public Utilities Code and Sections 44336, 49406, 49423, 49455, 87408, 87408.5, and 87408.6 of the Education Code~~.

SEC. 3. Section 3502.3 is added to the Business and Professions Code, to read:

3502.3. (a) Notwithstanding any other provision of law, in addition to any other practices that meet the general criteria set forth in this chapter or the board's regulations for inclusion in a delegation of services agreement, a delegation of services agreement may authorize a physician assistant to do any of the following:

(1) Order durable medical equipment, subject to any limitations set forth in Section 3502 or the delegation of services agreement. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

(2) After performance of a physical examination by the physician assistant under the supervision of a physician and surgeon consistent with this chapter, 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 supervising physician, 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 delegation of services agreement in effect prior to the enactment of this section or those adopted subsequent to enactment.

SEC. 4. Section 3528.5 is added to the Business and Professions Code, to read:

3528.5. (a) Except as provided in subdivisions (b), (c), *(d),* and (e), any accusation filed against a licensee pursuant to Section 11503 of the Government Code shall be filed within three years after the committee discovers the act or omission alleged as the ground for disciplinary action, or within seven years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first.

(b) An accusation filed against a licensee pursuant to Section 11503 of the Government Code alleging the procurement of a license by fraud or misrepresentation is not subject to the limitation provided for by subdivision (a).

(c) An accusation filed against a licensee pursuant to Section 11503 of the Government Code alleging unprofessional conduct based on incompetence, gross negligence, or repeated negligent acts of the licensee is not subject to the limitation provided for by subdivision (a) upon proof that the licensee intentionally concealed from discovery his or her incompetence, gross negligence, or repeated negligent acts.

(d) If an alleged act or omission involves a minor, the 7-year limitations period provided for by subdivision (a) and the 10-year limitations period provided for by subdivision (e) shall be tolled until the minor reaches the age of majority. *However, if the committee discovers an alleged act of sexual contact with a minor under Section 261, 286, 288, 288.5, 288a, or 289 of the Penal Code after the limitations periods described in this subdivision have otherwise expired, and there is independent evidence that corroborates the allegation, an accusation shall be filed within three years from the date the committee discovers that alleged act.*

(e) An accusation filed against a licensee pursuant to Section 11503 of the Government Code alleging sexual misconduct shall be filed within 3 years after the committee discovers the act or omission alleged as the ground for disciplinary action, or within 10 years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first. This subdivision shall apply to a complaint alleging sexual misconduct received by the committee on and after January 1, 2011.

(f) The limitations period provided by subdivision (a) shall be tolled during any period if material evidence necessary for prosecuting or determining whether a disciplinary action would

be appropriate is unavailable to the committee due to an ongoing criminal investigation.

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

(1) The date the committee receives a complaint or report describing the act or omission.

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

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

SEC. 5. Section 44336 of the Education Code is amended to read:

44336. When required by the commission, the application for a certification document or the renewal thereof shall be accompanied by a certificate in such form as shall be prescribed by the commission, from a physician and surgeon licensed under the provisions of the Business and Professions Code or a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code, showing that the applicant is free from any contagious and communicable disease or other disabling disease or defect unfitting the applicant to instruct or associate with children.

SEC. 6. Section 49406 of the Education Code is amended to read:

49406. (a) Except as provided in subdivision (h), no person shall be initially employed by a school district in a certificated or classified position unless the person has submitted to an examination within the past 60 days to determine that he or she is free of active tuberculosis, by a physician and surgeon licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code. This examination shall consist of either an approved intradermal tuberculin test or any other test for tuberculosis infection that is recommended by the federal Centers for Disease Control and

Prevention (CDC) and licensed by the federal Food and Drug Administration (FDA), which, if positive, shall be followed by an X-ray of the lungs in accordance with subdivision (f) of Section 120115 of the Health and Safety Code.

The X-ray film may be taken by a competent and qualified X-ray technician if the X-ray film is subsequently interpreted by a physician and surgeon licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

The district superintendent or his or her designee may exempt, for a period not to exceed 60 days following termination of the pregnancy, a pregnant employee from the requirement that a positive intradermal tuberculin test be followed by an X-ray of the lungs.

(b) Thereafter, employees who are test negative by either the tuberculin skin test or any other test for tuberculosis infection recommended by the CDC and licensed by the FDA shall be required to undergo the foregoing examination at least once each four years or more often if directed by the governing board upon recommendation of the local health officer for so long as the employee's test remains negative. Once an employee has a documented positive test for tuberculosis infection conducted pursuant to this subdivision which has been followed by an X-ray, the foregoing examination is no longer required, and a referral shall be made within 30 days of completion of the examination to the local health officer to determine the need for followup care.

(c) After the examination, each employee shall cause to be on file with the district superintendent of schools a certificate from the examining physician and surgeon or physician assistant showing the employee was examined and found free from active tuberculosis. The county board of education may require, by rule, that all their certificates be filed in the office of the county superintendent of schools or shall require their files be maintained in the office of the county superintendent of schools if a majority of the governing boards of the districts within the county so petition the county board of education, except that in either case a district or districts with a common board having an average daily attendance of 60,000 or more may elect to maintain the files for its employees in that district. "Certificate," as used in this section, means a certificate signed by the examining physician and surgeon

or physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code or a notice from a public health agency or unit of the American Lung Association that indicates freedom from active tuberculosis. The latter, regardless of form, shall constitute evidence of compliance with this section. Nothing in this section shall prevent the governing board, upon recommendation of the local health officer, from establishing a rule requiring a more extensive or more frequent physical examination than required by this section, but the rule shall provide for reimbursement on the same basis as required in this section.

(d) This examination is a condition of initial employment and the expense incident thereto shall be borne by the applicant unless otherwise provided by rules of the governing board. However, the board may, if an applicant is accepted for employment, reimburse that person in a like manner prescribed in this section for employees.

(e) The governing board of each district shall reimburse the employee for the cost, if any, of this examination. The board may provide for the examination required by this section or may establish a reasonable fee for the examination that is reimbursable to employees of the district complying with the provisions of this section.

(f) At the discretion of the governing board, this section shall not apply to those employees not requiring certification qualifications who are employed for any period of time less than a school year whose functions do not require frequent or prolonged contact with pupils.

The governing board may, however, require an examination described in subdivision (b) and may, as a contract condition, require the examination of persons employed under contract, other than those persons specified in subdivision (a), if the board believes the presence of these persons in and around school premises would constitute a health hazard to pupils.

(g) If the governing board of a school district determines by resolution, after hearing, that the health of pupils in the district would not be jeopardized thereby, this section shall not apply to any employee of the district who files an affidavit stating that he or she adheres to the faith or teachings of any well-recognized religious sect, denomination, or organization and in accordance

with its creed, tenets, or principles depends for healing upon prayer in the practice of religion and that to the best of his or her knowledge and belief he or she is free from active tuberculosis. If at any time there should be probable cause to believe that the affiant is afflicted with active tuberculosis, he or she may be excluded from service until the governing board of the employing district is satisfied that he or she is not so afflicted.

(h) A person who transfers his or her employment from one school or school district to another shall be deemed to meet the requirements of subdivision (a) if that person can produce a certificate which shows that he or she was examined within the past four years and was found to be free of communicable tuberculosis, or if it is verified by the school previously employing him or her that it has a certificate on file which contains that showing.

A person who transfers his or her employment from a private or parochial elementary school, secondary school, or nursery school to a school or school district subject to this section shall be deemed to meet the requirements of subdivision (a) if that person can produce a certificate as provided for in Section 121525 of the Health and Safety Code that shows that he or she was examined within the past four years and was found to be free of communicable tuberculosis, or if it is verified by the school previously employing him or her that it has a certificate on file which contains that showing.

(i) Any governing board or county superintendent of schools providing for the transportation of pupils under contract authorized by Section 39800, 39801, or any other provision of law shall require as a condition of the contract the examination for active tuberculosis, as provided by subdivision (a), of all drivers transporting these pupils, provided that private contracted drivers who transport these pupils on an infrequent basis, not to exceed once a month, shall be excluded from this requirement.

SEC. 7. Section 49423 of the Education Code is amended to read:

49423. (a) Notwithstanding Section 49422, any pupil who is required to take, during the regular schoolday, medication prescribed for him or her by a physician and surgeon or ordered for him or her by a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2

of the Business and Professions Code, may be assisted by the school nurse or other designated school personnel or may carry and self-administer prescription auto-injectable epinephrine if the school district receives the appropriate written statements identified in subdivision (b).

(b) (1) In order for a pupil to be assisted by a school nurse or other designated school personnel pursuant to subdivision (a), the school district shall obtain both a written statement from the physician and surgeon or physician assistant detailing the name of the medication, method, amount, and time schedules by which the medication is to be taken and a written statement from the parent, foster parent, or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the statement of the physician and surgeon or physician assistant.

(2) In order for a pupil to carry and self-administer prescription auto-injectable epinephrine pursuant to subdivision (a), the school district shall obtain both a written statement from the physician and surgeon or physician assistant detailing the name of the medication, method, amount, and time schedules by which the medication is to be taken, and confirming that the pupil is able to self-administer auto-injectable epinephrine, and a written statement from the parent, foster parent, or guardian of the pupil consenting to the self-administration, providing a release for the school nurse or other designated school personnel to consult with the health care provider of the pupil regarding any questions that may arise with regard to the medication, and releasing the school district and school personnel from civil liability if the self-administering pupil suffers an adverse reaction as a result of self-administering medication pursuant to this paragraph.

(3) The written statements specified in this subdivision shall be provided at least annually and more frequently if the medication, dosage, frequency of administration, or reason for administration changes.

(c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses auto-injectable epinephrine in a manner other than as prescribed.

SEC. 8. Section 49455 of the Education Code is amended to read:

49455. Upon first enrollment in a California school district of a child at a California elementary school, and at least every third

year thereafter until the child has completed the eighth grade, the child's vision shall be appraised by the school nurse or other authorized person under Section 49452. This evaluation shall include tests for visual acuity and color vision; however, color vision shall be appraised once and only on male children, and the results of the appraisal shall be entered in the health record of the pupil. Color vision appraisal need not begin until the male pupil has reached the first grade. Gross external observation of the child's eyes, visual performance, and perception shall be done by the school nurse and the classroom teacher. The evaluation may be waived, if the child's parents so desire, by their presenting of a certificate from a physician and surgeon, a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code, or an optometrist setting out the results of a determination of the child's vision, including visual acuity and color vision.

The provisions of this section shall not apply to any child whose parents or guardian file with the principal of the school in which the child is enrolling, a statement in writing that they adhere to the faith or teachings of any well-recognized religious sect, denomination, or organization and in accordance with its creed, tenets, or principles depend for healing upon prayer in the practice of their religion.

SEC. 9. Section 49458 is added to the Education Code, to read:

49458. When a school district or a county superintendent of schools requires a physical examination as a condition of participation in an interscholastic athletic program, the physical examination may be performed by a physician and surgeon or physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code.

SEC. 10. Section 87408 of the Education Code is amended to read:

87408. (a) When a community college district wishes to employ a person in an academic position and that person has not previously been employed in an academic position in this state, the district shall require a medical certificate showing that the applicant is free from any communicable disease, including, but not limited to, active tuberculosis, unfitting the applicant to instruct or associate with students. The medical certificate shall be

1 submitted directly to the governing board by a physician and
2 surgeon licensed under the Business and Professions Code, a
3 physician assistant practicing in compliance with Chapter 7.7
4 (commencing with Section 3500) of Division 2 of the Business
5 and Professions Code, or a commissioned medical officer exempted
6 from licensure. The medical examination shall have been conducted
7 not more than six months before the submission of the certificate
8 and shall be at the expense of the applicant. A governing board
9 may offer a contract of employment to an applicant subject to the
10 submission of the required medical certificate. Notwithstanding
11 Section 87031, the medical certificate shall become a part of the
12 personnel record of the employee and shall be open to the employee
13 or his or her designee.
14 (b) The governing board of a community college district may
15 require academic employees to undergo a periodic medical
16 examination by a physician and surgeon licensed under the
17 Business and Professions Code, a physician assistant practicing
18 in compliance with Chapter 7.7 (commencing with Section 3500)
19 of Division 2 of the Business and Professions Code, or a
20 commissioned medical officer exempted from licensure, to
21 determine that the employee is free from any communicable
22 disease, including, but not limited to, active tuberculosis, unfitting
23 the applicant to instruct or associate with students. The periodic
24 medical examination shall be at the expense of the district. The
25 medical certificate shall become a part of the personnel record of
26 the employee and shall be open to the employee or his or her
27 designee.
28 SEC. 11. Section 87408.5 of the Education Code is amended
29 to read:
30 87408.5. (a) When a community college district wishes to
31 employ a retirant who is retired for service, and such person has
32 not been previously employed as a retirant, such district shall
33 require, as a condition of initial employment as a retirant, a medical
34 certificate showing that the retirant is free from any disabling
35 disease unfitting him or her to instruct or associate with students.
36 The medical certificate shall be completed and submitted directly
37 to the community college district by a physician and surgeon
38 licensed under the Business and Professions Code, a physician
39 assistant practicing in compliance with Chapter 7.7 (commencing
40 with Section 3500) of Division 2 of the Business and Professions

Code, or a commissioned medical officer exempted from licensure. A medical examination shall be required for the completion of the medical certificate. The examination shall be conducted not more than six months before the completion and submission of the certificate and shall be at the expense of the retirant. The medical certificate shall become a part of the personnel record of the employee and shall be open to the employee or his or her designee.

(b) The community college district that initially employed the retirant, or any district that subsequently employs the retirant, may require a periodic medical examination by a physician and surgeon licensed under the Business and Professions Code, a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code, or a commissioned medical officer exempted from licensure, to determine that the retirant is free from any communicable disease unfitting him or her to instruct or associate with students. The periodic medical examination shall be at the expense of the community college district. The medical certificate shall become a part of the personnel record of the retirant and shall be open to the retirant or his or her designee.

SEC. 12. Section 87408.6 of the Education Code is amended to read:

87408.6. (a) Except as provided in subdivision (h), no person shall be initially employed by a community college district in an academic or classified position unless the person has submitted to an examination within the past 60 days to determine that he or she is free of active tuberculosis, by a physician and surgeon licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code. This examination shall consist of an approved intradermal tuberculin test or any other test for tuberculosis infection recommended by the federal Centers for Disease Control and Prevention (CDC) and licensed by the federal Food and Drug Administration (FDA), that, if positive, shall be followed by an X-ray of the lungs.

The X-ray film may be taken by a competent and qualified X-ray technician if the X-ray film is subsequently interpreted by a physician and surgeon licensed under Chapter 5 (commencing

with Section 2000) of Division 2 of the Business and Professions Code.

The district superintendent, or his or her designee, may exempt, for a period not to exceed 60 days following termination of the pregnancy, a pregnant employee from the requirement that a positive intradermal tuberculin test be followed by an X-ray of the lungs.

(b) Thereafter, employees who are skin test negative, or negative by any other test recommended by the CDC and licensed by the FDA, shall be required to undergo the foregoing examination at least once each four years or more often if directed by the governing board upon recommendation of the local health officer for so long as the employee remains test negative by either the tuberculin skin test or any other test recommended by the CDC and licensed by the FDA. Once an employee has a documented positive skin test or any other test that has been recommended by the CDC and licensed by the FDA that has been followed by an X-ray, the foregoing examinations shall no longer be required, and referral shall be made within 30 days of completion of the examination to the local health officer to determine the need for followup care.

(c) After the examination, each employee shall cause to be on file with the district superintendent a certificate from the examining physician and surgeon or physician assistant showing the employee was examined and found free from active tuberculosis. "Certificate," as used in this subdivision, means a certificate signed by the examining physician and surgeon or physician assistant, or a notice from a public health agency or unit of the American Lung Association that indicates freedom from active tuberculosis. The latter, regardless of form, shall constitute evidence of compliance with this section.

(d) This examination is a condition of initial employment and the expense incident thereto shall be borne by the applicant unless otherwise provided by rules of the governing board. However, the board may, if an applicant is accepted for employment, reimburse the person in a like manner prescribed for employees in subdivision (e).

(e) The governing board of each district shall reimburse the employee for the cost, if any, of this examination. The board may provide for the examination required by this section or may

establish a reasonable fee for the examination that is reimbursable to employees of the district complying with this section.

(f) At the discretion of the governing board, this section shall not apply to those employees not requiring certification qualifications who are employed for any period of time less than a college year whose functions do not require frequent or prolonged contact with students.

The governing board may, however, require the examination and may, as a contract condition, require the examination of persons employed under contract, other than those persons specified in subdivision (a), if the board believes the presence of these persons in and around college premises would constitute a health hazard to students.

(g) If the governing board of a community college district determines by resolution, after hearing, that the health of students in the district would not be jeopardized thereby, this section shall not apply to any employee of the district who files an affidavit stating that he or she adheres to the faith or teachings of any well-recognized religious sect, denomination, or organization and in accordance with its creed, tenets, or principles depends for healing upon prayer in the practice of religion and that to the best of his or her knowledge and belief he or she is free from active tuberculosis. If at any time there should be probable cause to believe that the affiant is afflicted with active tuberculosis, he or she may be excluded from service until the governing board of the employing district is satisfied that he or she is not so afflicted.

(h) A person who transfers his or her employment from one campus or community college district to another shall be deemed to meet the requirements of subdivision (a) if the person can produce a certificate that shows that he or she was examined within the past four years and was found to be free of communicable tuberculosis, or if it is verified by the college previously employing him or her that it has a certificate on file that contains that showing.

A person who transfers his or her employment from a private or parochial elementary school, secondary school, or nursery school to the community college district subject to this section shall be deemed to meet the requirements of subdivision (a) if the person can produce a certificate as provided for in Section 121525 of the Health and Safety Code that shows that he or she was examined within the past four years and was found to be free of

communicable tuberculosis, or if it is verified by the school previously employing him or her that it has the certificate on file.

(i) Any governing board of a community college district providing for the transportation of students under contract shall require as a condition of the contract the examination for active tuberculosis, as provided in subdivision (a), of all drivers transporting the students, provided that privately contracted drivers who transport the students on an infrequent basis, not to exceed once a month, shall be excluded from this requirement.

(j) Examinations required pursuant to subdivision (i) shall be made available without charge by the local health officer.

SEC. 13. Section 2881 of the Public Utilities Code is amended to read:

2881. (a) The commission shall design and implement a program to provide a telecommunications device capable of serving the needs of individuals who are deaf or hearing impaired, together with a single party line, at no charge additional to the basic exchange rate, to any subscriber who is certified as an individual who is deaf or hearing impaired by a licensed physician and surgeon, audiologist, or a qualified state or federal agency, as determined by the commission, and to any subscriber that is an organization representing individuals who are deaf or hearing impaired, as determined and specified by the commission pursuant to subdivision (e). A licensed hearing aid dispenser may certify the need of an individual to participate in the program if that individual has been previously fitted with an amplified device by the dispenser and the dispenser has the individual's hearing records on file prior to certification. In addition, a physician assistant may certify the needs of an individual who has been diagnosed by a physician and surgeon as being deaf or hearing impaired to participate in the program after reviewing the medical records or copies of the medical records containing that diagnosis.

(b) The commission shall also design and implement a program to provide a dual-party relay system, using third-party intervention to connect individuals who are deaf or hearing impaired and offices of organizations representing individuals who are deaf or hearing impaired, as determined and specified by the commission pursuant to subdivision (e), with persons of normal hearing by way of intercommunications devices for individuals who are deaf or hearing impaired and the telephone system, making available

reasonable access of all phases of public telephone service to telephone subscribers who are deaf or hearing impaired. In order to make a dual-party relay system that will meet the requirements of individuals who are deaf or hearing impaired available at a reasonable cost, the commission shall initiate an investigation, conduct public hearings to determine the most cost-effective method of providing dual-party relay service to the deaf or hearing impaired when using a telecommunications device, and solicit the advice, counsel, and physical assistance of statewide nonprofit consumer organizations of the deaf, during the development and implementation of the system. The commission shall phase in this program, on a geographical basis, over a three-year period ending on January 1, 1987. The commission shall apply for certification of this program under rules adopted by the Federal Communications Commission pursuant to Section 401 of the federal Americans with Disabilities Act of 1990 (Public Law 101-336).

(c) The commission shall also design and implement a program whereby specialized or supplemental telephone communications equipment may be provided to subscribers who are certified to be disabled at no charge additional to the basic exchange rate. The certification, including a statement of visual or medical need for specialized telecommunications equipment, shall be provided by a licensed optometrist, physician and surgeon, or physician assistant, acting within the scope of practice of his or her license, or by a qualified state or federal agency as determined by the commission. The commission shall, in this connection, study the feasibility of, and implement, if determined to be feasible, personal income criteria, in addition to the certification of disability, for determining a subscriber's eligibility under this subdivision.

(d) The commission shall establish a rate recovery mechanism through a surcharge not to exceed one-half of 1 percent uniformly applied to a subscriber's intrastate telephone service, other than one-way radio paging service and universal telephone service, both within a service area and between service areas, to allow providers of the equipment and service specified in subdivisions (a), (b), and (c), to recover costs as they are incurred under this section. The surcharge shall be in effect until January 1, 2014. The commission shall require that the programs implemented under this section be identified on subscribers' bills, and shall establish

a fund and require separate accounting for each of the programs implemented under this section.

(e) The commission shall determine and specify those statewide organizations representing the deaf or hearing impaired that shall receive a telecommunications device pursuant to subdivision (a) or a dual-party relay system pursuant to subdivision (b), or both, and in which offices the equipment shall be installed in the case of an organization having more than one office.

(f) The commission may direct any telephone corporation subject to its jurisdiction to comply with its determinations and specifications pursuant to this section.

(g) The commission shall annually review the surcharge level and the balances in the funds established pursuant to subdivision (d). Until January 1, 2014, the commission shall be authorized to make, within the limits set by subdivision (d), any necessary adjustments to the surcharge to ensure that the programs supported thereby are adequately funded and that the fund balances are not excessive. A fund balance which is projected to exceed six months' worth of projected expenses at the end of the fiscal year is excessive.

(h) The commission shall prepare and submit to the Legislature, on or before December 31 of each year, a report on the fiscal status of the programs established and funded pursuant to this section and Sections 2881.1 and 2881.2. The report shall include a statement of the surcharge level established pursuant to subdivision (d) and revenues produced by the surcharge, an accounting of program expenses, and an evaluation of options for controlling those expenses and increasing program efficiency, including, but not limited to, all of the following proposals:

(1) The establishment of a means test for persons to qualify for program equipment or free or reduced charges for the use of telecommunication services.

(2) If and to the extent not prohibited under Section 401 of the federal Americans with Disabilities Act of 1990 (Public Law 101-336), the imposition of limits or other restrictions on maximum usage levels for the relay service, which shall include the development of a program to provide basic communications requirements to all relay users at discounted rates, including discounted toll-call rates, and, for usage in excess of those basic requirements, at rates which recover the full costs of service.

(3) More efficient means for obtaining and distributing equipment to qualified subscribers.

(4) The establishment of quality standards for increasing the efficiency of the relay system.

(i) In order to continue to meet the access needs of individuals with functional limitations of hearing, vision, movement, manipulation, speech and interpretation of information, the commission shall perform ongoing assessment of, and if appropriate, expand the scope of the program to allow for additional access capability consistent with evolving telecommunications technology.

(j) The commission shall structure the programs required by this section so that any charge imposed to promote the goals of universal service reasonably equals the value of the benefits of universal service to contributing entities and their subscribers.

SEC. 14. Section 2708 of the Unemployment Insurance Code is amended to read:

2708. (a) (1) In accordance with the director's authorized regulations, and except as provided in subdivision (c) and Sections 2708.1 and 2709, a claimant shall establish medical eligibility for each uninterrupted period of disability by filing a first claim for disability benefits supported by the certificate of a treating physician or practitioner that establishes the sickness, injury, or pregnancy of the employee, or the condition of the family member that warrants the care of the employee. For subsequent periods of uninterrupted disability after the period covered by the initial certificate or any preceding continued claim, a claimant shall file a continued claim for those benefits supported by the certificate of a treating physician or practitioner. A certificate filed to establish medical eligibility for the employee's own sickness, injury, or pregnancy shall contain a diagnosis and diagnostic code prescribed in the International Classification of Diseases, or, where no diagnosis has yet been obtained, a detailed statement of symptoms.

(2) A certificate filed to establish medical eligibility of the employee's own sickness, injury, or pregnancy shall also contain a statement of medical facts including secondary diagnoses when applicable, within the physician's or practitioner's knowledge, based on a physical examination and a documented medical history of the claimant by the physician or practitioner, indicating the physician's or practitioner's conclusion as to the claimant's

disability, and a statement of the physician's or practitioner's opinion as to the expected duration of the disability.

(b) An employee shall be required to file a certificate to establish eligibility when taking leave to care for a family member with a serious health condition. The certificate shall be developed by the department. In order to establish medical eligibility of the serious health condition of the family member that warrants the care of the employee, the information shall be within the physician's or practitioner's knowledge and shall be based on a physical examination and documented medical history of the family member and shall contain all of the following:

(1) A diagnosis and diagnostic code prescribed in the International Classification of Diseases, or, where no diagnosis has yet been obtained, a detailed statement of symptoms.

(2) The date, if known, on which the condition commenced.

(3) The probable duration of the condition.

(4) An estimate of the amount of time that the physician or practitioner believes the employee is needed to care for the child, parent, spouse, or domestic partner.

(5) (A) A statement that the serious health condition warrants the participation of the employee to provide care for his or her child, parent, spouse, or domestic partner.

(B) "Warrants the participation of the employee" includes, but is not limited to, providing psychological comfort, and arranging "third party" care for the child, parent, spouse, or domestic partner, as well as directly providing, or participating in, the medical care.

(c) The department shall develop a certification form for bonding that is separate and distinct from the certificate required in subdivision (a) for an employee taking leave to bond with a minor child within the first year of the child's birth or placement in connection with foster care or adoption.

(d) The first and any continuing claim of an individual who obtains care and treatment outside this state shall be supported by a certificate of a treating physician or practitioner duly licensed or certified by the state or foreign country in which the claimant is receiving the care and treatment. If a physician or practitioner licensed by and practicing in a foreign country is under investigation by the department for filing false claims and the department does not have legal remedies to conduct a criminal investigation or prosecution in that country, the department may

suspend the processing of all further certifications until the physician or practitioner fully cooperates, and continues to cooperate with the investigation. A physician or practitioner licensed by and practicing in a foreign country who has been convicted of filing false claims with the department may not file a certificate in support of a claim for disability benefits for a period of five years.

(e) For purposes of this part:

(1) "Physician" has the same meaning as defined in Section 3209.3 of the Labor Code.

(2) "Practitioner" means a person duly licensed or certified in California acting within the scope of his or her license or certification who is a dentist, podiatrist, physician assistant, or as to normal pregnancy or childbirth, a midwife, nurse midwife, or nurse practitioner.

(f) For a claimant who is hospitalized in or under the authority of a county hospital in this state, a certificate of initial and continuing medical disability, if any, shall satisfy the requirements of this section if the disability is shown by the claimant's hospital chart, and the certificate is signed by the hospital's registrar. For a claimant hospitalized in or under the care of a medical facility of the United States government, a certificate of initial and continuing medical disability, if any, shall satisfy the requirements of this section if the disability is shown by the claimant's hospital chart, and the certificate is signed by a medical officer of the facility duly authorized to do so.

(g) Nothing in this section shall be construed to preclude the department from requesting additional medical evidence to supplement the first or any continued claim if the additional evidence can be procured without additional cost to the claimant. The department may require that the additional evidence include any or all of the following:

(1) Identification of diagnoses.

(2) Identification of symptoms.

(3) A statement setting forth the facts of the claimant's disability. The statement shall be completed by any of the following individuals:

(A) The physician or practitioner treating the claimant.

1 (B) The registrar, authorized medical officer, or other duly
2 authorized official of the hospital or health facility treating the
3 claimant.
4 (C) An examining physician or other representative of the
5 department.

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SB 1111

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1111
Author: Negrete McLeod
Bill Date: April 12, 2010, amended
Subject: Regulatory Boards
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Business, Professions, and Economic Development Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would enact the Consumer Health Protection Enforcement Act which includes various provisions affecting the investigation and enforcement of disciplinary actions against licensees of healing arts boards.

ANALYSIS:

This bill states the legislative findings on the needs to timely investigate and prosecute licensed health care professionals who have violated the law. The legislature also indicates the importance of providing the healing arts boards with the regulatory tools and authorities needed in order for them to be able to reduce the timeframe for investigating and prosecuting violations of the law by healing arts professionals to between 12 and 18 months.

This bill sets forth numerous requirements for all healing arts boards within the Department of Consumer Affairs (DCA). Specifically this bill:

- Adds section 720.28 to the Business and Professions Code. This section requires all boards to post on the internet, the status of every license issued. This section mirrors section 2027 of the Medical Practice Act.

- Allows the Director of the DCA to audit all healing arts boards. Current law allows the DCA to audit the Medical Board and the Board of Podiatric Medicine.

- Allows an Administrative Law Judge to direct a licensee to pay the Board's costs of probation when that licensee is issued an order in resolution of a

disciplinary proceeding to be placed on probation. This authority currently exists for the Board.

- Allows a healing arts board to appoint two members to conduct hearings to hear appeals of citations decisions and assessments of fines.

- Allows healing arts boards to contract with either the Medical Board or with the Department of Justice to provide investigative services.

- Establishes within the Division of Investigations the Health Quality Enforcement Unit to focus on health care quality cases. This unit will work closely with the Attorney General's Health Quality Enforcement Section in investigation and prosecution of complex and varied disciplinary actions against licensees of the healing arts boards.

- Allows the Board of Registered Nursing to hire designated investigators with peace officer status and allows the Board to employ investigators who are not peace officers to provide investigative services.

- Adds section 720.2 to the Business and Professions Code which allows healing arts board to delegate to its executive officer the authority to adopt a proposed default decision where an administrative action to revoke a license has been filed and the licensee failed to file a notice of defense or to appear at the hearing and a proposed default decision revoking the license has been issued. This language mirrors section 2224 of the Medical Practice Act.

- Allows healing arts boards to delegate to its executive officer the authority to adopt a proposed settlement agreement where an administrative action to revoke a license has been filed and the licensee has agreed to the revocation or surrender of his or her license.

- Allows healing arts boards to enter into a settlement with a licensee or applicant in lieu of the issuance of an accusation or statement of issues against the licensee or applicant.

- Allows the executive director of a healing arts board to petition the Director of the DCA to issue a temporary order that a licensee cease all practice and activities if there is evidence that licensee poses an imminent risk to patients.

- Defines imminent risk of serious harm to the public health, safety, or welfare as a reasonable likelihood that permitting the licensee to continue to practice will result in serious physical or emotional injury, unlawful sexual contact, or death to an individual within the next 90 days.

- Requires the automatic suspension of a licensee who is incarcerated after conviction of a felony. This is the current procedure for the Board.

- Adds section 720.10 to the Business and Professions Code. This specifies certain requirements for any applicant or licensee who is required to register as a sex offender. This language mirrors section 2232 of the Medical Practice Act.

- Specifies that requests for certified documents must be received within 10 days of the receipt of the request unless the licensee is unable to provide the records within 10 days for good cause. Specifies a definition for good cause. This requirement currently exists for the Board.

- Adds sections 720.18, 720.20, and 720.22 to the Business and Professions Code. These sections pertain to requests for certified medical records and include a definition of certified medical records. These provisions are similar in language to sections 2225.5 and 2226 of the Medical Practice Act.

- Adds section720.24 to the Business and Professions Code. This section requires that employers of health care practitioners must report to their respective board the suspension or termination of any licensee it employs. This section defines "suspension or termination for cause" and specifies fines for noncompliance. These provisions are similar to but less extensive than those in section 805 of the Business and Professions Code having to do with peer review reporting.

- Requires healing arts boards to report annually to the DCA and to the legislature, 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. This requirement already exists for the Board.

- Requires the Attorney General's office to serve for submit to a healing arts board an accusation within 60 days from receipt, a default decision within five days following the time period allowed for filing the notice of defense, and to set hearing dates within three days of receiving notice of defense unless instructed otherwise.

- Adds section 720.32 to the Business and Professions Code. This section grants the healing arts boards the authority to deny a license, certificate or permit to an applicant who may be unable to practice safely due to mental or physical illness. The Board currently has this authority under section 820 of the Business and Professions Code.

- Adds section 720.34 to the Business and Professions Code. This section allows healing arts boards to issue a limited license to applicants who are otherwise eligible to for a license but are unable to practice some aspects of

his or her profession safely due to disability. The Board currently has this authority under section 2088 of the Medical Practice Act.

- Requires a healing arts board to report to the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) on any adverse action taken against a licensee, any dismissal or closure of proceedings by reason of surrender, any loss license by the practitioner or entity, and any negative action or finding by the board regarding a licensee. This reporting is currently done by the Board.

- Requires a healing arts board to conduct a search on the NPDB or the HIPDB prior to granting or renewing a license to an applicant. Allows a board to charge a fee to cover the cost of the search.

- Establishes the Emergency Health Care Enforcement Reserve Fund in the State Treasury to be administered by the DCA. This fund shall be used to support the investigation and prosecution of healing arts board's cases. This fund will consist of moneys that will be taken from the individual board's reserve funds when those reserve funds exceed for than four months of operating expenditures.

- Adds section 734 to the Business and Professions code. These sections are identical to sections 2237, 2238, and 2239 of the Medical Practice Act, which are related to unprofessional conduct for drug related offenses.

- Adds section 737 to the Business and Professions Code. This section states that failure to furnish information in a timely manner to the board or cooperate in any disciplinary investigation constitutes unprofessional conduct. This section is similar to section 6068(i) of the Business and Professions Code.

- Amends section 802.1 of the Business and Professions Code to include all healing arts boards in the requirement for a licensee to report to their respective board when there is an indictment or information charging a felony against the licensee, or he or she has been convicted of a misdemeanor. This section already applies to the Board.

- Amends section 803.5 to require the district attorney, city attorney, or other prosecuting attorney to report to the appropriate healing arts board if a licensee has been charged with a felony immediately upon obtaining information that the defendant is a licensee or a healing arts board. The Board is already included in this section.

- Adds section 803.7 to the Business and Professions Code. This section would require the Department of Justice to provide reports within 30 days of subsequent arrests, convictions, or other updates of licensees.

- Adds a new article under the Business and Professions Code. *Article 15. Healing Arts Licensing Fees* allows the DCA to annually establish a maximum fee amount for each board. That fee will be adjusted with the California Consumer Price Index.

- Adds a new article under the Business and Professions Code. *Article 16. Unlicensed Practice* specifies that engaging in any practice, including healing arts without a current valid license is a public offense, punishable by a fine not to exceed $100,000 or imprisonment.

- Adds various sections to the Business and Professions Code which would establish diversion and recovery programs to identify and rehabilitate dentists, osteopathic physicians, physical therapists, registered nurses, physician assistants, pharmacists, and veterinarians whose competency may be impaired due to alcohol and drug abuse. This does not apply to the Board.

- Provides that it is the intent of the legislature that the DCA shall 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.

- Amends sections 12529, 12529.5, and 12529.6 of the Government Code to expand the use of the vertical enforcement and prosecution model for cases handled by all other healing arts boards. The Board has been utilizing the vertical enforcement model for several years.

The provisions in this bill are intended to better allow the DCA healing arts boards to investigate and prosecute consumer complaints in a more timely manner. Both the mission as well as the highest priority for all healing arts boards is the protection of the public. Improving these timeframes will better allow these boards to do so. This bill aims to provide the tools necessary for accomplish the utmost consumer protection.

FISCAL: None

POSITION: Recommendation: Support

April 21, 2010

AMENDED IN SENATE APRIL 12, 2010

SENATE BILL **No. 1111**

Introduced by Senator Negrete McLeod

February 17, 2010

An act to amend Sections 27, 116, 125.9, 155, 159.5, 160, 726, 802.1, 803, 803.5, 803.6, ~~and~~ *1005, and* 2715 of, to amend and repeal Section 125.3 of, to add Sections *27.5,* 125.4, 734, 735, 736, 737, *802.2,* 803.7, *1006, 1007,* 1699.2, 2372, *2815.6,* 2669.2, 2770.18, 3534.12, 4375, and 4873.2 to, to add Article 10.1 (commencing with Section 720)~~, Article 15 (commencing with Section 870),~~ and Article 16 (commencing with Section 880) to Chapter 1 of Division 2 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, to ~~amend Sections 12529, 12529.5, 12529.6, and 12529.7 of~~ *add Section 12529.8 to* the Government Code, and to amend Section 830.3 of the Penal Code, relating to regulatory boards, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 1111, as amended, Negrete McLeod. Regulatory boards.

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. *Existing law, the Chiropractic Act, enacted by initiative, provides for*

the licensure and regulation of chiropractors by the State Board of Chiropractic Examiners.

(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 *and the State Board of Chiropractic Examiners* to disclose on the Internet information on their respective licensees, as specified. 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 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 or his or her designee to audit and review the aforementioned activities by any of the healing arts boards.

Existing law authorizes an administrative law judge to order a licentiate in a disciplinary proceeding to pay, upon request of the licensing authority, a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

This bill would instead authorize any entity within the department, *the State Board of Chiropractic Examiners,* or the administrative law judge to order a licensee or applicant in any penalty or disciplinary hearing to pay a sum not to exceed the ~~actual~~ *reasonable* costs of the investigation, prosecution, and enforcement of the case, *in full,* within 30 days of the effective date of an order to pay costs, *unless subject to an agreed upon payment plan.* The bill would also authorize any entity within the department to request that the administrative law judge charge a licensee on probation the costs of the monitoring of his or her probation, and would prohibit relicensure if those costs are not paid. The bill would authorize any board within the department *and the State Board of Chiropractic Examiners* to contract with a collection agency for the purpose of collecting outstanding fees, fines, or cost recovery amounts, *upon a final decision,* and would authorize the release of personal information, including the birth date, telephone number, and social security number of the person who owes that money to the board.

Existing law provides for the regulation of citation or administrative fine assessments issued pursuant to a citation. Hearings to contest citations or administrative fine assessments are conducted pursuant to a formal adjudication process.

This bill would authorize *a* healing ~~arts boards~~ *board* to proceed pursuant to an alternative adjudication process, as specified, *provided the board has adopted specified regulations.*

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 has been convicted of a felony or misdemeanor.

This bill would expand that requirement to a licensee of any healing arts board, as specified, ~~would require those licensees to submit a written report,~~ and would further require a report upon the arrest of the licensee or when disciplinary action is taken against a licensee by another healing arts board or by a healing arts board of another state *or an agency of the federal government. The bill would also require a licensee who is arrested or charged with a misdemeanor or felony to inform law enforcement and the court that he or she is a licensee of a healing arts board.*

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. Existing law also 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 make those provisions applicable to any described healing arts board. By imposing additional duties on these local agencies, the bill would impose a state-mandated local program.

(2) Under existing law, healing arts licensees are regulated by various healing arts boards and these boards are authorized to issue, deny, suspend, and revoke licenses based on various grounds and to take disciplinary action against a licensee for the failure to comply with their

laws and regulations. Existing law requires or authorizes a healing arts board to appoint an executive officer or an executive director to, among other things, perform duties delegated by the board. *Under existing law, the State Board of Chiropractic Examiners has the authority to issue, suspend, revoke a license to practice chiropractic, and to place a licensee on probation for various violations. Existing law requires the State Board of Chiropractic Examiners to employ an executive officer to carryout certain duties.*

This bill would authorize ~~the~~ *a healing arts board to delegate to its* 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 *the revocation or* surrender *of* his or her license, to adopt a proposed default decision or a proposed settlement agreement. The bill would also authorize a healing arts board to enter into a settlement with a licensee or applicant ~~prior to~~ *in lieu of* the issuance of an accusation or statement of issues against the licensee or applicant.

Upon receipt of evidence that a licensee of a healing arts board has engaged in conduct that poses an imminent risk of harm to the public health, safety, or welfare, ~~or has failed to comply with a request to inspect or copy records,~~ the bill would authorize the executive officer of the healing arts board to petition the director or his or her designee to issue a temporary order that the licensee cease all practice and activities under his or her license. The bill would require the executive officer to provide notice to the licensee of the hearing at least ~~one hour~~ *5 business days* prior to the hearing and would provide a mechanism for the presentation of evidence and oral or written arguments. The bill would allow for the permanent revocation of the license ~~if the director makes a determination that the action is necessary to protect~~ *upon a preponderance of the evidence that an imminent risk to* the public health, safety, or welfare *exists.*

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 specify that no hearing is required, however, if the conviction was for a violation of federal law or state law for the use of dangerous drugs or controlled substances or specified sex offenses; a violation for the use of dangerous

drugs or controlled substances would also constitute unprofessional conduct and a crime, thereby imposing a state-mandated local program.

The bill would prohibit the issuance of a healing arts license to any person who is a registered sex offender, and would provide for the revocation of a license upon the conviction of certain sex offenses, as defined. The bill would provide that 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 as a sex offender, be considered a crime substantially related to the qualifications, functions, or duties of a licensee.

The bill would also prohibit a licensee of 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 ~~10~~ *15* days, *if a licensee, or 30 days, if a health care facility,* 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 the 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 also set forth procedures related to the inspection of patient records and patient confidentiality. The bill would require cooperation between state agencies and healing arts boards when investigating a licensee, and would require a state agency to provide to the board all records in the custody of the state agency. The bill would require all local and state law enforcement agencies, state and local governments, state agencies, licensed health care facilities, and any employers of any licensee to provide records to a healing arts board upon request by that board, and would make an additional requirement specific to the Department of Justice. By imposing additional duties on local agencies, the bill would impose a state-mandated local program.

The bill would require the 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. The bill would require the healing arts boards to ~~search~~ *submit licensee information to* specified national databases*, and to search those databases* prior to licensure of an applicant or licensee ~~who holds a license in another state~~, and would authorize a healing arts board to charge a fee for the cost of conducting the search. *The bill would authorize a healing arts board to automatically suspend the license of any licensee who also has an out-of-state license or a license issued by an agency of the federal government that is suspended or revoked, except as specified.*

The bill would authorize the healing arts boards to refuse to issue a license to an applicant if the applicant ~~appears to~~ *may* be unable to practice safely due to mental illness or chemical dependency, subject to specified procedural requirements and medical examinations. The bill would also authorize the healing arts boards to issue limited licenses to practice to an applicant with a disability, as specified.

(3) This bill would make it a crime to violate any of the provisions of (2) above; to engage in the practice of healing arts without a current and valid license, except as specified; *or* to fraudulently buy, sell, or obtain a license to practice healing arts~~; or to represent oneself as engaging or authorized to engage in healing arts if he or she is not authorized to do so~~. *The bill would, except as otherwise specified, make the provisions of paragraph (2) applicable to licensees subject to the jurisdiction of the State Board of Chiropractic Examiners.* By creating new crimes, the bill would impose a state-mandated local program.

This bill would also provide that it is an act of unprofessional conduct for any licensee of a healing arts board to fail to furnish information in a timely manner to the board or the board's investigators, or to fail to cooperate and participate in any disciplinary investigation pending against him or her, except as specified.

~~(4) Existing law requires regulatory fees to be deposited into special funds within the Professions and Vocations Fund, and certain of those special funds are continuously appropriated for those purposes. Those funds are created, and those fees are set, by the Legislature by statute or, if specified, by administrative regulation.~~

~~This bill would authorize the Department of Consumer Affairs to adjust those healing arts regulatory fees consistent with the California Consumer Price Index. By adding a new source of revenue for deposit into certain continuously appropriated funds, the bill would make an appropriation.~~

(4) Existing law provides in the State Treasury the Professions and Vocations Fund, consisting of the special funds of the healing arts boards, many of which are continuously appropriated.

This bill would establish in the State Treasury the Emergency Health Care Enforcement Reserve Fund, which would be a continuously appropriated fund, and would require that any moneys in a healing arts board fund consisting of more than 4 months operating expenditures be transferred to the fund and would authorize expenditure for specified enforcement purposes, thereby making an appropriation. The bill would require the fund to be administered by the department, and would authorize a healing arts board to loan its surplus moneys in the fund to another healing arts board, thereby making an appropriation.

Existing law requires specified agencies within the Department of Consumer Affairs with unencumbered funds equal to or more than the agency's operating budget for the next 2 fiscal years to reduce license fees in order to reduce surplus funds to an amount less than the agency's operating budget, as specified. With respect to certain other boards within the department, existing law imposes various reserve fund requirements.

Under this bill, if a healing arts board's fund reserve exceeds its statutory maximum, the bill would authorize the board to lower its fees by resolution in order to reduce its fund reserves to an amount below its statutory maximum.

The bill would also authorize the department to request that the Department of Finance augment the amount available for expenditures to pay enforcement costs for the services of the Attorney General's Office and the Office of Administrative Hearings and the bill would impose specified procedures for instances when the augmentation exceeds 20% of the board's budget for the enforcement costs for these services. The bill would make findings and statements of intent with respect to this provision.

(5) Existing law authorizes the director to employ investigators, inspectors, and deputies as are necessary to investigate and prosecute all violations of any law, the enforcement of which is charged to the department, or to any board in the department. Inspectors used by the boards are not required to be employees of the Division of Investigation, but may be employees of, or under contract to, the boards.

This bill would authorize healing arts boards *and the State Board of Chiropractic Examiners* to employ investigators who are not employees of the Division of Investigation, and would authorize those boards to

contract for investigative services provided by the ~~Medical Board of California or provided by the~~ Department of Justice. The bill would also provide within the Division of Investigation the Health Quality Enforcement Unit to provide investigative services for healing arts proceedings.

Existing law provides that the chief and all investigators of the Division of Investigation of the department and all investigators of the Medical Board of California have the authority of peace officers.

This bill would include within that provision investigators of the Board of Registered Nursing and would also provide that investigators employed by the Medical Board of California, the Dental Board of California, and the Board of Registered Nursing are not required to be employed by the division. The bill would also authorize the Board of Registered Nursing to employ nurse consultants and other personnel as it deems necessary.

(6) 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.

This bill would make the provisions establishing these diversion programs inoperative on January 1, 2013.

(7) Existing law provides in the Department of Justice the Health Quality Enforcement Section, whose primary responsibility is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California and any committee of the board, the California *Board of* Podiatric Medicine, and the Board of Psychology.

This bill would ~~require~~ *authorize a healing arts board to utilize the services of* the Health Quality Enforcement Section ~~to provide investigative and prosecutorial services to any healing arts board, as defined, upon request by the executive officer of the board~~ *or licensing section.* ~~The~~ *If utilized, the* bill would ~~also~~ require the Attorney General to assign attorneys employed by the office of the Attorney General to work on location at the ~~Health Quality Enforcement Unit~~ *licensing unit* of the Division of Investigation of the Department of Consumer Affairs, as specified.

(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.

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

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

1 SECTION 1. This act shall be known and may be cited as the
2 Consumer Health Protection Enforcement Act.
3 SEC. 2. (a) The Legislature finds and declares the following:
4 (1) In recent years, it has been reported that many of the healing
5 arts boards within the Department of Consumer Affairs take, on
6 average, more than three years to investigate and prosecute
7 violations of law, a timeframe that does not adequately protect
8 consumers.
9 (2) The excessive amount of time that it takes healing arts boards
10 to investigate and prosecute licensed professionals who have
11 violated the law has been caused, in part, by legal and procedural
12 impediments to the enforcement programs.
13 (3) Both consumers and licensees have an interest in the quick
14 resolution of complaints and disciplinary actions. Consumers need
15 prompt action against licensees who do not comply with
16 professional standards, and licensees have an interest in timely
17 review of consumer complaints to keep the trust of their patients.
18 (b) It is the intent of the Legislature that the changes made by
19 this act will improve efficiency and increase accountability within
20 the healing arts boards of the Department of Consumer Affairs,
21 and will remain consistent with the long-held paramount goal of
22 consumer protection.
23 (c) It is further the intent of the Legislature that the changes
24 made by this act will provide the healing arts boards within the
25 Department of Consumer Affairs with the regulatory tools and
26 authorities necessary to reduce the average timeframe for

investigating and prosecuting violations of law by healing arts practitioners to between 12 and 18 months.

SEC. 3. Section 27 of the Business and Professions Code is amended to read:

27. (a) ~~Every~~ *Each* entity specified in ~~subdivision (b)~~ *subdivisions (b) and (c)* shall provide on the Internet information regarding the status of every license issued by that entity, *whether the license is current, expired, canceled, suspended, or revoked,* 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 its 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 and Funeral Bureau shall disclose information on its licensees, including cemetery brokers, cemetery salespersons, cemetery managers, crematory managers, cemetery authorities, crematories, cremated remains disposers, embalmers, funeral establishments, and funeral directors.

(10) The Professional Fiduciaries Bureau shall disclose information on its licensees.

(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 Bureau for Private Postsecondary Education shall disclose information on private postsecondary institutions under

its jurisdiction, including disclosure of notices to comply issued pursuant to Section 94935 of the Education Code.

~~(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 and Hearing Aid Dispensers 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 of 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) The State Board of Chiropractic Examiners shall disclose information on its licensees.

~~(c)~~

(d) "Internet" for the purposes of this section has the meaning set forth in paragraph (6) of subdivision (f) of Section 17538.

SEC. 4. Section 27.5 is added to the Business and Professions Code, to read:

27.5. (a) Each entity specified in subdivision (b) shall provide on the Internet information regarding the status of every license issued by that entity, whether the license is current, expired, canceled, suspended, or revoked, 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. The information may not include the licensee's address, but may include the city and county of the licensee's address of record.

(b) Each of the following entities within the Department of Consumer Affairs shall comply with the requirements of this section:

(1) The Board of Registered Nursing shall disclose information on its licensees.

(2) The Board of Vocational Nursing and Psychiatric Technicians of the State of California shall disclose information on its licensees.

(3) The Veterinary Medical Board shall disclose information on its licensees and registrants.

(4) The Physical Therapy Board of California shall disclose information on its licensees.

(5) The California State Board of Pharmacy shall disclose information on its licensees.

(6) The Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board shall disclose information on its licensees.

(7) The Respiratory Care Board of California shall disclose information on its licensees.

(8) The California Board of Occupational Therapy shall disclose information on its licensees.

(9) The Naturopathic Medicine Committee within the Osteopathic Medical Board of California shall disclose information on its licensees.

(10) The Physician Assistant Committee of the Medical Board of California shall disclose information on its licensees.

(11) 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 (f) of Section 17538.

~~SEC. 4.~~

SEC. 5. Section 116 of the Business and Professions Code is amended to read:

116. (a) The director or his or her designee 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 any of the healing arts boards ~~defined~~ *listed* in Section 720. The director may make recommendations for changes to the disciplinary system to the appropriate board, the Legislature, or both*, for their consideration.*

(b) The director shall report to the Chairpersons of the Senate Business and Professions Committee and the Assembly Health Committee annually regarding his or her findings from any audit, review, or monitoring and evaluation conducted pursuant to this section.

~~SEC. 5.~~

SEC. 6. Section 125.3 of the Business and Professions Code, as amended by Section 2 of Chapter 223 of the Statutes of 2006, is amended to read:

125.3. (a) (1) Except as otherwise provided by law, in any order issued in resolution of a penalty or disciplinary proceeding or hearing on a citation issued pursuant to Section 125.9 or regulations adopted *pursuant* thereto, before any board specified in Section 101, the board or the administrative law judge may direct any licensee or applicant found to have committed a violation or violations of law to pay to the board a sum not to exceed the ~~actual~~ *reasonable* costs of the investigation, prosecution, and enforcement of the case.

(2) In an order issued pursuant to paragraph (1) that places a license on probation, the administrative law judge may direct a licensee to pay the board's ~~actual~~ *reasonable* costs of monitoring that licensee while he or she remains on probation, if so requested by the entity bringing the proceeding. The board shall provide the administrative law judge with a good faith estimate of the probation monitoring costs at the time of the request.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of ~~actual~~ *reasonable* costs of investigation, prosecution, and enforcement of the case. The costs shall include the amount of investigative, prosecution, and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of ~~actual~~ *reasonable* costs of investigation, prosecution, and enforcement of the case and probation monitoring costs when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase any cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) In determining reasonable costs pursuant to subdivision (a), the administrative law judge shall only consider the public resources expended pursuant to the investigation, prosecution, and enforcement of the case. The administrative law judge shall provide an explanation as to how the amount ordered for reasonable costs was determined if the actual costs were not ordered.

~~(e)~~

(f) If an order for recovery of costs is made, payment is due and payable, *in full,* 30 days after the effective date of the order, *unless the licensee and the board have agreed to a payment plan.* If timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licentiate to pay costs.

~~(f)~~

(g) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

~~(g)~~

(h) (1) Except as provided in paragraph (2), the board shall not renew ~~or reinstate the license~~, *reinstate the license, or terminate the probation* of any licentiate who has failed to pay all of the costs ordered under this section. *This paragraph shall not apply to an administrative law judge when preparing a proposed decision.*

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licentiate who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

~~(h)~~

(i) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

~~(i)~~

(j) Nothing in this section shall preclude a board from including the recovery of the costs of investigation, prosecution, and enforcement of a case in any stipulated settlement.

~~(j)~~

(k) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for broader authority for the recovery of costs in an administrative disciplinary proceeding.

~~(k)~~

(l) Notwithstanding the provisions of this section, the Medical Board of California shall not request nor obtain from a physician and surgeon, investigation and prosecution costs for a disciplinary proceeding against the licentiate. The board shall ensure that this subdivision is revenue neutral with regard to it and that any loss of revenue or increase in costs resulting from this subdivision is offset by an increase in the amount of the initial license fee and the biennial renewal fee, as provided in subdivision (e) of Section 2435.

~~(l)~~

(m) For purposes of this chapter, costs of prosecution shall include, but not be limited to, costs of attorneys, expert consultants, witnesses, any administrative filing and service fees, and any other cost associated with the prosecution of the case.

~~SEC. 6.~~

SEC. 7. Section 125.3 of the Business and Professions Code, as added by Section 1 of Chapter 1059 of the Statutes of 1992, is repealed.

~~SEC. 7.~~

SEC. 8. Section 125.4 is added to the Business and Professions Code, to read:

125.4. *(a)* Notwithstanding any other provision of law, a board may contract with a collection agency for the purpose of collecting outstanding fees, fines, or cost recovery amounts from any person who owes that money to the board, and, for those purposes, may provide to the collection agency the personal information of that person, including his or her birth date, telephone number, and social security number. The contractual agreement shall provide that the collection agency may use or release personal information only as authorized by the contract, and shall provide safeguards to ensure that the personal information is protected from unauthorized disclosure. The contractual agreement shall hold the collection agency liable for the unauthorized use or disclosure of personal information received or collected under this section.

(b) A board shall not use a collection agency to recover outstanding fees, fines, or cost recovery amounts until the person has exhausted all appeals and the decision is final.

~~SEC. 8.~~

SEC. 9. Section 125.9 of the Business and Professions Code is amended to read:

125.9. (a) Except with respect to persons regulated under Chapter 11 (commencing with Section 7500), and Chapter 11.6 (commencing with Section 7590) of Division 3, any board, bureau, commission, or committee within the department, the board created by the Chiropractic Initiative Act, and the Osteopathic Medical Board of California, may establish, by regulation, a system for the issuance to a licensee of a citation that may contain an order of abatement or an order to pay an administrative fine assessed by the board, bureau, commission, or committee where the licensee is in violation of the applicable licensing act or any regulation adopted pursuant thereto.

(b) The system shall contain the following provisions:

(1) Citations shall be in writing and shall describe with particularity the nature of the violation, including specific reference to the provision of law determined to have been violated.

(2) Whenever appropriate, the citation shall contain an order of abatement fixing a reasonable time for abatement of the violation.

(3) In no event shall the administrative fine assessed by the board, bureau, commission, or committee exceed five thousand dollars ($5,000) for each inspection or each investigation made with respect to the violation, or five thousand dollars ($5,000) for each violation or count if the violation involves fraudulent billing submitted to an insurance company, the Medi-Cal program, or Medicare. In assessing a fine, the board, bureau, commission, or committee shall give due consideration to the appropriateness of the amount of the fine with respect to factors such as the gravity of the violation, the good faith of the licensee, and the history of previous violations.

(4) A citation or fine assessment issued pursuant to a citation shall inform the licensee that if he or she desires a hearing to appeal the finding of a violation, that hearing shall be requested by written notice to the board, bureau, commission, or committee within 30 days of the date of issuance of the citation or assessment. If a hearing is not requested pursuant to this section, payment of any fine shall not constitute an admission of the violation charged. Hearings shall be held pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code or, at the discretion of a healing arts board, as ~~defined~~ *listed* in Section 720, pursuant to paragraph (5).

~~(5) (A) If the healing arts board is a board or committee, the executive officer and two members of that board or committee shall hear the appeal and issue a citation decision. A licensee desiring to appeal the citation decision shall file a written appeal of the citation decision with the board or committee within 30 days of issuance of the decision. The appeal shall be considered by the board or committee itself and shall issue a written decision on the appeal. The members of the board or committee who issued the citation decision shall not participate in the appeal before the board or committee unless one or both of the members are needed to establish a quorum to act on the appeal.~~

~~(B) If the healing arts board is a bureau, the director shall appoint a designee to hear the appeal and issue a citation decision.~~

~~A licensee desiring to appeal the citation decision shall file a written appeal of the citation decision with the bureau within 30 days of issuance of the decision. The appeal shall be considered by the director or his or her designee who shall issue a written decision on the appeal.~~

~~(C) The hearings specified in this paragraph are not subject to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.~~

~~(D) A healing arts board may adopt regulations to implement this paragraph, which may include the use of telephonic hearings.~~

(5) (A) If the healing arts board is a board or committee, two members of that board or committee shall hear the appeal and issue a citation decision. One of the two members shall be a licensee of the board.

(B) If the healing arts board is a bureau, the director shall appoint a designee to hear the appeal and issue a citation decision.

(C) A hearing held pursuant to this paragraph is not subject to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(D) A board or committee choosing to utilize the provisions of this paragraph shall first have adopted regulations providing for notice and opportunity to be heard. The regulations shall provide the licensee with due process and describe, in detail, the process for that hearing. Appeal of the citation decision may be made through the filing of a petition for writ of mandate.

(E) A healing arts board may permit the use of telephonic hearings. The decision to have a telephonic hearing shall be at the discretion of the licensee subject to the citation.

(6) Failure of a licensee to pay a fine within 30 days of the date of assessment, unless the citation is being appealed, may result in disciplinary action being taken by the board, bureau, commission, or committee. Where a citation is not contested and a fine is not paid, the full amount of the assessed fine shall be added to the fee for renewal of the license. A license shall not be renewed without payment of the renewal fee and fine.

(c) The system may contain the following provisions:

(1) A citation may be issued without the assessment of an administrative fine.

(2) Assessment of administrative fines may be limited to only particular violations of the applicable licensing act.

(d) Notwithstanding any other provision of law, if a fine is paid to satisfy an assessment based on the finding of a violation, payment of the fine shall be represented as satisfactory resolution of the matter for purposes of public disclosure.

(e) Administrative fines collected pursuant to this section shall be deposited in the special fund of the particular board, bureau, commission, or committee.

~~SEC. 9.~~

SEC. 10. Section 155 of the Business and Professions Code is amended to read:

155. (a) In accordance with Section 159.5, the director may employ such investigators, inspectors, and deputies as are necessary *to* properly ~~to~~ investigate and prosecute all violations of any law, the enforcement of which is charged to the department or to any board, agency, or commission in the department.

(b) It is the intent of the Legislature that inspectors used by boards, bureaus, or commissions in the department shall not be required to be employees of the Division of Investigation, but may either be employees of, or under contract to, the boards, bureaus, or commissions. Contracts for services shall be consistent with Article 4.5 (commencing with Section 19130) of Chapter 6 of Part 2 of Division 5 of Title 2 of the Government Code. All civil service employees currently employed as inspectors whose functions are transferred as a result of this section shall retain their positions, status, and rights in accordance with Section 19994.10 of the Government Code and the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code).

(c) Investigators used by any healing arts board, as ~~defined~~ *listed* in Section 720, shall not be required to be employees of the Division of Investigation and the healing arts board may contract for investigative services provided by ~~the Medical Board of California or provided by~~ the Department of Justice.

(d) Nothing in this section limits the authority of, or prohibits, investigators in the Division of Investigation in the conduct of inspections or investigations of any licensee, or in the conduct of investigations of any officer or employee of a board or the department at the specific request of the director or his or her designee.

~~SEC. 10.~~

SEC. 11. Section 159.5 of the Business and Professions Code is amended to read:

159.5. There is in the department the Division of Investigation. The division is in the charge of a person with the title of chief of the division. There is in the division the Health Quality Enforcement Unit. The primary responsibility of the unit is to investigate complaints against licensees and applicants within the jurisdiction of the healing arts boards ~~specified~~ *listed* in Section 720.

Except as provided in Section 16 of Chapter 1394 of the Statutes of 1970, all positions for the personnel necessary to provide investigative services, as specified in Section 160 of this code and in subdivision (b) of Section 830.3 of the Penal Code, shall be in the division and the personnel shall be appointed by the director.

~~SEC. 11.~~

SEC. 12. Section 160 of the Business and Professions Code is amended to read:

160. (a) The Chief and designated investigators of the Division of Investigation of the department, designated investigators of the Medical Board of California, designated investigators of the Dental Board of California, and 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.

(b) The Division of Investigation, the Medical Board of California, the Dental Board of California, and the Board of Registered Nursing may employ investigators who are not peace officers to provide investigative services.

~~SEC. 12.~~

SEC. 13. 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 "healing arts 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 Physician Assistant Committee of the Medical Board of California.

(14) The Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.

(15) The California Board of Occupational Therapy.

(16) The Osteopathic Medical Board of California.

(17) The Naturopathic Medicine Committee ~~of~~ *within* the Osteopathic Medical Board of California.

(18) The Dental Hygiene Committee of California.

(19) The Veterinary Medical Board.

(b) Unless otherwise provided, as used in this article, "board" means all healing arts boards described under subdivision (a) and "licensee" means a licensee of a healing arts board described in subdivision (a).

720.2. (a) ~~The~~ *A healing arts board may delegate to its* executive officer or executive director ~~of a healing arts board may~~ *the authority to* adopt a proposed default decision where an administrative action to revoke a license has been filed 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~~ *A healing arts board may delegate to its* executive officer or executive director ~~of a healing arts board may~~ *the*

authority to adopt a proposed settlement agreement where an administrative action to revoke a license has been filed by the healing arts board and the licensee has agreed to ~~surrender~~ *the revocation or surrender of* his or her license.

720.4. (a) Notwithstanding Section 11415.60 of the Government Code, a healing arts board may enter into a settlement with a licensee or applicant ~~prior to the board's~~ *in lieu of the* issuance of an accusation or statement of issues against that licensee or applicant, as applicable.

(b) The settlement shall include language identifying the factual basis for the action being taken and a list of the statutes or regulations violated.

~~(b) No~~

(c) A person who enters a settlement pursuant to this section ~~may petition~~ *is not precluded from filing a petition, in the timeframe permitted by law,* to modify the terms of the settlement or petition for early termination of probation, if probation is part of the settlement.

~~(c) Any settlement~~

(d) Any settlement against a licensee executed pursuant to this section shall be considered discipline and a public record and shall be posted on the applicable board's Internet Web site. *Any settlement against an applicant executed pursuant to this section shall be considered a public record and shall be posted on the applicable board's Internet Web site.*

720.6. (a) Notwithstanding any other provision of law, upon receipt of evidence that a licensee of a healing arts board has engaged in conduct that poses an imminent risk of serious harm to the public health, safety, or welfare, ~~or has failed to comply with a request to inspect or copy records made pursuant to Section 720.16,~~ the executive officer of that board may petition the director to issue a temporary order that the licensee cease all practice and activities that require a license by that board.

(b) (1) The executive officer of the healing arts board shall, to the extent practicable, provide telephonic, electronic mail, message, or facsimile written notice to the licensee of a hearing on the petition at least ~~24 hours~~ *five business days* prior to the hearing. The licensee and his or her counsel and the executive officer or his or her designee shall have the opportunity to present oral or written argument before the director. After presentation of the

evidence ~~and consideration of any arguments presented, the director may issue an order that the licensee cease all practice and activities that require a license by that board when, in the opinion of the director, the action is necessary to protect the public health, safety, or welfare.~~*, if, in the director's opinion, the petitioner has established by a preponderance of the evidence that an imminent risk of serious harm to the public health, safety, or welfare exists, the director may issue an order that the licensee cease all practice and activities that require a license by that board.*

(2) The hearing specified in this subdivision shall not be subject to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) Any order to cease practice issued pursuant to this section shall automatically be vacated within ~~120~~ *90* days of issuance, or until the healing arts board~~, pursuant to Section 494, files a petition~~ *files a petition pursuant to Section 494* for an interim suspension order and the petition is denied or granted, whichever occurs first.

(d) A licensee who fails or refuses to comply with an order of the director to cease practice pursuant to this section is subject to disciplinary action to revoke or suspend his or her license by ~~his or her~~ *the* respective healing arts board and an administrative fine assessed by the board not to exceed twenty-five thousand dollars ($25,000). The remedies provided herein are in addition to any other authority of the healing arts board to sanction a licensee for practicing or engaging in activities subject to the jurisdiction of the board without proper legal authority.

(e) Upon receipt of new information, the executive officer for the healing arts board who requested the temporary suspension order shall review the basis for the license suspension to determine if the grounds for the suspension continue to exist. The executive officer shall immediately notify the director if the executive officer believes that the licensee no longer poses an imminent risk of serious harm to the public health, safety, or welfare ~~or that the licensee has complied with the request to inspect or copy records pursuant to Section 720.16~~. The director shall review the information from the executive officer and may vacate the suspension order, if he or she believes that the suspension is no longer necessary to protect the public health, safety, or welfare.

(f) Any petition and order to cease practice shall be displayed on the Internet Web site of the applicable healing arts board, except

that if the petition is not granted or the director vacates the suspension order pursuant to subdivision (e), the petition and order shall be removed from the respective board's Internet Web site.

(g) If the position of director is vacant, the chief deputy director of the department shall fulfill the duties of this section.

(h) Temporary suspension orders shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure and shall be heard only in the superior court in, and for, the Counties of Sacramento, San Francisco, Los Angeles, or San Diego.

(i) For the purposes of this section, "imminent risk of serious harm to the public health, safety, or welfare" means that there is a reasonable likelihood that allowing the licensee to continue to practice will result in serious physical or emotional injury, unlawful sexual contact, or death to an individual or individuals within the next 90 days.

720.8. (a) The license of a licensee of a healing arts 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 healing arts board shall, immediately upon receipt of the certified copy of the record of conviction, 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 healing arts board shall notify the licensee *in writing* 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~~ *Hearings* it is determined that the felony for which the licensee was convicted was substantially related to the qualifications, functions, or duties of a 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 healing arts board.

(c) Notwithstanding subdivision (b), a conviction of a charge of violating any federal statute or regulation or any statute or regulation of this state, regulating dangerous drugs or controlled substances, or a conviction of 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 healing arts 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 healing arts board.

(d) (1) Discipline may be ordered against a licensee in accordance with the laws and regulations of the healing arts 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 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~~ *Hearings*. The hearing shall not be had 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 healing arts board from pursuing disciplinary action based on any cause other than the overturned conviction.

(e) The record of the proceedings resulting in a conviction, including a transcript of the testimony in those proceedings, 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 healing arts board shall not apply to proceedings conducted pursuant to this section.

720.10. 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 subdivision (c) of Section 729, with a patient, or has committed an act or 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 healing arts board, the patient shall no longer be considered a patient of the licensee when the order for medical services and procedures provided by the licensee is terminated, discontinued, or not renewed by the prescribing physician and surgeon.~~

720.12. (a) Except as otherwise provided, with regard to an individual who is required to register as a sex offender pursuant to Section 290 of the Penal Code, or the equivalent in another state or territory, under military law, or under federal law, the healing arts board shall be subject to the following requirements:

(1) The healing arts board shall deny an application by the individual for licensure 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.

(2) If the individual is licensed under this division, the healing arts board shall promptly revoke the license of the individual 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. The healing arts board shall not stay the revocation and place the license on probation.

(3) The healing arts board shall not reinstate or reissue the individual's license. The healing arts board shall not issue a stay of license denial ~~and~~ *nor* place the license on probation.

(b) This section shall not apply to any of the following:

(1) An individual who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law or the law of the jurisdiction that requires his or her registration as a sex offender.

(2) An individual 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. However, nothing in this paragraph shall prohibit the healing arts board from exercising its discretion to discipline a licensee under any other provision of state law based upon the licensee's conviction under Section 314 of the Penal Code.

(3) Any administrative adjudication proceeding under Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code that is fully adjudicated prior to January 1, 2008. A petition for reinstatement of a revoked or surrendered license shall be considered a new proceeding for purposes of this paragraph, and the prohibition against reinstating a license to an individual who is required to register as a sex offender shall be applicable.

720.14. (a) A licensee of a healing arts 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 healing arts board.

(2) A provision that prohibits another party to the dispute from filing a complaint with the healing arts board.

(3) A provision that requires another party to the dispute to withdraw a complaint he or she has filed with the healing arts 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.

720.16. (a) Notwithstanding any other provision of law making a communication between a licensee of a healing arts board and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted by a healing arts board. Members of a healing arts board, deputies, employees, agents, the office of the Attorney General, 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 healing arts board about that licensee.

(b) Notwithstanding any other provision of law, the Attorney General and his or her investigative agents, and a healing arts board and its investigators and representatives may inquire into any alleged violation of the laws under the jurisdiction of the healing arts board or any other federal or state law, regulation, or rule relevant to the practice regulated by the healing arts 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 certified 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, the documents shall be provided within 10 business days of receipt of the request, unless the licensee is unable to provide the certified 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 certified documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. A healing arts 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 healing arts 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) The licensee shall cooperate with the healing arts board in furnishing information or assistance as may be required, including, but not limited to, participation in an interview with investigators or representatives of the healing arts board.

(g) If a board complies with Section 2225, that board shall not be subject to the requirements of this section.

(h) This section shall not apply to a licensee who does not have access to, and control over, certified medical records.

720.18. (a) (1) Notwithstanding any other provision of law, 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 healing arts board, within ~~10~~ *15* days of receiving the request and authorization, shall pay to the healing arts board a civil penalty of *up to* one thousand dollars ($1,000) per day for each day that the documents have not been produced after the ~~10th~~ *15th* day, up to ~~one hundred thousand dollars ($100,000)~~ *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 healing arts 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 healing arts board within ~~10~~ *30* days of receiving the request, authorization, and notice shall subject the health care facility to a civil penalty, payable to the healing arts board, of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced after the ~~10th~~ *30th* day, up to ~~one hundred thousand dollars ($100,000)~~ *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 a healing arts board in obtaining the patient's authorization. A healing arts board shall pay the reasonable costs of copying the certified medical records, but shall

not be required to make that payment 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 healing arts board, shall pay to the healing arts board a civil penalty of up to 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 healing arts 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 healing arts 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 healing arts 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 healing arts 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 ~~one hundred thousand dollars ($100,000)~~ *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 healing arts 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 healing arts 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), 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 healing arts 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 healing arts board pursuant to this section shall be deposited into the fund administered by the healing arts 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 ~~1684.5~~ *1684.1*, 2225.5, or 2969, 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.

720.20. (a) Notwithstanding any other provision of law, a state agency shall, upon receiving a request in writing from a healing arts board *for records*, immediately provide to the healing arts board all records in the custody of the state agency, including, but not limited to, confidential records, medical records, and records related to closed or open investigations.

(b) If a state agency has knowledge that a person it is investigating is licensed by a healing arts board, the state agency shall notify the healing arts board that it is conducting an investigation against one of its licentiates. The notification of investigation to the healing arts board ~~is to~~ *shall* include the name, address, and, if known, the professional ~~licensure~~ *license* type and license number of the person being investigated and the name and address or telephone number of a person who can be contacted for further information about the investigation. The state agency shall cooperate with the healing arts board in providing any requested information.

720.22. Notwithstanding any other provision of law, all local and state law enforcement agencies, state and local governments, state agencies, licensed health care facilities, and employers of a licensee of a healing arts board shall provide records to the healing arts board upon request prior to receiving payment from the board *for the cost of providing the records*.

720.24. (a) ~~Any~~ *Notwithstanding any other provision of law, any* employer of a health care licensee shall report to the board the suspension or termination for cause, or any resignation in lieu of suspension or termination for cause, of any health care licensee in its employ within ~~five~~ *15* business days. The report shall not be made until after the conclusion of the review process specified in Section 52.3 of Title 2 of the California Code of Regulations and Skelly v. State Personnel Bd. (1975) 15 Cal.3d 194, for public employees. This required reporting shall not constitute a waiver of confidentiality of medical records. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800 and shall not be subject to discovery in civil cases.

(b) For purposes of the section, "suspension or termination for cause" ~~is defined as suspension~~ *or "resignation in lieu of suspension or termination for cause" is defined as resignation,*

suspension, or termination from employment for any of the following reasons:

(1) Use of controlled substances or alcohol to the extent that it impairs the licensee's ability to safely practice.

(2) Unlawful sale of a controlled substance or other prescription items.

(3) Patient or client abuse, neglect, physical harm, or sexual contact with a patient or client.

~~(4) Falsification of medical records.~~

~~(5)~~

(4) Gross negligence or incompetence.

~~(6)~~

(5) Theft from a patient or client, any other employee, or the employer.

~~(c) Failure of an employer to make a report required by this section is punishable by an administrative fine not to exceed one hundred thousand dollars ($100,000) per violation.~~

~~(d) Pursuant to Section 43.8 of the Civil Code, no person shall incur any civil penalty as a result of making any report required by this chapter.~~

~~(e) This section shall not apply to any of the reporting requirements under Section 805.~~

(c) As used in this section, the following definitions apply:

(1) "Gross negligence" means a substantial departure from the standard of care, which, under similar circumstances, would have ordinarily been exercised by a competent licensee, and which has or could have resulted in harm to the consumer. An exercise of so slight a degree of care as to justify the belief that there was a conscious disregard or indifference for the health, safety, or welfare of the consumer shall be considered a substantial departure from the standard of care.

(2) "Incompetence" means the lack of possession of and the failure to exercise that degree of learning, skill, care, and experience ordinarily possessed by a responsible licensee.

(3) "Willful" means a knowing and intentional violation of a known legal duty.

(d) (1) Willful failure of an employer to make a report required by this section is punishable by an administrative fine not to exceed one hundred thousand dollars ($100,000) per violation.

(2) Any failure of an employer, other than willful failure, to make a report required by this section is punishable by an administrative fine not to exceed fifty thousand dollars ($50,000).

(e) Pursuant to Section 43.8 of the Civil Code, no person shall incur any civil penalty as a result of making any report required by this article.

(f) No report is required under this section where a report of the action taken is already required under Section 805.

720.26. (a) Each healing arts 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 Sections 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 healing arts board against licensees for unprofessional conduct that have not been finally adjudicated, as well as disciplinary actions taken against licensees.

(c) ~~If a board~~ *A board that* complies with Section 2313~~, that board~~ shall not be subject to the requirements of this section.

720.28. Unless otherwise provided, on or after July 1, 2013, every healing arts board shall post on the Internet the following information in its possession, custody, or control regarding every licensee for which the board licenses:

(a) With regard to the status of every healing arts license, whether or not the licensee *or former licensee* is in good standing, subject to a temporary restraining order, subject to an interim suspension order, subject to a restriction or cease practice ordered pursuant to Section 23 of the Penal Code, or subject to any of the enforcement actions described in Section 803.1.

(b) With regard to prior discipline of a licensee, whether or not the licensee *or former licensee* has been subject to discipline by the healing arts board or by the board of another state or jurisdiction, as described in Section 803.1.

(c) Any felony conviction of a licensee reported to the healing arts board ~~after January 3, 1991~~.

(d) All current accusations filed by the Attorney General, including those accusations that are on appeal. For purposes of this paragraph, "current accusation" means an accusation that has not been dismissed, withdrawn, or settled, and has not been finally decided upon by an administrative law judge and the board unless an appeal of that decision is pending.

(e) Any malpractice judgment or arbitration award imposed against a licensee and reported to the healing arts board ~~after January 1, 1993~~.

(f) Any hospital disciplinary action imposed against a licensee that resulted in the termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason pursuant to Section 720.18 or 805.

(g) Any misdemeanor conviction of a licensee that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed.

(h) 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 healing arts board and shall be adopted by regulation.

720.30. (a) The office of the Attorney General shall serve, or submit to a healing arts board for service, an accusation within 60 calendar days of receipt from the healing arts board.

(b) The office of the Attorney General shall serve, or submit to a healing arts board for service, a default decision within five days following the time period allowed for the filing of a notice of defense.

(c) The office of the Attorney General shall set a hearing date within three days of receiving a notice of defense, unless the healing arts board gives the office of the Attorney General instruction otherwise.

720.32. (a) Whenever it appears that an applicant for a license, certificate, or permit from a healing arts board may be unable to practice his or her profession safely because the applicant's ability to practice ~~would~~ *may* be impaired due to mental illness, or physical illness affecting competency, the healing arts board may order the applicant to be examined by one or more physicians and surgeons or psychologists designated by the healing arts board. The report of the examiners shall be made available to the applicant and may

be received as direct evidence in proceedings conducted pursuant to Chapter 2 (commencing with Section 480) of Division 1.5.

(b) An applicant's failure to comply with an order issued under subdivision (a) shall authorize the board to deny an applicant a license, certificate, or permit.

(c) A healing arts board shall not grant a license, certificate, or permit until it has received competent evidence of the absence or control of the condition that caused its action and until it is satisfied that with due regard for the public health and safety the person may safely practice the profession for which he or she seeks licensure.

720.34. (a) An applicant for a license, certificate, or permit from a healing arts board who is otherwise eligible for that license but is unable to practice some aspects of his or her profession safely due to a disability may receive a limited license if he or she does both of the following:

(1) Pays the initial licensure fee.

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

(b) The healing arts board may require the applicant described in subdivision (a) to obtain an independent clinical evaluation of his or her ability to practice 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 healing arts board.

720.35. (a) ~~Each~~ *Each healing arts board listed in Section 720 shall report to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank the following information on each of its licensees:*

(1) Any adverse action taken by the board as a result of any disciplinary proceeding, including any revocation or suspension of a license and the length of that suspension, or any reprimand, censure, or probation.

(2) Any dismissal or closure of a disciplinary proceeding by reason of a licensee surrendering his or her license or leaving the state.

(3) Any other loss of the license of a licensee, whether by operation of law, voluntary surrender, or otherwise.

(4) Any negative action or finding by the board regarding a licensee.

(b) Each healing arts board shall conduct a search on the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank prior to granting or renewing a license, certificate, or permit to an applicant ~~who is licensed by another state~~.

~~(b)~~

(c) A healing arts board may charge a fee to cover the actual cost to conduct the search specified in subdivision ~~(a)~~ *(b)*.

720.36. (a) Unless otherwise provided, if a licensee possesses a license or is otherwise authorized to practice in any state other than California or by any agency of the federal government and that license or authority is suspended or revoked outright and is reported to the National Practitioner Data Bank, the California license of the licensee shall be suspended automatically for the duration of the suspension or revocation, unless terminated or rescinded as provided in subdivision (c). The healing arts board shall notify the licensee of the license suspension and of his or her right to have the issue of penalty heard as provided in this section.

(b) Upon its own motion or for good cause shown, a healing arts 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 specific healing art.

(c) The issue of penalty shall be heard by an administrative law judge sitting alone or with a panel of the board, in the discretion of the board. A licensee may request a hearing on the penalty and that hearing shall be held within 90 days from the date of the request. If the order suspending or revoking the license or authority to practice is overturned on appeal, any discipline ordered pursuant to this section shall automatically cease. Upon a showing to the administrative law judge or panel by the licensee that the out-of-state action is not a basis for discipline in California, the suspension shall be rescinded. If an accusation for permanent discipline is not filed within 90 days of the suspension imposed pursuant to this section, the suspension shall automatically terminate.

(d) The record of the proceedings that resulted in the suspension or revocation of the licensee's out-of-state license or authority to

practice, including a transcript of the testimony therein, may be received in evidence.

(e) This section shall not apply to a licensee who maintains his or her primary practice in California, as evidenced by having maintained a practice in this state for not less than one year immediately preceding the date of suspension or revocation. Nothing in this section shall preclude a licensee's license from being suspended pursuant to any other provision of law.

(f) This section shall not apply to a licensee whose license has been surrendered, whose only discipline is a medical staff disciplinary action at a federal hospital and not for medical disciplinary cause or reason as that term is defined in Section 805, or whose revocation or suspension has been stayed, even if the licensee remains subject to terms of probation or other discipline.

(g) This section shall not apply to a suspension or revocation imposed by a state that is based solely on the prior discipline of the licensee by another state.

(h) The other provisions of this article setting forth a procedure for the suspension or revocation of a licensee's license or certificate shall not apply to summary suspensions issued pursuant to this section. If a summary suspension has been issued pursuant to this section, the licensee may request that the hearing on the penalty conducted pursuant to subdivision (c) be held at the same time as a hearing on the accusation.

(i) A board that complies with Section 2310 shall not be subject to the requirements of this section.

~~720.36. Unless it is~~

720.37. Unless otherwise expressly provided, any person, whether licensed pursuant to this division or not, who violates any provision of this article 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), or by imprisonment *in a county jail* for a term of not less than 60 days nor no more than 180 days, or by both the fine and imprisonment.

720.38. (a) The Emergency Health Care Enforcement Reserve Fund is hereby established in the State Treasury, to be administered by the department. Notwithstanding Section 13340 of the Government Code, all moneys in the fund are hereby continuously appropriated and shall be used to support the investigation and prosecution of any matter within the authority

of any of the healing arts boards. The department, upon direction of a healing arts board, shall pay out the funds or approve such payments as deemed necessary from those funds as have been designated for the purpose of this section.

(b) Notwithstanding any other law, the funds of the Emergency Health Care Enforcement Reserve Fund are those moneys from the healing arts board's individual funds, which shall be deposited into the Emergency Health Care Enforcement Reserve Fund when the amount within those funds exceeds more than four months operating expenditures of the healing arts board.

(c) Notwithstanding any other law, the department, with approval of a healing arts board, may loan to any other board moneys necessary for the purpose of this section when it has been established that insufficient funds exist for that board, provided that the moneys will be repaid.

720.40. Notwithstanding any other provision of law, if a healing arts board's fund reserve exceeds its statutory maximum, the board may lower its fees by resolution in order to reduce its reserves to an amount below its maximum.

720.42. (a) The Legislature finds that there are occasions when a healing arts board, as listed in Section 720, urgently requires additional expenditure authority in order to fund unanticipated enforcement and litigation activities. Without sufficient expenditure authority to obtain the necessary additional resources for urgent litigation and enforcement matters, the board is unable to adequately protect the public. Therefore, it is the intent of the Legislature that, apart from, and in addition to, the expenditure authority that may otherwise be established, the healing arts boards, as listed in Section 720, shall be given the increase in its expenditure authority in any given current fiscal year that is authorized by the Department of Finance pursuant to the provisions of subdivision (b) of this section, for costs and services in urgent litigation and enforcement matters, including, but not limited to, costs for the services of the Attorney General and the Office of Administrative Hearings.

(b) Notwithstanding any other provision of law, upon the request of the department, the Department of Finance may augment the amount available for expenditures to pay enforcement costs for the services of the Attorney General's Office and the Office of Administrative Hearings. If an augmentation exceeds 20% of the

board's budget for the Attorney General, it may be made no sooner than 30 days after notification in writing to chairpersons of the committees in each house of the Legislature that consider appropriations and the Chairperson of the Joint Legislative Budget Committee, or no sooner than whatever lesser time the chairperson of the Joint Legislative Budget Committee may in each instance determine.

~~SEC. 13.~~

SEC. 14. 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.

(b) For purposes of Division 1.5 (commencing with Section 475)~~, and the licensing laws and regulations of a healing arts board, as defined in Section 720,~~ the commission of, and conviction for, any act of sexual abuse, sexual 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 licensee of a healing arts board *listed in Section 720.*

(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. 14.~~

SEC. 15. Section 734 is added to the Business and Professions Code, to read:

734. (a) The conviction of a charge of violating any federal statute or regulation or any statute or regulation of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct. The record of the conviction is conclusive evidence of the unprofessional conduct. A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section.

(b) Discipline may be ordered against a licensee in accordance with the laws and regulations of the healing arts board or the board may order the denial of the license when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing that person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

~~SEC. 15.~~

SEC. 16. Section 735 is added to the Business and Professions Code, to read:

735. A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

~~SEC. 16.~~

SEC. 17. Section 736 is added to the Business and Professions Code, to read:

736. (a) The use or prescribing for or administering to himself or herself of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that the use impairs the ability of the licensee to practice safely; or any misdemeanor or felony involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of the unprofessional conduct.

(b) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. Discipline may be ordered against a licensee in accordance with the laws and regulations of the healing arts board or the board may order the denial of the license when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing that person to withdraw his or her plea of guilty and to enter a plea of

not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

(c) A violation of subdivision (a) is a misdemeanor punishable by a fine of up to ten thousand dollars ($10,000), imprisonment in the county jail of up to six months, or both the fine and imprisonment.

~~SEC. 17.~~

SEC. 18. Section 737 is added to the Business and Professions Code, to read:

737. It shall be unprofessional conduct for any licensee of a healing arts board to fail to comply with the following:

(a) Furnish information in a timely manner to the healing arts board or the board's investigators or representatives if ~~legally~~ requested by the board.

(b) Cooperate and participate in any ~~disciplinary~~ investigation or other regulatory or disciplinary proceeding pending against ~~himself or herself~~ *the licensee*. However, this subdivision shall not be construed to deprive a licensee of any privilege guaranteed by the Fifth Amendment to the Constitution of the United States, or any other constitutional or statutory privileges. This subdivision shall not be construed to require a licensee to cooperate with a request that requires him or her to waive any constitutional or statutory privilege or to comply with a request for information or other matters within an unreasonable period of time in light of the time constraints of the licensee's practice. Any exercise by a licensee of any constitutional or statutory privilege shall not be used against the licensee in a regulatory or disciplinary proceeding against ~~him or her~~ *the licensee*.

~~SEC. 18.~~

SEC. 19. Section 802.1 of the Business and Professions Code is amended to read:

802.1. (a) (1) A licensee of a healing arts board ~~defined under Section 720 shall submit a written report of~~ *listed in Section 720 shall report* 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 arrest of the licensee.

(C) The conviction of the licensee, including any verdict of guilty, or plea of guilty or no contest, of any felony or misdemeanor.

(D) Any disciplinary action taken by another licensing entity or authority of this state or of another state *or an agency of the federal government.*

(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 the charging of a felony, the arrest, the conviction, or the 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).~~ *dollars ($5,000) and shall constitute unprofessional conduct.*

SEC. 20. Section 802.2 is added to the Business and Professions Code, to read:

802.2. A licensee of a healing arts board listed in Section 720 shall identify himself or herself as a licensee of the board to law enforcement and the court upon being arrested or charged with a misdemeanor or felony. The healing arts boards shall inform its licensees of this requirement.

~~SEC. 19.~~

SEC. 21. 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 a healing arts board ~~defined~~ *listed* in Section 720, 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 board that issued the license.

~~SEC. 20.~~

SEC. 22. 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 *appropriate* healing arts board ~~defined~~ *listed* in Section 720 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. 21. 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 appropriate healing arts boards defined in Section 720 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. 23. 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,~~ *appropriate healing arts board listed in Section 720* 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 healing arts* board.

~~SEC. 22.~~

SEC. 24. Section 803.7 is added to the Business and Professions Code, to read:

803.7. The Department of Justice shall ensure that subsequent reports authorized to be issued to any board identified in Section 101 are submitted to that board within 30 days from notification of subsequent arrests, convictions, or other updates.

~~SEC. 23. Article 15 (commencing with Section 870) is added to Chapter 1 of Division 2 of the Business and Professions Code, to read:~~

~~Article 15. Healing Arts Licensing Fees~~

~~870. (a) Notwithstanding any provision of law establishing a fee or a fee range in this division, the department may annually establish a maximum fee amount for each healing arts board, as defined in Section 720, adjusted consistent with the California Consumer Price Index.~~

~~(b) The department shall promulgate regulations pursuant to the Administrative Procedures Act to establish the maximum fee amount calculated pursuant to subdivision (a).~~

~~(c) A healing arts board, as defined in Section 720, shall establish, through regulations, the specific amount of all fees authorized by statute at a level that is at or below the amount established pursuant to subdivision (b).~~

~~SEC. 24.~~

SEC. 25. Article 16 (commencing with Section 880) is added to Chapter 1 of Division 2 of the Business and Professions Code, to read:

Article 16. Unlicensed Practice

880. (a) (1) It is a public offense, punishable by a fine not to exceed one hundred thousand dollars ($100,000), by imprisonment

in a county jail not to exceed one year, or by both that fine and imprisonment, ~~for a person to do any of the following:~~ *for:*

(A) Any person who does not hold a current and valid license to practice a healing art under this division who engages in that practice.

(B) Any person who fraudulently buys, sells, or obtains a license to practice any healing art in this division or to violate any provision of this division.

~~(C) Any person who represents himself or herself as engaging or authorized to engage in a healing art of this division who is not authorized to do so.~~

(2) Subparagraph (A) of paragraph (1) shall not apply to any person who is already being charged with a crime under the specific healing arts licensing provisions for which he or she engaged in unauthorized practice.

(b) Notwithstanding any other provision of law, any person who is licensed under this division, but ~~who is not authorized to provide some or all services of another healing art, who practices or~~ supervises the practice of ~~those unauthorized services~~ *any person who does not hold a current and valid license to practice a healing art under this division*, is guilty of a public crime, punishable by a fine not to exceed one hundred thousand dollars ($100,000), by imprisonment in a county jail not to exceed one year, or by both that fine and imprisonment.

SEC. 26. Section 1005 of the Business and Professions Code is amended to read:

1005. The provisions of Sections 12.5, 23.9, 29.5, 30, 31, 35, 104, 114, 115, 119, 121, 121.5, 125, *125.3. 125.4,* 125.6, *125.9,* 136, 137, 140, 141, 143, *155,* 163.5, 461, 462, 475, 480, 484, 485, 487, 489, 490, 490.5, 491, 494, 495, 496, 498, 499, 510, 511, 512, 701, 702, 703, 704, 710, 716, *720.2, 720.4, 720.8, 720.10, 720.12, 720.14, 720.16, 720.18, 720.20, 720.22, 720.24, 720.28, 720.30, 720.32, 720.35, 720.36,* 730.5, 731, ~~and~~ *734, 735, 736, 737, 802.1, 803, 803.5, 803.6, 803.7,* 851, *and 880* are applicable to persons licensed by the State Board of Chiropractic Examiners under the Chiropractic Act.

SEC. 27. Section 1006 is added to the Business and Professions Code, to read:

1006. (a) Notwithstanding any other provision of law, upon receipt of evidence that a licensee of the State Board of

Chiropractic Examiners has engaged in conduct that poses an imminent risk of serious harm to the public health, safety, or welfare, the executive officer may issue a temporary order that the licensee cease all practice and activities that require a license by the board.

(b) Before the executive officer may take any action pursuant to this section, the board shall delegate to the executive officer authority to issue a temporary cease practice order as specified in subdivision (a). The board may, by affirmative vote, rescind the executive officer's authority to issue cease temporary practice orders pursuant to subdivision (a).

(c) A licensee may appeal the temporary cease practice order decision pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) Any temporary order to cease practice issued pursuant to this section shall automatically be vacated within 90 days of issuance, or until the board files a petition pursuant to Section 494 for an interim suspension order and the petition is denied or granted, whichever occurs first.

(e) A licensee who fails or refuses to comply with a temporary order of the executive officer to cease practice pursuant to this section shall be subject to disciplinary action to revoke or suspend his or her license and by the board and an administrative fine assessed by the board not to exceed twenty-five thousand dollars ($25,000). The remedies provided herein are in addition to any other authority of the board to sanction a licensee for practicing or engaging in activities subject to the jurisdiction of the board without proper legal authority.

(f) Upon receipt of new information, the executive officer shall review the basis for the interim license suspension order pursuant to subdivision (d) to determine if the grounds for the suspension continue to exist. The executive officer may vacate the suspension order, if he or she believes that the suspension is no longer necessary to protect the public health, safety, or welfare as described in subdivision (a) of Section 494.

(g) Any order to cease practice including an order pursuant to Section 494 shall be displayed on the board's Internet Web site, except that if the executive officer vacates the suspension order

pursuant to subdivision (e), the petition and order shall be removed from the respective board's Internet Web site.

(h) Temporary suspension orders shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure and shall be heard only in the superior court in, and for, the Counties of Sacramento, San Francisco, Los Angeles, or San Diego.

(i) For the purposes of this section, "imminent risk of serious harm to the public health, safety, or welfare" means that there is a reasonable likelihood that permitting the licensee to continue to practice will result in serious physical or emotional injury, unlawful sexual contact, or death to an individual or individuals within the next 90 days.

SEC. 28. Section 1007 is added to the Business and Professions Code, to read:

1007. (a) The State Board of Chiropractic Examiners shall report annually to 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 Sections 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) The total number of complaints closed or resolved without discipline, prior to accusation.

(8) The total number of complaints and reports referred for formal investigation.

(9) The total number of accusations filed and the final disposition of accusations through the board and court review, respectively.

(10) 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.

(11) The total number of final licensee disciplinary actions taken, by category.

(12) 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.

(13) 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.

(14) 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.

(15) The total number of probation violation reports and probation revocation filings, and their dispositions.

(16) The total number of petitions for reinstatement, and their dispositions.

(17) 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.

~~SEC. 25.~~

SEC. 29. 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, 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. 26.~~

SEC. 30. Section 2372 is added to the Business and Professions Code, to read:

2372. This article 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. 27.~~

SEC. 31. 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, 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. 28.~~

SEC. 32. 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.

The board, in accordance with the provisions of the Civil Service Law, may employ 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 *alleged* nursing practice ~~activities~~ *violations*.

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. 29.~~

SEC. 33. 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, 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. 34. Section 2815.6 is added to the Business and Professions Code, to read:

2815.6. (a) It is the intent of the Legislature that, notwithstanding Section 128.5, in order to maintain an appropriate fund reserve, and in setting fees pursuant to this chapter, the Board of Registered Nursing shall seek to maintain a reserve in the Board of Registered Nursing Fund of not less than three and no more than six months' operating expenditures.

~~SEC. 30.~~

SEC. 35. 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, 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. 31.~~

SEC. 36. Section 4375 is added to the Business and Professions Code, to read:

4375. This article 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. 32.~~

SEC. 37. 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, 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. 33. Section 12529 of the Government Code, as amended by Section 8 of Chapter 505 of the Statutes of 2009, is amended to read:~~

~~12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, any committee under the jurisdiction of the Medical Board of California, or any other healing arts board, as defined in Section 720 of the Business and Professions Code, as requested by the executive officer of that board.~~

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

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

~~(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, the committees under the jurisdiction of the Medical Board of California, and any other healing arts board, as defined in Section 720 of the Business and Professions Code, with the intent that the expenses be proportionally shared as to services rendered.~~

~~(e) 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. 34. Section 12529 of the Government Code, as amended by Section 9 of Chapter 505 of the Statutes of 2009, is amended to read:~~

~~12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, any committee under the jurisdiction of the Medical Board of California, or any other healing arts board, as defined in Section 720 of the Business and Professions Code, as requested by the executive officer of that board, and to provide ongoing review of the investigative activities conducted in support of those prosecutions, as provided in subdivision (b) of Section 12529.5.~~

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

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

~~(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, the committees under the jurisdiction of the Medical Board of California, and any other healing arts board, as defined in Section 720 of the Business and Professions Code, with the intent that the expenses be proportionally shared as to services rendered.~~

~~(e) This section shall become operative January 1, 2013.~~

~~SEC. 35. Section 12529.5 of the Government Code, as amended by Section 10 of Chapter 505 of the Statutes of 2009, is amended to read:~~

~~12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, or the Board of Psychology shall be made available to the Health Quality Enforcement Section. Complaints or relevant information may be referred to the Health Quality Enforcement Section as determined by the executive officer of any other healing arts board, as defined in Section 720 of the Business and Professions Code.~~

~~(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to work on location at the intake unit of the Medical Board of California, the California Board of Podiatric Medicine, or the Board of Psychology, and shall assign attorneys to work on location at the Health Quality Enforcement Unit of the Division of Investigation of the Department of Consumer Affairs to assist in evaluating and screening complaints and to assist in developing uniform standards and procedures for processing complaints.~~

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

~~(d) The determination to bring a disciplinary proceeding against a licensee of the boards shall be made by the executive officer of the boards or committees as appropriate in consultation with the senior assistant.~~

~~(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. 36. Section 12529.5 of the Government Code, as amended by Section 11 of Chapter 505 of the Statutes of 2009, is amended to read:~~

~~12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, or the Board of Psychology shall be made available to the Health Quality Enforcement Section. Complaints or relevant information may be referred to the Health Quality Enforcement Section as determined by the executive officer of any other healing arts board, as defined in Section 720 of the Business and Professions Code.~~

~~(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to assist the boards in intake and investigations, shall assign attorneys to work on location at the Health Quality Enforcement Unit of the Division of Investigation of the Department of Consumer Affairs, and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit of the boards, to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations.~~

~~A deputy attorney general of the Health Quality Enforcement Section shall frequently be available on location at each of the working offices at the major investigation centers of the boards, to provide consultation and related services and engage in case review with the boards' investigative, medical advisory, and intake staff and the Division of Investigation. The Senior Assistant Attorney General and deputy attorneys general working at his or her direction shall consult as appropriate with the investigators of the boards, medical advisors, and executive staff in the investigation and prosecution of disciplinary cases.~~

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

~~(d) The determination to bring a disciplinary proceeding against a licensee of the boards shall be made by the executive officer of the boards or committees as appropriate in consultation with the senior assistant.~~

~~(e) This section shall become operative January 1, 2013.~~

~~SEC. 37. Section 12529.6 of the Government Code is amended to read:~~

~~12529.6. (a) The Legislature finds and declares that the healing arts boards, as defined in Section 720 of the Business and Professions Code, by ensuring the quality and safety of health care, perform one of the most critical functions of state government. Because of the critical importance of a board's public health and safety function, the complexity of cases involving alleged misconduct by health care practitioners, and the evidentiary burden in a healing arts board's disciplinary cases, the Legislature finds and declares that using a vertical enforcement and prosecution model for those investigations is in the best interests of the people of California.~~

~~(b) Notwithstanding any other provision of law, each complaint that is referred to a district office of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, or the Health Quality Enforcement Unit for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so assigned shall, under the direction but not the supervision of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action.~~

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

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

~~(e) It is the intent of the Legislature to enhance the vertical enforcement and prosecution model as set forth in subdivision (a). The Medical Board of California shall do all of the following:~~

~~(1) Increase its computer capabilities and compatibilities with the Health Quality Enforcement Section in order to share case information.~~

~~(2) Establish and implement a plan to collocate, when feasible, its enforcement staff and the staff of the Health Quality Enforcement Section, in order to carry out the intent of the vertical enforcement and prosecution model.~~

~~(3) 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.~~

~~(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.~~

~~SEC. 38. Section 12529.7 of the Government Code is amended to read:~~

~~12529.7. By March 1, 2012, the Department of Consumer Affairs, in consultation with the healing arts boards, as defined in Section 720 of the Business and Professions Code, and the Department of Justice, shall report and make recommendations to the Governor and the Legislature on the vertical enforcement and prosecution model created under Section 12529.6.~~

SEC. 38. Section 12529.8 is added to the Government Code, to read:

12529.8. (a) Any healing arts board listed in Section 720 of the Business and Professions Code may utilize the model prescribed in Sections 12529 to 12529.6, inclusive, for the investigation and prosecution of some or all of its enforcement actions and may utilize the services of the Department of Justice Health Quality Enforcement Section or the licensing section. If a board elects to proceed pursuant to this section and utilizes the services of the licensing section, the Department of Justice shall

assign attorneys to work on location at the licensing unit of the Division of Investigation of the Department of Consumer Affairs.

(b) The report requirements contained in Section 12529.7 shall apply to any healing arts board that utilizes those provisions for enforcement.

(c) This section shall not apply to any healing arts board listed in subdivision (a) of Section 12529.

SEC. 39. Section 830.3 of the Penal Code is amended to read:

830.3. The following persons are peace officers whose authority extends to any place in the state for the purpose of performing their primary duty or when making an arrest pursuant to Section 836 of the Penal Code as to any public offense with respect to which there is immediate danger to person or property, or of the escape of the perpetrator of that offense, or pursuant to Section 8597 or 8598 of the Government Code. These peace officers may carry firearms only if authorized and under those terms and conditions as specified by their employing agencies:

(a) Persons employed by the Division of Investigation of the Department of Consumer Affairs and investigators of the Medical Board of California, the Dental Board of California, and the Board of Registered Nursing who are designated by the Director of Consumer Affairs, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 160 of the Business and Professions Code.

(b) Voluntary fire wardens designated by the Director of Forestry and Fire Protection pursuant to Section 4156 of the Public Resources Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 4156 of that code.

(c) Employees of the Department of Motor Vehicles designated in Section 1655 of the Vehicle Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 1655 of that code.

(d) Investigators of the California Horse Racing Board designated by the board, provided that the primary duty of these peace officers shall be the enforcement of Chapter 4 (commencing with Section 19400) of Division 8 of the Business and Professions Code and Chapter 10 (commencing with Section 330) of Title 9 of Part 1 of this code.

(e) The State Fire Marshal and assistant or deputy state fire marshals appointed pursuant to Section 13103 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 13104 of that code.

(f) Inspectors of the food and drug section designated by the chief pursuant to subdivision (a) of Section 106500 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 106500 of that code.

(g) All investigators of the Division of Labor Standards Enforcement designated by the Labor Commissioner, provided that the primary duty of these peace officers shall be the enforcement of the law as prescribed in Section 95 of the Labor Code.

(h) All investigators of the State Departments of Health Care Services, Public Health, Social Services, Mental Health, and Alcohol and Drug Programs, the Department of Toxic Substances Control, the Office of Statewide Health Planning and Development, and the Public Employees' Retirement System, provided that the primary duty of these peace officers shall be the enforcement of the law relating to the duties of his or her department or office. Notwithstanding any other provision of law, investigators of the Public Employees' Retirement System shall not carry firearms.

(i) The Chief of the Bureau of Fraudulent Claims of the Department of Insurance and those investigators designated by the chief, provided that the primary duty of those investigators shall be the enforcement of Section 550.

(j) Employees of the Department of Housing and Community Development designated under Section 18023 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 18023 of that code.

(k) Investigators of the office of the Controller, provided that the primary duty of these investigators shall be the enforcement of the law relating to the duties of that office. Notwithstanding any other law, except as authorized by the Controller, the peace officers designated pursuant to this subdivision shall not carry firearms.

(*l*) Investigators of the Department of Corporations designated by the Commissioner of Corporations, provided that the primary

duty of these investigators shall be the enforcement of the provisions of law administered by the Department of Corporations. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(m) Persons employed by the Contractors' State License Board designated by the Director of Consumer Affairs pursuant to Section 7011.5 of the Business and Professions Code, provided that the primary duty of these persons shall be the enforcement of the law as that duty is set forth in Section 7011.5, and in Chapter 9 (commencing with Section 7000) of Division 3, of that code. The Director of Consumer Affairs may designate as peace officers not more than three persons who shall at the time of their designation be assigned to the special investigations unit of the board. Notwithstanding any other provision of law, the persons designated pursuant to this subdivision shall not carry firearms.

(n) The Chief and coordinators of the Law Enforcement Division of the Office of Emergency Services.

(o) Investigators of the office of the Secretary of State designated by the Secretary of State, provided that the primary duty of these peace officers shall be the enforcement of the law as prescribed in Chapter 3 (commencing with Section 8200) of Division 1 of Title 2 of, and Section 12172.5 of, the Government Code. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(p) The Deputy Director for Security designated by Section 8880.38 of the Government Code, and all lottery security personnel assigned to the California State Lottery and designated by the director, provided that the primary duty of any of those peace officers shall be the enforcement of the laws related to ~~assuring~~ *ensuring* the integrity, honesty, and fairness of the operation and administration of the California State Lottery.

(q) Investigators employed by the Investigation Division of the Employment Development Department designated by the director of the department, provided that the primary duty of those peace officers shall be the enforcement of the law as that duty is set forth in Section 317 of the Unemployment Insurance Code.

Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(r) The chief and assistant chief of museum security and safety of the California Science Center, as designated by the executive

director pursuant to Section 4108 of the Food and Agricultural Code, provided that the primary duty of those peace officers shall be the enforcement of the law as that duty is set forth in Section 4108 of the Food and Agricultural Code.

(s) Employees of the Franchise Tax Board designated by the board, provided that the primary duty of these peace officers shall be the enforcement of the law as set forth in Chapter 9 (commencing with Section 19701) of Part 10.2 of Division 2 of the Revenue and Taxation Code.

(t) Notwithstanding any other provision of this section, a peace officer authorized by this section shall not be authorized to carry firearms by his or her employing agency until that agency has adopted a policy on the use of deadly force by those peace officers, and until those peace officers have been instructed in the employing agency's policy on the use of deadly force.

Every peace officer authorized pursuant to this section to carry firearms by his or her employing agency shall qualify in the use of the firearms at least every six months.

(u) Investigators of the Department of Managed Health Care designated by the Director of the Department of Managed Health Care, provided that the primary duty of these investigators shall be the enforcement of the provisions of laws administered by the Director of the Department of Managed Health Care. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(v) The Chief, Deputy Chief, supervising investigators, and investigators of the Office of Protective Services of the State Department of Developmental Services, provided that the primary duty of each of those persons shall be the enforcement of the law relating to the duties of his or her department or office.

SEC. 40. (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. 41. 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 1150

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1150
Author: Negrete McLeod
Bill Date: February 18, 2010, introduced
Subject: Healing Arts: advertisements
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would impose various requirements relating to healthcare practitioner advertising, cosmetic surgery, outpatient settings, and accreditation.

ANALYSIS:

This bill contains various requirements relating to advertising and cosmetic surgery and is essentially the same as last year's SB 674 that the Board supported. Specifically this bill:

- Requires all healthcare practitioners to include specific professional designation following his or her name on all advertising. This will increase consumer awareness and protection.

- Specifies the definition of advertising as it relates to healthcare practitioners to be virtually any promotional communications not including insurance provider directories, billing statements, or appointment reminders. This will ensure that all materials used to solicit consumers will disclose the professional designations.

- Requires the Board to adopt regulations by January 1, 2012 on the appropriate level of physician availability necessary within clinics in which laser or intense pulse light devices are used for elective cosmetic surgery. Three public forums were held in 2008 to study this issue. The forums determined that current law and regulations were sufficient related to supervision; it was a lack of enforcement that was contributing to the problems occurring in the use of lasers and intense pulse light devises. These forums did not address physician

availability. The Board has established its own committee on physician responsibility with its first formal meeting at the April 2010 Board meeting.

- Specifies that the requirement to include professional designations following the healthcare practitioner's name on all advertisements would not apply until January 1, 2012 for any advertising that is published annually and prior to January 1, 2011. This provides for a physician to revise their advertisements in order to comply with the law.

- Requires the Board to post on its internet website a factsheet to educate consumers about cosmetic surgery and procedures, including the risks. The fact sheet must include a comprehensive list of questions for patients to ask their physicians prior to having cosmetic surgery. This will enhance consumer awareness and protection.

- Adds to the definition of "outpatient settings" facilities the offer in vitro fertilization. This will enhance consumer protection in that these clinics will be required to be accredited.

- Requires the Board to adopt standards for outpatient settings to be able to offer in vitro fertilization. These standards could be different than the existing standards for current outpatient settings. This will enhance consumer protection.

- Requires outpatient settings submit for approval a detailed plan, standardized procedures and protocols to be followed in the event of serious complications or side effects from surgery at the time of accreditation.

- Requires the Board to disclose to the public whether an outpatient setting is accredited, certified, or licensed, whether the accreditation has been revoked or suspended, and if the setting has been reprimanded by the accrediting agency. This will allow the public access to the status of all outpatient settings.

- Requires an accrediting agency to immediately report to the Board if an outpatient setting's certification or accreditation is denied. This will alert the Board of an issue that may need action.

- Requires the Board to ensure that outpatient settings are inspected by the accrediting agencies no less than once every three years and as often as needed to ensure the quality of care provided. The Board may also inspect outpatient settings. Reports of the inspections are to be kept on file with the Board or the accrediting agency along with a plan of correction. All reports of inspections and plans of correction of open to the public. This will help settings remain in compliance with the law.

- Removes the requirement that the Board or accrediting agency give reasonable prior notice and present proper identification prior to an inspection. This will improve the ongoing accountability for compliance in the outpatient settings.

- Requires the Board to evaluate the performance of an approved accrediting agency no less than every three years. This will help to keep the accrediting agencies accountable and efficient.

- Requires outpatient settings to agree to, and post conspicuously, a plan of correction and a list of deficiencies in a clinic location accessible to the public. This will increase public awareness of possible harm.

- Allows the Board to issue a citation to the accrediting agency if it is not meeting the criteria set by the Board. This will further the accountability for accrediting agencies.

This bill aims to improve the regulation and oversight of outpatient settings, surgery centers, and fertility clinics by ensuring that quality of care standards are in place and evaluated regularly. With the number of cosmetic procedures being performed in the United States quickly increasing and the recent issues of women giving birth to large numbers of multiples, there is great need for state oversight of clinic operations. Clinics that assist women in any reproductive technology should operate under specified standards and guidelines.

Advertising for these cosmetic and fertility procedures has also increased and needs to be restricted to health care professionals. Consumers need to be education when considering cosmetic surgeries and being solicited by advertising.

FISCAL: Unknown but could be substantial if the Board does the inspections.

POSITION: Support

April 21, 2010

SENATE BILL No. 1150

Introduced by Senator Negrete McLeod

February 18, 2010

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 1150, as introduced, 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, 2012, 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. By changing the definition of a crime, this bill would impose a state-mandated local program.

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.

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

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

1 SECTION 1. Section 651 of the Business and Professions Code
2 is amended to read:
3 651. (a) It is unlawful for any person licensed under this
4 division or under any initiative act referred to in this division to
5 disseminate or cause to be disseminated any form of public
6 communication containing a false, fraudulent, misleading, or
7 deceptive statement, claim, or image for the purpose of or likely
8 to induce, directly or indirectly, the rendering of professional
9 services or furnishing of products in connection with the
10 professional practice or business for which he or she is licensed.
11 A "public communication" as used in this section includes, but is
12 not limited to, communication by means of mail, television, radio,
13 motion picture, newspaper, book, list or directory of healing arts
14 practitioners, Internet, or other electronic communication.
15 (b) A false, fraudulent, misleading, or deceptive statement,
16 claim, or image includes a statement or claim that does any of the
17 following:
18 (1) Contains a misrepresentation of fact.
19 (2) Is likely to mislead or deceive because of a failure to disclose
20 material facts.
21 (3) (A) Is intended or is likely to create false or unjustified
22 expectations of favorable results, including the use of any
23 photograph or other image that does not accurately depict the
24 results of the procedure being advertised or that has been altered
25 in any manner from the image of the actual subject depicted in the
26 photograph or image.
27 (B) Use of any photograph or other image of a model without
28 clearly stating in a prominent location in easily readable type the
29 fact that the photograph or image is of a model is a violation of
30 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

1 or she is certified or eligible for certification by a private or public
2 board or parent association, including, but not limited to, a
3 multidisciplinary board or association, unless that board or
4 association is (i) an American Board of Medical Specialties
5 member board, (ii) a board or association with equivalent
6 requirements approved by that physician and surgeon's licensing
7 board, or (iii) a board or association with an Accreditation Council
8 for Graduate Medical Education approved postgraduate training
9 program that provides complete training in that specialty or
10 subspecialty. A physician and surgeon licensed under Chapter 5
11 (commencing with Section 2000) by the Medical Board of
12 California who is certified by an organization other than a board
13 or association referred to in clause (i), (ii), or (iii) shall not use the
14 term "board certified" in reference to that certification, unless the
15 physician and surgeon is also licensed under Chapter 4
16 (commencing with Section 1600) and the use of the term "board
17 certified" in reference to that certification is in accordance with
18 subparagraph (A). A physician and surgeon licensed under Chapter
19 5 (commencing with Section 2000) by the Medical Board of
20 California who is certified by a board or association referred to in
21 clause (i), (ii), or (iii) shall not use the term "board certified" unless
22 the full name of the certifying board is also used and given
23 comparable prominence with the term "board certified" in the
24 statement.
25 For purposes of this subparagraph, a "multidisciplinary board
26 or association" means an educational certifying body that has a
27 psychometrically valid testing process, as determined by the
28 Medical Board of California, for certifying medical doctors and
29 other health care professionals that is based on the applicant's
30 education, training, and experience.
31 For purposes of the term "board certified," as used in this
32 subparagraph, the terms "board" and "association" mean an
33 organization that is an American Board of Medical Specialties
34 member board, an organization with equivalent requirements
35 approved by a physician and surgeon's licensing board, or an
36 organization with an Accreditation Council for Graduate Medical
37 Education approved postgraduate training program that provides
38 complete training in a specialty or subspecialty.
39 The Medical Board of California shall adopt regulations to
40 establish and collect a reasonable fee from each board or

1 association applying for recognition pursuant to this subparagraph.
2 The fee shall not exceed the cost of administering this
3 subparagraph. Notwithstanding Section 2 of Chapter 1660 of the
4 Statutes of 1990, this subparagraph shall become operative July
5 1, 1993. However, an administrative agency or accrediting
6 organization may take any action contemplated by this
7 subparagraph relating to the establishment or approval of specialist
8 requirements on and after January 1, 1991.
9 (C) A doctor of podiatric medicine licensed under Chapter 5
10 (commencing with Section 2000) by the Medical Board of
11 California may include a statement that he or she is certified or
12 eligible or qualified for certification by a private or public board
13 or parent association, including, but not limited to, a
14 multidisciplinary board or association, if that board or association
15 meets one of the following requirements: (i) is approved by the
16 Council on Podiatric Medical Education, (ii) is a board or
17 association with equivalent requirements approved by the
18 California Board of Podiatric Medicine, or (iii) is a board or
19 association with the Council on Podiatric Medical Education
20 approved postgraduate training programs that provide training in
21 podiatric medicine and podiatric surgery. A doctor of podiatric
22 medicine licensed under Chapter 5 (commencing with Section
23 2000) by the Medical Board of California who is certified by a
24 board or association referred to in clause (i), (ii), or (iii) shall not
25 use the term "board certified" unless the full name of the certifying
26 board is also used and given comparable prominence with the term
27 "board certified" in the statement. A doctor of podiatric medicine
28 licensed under Chapter 5 (commencing with Section 2000) by the
29 Medical Board of California who is certified by an organization
30 other than a board or association referred to in clause (i), (ii), or
31 (iii) shall not use the term "board certified" in reference to that
32 certification.
33 For purposes of this subparagraph, a "multidisciplinary board
34 or association" means an educational certifying body that has a
35 psychometrically valid testing process, as determined by the
36 California Board of Podiatric Medicine, for certifying doctors of
37 podiatric medicine that is based on the applicant's education,
38 training, and experience. For purposes of the term "board certified,"
39 as used in this subparagraph, the terms "board" and "association"
40 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, 2012, to any advertisement that is published annually and prior to July 1, 2011.

(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.

~~(i)~~

(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.

~~(j)~~

(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.

~~(k)~~

(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, 2012, 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) "Division of Medical Quality" means the Division of Medical Quality of the Medical Board of California.~~

~~(c)~~

(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.

~~"Outpatient~~

(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.

~~(d)~~

(c) "Accreditation agency" means a public or private organization that is approved to issue certificates of accreditation to outpatient settings by the ~~division~~ *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 ~~division~~ *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.

~~(iii) Submit~~

(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.

~~(D)~~

(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 ~~Health Services~~ *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 ~~division~~ *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 ~~division~~ *board* to protect the public health and safety.

(d) No accreditation standard adopted or approved by the ~~division~~ *board*, and no standard included in any certification program of any accreditation agency approved by the ~~division~~ *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 ~~division~~ *board* under this chapter.

(b) The ~~division~~ *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 ~~division~~ *board*, and shall 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, *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 ~~division~~ *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.

~~(a)~~

(3) The ~~Division of Medical Quality or an accreditation agency may, upon reasonable prior notice and presentation of proper identification,~~ *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.

~~(b)~~

(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 ~~division~~ *board* or the accreditation agency, to correct the deficiencies.

(3) Suspend or revoke the outpatient setting's certification of accreditation.

~~(c)~~

(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.

~~(d)~~

(e) If the ~~division~~ *board* determines that deficiencies found during an inspection suggests that the accreditation agency does not comply with the standards approved by the ~~division~~ *board*, the ~~division~~ *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 ~~division may~~ *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 ~~division~~ *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 ~~division~~ *board*, the ~~division~~ *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.

~~(b)~~

(c) Before terminating approval of an accreditation agency, the ~~division~~ *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.

~~(c)~~

(d) (1) If approval of the accreditation agency is terminated by the ~~division~~ *board*, outpatient settings accredited by that agency shall be notified by the ~~division~~ *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 ~~division~~ *board* for good cause.

(2) The ~~division~~ *board* may require that an outpatient setting, that has been accredited by an accreditation agency whose approval has been terminated by the ~~division~~ *board*, cease operations immediately ~~in the event that the division~~ *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 ~~division~~ *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 ~~division~~ *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.

1 *(i) It is the intent of the Legislature that the department, pursuant*
2 *to its existing regulations, inspect the peer review process utilized*
3 *by acute care hospitals as part of its periodic inspection of those*
4 *hospitals pursuant to this section.*
5 SEC. 12. No reimbursement is required by this act pursuant to
6 Section 6 of Article XIII B of the California Constitution because
7 the only costs that may be incurred by a local agency or school
8 district will be incurred because this act creates a new crime or
9 infraction, eliminates a crime or infraction, or changes the penalty
10 for a crime or infraction, within the meaning of Section 17556 of
11 the Government Code, or changes the definition of a crime within
12 the meaning of Section 6 of Article XIII B of the California
13 Constitution.

O

SB 1172

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1172
Author: Negrete McLeod
Bill Date: April 12, 2010, amended
Subject: Diversion Programs
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require all healing arts boards under the Department of Consumer Affairs (DCA) to order a licensee to cease practice if the licensee tests positive for any substance that is prohibited under the terms of the licensees probation or diversion program. This bill allows a healing arts board to adopt regulations authorizing the board to order a licensee to cease practice for major violations or when ordered to undergo a clinical diagnostic evaluation.

ANALYSIS:

Senate Bill 1441 (Ridley-Thomas, 2008) established the Substance Abuse Coordination Committee within the DCA. This committee was responsible for formulating uniform and specific standards in specified areas for each healing arts board must use in dealing with substance-abusing licensees. These sixteen standards are required whether or not a board chooses to have a formal diversion program.

Many of the uniform standards established under SB 1441 do not require statutes for implementation, however, current law does not give all boards the authority to order a cease practice. Therefore this authority needs to be codified in law in order to fully implement the uniform standards established by the Substance Abuse Coordination Committee.

This bill would require all healing arts boards to order a licensee to cease practice if he or she tests positive for alcohol or any dangerous drugs. This bill also allows a healing arts board to adopt regulations authorizing the board to order a licensee to cease practice for major violations or when ordered to undergo a clinical diagnostic evaluation. The requirement to order a licensee to cease practice is regardless of whether or not the board has a diversion program.

The Board is prohibited from disclosing to the public that a licensee is participating in a board diversion program unless participation was ordered as a term of probation. Any restrictions placed on a licensee's practice are to be disclosed to the public.

This bill contains provisions requiring an external audit of the DCA's services relating to the treatment and rehabilitation of impaired physicians and other board's licensees to be performed once every three years. The audit must be performed by a qualified, independent review team from outside the DCA. The report of the audit is to be submitted to the legislature, as well as the DCA and the boards within the DCA, by June 30 of each year an audit it performed.

FISCAL: None

POSITION: Recommendation: Support

April 21, 2010

AMENDED IN SENATE APRIL 12, 2010

SENATE BILL No. 1172

Introduced by Senator Negrete McLeod

February 18, 2010

~~An act to amend Sections 156, 1695, 2360, 2662, 2770, 3534, 4360, and 4860 of the Business and Professions Code, relating to regulatory boards.~~ *An act to amend Section 156.1 of, and to add Sections 315.2, 315.4, and 315.6 to, the Business and Professions Code, relating to regulatory boards.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1172, as amended, Negrete McLeod. Regulatory ~~boards.~~ *boards: diversion programs.*

~~Existing~~

(1) Existing law provides for the regulation of specified professions and vocations by various boards, as defined, within the Department of Consumer Affairs. ~~The department is under the control of the Director of Consumer Affairs. Existing law authorizes the director to enter into contracts for and on behalf of any board within the department.~~ *Under existing law, individuals or entities contracting with the department or any board within the department for the provision of services relating to the treatment and rehabilitation of licentiates impaired by alcohol or dangerous drugs are required to retain all records and documents pertaining to those services for 3 years or until they are audited, whichever occurs first. Under existing law, those records and documents are required to be kept confidential and are not subject to discovery or subpoena.*

~~This bill would make a technical, nonsubstantive change to that provision.~~

This bill would specify that those records and documents shall be kept for 3 years and are not subject to discovery or subpoena unless otherwise expressly provided by law and would prohibit the licentiate from waiving confidentiality. The bill would require the department or board contracting for those services to have an audit conducted at least once every 3 years by a specified independent reviewer or review team, would require that reviewer or review team to prepare an audit report and to submit it to the Legislature, the department, and the board by June 30 every 3 years, with the first report due in 2013, and would require the department, the contract vendor, and the board to respond to the report, as specified.

(2) Existing law provides for the licensure and regulation of various healing arts by boards within the Department of Consumer Affairs. Under existing law, these boards are authorized to issue, deny, suspend, and revoke licenses based on various grounds and to take disciplinary action against their licensees.

Existing law establishes diversion and recovery programs to identify and rehabilitate dentists, osteopathic physicians and surgeons, physical therapists, physical therapy assistants, registered nurses, physician assistants, pharmacists and intern pharmacists, veterinarians, and registered veterinary technicians whose competency may be impaired due to, among other things, alcohol and drug abuse.

~~This bill would, with respect to those programs, revise references to alcohol and drug abuse to include other substances.~~

The bill would require a healing arts board to order a licensee to cease practice if the licensee tests positive for any prohibited substance under the terms of the licensee's probation or diversion program. The bill would also authorize a board to adopt regulations authorizing it to order a licensee on probation or in a diversion program to cease practice for major violations and when the board orders a licensee to undergo a clinical diagnostic evaluation, as specified. Except as provided, the bill would prohibit a healing arts board from disclosing to the public that a licensee is participating in a board diversion program.

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

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

SECTION 1. Section 156.1 of the Business and Professions Code is amended to read:

156.1. (a) Notwithstanding any other provision of law, individuals or entities contracting with the department or any board within the department for the provision of services relating to the treatment and rehabilitation of licentiates impaired by alcohol or dangerous drugs~~,~~ shall retain all records and documents pertaining to those services until such time as these records and documents have been reviewed for audit ~~by the department~~ *pursuant to subdivision (c)*. These records and documents shall be retained for ~~a maximum of~~ three years from the date of the last treatment or service rendered to that licentiate, ~~or until such time as the records pertaining to treatment or services rendered to that licentiate are audited, whichever occurs first,~~ after which time the records and documents may be purged and destroyed by the contract vendor. This provision shall supersede any other provision of law relating to the purging or destruction of records pertaining to those treatment and rehabilitation programs.

(b) ~~Notwithstanding any other provision of law, all~~ *Unless otherwise expressly provided by statute or regulation, all* records and documents pertaining to services for the treatment and rehabilitation of licentiates impaired by alcohol or dangerous drugs provided by any contract vendor to the department or to any board within the department shall be kept confidential and are not subject to discovery or subpoena. *A licentiate may not waive confidentiality pursuant to this subdivision.*

(c) (1) An external independent audit of an individual or entity contracting with the department pursuant to subdivision (a) shall be conducted at least once every three years by a qualified, independent reviewer or review team from outside the department with no real or apparent conflict of interest with the contractor providing the services. The independent reviewer or review team shall be competent in the professional practice of internal auditing and assessment processes.

(2) The independent reviewer or review team shall prepare an audit report that assesses the contractor's performance in adhering to any standards established by the department or the board and shall submit that report to the Legislature, the department, and

the board by June 30 every three years, with the first report due in 2013. The audit report shall make findings and identify any material inadequacies, deficiencies, irregularities, or any other noncompliance with the terms of the contract.

(3) The department, contract vendor, and the board shall respond to the assessment and findings in the audit report prior to submission to the Legislature.

~~(c)~~

(d) With respect to all other contracts for services with the department or any board within the department other than those set forth in subdivision (a), the director or chief deputy director may request an examination and audit by the department's internal auditor of all performance under the contract. For this purpose, all documents and records of the contract vendor in connection with such performance shall be retained by such vendor for a period of three years after final payment under the contract. Nothing in this section shall affect the authority of the State Auditor to conduct any examination or audit under the terms of Section 8546.7 of the Government Code.

SEC. 2. Section 315.2 is added to the Business and Professions Code, to read:

315.2. (a) A board, as described in Section 315, shall order a licensee of the board to cease practice if the licensee tests positive for any substance that is prohibited under the terms of the licensee's probation or diversion program.

(b) An order to cease practice under this section shall not be governed by the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) A cease practice order under this section shall not constitute disciplinary action.

(d) A licensee may petition to return to practice pursuant to the uniform and specific standards adopted and authorized under Section 315.

SEC. 3. Section 315.4 is added to the Business and Professions Code, to read:

315.4. (a) A board, as described in Section 315, may adopt regulations authorizing the board to order a licensee on probation or in a diversion program to cease practice for major violations and when the board orders a licensee to undergo a clinical

diagnostic evaluation pursuant to the uniform and specific standards adopted and authorized under Section 315.

(b) An order to cease practice under this section shall not be governed by the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) A cease practice order under this section shall not constitute disciplinary action.

(d) The regulations shall also include provisions for a licensee to petition to return to practice pursuant to the uniform and specific standards adopted and authorized under Section 315.

SEC. 4. Section 315.6 is added to the Business and Professions Code, to read:

315.6. Unless otherwise authorized by statute or regulation, a board, as described in Section 315, shall not disclose to the public that a licensee is participating in a board diversion program unless participation was ordered as a term of probation. However, a board shall disclose to the public any restrictions that are placed on a licensee's practice as a result of the licensee's participation in a board diversion program provided that the disclosure does not contain information linking the restriction to the licensee's participation in the board's diversion program.

~~SECTION 1. Section 156 of the Business and Professions Code is amended to read:~~

~~156. (a) The director may, for the department and at the request and with the consent of a board or bureau within the department on whose behalf the contract is to be made, enter into contracts pursuant to Chapter 3 (commencing with Section 11250) of Part 1 of Division 3 of Title 2 of the Government Code or Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code for and on behalf of any board or bureau within the department.~~

~~(b) In accordance with subdivision (a), the director may, in his or her discretion, negotiate and execute contracts for examination purposes that include provisions that hold harmless a contractor where liability resulting from a contract between a board in the department and the contractor is traceable to the state or its officers, agents, or employees.~~

~~SEC. 2. Section 1695 of the Business and Professions Code is amended to read:~~

~~1695. It is the intent of the Legislature that the Dental Board of California seek ways and means to identify and rehabilitate licensees whose competency may be impaired due to abuse of dangerous drugs or alcohol or other substances, so that licensees so afflicted may be treated and returned to the practice of dentistry in a manner that will not endanger the public health and safety. It is also the intent of the Legislature that the Dental Board of California shall implement this legislation in part by establishing a diversion program as a voluntary alternative approach to traditional disciplinary actions.~~

~~SEC. 3. Section 2360 of the Business and Professions Code is amended to read:~~

~~2360. It is the intent of the Legislature that the Osteopathic Medical Board of California seek ways and means to identify and rehabilitate osteopathic physicians and surgeons whose competency may be impaired due to abuse of dangerous drugs or alcohol or other substances, so that osteopathic physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner that will not endanger the public health and safety. It is also the intent of the Legislature that the Osteopathic Medical Board of California shall implement this legislation by establishing a diversion program as a voluntary alternative approach to traditional disciplinary actions.~~

~~SEC. 4. Section 2662 of the Business and Professions Code is amended to read:~~

~~2662. It is the intent of the Legislature that the board shall seek ways and means to identify and rehabilitate physical therapists and physical therapist assistants whose competency is impaired due to abuse of dangerous drugs or alcohol or other substances so that they may be treated and returned to the practice of physical therapy in a manner that will not endanger the public health and safety.~~

~~SEC. 5. Section 2770 of the Business and Professions Code is amended to read:~~

~~2770. It is the intent of the Legislature that the Board of Registered Nursing seek ways and means to identify and rehabilitate registered nurses whose competency may be impaired due to abuse of alcohol or drugs or other substances, or due to mental illness so that registered nurses so afflicted may be rehabilitated and returned to the practice of nursing in a manner~~

~~that will not endanger the public health and safety. It is also the intent of the Legislature that the Board of Registered Nursing shall implement this legislation by establishing a diversion program as a voluntary alternative to traditional disciplinary actions.~~

~~SEC. 6. Section 3534 of the Business and Professions Code is amended to read:~~

~~3534. (a) It is the intent of the Legislature that the examining committee shall seek ways and means to identify and rehabilitate physician assistants whose competency is impaired due to abuse of dangerous drugs or alcohol or other substances so that they may be treated and returned to the practice of medicine in a manner that will not endanger the public health and safety.~~

~~SEC. 7. Section 4360 of the Business and Professions Code is amended to read:~~

~~4360. The board shall operate a pharmacists recovery program to rehabilitate pharmacists and intern pharmacists whose competency may be impaired due to abuse of alcohol or other substances, drug use, or mental illness. The intent of the pharmacists recovery program is to return these pharmacists and intern pharmacists to the practice of pharmacy in a manner that will not endanger the public health and safety.~~

~~SEC. 8. Section 4860 of the Business and Professions Code is amended to read:~~

~~4860. It is the intent of the Legislature that the Veterinary Medical Board seek ways and means to identify and rehabilitate veterinarians and registered veterinary technicians with impairment due to abuse of dangerous drugs or alcohol or other substances, affecting competency so that veterinarians and registered veterinary technicians so afflicted may be treated and returned to the practice of veterinary medicine in a manner that will not endanger the public health and safety.~~

O

SB 1410

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1410
Author: Cedillo
Bill Date: February 19, 2010, introduced
Subject: Physician Assistants
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would delete the limitation that an applicant for licensure may only make four attempts to obtain a passing score on Step III of the United States Medical Licensing Examination (USMLE).

This bill has an urgency clause and would take effect immediately upon passage. This bill also contains provisions to make the removal of the limitation of attempts retroactive to January 1, 2007.

ANALYSIS:

Currently, applicants for licensure are required to pass Step III within four attempts in order to be eligible to be licensed as a physician in California. This bill would give applicants an unlimited number of attempts to take and ass the examination.

The limitation was established in 2006 by AB 1796 (Bermudez, Chapter 843) which was sponsored by the Board. In the interests of furthering the Board's mission of consumer protection, this limitation was deemed necessary to allow the Board to better assess applicants' ability to practice medicine safely. The requirement to past Step III within four attempts was designed to assure that physicians who are issued full and unrestricted licenses are current in their medical knowledge at the time they receive their initial license.

Subsequent legislation, SB 1048 (Chapter 588, 2007), included provisions to allow an applicant who obtains a passing score on Step III of the USMLE in more than four attempts to be considered for licensure if the applicant has been licensed in another state for at least four years. This bill would repeal these provisions as well as they would be unnecessary if applicants have unlimited attempts to pass the exam.

Previous study of the issue of physicians' ability to practice medicine safely with regard to the number of attempts needed to pass Step III of the USMLE indicate that there is a correlation between the number of times a physician has to take the exam to obtain a passing score and his or her competency as a physician. Of the physicians found to have taken Step III of the USMLE more than four times in order to pass, there were a large number found to be substandard by the report submitted to the Federation of State Medical Boards.

Allowing applicants for licensure unlimited attempts to pass Step III of the USMLE allows for substandard physicians to be practicing in California and puts patients at risk. The number of attempts needed to pass required exams is not disclosed to the public. Consumers do not know they are being treated by a physician who had to take the very exam that indicates their ability and readiness to treat them multiple times before they were considered adequate for licensure. In the interests of patient protection, the competency of a physician should be evaluated and questioned when that physician continues to retake Step III of the USMLE without any limitation. The current requirement of licensure in another state for four years with a clear record and board certification provides this consumer protection.

FISCAL: None

POSITION: Recommendation: Oppose

April 21, 2010

SENATE BILL No. 1410

Introduced by Senator Cedillo

February 19, 2010

An act to amend Section 2177 of, and to add Sections 2177.5 and 2177.7 to, the Business and Professions Code, relating to medicine, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 1410, as introduced, Cedillo. Medicine: licensure examinations.

Existing law, the Medical Practice Act, requires the Medical Board of California to issue a physician's and surgeon's certificate to a qualified applicant. Under the act, an applicant for a physician's and surgeon's certificate is required to include specified information with his or her application and to obtain a passing score on an entire examination or on each part of an examination. Existing law authorizes applicants to take the written examinations conducted or accepted by the board in separate parts. Existing law requires an applicant to obtain a passing score on Part III of the United States Medical Licensing Examination within not more than 4 attempts of taking that part of the examination.

This bill would delete the prohibition on taking Part III of the United States Medical Licensing Examination more than 4 times, and would make that change retroactive to January 1, 2007. The bill would also require the board to accept as a passing score from an applicant the passing score that was adopted by the board and in effect on the date the applicant registered for that examination or part of the examination, and would make that requirement retroactive to January 1, 2007. The bill would further require the board to adopt a formal process for determining whether to adopt recommended passing scores from the Federation of State Medical Boards.

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

Vote: ⅔. 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) Under Section 2177 of the Business and Professions Code,
4 an applicant who is seeking a physician's and surgeon's certificate
5 in California must obtain a passing score on Part III of the United
6 States Medical Licensing Examination (USMLE) within not more
7 than four attempts in order to be eligible for a certificate. The
8 examination has three parts. However, only Part III has a limit on
9 the number of times that an applicant may attempt to pass the part.
10 (b) The USMLE is administered by the Federation of State
11 Medical Boards (FSMB), a national nonprofit entity. Periodically,
12 the FSMB recommends passing scores to the various state medical
13 boards. It is left to the discretion of each state board to determine
14 whether to adopt the recommended score. Historically, the Medical
15 Board of California (MBC) has not had a formal procedure
16 regarding adoption of the FSMB recommended passing score.
17 (c) When an applicant registers for the USMLE, he or she has
18 an eligibility period of three months in which to take the
19 examination. Multiple examination dates are available within the
20 three-month period. The lack of a formal adoption process within
21 the MBC combined with a three-month window to take the
22 examination after registration has created some confusion as the
23 MBC may increase the accepted passing score at any time without
24 public record, input, or notification to applicants that have already
25 registered for the examination. In fact, there is an instance where
26 an applicant registered for the USMLE under one passing score
27 and found out after her examination date that the accepted passing
28 score had been increased without her knowledge. This applicant
29 would have passed the examination under the criteria in place
30 when she registered for the examination but because the passing
31 score was increased between the time she registered and sat for
32 the examination, she did not pass.

(d) Furthermore, prior to the enactment of Chapter 843 of the Statutes of 2006 (AB 1796), California did not limit the number of times an applicant may take any part of the USMLE. Under the new law, which places an arbitrary limit of attempts on Part III of the examination, highly qualified and much needed physicians and surgeons are being denied a license to practice medicine in California. Their only option is to move to another state, become licensed and practice there, and return four years later.

(e) Failing to pass the USMLE under an arbitrary cap on the number of attempts does not translate into a lack of competency in providing high-quality medical care. Furthermore, existing law does not take into consideration learning disabilities, a history of poor performance on standardized tests, hardships, or other variables that may impede the ability of an individual to pass the examination, essentially discriminating against certain applicants.

(f) Twenty-eight states in the United States and one territory have more lenient policies regarding the USMLE, which may include having no cap or allowing for more attempts than California. Those states and the one territory include AL, AZ, CO, CT, DE, FL, GU, HI, IA, IL, KS, MA, MI, MN, MS, MT, NM, NV, NJ, NY, NC, ND, OH, OK, PA, TN, VA, VI, and WY. In fact, AZ, CO, CT, DE, GU, HI, IA, KS, MA, MI, MN, MS, MT, NJ, NY, NC, ND, OH, PA, TN, VI, VA, and WY have no limit on the number of times an applicant may take the examination.

(g) Lastly, even though AB 1796 was signed by the Governor, he expressed concerns with the measure. The Governor issued a signing message stating that AB 1796 failed to provide the appropriate exceptions to the requirement that physicians and surgeons applying for licensure pass Part III of the USMLE within four attempts, and that AB 1796 may have unintended consequences. The Governor requested that the MBC address his concerns. Subsequently, the MBC requested that language be added to Section 2177 of the Business and Professions Code that would cross-reference Section 2135.5 of the Business and Professions Code to exempt from the four-attempt limitation an applicant who holds an unlimited and restricted license as a physician and surgeon in another state and who has held that license continuously for a minimum of four years prior to the date of application. This amendment was added by Chapter 588 of the Statutes of 2007 (SB

1048), which was an omnibus bill for the Senate Committee on Business and Professions.

(h) The inclusion of those changes by SB 1048 has proven to be an inadequate approach to addressing the need for flexibility and consideration of other factors that may contribute to an individual failing to pass Part III of the USMLE within four attempts. It is now viewed by the Legislature as unreasonable to require an individual to leave the state, go through all the steps necessary to obtain licensure in another state, and then return to California after four years to obtain a license to practice medicine.

(i) It is further unreasonable for the MBC to change the passing score for an examination once an applicant has registered for that examination without any formal procedure or notification to the applicant.

SEC. 2. Section 2177 of the Business and Professions Code is amended to read:

2177. (a) A passing score is required for an entire examination or for each part of an examination, as established by resolution of the ~~Division of Licensing~~ *board.*

(b) Applicants may elect to take the written examinations conducted or accepted by the ~~division~~ *board* in separate parts.

(c) ~~(1)~~ An applicant shall have obtained a passing score on Part III of the United States Medical Licensing Examination ~~within not more than four attempts~~ in order to be eligible for a physician's and surgeon's certificate.

~~(2) Notwithstanding paragraph (1), an applicant who obtains a passing score on Part III of the United States Medical Licensing Examination in more than four attempts and who meets the requirements of Section 2135.5 shall be eligible to be considered for issuance of a physician's and surgeon's certificate.~~

(d) The changes made to subdivision (c) by the act adding this subdivision shall apply retroactively to January 1, 2007.

SEC. 3. Section 2177.5 is added to the Business and Professions Code, to read:

2177.5. (a) Notwithstanding subdivision (a) of Section 2177, the board shall accept as a passing score on an examination or part of an examination from an applicant the passing score that was adopted by the board and in effect on the date the applicant registered for that examination or part of the examination.

(b) This section shall apply retroactively to January 1, 2007.

1 SEC. 4. Section 2177.7 is added to the Business and Professions
2 Code, to read:
3 2177.7. The board shall adopt a formal process for determining
4 whether to adopt recommended passing scores from the Federation
5 of State Medical Boards.
6 SEC. 5. This act is an urgency statute necessary for the
7 immediate preservation of the public peace, health, or safety within
8 the meaning of Article IV of the Constitution and shall go into
9 immediate effect. The facts constituting the necessity are:
10 In order to allow for the licensure of competent physicians and
11 surgeons at the earliest possible time, it is necessary that this act
12 take effect immediately.

O

SB 1489

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1489
Author: Committee on Business, Professions, and Economic Development
Bill Date: April 5, 2010, amended
Subject: Omnibus
Sponsor: Committee

STATUS OF BILL:

This bill is in the Senate Business, Professions and Economic Development Committee.

DESCRIPTION OF CURRENT 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):

- **2062 & 2177** – Deletes obsolete references to licensing exams. The Board no longer administers exams
- **2096 & 2102** – Reinstates postgraduate training requirement for licensure.
- **2184** – Allows the Board to consider good cause or reason, or time spent in various training programs when addressing the validity of the written examination scores require for licensure.
- **2516** – Clarifies provisions related to the reporting requirements for licensed midwives.

The Board's Midwifery provision, clarifying certain provisions in the reporting statute, is expected to be placed into the bill when it is amended.

FISCAL: None to MBC

POSITION: Support MBC Provisions

April 17, 2010

AMENDED IN SENATE APRIL 5, 2010

SENATE BILL No. 1489

Introduced by Committee on Business, Professions and Economic Development (Senators Negrete McLeod (Chair), Aanestad, Calderon, Correa, Florez, Oropeza, Walters, Wyland, and Yee)

March 11, 2010

An act to amend Sections 2065, 2096, 2102, 2103, 2177, 2184, ~~2397~~, 2570.19, 3025.1, 3046, 3057.5, 3147, 3147.6, 3147.7, 4017, 4028, 4037, 4052.3, 4059, 4072, 4101, 4119, 4127.1, 4169, 4181, 4191, 4196, 4425, 4426, 4980.40.5, 4980.43, 4980.80, 4982.25, 4984.8, 4989.54, 4990.02, 4990.12, 4990.18, 4990.22, 4990.30, 4990.38, 4992.36, 4996.17, 4996.23, 4999.46, 4999.58, and 4999.90 of, to add Section 4200.1 to, to add and repeal Sections 4999.57 and 4999.59 of, to repeal Sections *2026,* 4980.07, 4982.2, and 4984.6 of, and to repeal Article 3 (commencing with Section 4994) of Chapter 14 of Division 2 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1489, as amended, Committee on Business, Professions and Economic Development. Healing arts.

(1) Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California ~~and for the licensure and regulation of podiatrists by the California Board of Podiatric Medicine within the Medical Board of California~~. Existing ~~law exempts a licensee of either of those boards from liability for civil damages for acts or omissions by the licensee in rendering specified emergency care and for injury or death caused in an emergency situation occurring in the licensee's office or a hospital on account of a failure to inform a patient of the possible consequences~~

~~of a medical procedure, as specified. Existing law prohibits construing these provisions to authorize a podiatrist to act beyond certain scope of practice limitations.~~

~~This bill would delete that prohibition.~~

~~Existing~~

law requires an applicant for a physician's and surgeon's certificate whose professional instruction was acquired in a country other than the United States or Canada to provide evidence satisfactory to the board of, among other things, satisfactory completion of at least one year of specified postgraduate training.

This bill would require the applicant to instead complete at least 2 years of that postgraduate training.

Existing law requires an applicant for a physician's and surgeon's certificate to obtain a passing score on the written examination designated by the board and makes passing scores on a written examination valid for 10 years from the month of the examination for purposes of qualification for a license. Existing law authorizes the board to extend this period of validity for good cause or for time spent in a postgraduate training program.

This bill would limit this 10-year period of validity to passing scores obtained on Step 3 of the United States Medical Licensing Examination and would also authorize the board to extend that period for applicants who hold a valid, unlimited license as a physician and surgeon in another state or a Canadian province and have actively practiced medicine in that state or province.

(2) Existing law, the Optometry Practice Act, provides for the licensure and regulation of optometrists by the State Board of Optometry. Existing law authorizes the renewal of an expired license within 3 years after its expiration if the licensee files an application for renewal and pays all accrued and unpaid renewal fees and the delinquency fee prescribed by the board.

This bill would also require the licensee to submit proof of completion of the required hours of continuing education for the last 2 years.

Existing law authorizes the restoration of a license that is not renewed within 3 years after its expiration if the holder of the expired license, among other requirements, passes the clinical portion of the regular examination of applicants, or other clinical examination approved by the board, and pays a restoration fee equal to the renewal fee in effect on the last regular renewal date for licenses.

This bill would instead require the holder of the expired license to take the National Board of Examiners in Optometry's Clinical Skills examination, or other clinical examination approved by the board, and to also pay any delinquency fees prescribed by the board.

Existing law alternatively authorizes the restoration of a license that is not renewed within 3 years after its expiration if the person provides proof that he or she holds an active license from another state, files an application for renewal, and pays the accrued and unpaid renewal fees and the delinquency fee prescribed by the board.

This bill would also require the person to submit proof of completion of the required hours of continuing education for the last 2 years and take and satisfactorily pass the board's jurisprudence examination. The bill would also require that the person not have committed specified crimes or acts constituting grounds for licensure denial.

(3) Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy and requires an applicant for a license to pass a national licensure examination and the board's jurisprudence examination. Existing law prohibits boards in the Department of Consumer Affairs from restricting an applicant who failed a licensure examination from taking the examination again, except as specified.

This bill would authorize an applicant for a pharmacist license to take the licensure examination and the jurisprudence examination 4 times each. The bill would also authorize the applicant to take those examinations 4 additional times each if additional pharmacy coursework is completed, as specified.

(4) Existing law provides for the licensure and regulation of marriage and family therapists, licensed clinical social workers, educational psychologists, and professional clinical counselors by the Board of Behavioral Sciences. Existing law authorizes a licensed marriage and family therapist, licensed clinical social worker, or licensed educational psychologist whose license has been revoked, suspended, or placed on probation to petition the board for reinstatement or modification of the penalty, as specified. Existing law also authorizes the board to deny an application or suspend or revoke those licenses due to the revocation, suspension, or restriction by the board of a license to practice as a clinical social worker, marriage and family therapist, or educational psychologist.

This bill would make those provisions apply with respect to licensed professional clinical counseling, as specified.

Existing law requires an applicant applying for a marriage and family therapist license to complete a minimum of 3,000 hours of experience during a period of at least 104 weeks. Existing law requires that this experience consist of at least 500 hours of experience in diagnosing and treating couples, families, and children, and requires that an applicant be credited with 2 hours of experience for each hour of therapy provided for the first 150 hours of treating couples and families in conjoint therapy.

This bill would instead require that an applicant receive that 2-hour credit for up to 150 hours of treating couples and families in conjoint therapy.

Existing law requires an applicant for a professional clinical counselor license to complete a minimum of 3,000 hours of clinical mental health experience under the supervision of an approved supervisor and prohibits a supervisor from supervising more than 2 interns.

This bill would prohibit the board from crediting an applicant for experience obtained under the supervision of a spouse or relative by blood or marriage, or a person with whom the applicant has had or currently has a personal, professional, or business relationship that undermines the authority or effectiveness of the supervision. The bill would also delete the provision prohibiting a supervisor from supervising more than 2 interns.

Existing law requires an intern to receive an average of at least one hour of direct supervisor contact for every 10 hours of client contact in each setting and authorizes an intern working in a governmental entity, a school, college, or university, or a nonprofit and charitable institution to obtain up to 30 hours of the required weekly direct supervisor contract via two-way, real time videoconferencing.

This bill would delete that 30-hour limit and would require an intern to receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of face-to-face psychotherapy, as defined, is performed in each setting in which experience is obtained.

Existing law imposes specified requirements with respect to persons who apply for a professional clinical counselor license between January 1, 2011, and December 31, 2013, inclusive. With respect to those applicants, existing law authorizes the board to accept experience gained outside of California if it is substantially equivalent to that required by the Licensed Professional Clinical Counselor Act and if the applicant has gained a minimum of 250 hours of supervised clinical experience

in direct counseling in California while registered as an intern with the board.

This bill would eliminate that 250-hour requirement with respect to persons with a counseling license in another jurisdiction, as specified, who have held that license for at least 2 years immediately prior to applying with the board.

Existing law authorizes the board to refuse to issue or suspend or revoke a professional clinical counselor license or intern registration if the licensee or registrant has been guilty of unprofessional conduct, as specified.

This bill would specify that unprofessional conduct includes (1) engaging in conduct that subverts a licensing examination, (2) revocation, suspension, or restriction by the board of a license to practice as a clinical social worker, educational psychologist, or marriage and family therapist, and (3) conduct in the supervision of an associate clinical social worker that violates the profession's governing professional clinical counseling or regulations of the board.

The bill would make other technical, nonsubstantive changes in various provisions governing the healing arts and would delete certain obsolete and duplicative language.

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 2026 of the Business and Professions*
2 *Code is repealed.*
3 ~~2026. The California Research Bureau (CRB) of the California~~
4 ~~State Library shall study the role of public disclosure in the public~~
5 ~~protection mandate of the board. The ensuing CRB report shall~~
6 ~~include, but not be limited to, considering whether the public is~~
7 ~~adequately informed about physician misconduct by the current~~
8 ~~laws and regulations providing for disclosure. The study shall~~
9 ~~present policy options for improving public access. The board shall~~
10 ~~work cooperatively with the CRB, providing cost-free access and~~
11 ~~reproduction assistance to the board's records while protecting the~~
12 ~~identity and privacy of all persons involved in any complaint. The~~
13 ~~provision of confidential data, information, and case files by the~~
14 ~~board to the CRB shall not constitute a waiver of any exemption~~
15 ~~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. Data will be presented in aggregate categories. This study shall be commenced as soon as possible and a report to the Legislature completed no later than July 1, 2008.~~

~~SECTION 1.~~

SEC. 2. Section 2065 of the Business and Professions Code is amended to read:

2065. Unless otherwise provided by law, no postgraduate trainee, intern, resident, postdoctoral fellow, or instructor may engage in the practice of medicine, or receive compensation therefor, or offer to engage in the practice of medicine unless he or she holds a valid, unrevoked, and unsuspended physician's and surgeon's certificate issued by the board. However, a graduate of an approved medical school, who is registered with the board and who is enrolled in a postgraduate training program approved by the board, may engage in the practice of medicine whenever and wherever required as a part of the program under the following conditions:

(a) A graduate enrolled in an approved first-year postgraduate training program may so engage in the practice of medicine for a period not to exceed one year whenever and wherever required as a part of the training program, and may receive compensation for that practice.

(b) A graduate who has completed the first year of postgraduate training may, in an approved residency or fellowship, engage in the practice of medicine whenever and wherever required as part of that residency or fellowship, and may receive compensation for that practice. The resident or fellow shall qualify for, take, and pass the next succeeding written examination for licensure, or shall qualify for and receive a physician's and surgeon's certificate by one of the other methods specified in this chapter. If the resident or fellow fails to receive a license to practice medicine under this chapter within one year from the commencement of the residency or fellowship or if the board denies his or her application for licensure, all privileges and exemptions under this section shall automatically cease.

~~SEC. 2.~~

SEC. 3. Section 2096 of the Business and Professions Code is amended to read:

2096. (a) 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), except as provided in subdivision (b), shall show by evidence satisfactory to the board that he or she has satisfactorily completed at least one year of postgraduate training.

(b) An applicant applying pursuant to Section 2102 shall show by evidence satisfactory to the board that he or she has satisfactorily completed at least two years of postgraduate training.

(c) The postgraduate training required by this section shall include at least four months of general medicine and shall be obtained 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).

(d) 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. 3.~~

SEC. 4. Section 2102 of the Business and Professions Code is amended to read:

2102. An 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 subdivision (b) of 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) Passage of 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.

(e) Nothing in this section prohibits the board from disapproving a 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. 4.~~

SEC. 5. Section 2103 of the Business and Professions Code is amended to read:

2103. An applicant who is a citizen of the United States shall be eligible for a physician's and surgeon's certificate if he or she has completed the following requirements:

(a) Submitted official evidence satisfactory to the board of completion of a resident course or professional instruction equivalent to that required in Section 2089 in a medical school located outside the United States or Canada. 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).

(b) Submitted official evidence satisfactory to the board of completion of all formal requirements of the medical school for graduation, except the applicant shall not be required to have completed an internship or social service or be admitted or licensed

to practice medicine in the country in which the professional instruction was completed.

(c) Attained a score satisfactory to an approved medical school on a qualifying examination acceptable to the board.

(d) Successfully completed one academic year of supervised clinical training in a program approved by the board pursuant to Section 2104. The board shall also recognize as compliance with this subdivision the successful completion of a one-year supervised clinical medical internship operated by a medical school pursuant to Chapter 85 of the Statutes of 1972 and as amended by Chapter 888 of the Statutes of 1973 as the equivalent of the year of supervised clinical training required by this section.

(1) Training received in the academic year of supervised clinical training approved pursuant to Section 2104 shall be considered as part of the total academic curriculum for purposes of meeting the requirements of Sections 2089 and 2089.5.

(2) An applicant who has passed the basic science and English language examinations required for certification by the Educational Commission for Foreign Medical Graduates may present evidence of those passing scores along with a certificate of completion of one academic year of supervised clinical training in a program approved by the board pursuant to Section 2104 in satisfaction of the formal certification requirements of subdivision (b) of Section 2102.

(e) Satisfactorily completed the postgraduate training required under Section 2096.

(f) Passed the written examination required for certification as a physician and surgeon under this chapter.

~~SEC. 5.~~

SEC. 6. Section 2177 of the Business and Professions Code is amended to read:

2177. (a) A passing score is required for an entire examination or for each part of an examination, as established by resolution of the board.

(b) Applicants may elect to take the written examinations conducted or accepted by the board in separate parts.

(c) (1) An applicant shall have obtained a passing score on Step 3 of the United States Medical Licensing Examination within not more than four attempts in order to be eligible for a physician's and surgeon's certificate.

(2) Notwithstanding paragraph (1), an applicant who obtains a passing score on Step 3 of the United States Medical Licensing Examination in more than four attempts and who meets the requirements of Section 2135.5 shall be eligible to be considered for issuance of a physician's and surgeon's certificate.

~~SEC. 6.~~

SEC. 7. Section 2184 of the Business and Professions Code is amended to read:

2184. (a) Each applicant shall obtain on the written examination a passing score, established by the board pursuant to Section 2177.

(b) (1) Passing scores on Step 3 of the United States Medical Licensing Examination shall be valid for a period of 10 years from the month of the examination for purposes of qualification for licensure in California.

(2) The period of validity provided for in paragraph (1) may be extended by the board for any of the following:

(A) For good cause.

(B) For time spent in a postgraduate training program, including, but not limited to, residency training, fellowship training, remedial or refresher training, or other training that is intended to maintain or improve medical skills.

(C) For an applicant who holds a valid, unlimited license as a physician and surgeon in another state or a Canadian province and has actively practiced medicine in that state or province.

(3) Upon expiration of the 10-year period plus any extension granted by the board under paragraph (2), the applicant shall pass the Special Purpose Examination of the Federation of State Medical Boards or a clinical competency written examination determined by the board to be equivalent.

~~SEC. 7. Section 2397 of the Business and Professions Code is amended to read:~~

~~2397. (a) A licensee shall not be liable for civil damages for injury or death caused in an emergency situation occurring in the licensee's office or in a hospital on account of a failure to inform a patient of the possible consequences of a medical procedure where the failure to inform is caused by any of the following:~~

~~(1) The patient was unconscious.~~

~~(2) The medical procedure was undertaken without the consent of the patient because the licensee reasonably believed that a~~

~~medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient.~~

~~(3) A medical procedure was performed on a person legally incapable of giving consent, and the licensee reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of a person authorized to give such consent for the patient.~~

~~(b) This section is applicable only to actions for damages for injuries or death arising because of a licensee's failure to inform, and not to actions for damages arising because of a licensee's negligence in rendering or failing to render treatment.~~

~~(c) As used in this section:~~

~~(1) "Hospital" means a licensed general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code.~~

~~(2) "Emergency situation occurring in the licensee's office" means a situation occurring in an office, other than a hospital, used by a licensee for the examination or treatment of patients, requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death.~~

~~(3) "Emergency situation occurring in a hospital" means a situation occurring in a hospital, whether or not it occurs in an emergency room, requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death.~~

SEC. 8. Section 2570.19 of the Business and Professions Code is amended to read:

2570.19. (a) There is hereby created a California Board of Occupational Therapy, hereafter referred to as the board. The board shall enforce and administer this chapter.

(b) The members of the board shall consist of the following:

(1) Three occupational therapists who shall have practiced occupational therapy for five years.

(2) One occupational therapy assistant who shall have assisted in the practice of occupational therapy for five years.

(3) Three public members who shall not be licentiates of the board or of any board referred to in Section 1000 or 3600.

(c) The Governor shall appoint the three occupational therapists and one occupational therapy assistant to be members of the board. The Governor, the Senate Committee on Rules, and the Speaker of the Assembly shall each appoint a public member. Not more than one member of the board shall be appointed from the full-time faculty of any university, college, or other educational institution.

(d) All members shall be residents of California at the time of their appointment. The occupational therapist and occupational therapy assistant members shall have been engaged in rendering occupational therapy services to the public, teaching, or research in occupational therapy for at least five years preceding their appointments.

(e) The public members may not be or have ever been occupational therapists or occupational therapy assistants or in training to become occupational therapists or occupational therapy assistants. The public members may not be related to, or have a household member who is, an occupational therapist or an occupational therapy assistant, and may not have had, within two years of the appointment, a substantial financial interest in a person regulated by the board.

(f) The Governor shall appoint two board members for a term of one year, two board members for a term of two years, and one board member for a term of three years. Appointments made thereafter shall be for four-year terms, but no person shall be appointed to serve more than two consecutive terms. Terms shall begin on the first day of the calendar year and end on the last day of the calendar year or until successors are appointed, except for the first appointed members who shall serve through the last calendar day of the year in which they are appointed, before commencing the terms prescribed by this section. Vacancies shall be filled by appointment for the unexpired term. The board shall annually elect one of its members as president.

(g) The board shall meet and hold at least one regular meeting annually in the Cities of Sacramento, Los Angeles, and San Francisco. The board may convene from time to time until its business is concluded. Special meetings of the board may be held at any time and place designated by the board.

(h) Notice of each meeting of the board shall be given in accordance with the Bagley-Keene Open Meeting Act (Article 9

(commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(i) Members of the board shall receive no compensation for their services, but shall be entitled to reasonable travel and other expenses incurred in the execution of their powers and duties in accordance with Section 103.

(j) The appointing power shall have the power to remove any member of the board from office for neglect of any duty imposed by state law, for incompetency, or for unprofessional or dishonorable conduct.

(k) This section shall become inoperative on July 1, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute that is enacted before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed. The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473).

SEC. 9. Section 3025.1 of the Business and Professions Code is amended to read:

3025.1. The board may adopt rules and regulations that are, in its judgment, reasonable and necessary to ensure that optometrists have the knowledge to adequately protect the public health and safety by establishing educational requirements for admission to the examinations for licensure.

SEC. 10. Section 3046 of the Business and Professions Code is amended to read:

3046. In order to obtain a license to practice optometry in California, an applicant shall have graduated from an accredited school of optometry, passed the required examinations for licensure, and not have met any of the grounds for denial established in Section 480. The proceedings under this section shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 11. Section 3057.5 of the Business and Professions Code is amended to read:

3057.5. Notwithstanding any other provision of this chapter, the board shall permit a person who meets all of the following requirements to take the examinations for a certificate of registration as an optometrist:

(a) Is over the age of 18 years.

(b) Is not subject to denial of a certificate under Section 480.

(c) Has a degree as a doctor of optometry issued by a university located outside of the United States.

SEC. 12. Section 3147 of the Business and Professions Code is amended to read:

3147. Except as otherwise provided by Section 114, an expired license may be renewed at any time within three years after its expiration by filing an application for renewal on a form prescribed by the board, paying all accrued and unpaid renewal fees, paying any delinquency fees prescribed by the board, and submitting proof of completion of the required number of hours of continuing education for the last two years, as prescribed by the board pursuant to Section 3159. Renewal under this section shall be effective on the date on which all of those requirements are satisfied. If so renewed, the license shall continue as provided in Sections 3146 and 3147.5.

SEC. 13. Section 3147.6 of the Business and Professions Code is amended to read:

3147.6. Except as otherwise provided by Section 114, a license that is not renewed within three years after its expiration may be restored thereafter, if no fact, circumstance, or condition exists that, if the license were restored, would justify its revocation or suspension, provided all of the following conditions are met:

(a) The holder of the expired license is not subject to denial of a license under Section 480.

(b) The holder of the expired license applies in writing for its restoration on a form prescribed by the board.

(c) The holder of the expired license pays the fee or fees as would be required of him or her if he or she were then applying for a license for the first time.

(d) The holder of the expired license satisfactorily passes both of the following examinations:

(1) The National Board of Examiners in Optometry's Clinical Skills examination or other clinical examination approved by the board.

(2) The board's jurisprudence examination.

(e) After taking and satisfactorily passing the examinations identified in subdivision (d), the holder of the expired license pays a restoration fee equal to the sum of the license renewal fee in effect on the last regular renewal date for licenses and any delinquency fees prescribed by the board.

SEC. 14. Section 3147.7 of the Business and Professions Code is amended to read:

3147.7. The provisions of Section 3147.6 shall not apply to a person holding a license that has not been renewed within three years of expiration, if the person provides satisfactory proof that he or she holds an active license from another state and meets all of the following conditions:

(a) Is not subject to denial of a license under Section 480.

(b) Applies in writing for restoration of the license on a form prescribed by the board.

(c) Pays all accrued and unpaid renewal fees and any delinquency fees prescribed by the board.

(d) Submits proof of completion of the required number of hours of continuing education for the last two years.

(e) Takes and satisfactorily passes the board's jurisprudence examination.

SEC. 15. Section 4017 of the Business and Professions Code is amended to read:

4017. "Authorized officers of the law" means inspectors of the California State Board of Pharmacy, inspectors of the Food and Drug Branch of the State Department of Public Health, and investigators of the department's Division of Investigation or peace officers engaged in official investigations.

SEC. 16. Section 4028 of the Business and Professions Code is amended to read:

4028. "Licensed hospital" means an institution, place, building, or agency that maintains and operates organized facilities for one or more persons for the diagnosis, care, and treatment of human illnesses to which persons may be admitted for overnight stay, and includes any institution classified under regulations issued by the State Department of Public Health as a general or specialized hospital, as a maternity hospital, or as a tuberculosis hospital, but does not include a sanitarium, rest home, a nursing or convalescent home, a maternity home, or an institution for treating alcoholics.

SEC. 17. Section 4037 of the Business and Professions Code is amended to read:

4037. (a) "Pharmacy" means an area, place, or premises licensed by the board in which the profession of pharmacy is practiced and where prescriptions are compounded. "Pharmacy" includes, but is not limited to, any area, place, or premises

1 described in a license issued by the board wherein controlled
2 substances, dangerous drugs, or dangerous devices are stored,
3 possessed, prepared, manufactured, derived, compounded, or
4 repackaged, and from which the controlled substances, dangerous
5 drugs, or dangerous devices are furnished, sold, or dispensed at
6 retail.
7 (b) "Pharmacy" shall not include any area in a facility licensed
8 by the State Department of Public Health where floor supplies,
9 ward supplies, operating room supplies, or emergency room
10 supplies of dangerous drugs or dangerous devices are stored or
11 possessed solely for treatment of patients registered for treatment
12 in the facility or for treatment of patients receiving emergency care
13 in the facility.
14 SEC. 18. Section 4052.3 of the Business and Professions Code
15 is amended to read:
16 4052.3. (a) Notwithstanding any other provision of law, a
17 pharmacist may furnish emergency contraception drug therapy in
18 accordance with either of the following:
19 (1) Standardized procedures or protocols developed by the
20 pharmacist and an authorized prescriber who is acting within his
21 or her scope of practice.
22 (2) Standardized procedures or protocols developed and
23 approved by both the board and the Medical Board of California
24 in consultation with the American College of Obstetricians and
25 Gynecologists, the California Pharmacist Association, and other
26 appropriate entities. Both the board and the Medical Board of
27 California shall have authority to ensure compliance with this
28 clause, and both boards are specifically charged with the
29 enforcement of this provision with respect to their respective
30 licensees. Nothing in this clause shall be construed to expand the
31 authority of a pharmacist to prescribe any prescription medication.
32 (b) Prior to performing a procedure authorized under this
33 paragraph, a pharmacist shall complete a training program on
34 emergency contraception that consists of at least one hour of
35 approved continuing education on emergency contraception drug
36 therapy.
37 (c) A pharmacist, pharmacist's employer, or pharmacist's agent
38 may not directly charge a patient a separate consultation fee for
39 emergency contraception drug therapy services initiated pursuant
40 to this paragraph, but may charge an administrative fee not to

exceed ten dollars ($10) above the retail cost of the drug. Upon an oral, telephonic, electronic, or written request from a patient or customer, a pharmacist or pharmacist's employee shall disclose the total retail price that a consumer would pay for emergency contraception drug therapy. As used in this subparagraph, total retail price includes providing the consumer with specific information regarding the price of the emergency contraception drugs and the price of the administrative fee charged. This limitation is not intended to interfere with other contractually agreed-upon terms between a pharmacist, a pharmacist's employer, or a pharmacist's agent, and a health care service plan or insurer. Patients who are insured or covered and receive a pharmacy benefit that covers the cost of emergency contraception shall not be required to pay an administrative fee. These patients shall be required to pay copayments pursuant to the terms and conditions of their coverage. The provisions of this subparagraph shall cease to be operative for dedicated emergency contraception drugs when these drugs are reclassified as over-the-counter products by the federal Food and Drug Administration.

(d) A pharmacist may not require a patient to provide individually identifiable medical information that is not specified in Section 1707.1 of Title 16 of the California Code of Regulations before initiating emergency contraception drug therapy pursuant to this section.

(e) For each emergency contraception drug therapy initiated pursuant to this section, the pharmacist shall provide the recipient of the emergency contraception drugs with a standardized factsheet that includes, but is not limited to, the indications for use of the drug, the appropriate method for using the drug, the need for medical followup, and other appropriate information. The board shall develop this form in consultation with the State Department of Public Health, the American College of Obstetricians and Gynecologists, the California Pharmacists Association, and other health care organizations. The provisions of this section do not preclude the use of existing publications developed by nationally recognized medical organizations.

SEC. 19. Section 4059 of the Business and Professions Code is amended to read:

4059. (a) A person may not furnish any dangerous drug, except upon the prescription of a physician, dentist, podiatrist, optometrist,

1 veterinarian, or naturopathic doctor pursuant to Section 3640.7. A
2 person may not furnish any dangerous device, except upon the
3 prescription of a physician, dentist, podiatrist, optometrist,
4 veterinarian, or naturopathic doctor pursuant to Section 3640.7.
5 (b) This section does not apply to the furnishing of any
6 dangerous drug or dangerous device by a manufacturer, wholesaler,
7 or pharmacy to each other or to a physician, dentist, podiatrist,
8 optometrist, veterinarian, or naturopathic doctor pursuant to Section
9 3640.7, or to a laboratory under sales and purchase records that
10 correctly give the date, the names and addresses of the supplier
11 and the buyer, the drug or device, and its quantity. This section
12 does not apply to the furnishing of any dangerous device by a
13 manufacturer, wholesaler, or pharmacy to a physical therapist
14 acting within the scope of his or her license under sales and
15 purchase records that correctly provide the date the device is
16 provided, the names and addresses of the supplier and the buyer,
17 a description of the device, and the quantity supplied.
18 (c) A pharmacist, or a person exempted pursuant to Section
19 4054, may distribute dangerous drugs and dangerous devices
20 directly to dialysis patients pursuant to regulations adopted by the
21 board. The board shall adopt any regulations as are necessary to
22 ensure the safe distribution of these drugs and devices to dialysis
23 patients without interruption thereof. A person who violates a
24 regulation adopted pursuant to this subdivision shall be liable upon
25 order of the board to surrender his or her personal license. These
26 penalties shall be in addition to penalties that may be imposed
27 pursuant to Section 4301. If the board finds any dialysis drugs or
28 devices distributed pursuant to this subdivision to be ineffective
29 or unsafe for the intended use, the board may institute immediate
30 recall of any or all of the drugs or devices distributed to individual
31 patients.
32 (d) Home dialysis patients who receive any drugs or devices
33 pursuant to subdivision (c) shall have completed a full course of
34 home training given by a dialysis center licensed by the State
35 Department of Public Health. The physician prescribing the dialysis
36 products shall submit proof satisfactory to the manufacturer or
37 wholesaler that the patient has completed the program.
38 (e) A pharmacist may furnish a dangerous drug authorized for
39 use pursuant to Section 2620.3 to a physical therapist. A record
40 containing the date, name and address of the buyer, and name and

quantity of the drug shall be maintained. This subdivision shall not be construed to authorize the furnishing of a controlled substance.

(f) A pharmacist may furnish electroneuromyographic needle electrodes or hypodermic needles used for the purpose of placing wire electrodes for kinesiological electromyographic testing to physical therapists who are certified by the Physical Therapy Board of California to perform tissue penetration in accordance with Section 2620.5.

(g) Nothing in this section shall be construed as permitting a licensed physical therapist to dispense or furnish a dangerous device without a prescription of a physician, dentist, podiatrist, optometrist, or veterinarian.

(h) A veterinary food-animal drug retailer shall dispense, furnish, transfer, or sell veterinary food-animal drugs only to another veterinary food-animal drug retailer, a pharmacy, a veterinarian, or to a veterinarian's client pursuant to a prescription from the veterinarian for food-producing animals.

SEC. 20. Section 4072 of the Business and Professions Code is amended to read:

4072. (a) Notwithstanding any other provision of law, a pharmacist, registered nurse, licensed vocational nurse, licensed psychiatric technician, or other healing arts licentiate, if so authorized by administrative regulation, who is employed by or serves as a consultant for a licensed skilled nursing, intermediate care, or other health care facility, may orally or electronically transmit to the furnisher a prescription lawfully ordered by a person authorized to prescribe drugs or devices pursuant to Sections 4040 and 4070. The furnisher shall take appropriate steps to determine that the person who transmits the prescription is authorized to do so and shall record the name of the person who transmits the order. This section shall not apply to orders for Schedule II controlled substances.

(b) In enacting this section, the Legislature recognizes and affirms the role of the State Department of Public Health in regulating drug order processing requirements for licensed health care facilities as set forth in Title 22 of the California Code of Regulations as they may be amended from time to time.

SEC. 21. Section 4101 of the Business and Professions Code is amended to read:

4101. (a) A pharmacist may take charge of and act as the pharmacist-in-charge of a pharmacy upon application by the pharmacy and approval by the board. Any pharmacist-in-charge who ceases to act as the pharmacist-in-charge of the pharmacy shall notify the board in writing within 30 days of the date of that change in status.

(b) A designated representative or a pharmacist may take charge of, and act as, the designated representative-in-charge of a wholesaler or veterinary food-animal drug retailer upon application by the wholesaler or veterinary food-animal drug retailer and approval by the board. Any designated representative-in-charge who ceases to act as the designated representative-in-charge at that entity shall notify the board in writing within 30 days of the date of that change in status.

SEC. 22. Section 4119 of the Business and Professions Code is amended to read:

4119. (a) Notwithstanding any other provision of law, a pharmacy may furnish a dangerous drug or dangerous device to a licensed health care facility for storage in a secured emergency pharmaceutical supplies container maintained within the facility in accordance with facility regulations of the State Department of Public Health set forth in Title 22 of the California Code of Regulations and the requirements set forth in Section 1261.5 of the Health and Safety Code. These emergency supplies shall be approved by the facility's patient care policy committee or pharmaceutical service committee and shall be readily available to each nursing station. Section 1261.5 of the Health and Safety Code limits the number of oral dosage form or suppository form drugs in these emergency supplies to 24.

(b) Notwithstanding any other provision of law, a pharmacy may furnish a dangerous drug or a dangerous device to an approved service provider within an emergency medical services system for storage in a secured emergency pharmaceutical supplies container, in accordance with the policies and procedures of the local emergency medical services agency, if all of the following are met:

(1) The dangerous drug or dangerous device is furnished exclusively for use in conjunction with services provided in an ambulance, or other approved emergency medical services service provider, that provides prehospital emergency medical services.

(2) The requested dangerous drug or dangerous device is within the licensed or certified emergency medical technician's scope of practice as established by the Emergency Medical Services Authority and set forth in Title 22 of the California Code of Regulations.

(3) The approved service provider within an emergency medical services system provides a written request that specifies the name and quantity of dangerous drugs or dangerous devices.

(4) The approved emergency medical services provider administers dangerous drugs and dangerous devices in accordance with the policies and procedures of the local emergency medical services agency.

(5) The approved emergency medical services provider documents, stores, and restocks dangerous drugs and dangerous devices in accordance with the policies and procedures of the local emergency medical services agency.

Records of each request by, and dangerous drugs or dangerous devices furnished to, an approved service provider within an emergency medical services system, shall be maintained by both the approved service provider and the dispensing pharmacy for a period of at least three years.

The furnishing of controlled substances to an approved emergency medical services provider shall be in accordance with the California Uniform Controlled Substances Act.

SEC. 23. Section 4127.1 of the Business and Professions Code is amended to read:

4127.1. (a) A pharmacy shall not compound injectable sterile drug products in this state unless the pharmacy has obtained a license from the board pursuant to this section. The license shall be renewed annually and is not transferable.

(b) A license to compound injectable sterile drug products may only be issued for a location that is licensed as a pharmacy. Furthermore, the license to compound injectable sterile drug products may only be issued to the owner of the pharmacy license at that location. A license to compound injectable sterile drug products may not be issued until the location is inspected by the board and found in compliance with this article and regulations adopted by the board.

(c) A license to compound injectable sterile drug products may not be renewed until the location has been inspected by the board

and found to be in compliance with this article and regulations adopted by the board.

(d) Pharmacies operated by entities that are licensed by either the board or the State Department of Public Health and that have current accreditation from the Joint Commission on Accreditation of Healthcare Organizations, or other private accreditation agencies approved by the board, are exempt from the requirement to obtain a license pursuant to this section.

(e) The reconstitution of a sterile powder shall not require a license pursuant to this section if both of the following are met:

(1) The sterile powder was obtained from a manufacturer.

(2) The drug is reconstituted for administration to patients by a health care professional licensed to administer drugs by injection pursuant to this division.

SEC. 24. Section 4169 of the Business and Professions Code is amended to read:

4169. (a) A person or entity may not do any of the following:

(1) Purchase, trade, sell, or transfer dangerous drugs or dangerous devices at wholesale with a person or entity that is not licensed with the board as a wholesaler or pharmacy.

(2) Purchase, trade, sell, or transfer dangerous drugs that the person knew or reasonably should have known were adulterated, as set forth in Article 2 (commencing with Section 111250) of Chapter 6 of Part 5 of Division 104 of the Health and Safety Code.

(3) Purchase, trade, sell, or transfer dangerous drugs that the person knew or reasonably should have known were misbranded, as defined in Section 111335 of the Health and Safety Code.

(4) Purchase, trade, sell, or transfer dangerous drugs or dangerous devices after the beyond use date on the label.

(5) Fail to maintain records of the acquisition or disposition of dangerous drugs or dangerous devices for at least three years.

(b) Notwithstanding any other provision of law, a violation of this section or of subdivision (c) or (d) of Section 4163 may subject the person or entity that has committed the violation to a fine not to exceed the amount specified in Section 125.9 for each occurrence, pursuant to a citation issued by the board.

(c) Amounts due from any person under this section shall be offset as provided under Section 12419.5 of the Government Code. Amounts received by the board under this section shall be deposited into the Pharmacy Board Contingent Fund.

(d) This section shall not apply to a pharmaceutical manufacturer licensed by the Food and Drug Administration or by the State Department of Public Health.

SEC. 25. Section 4181 of the Business and Professions Code is amended to read:

4181. (a) Prior to the issuance of a clinic license authorized under Section 4180, the clinic shall comply with all applicable laws and regulations of the State Department of Public Health relating to the drug distribution service to ensure that inventories, security procedures, training, protocol development, recordkeeping, packaging, labeling, dispensing, and patient consultation occur in a manner that is consistent with the promotion and protection of the health and safety of the public. The policies and procedures to implement the laws and regulations shall be developed and approved by the consulting pharmacist, the professional director, and the clinic administrator.

(b) The dispensing of drugs in a clinic shall be performed only by a physician, a pharmacist, or other person lawfully authorized to dispense drugs, and only in compliance with all applicable laws and regulations.

SEC. 26. Section 4191 of the Business and Professions Code is amended to read:

4191. (a) Prior to the issuance of a clinic license authorized under this article, the clinic shall comply with all applicable laws and regulations of the State Department of Public Health and the board relating to drug distribution to ensure that inventories, security procedures, training, protocol development, recordkeeping, packaging, labeling, dispensing, and patient consultation are carried out in a manner that is consistent with the promotion and protection of the health and safety of the public. The policies and procedures to implement the laws and regulations shall be developed and approved by the consulting pharmacist, the professional director, and the clinic administrator.

(b) The dispensing of drugs in a clinic that has received a license under this article shall be performed only by a physician, a pharmacist, or other person lawfully authorized to dispense drugs, and only in compliance with all applicable laws and regulations.

SEC. 27. Section 4196 of the Business and Professions Code is amended to read:

4196. (a) No person shall conduct a veterinary food-animal drug retailer in the State of California unless he or she has obtained a license from the board. A license shall be required for each veterinary food-animal drug retailer owned or operated by a specific person. A separate license shall be required for each of the premises of any person operating a veterinary food-animal drug retailer in more than one location. The license shall be renewed annually and shall not be transferable.

(b) 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 fixed by the board at an amount not to exceed the annual fee for renewal of a license to conduct a veterinary food-animal drug retailer.

(c) No person other than a pharmacist, an intern pharmacist, a designated representative, an authorized officer of the law, or a person authorized to prescribe, shall be permitted in that area, place, or premises described in the permit issued by the board pursuant to Section 4041, wherein veterinary food-animal drugs are stored, possessed, or repacked. A pharmacist or designated representative shall be responsible for any individual who enters the veterinary food-animal drug retailer for the purpose of performing clerical, inventory control, housekeeping, delivery, maintenance, or similar functions relating to the veterinary food-animal drug retailer.

(d) Every veterinary food-animal drug retailer shall be supervised or managed by a designated representative-in-charge. The designated representative-in-charge shall be responsible for the veterinary food-animal drug retailer's compliance with state and federal laws governing veterinary food-animal drug retailers. As part of its initial application for a license, and for each renewal, each veterinary food-animal drug retailer 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 veterinary food-animal drug retailer license without identification of an approved designated representative-in-charge for the veterinary food-animal drug retailer.

(e) Every veterinary food-animal drug retailer 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 who 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 veterinary food-animal drug retailer 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) For purposes of this section, designated representative-in-charge means a person granted a designated representative license pursuant to Section 4053, or a registered pharmacist, who is the supervisor or manager of the facility.

SEC. 28. Section 4200.1 is added to the Business and Professions Code, to read:

4200.1. (a) Notwithstanding Section 135, an applicant may take the North American Pharmacist Licensure Examination four times, and may take the California Practice Standards and Jurisprudence Examination for Pharmacists four times.

(b) Notwithstanding Section 135, an applicant may take the North American Pharmacist Licensure Examination and the California Practice Standards and Jurisprudence Examination for Pharmacists four additional times each if he or she successfully completes, at a minimum, 16 additional semester units of education in pharmacy as approved by the board.

(c) The applicant shall comply with the requirements of Section 4200 for each application for reexamination made pursuant to subdivision (b).

(d) An applicant may use the same coursework to satisfy the additional educational requirement for each examination under subdivision (b), if the coursework was completed within 12 months of the date of his or her application for reexamination.

(e) For purposes of this section, the board shall treat each failing score on the pharmacist licensure examination administered by the board prior to January 1, 2004, as a failing score on both the North American Pharmacist Licensure Examination and the

California Practice Standards and Jurisprudence Examination for Pharmacists.

SEC. 29. Section 4425 of the Business and Professions Code is amended to read:

4425. (a) As a condition for the participation of a pharmacy in the Medi-Cal program pursuant to Chapter 7 (commencing with Section 14000) of Division 9 of the Welfare and Institutions Code, the pharmacy, upon presentation of a valid prescription for the patient and the patient's Medicare card, shall charge Medicare beneficiaries a price that does not exceed the Medi-Cal reimbursement rate for prescription medicines, and an amount, as set by the State Department of Health Care Services to cover electronic transmission charges. However, Medicare beneficiaries shall not be allowed to use the Medi-Cal reimbursement rate for over-the-counter medications or compounded prescriptions.

(b) The State Department of Health Care Services shall provide a mechanism to calculate and transmit the price to the pharmacy, but shall not apply the Medi-Cal drug utilization review process for purposes of this section.

(c) The State Department of Health Care Services shall monitor pharmacy participation with the requirements of subdivision (a).

(d) The State Department of Health Care Services shall conduct an outreach program to inform Medicare beneficiaries of their right to participate in the program described in subdivision (a), including, but not limited to, the following:

(1) Including on its Internet Web site the Medi-Cal reimbursement rate for, at minimum, 200 of the most commonly prescribed medicines and updating this information monthly.

(2) Providing a sign to participating pharmacies that the pharmacies shall prominently display at the point of service and at the point of sale, reminding the Medicare beneficiaries to ask that the charge for their prescription be the same amount as the Medi-Cal reimbursement rate and providing the department's telephone number, e-mail address, and Internet Web site address to access information about the program.

(e) If prescription drugs are added to the scope of benefits available under the federal Medicare program, the Senate Office of Research shall report that fact to the appropriate committees of the Legislature. It is the intent of the Legislature to evaluate the

need to continue the implementation of this article under those circumstances.

(f) This section shall not apply to a prescription that is covered by insurance.

SEC. 30. Section 4426 of the Business and Professions Code is amended to read:

4426. The State Department of Health Care Services shall conduct a study of the adequacy of Medi-Cal pharmacy reimbursement rates including the cost of providing prescription drugs and services.

SEC. 31. Section 4980.07 of the Business and Professions Code is repealed.

SEC. 32. Section 4980.40.5 of the Business and Professions Code is amended to read:

4980.40.5. (a) A doctor's or master's degree in marriage, family, and child counseling, marital and family therapy, psychology, clinical psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling, or marriage and family therapy, obtained from a school, college, or university approved by the Bureau for Private Postsecondary and Vocational Education as of June 30, 2007, shall be considered by the board to meet the requirements necessary for licensure as a marriage and family therapist and for registration as a marriage and family therapist intern provided that the degree is conferred on or before July 1, 2010.

(b) As an alternative to meeting the qualifications specified in subdivision (a) of Section 4980.40, the board shall accept as equivalent degrees those doctor's or master's degrees that otherwise meet the requirements of this chapter and are conferred by educational institutions accredited by any of the following associations:

(1) Northwest Commission on Colleges and Universities.

(2) Middle States Association of Colleges and Secondary Schools.

(3) New England Association of Schools and Colleges.

(4) North Central Association of Colleges and Secondary Schools.

(5) Southern Association of Colleges and Schools.

SEC. 33. Section 4980.43 of the Business and Professions Code is amended to read:

4980.43. (a) Prior to applying for licensure examinations, each applicant shall complete experience that shall comply with the following:

(1) A minimum of 3,000 hours completed during a period of at least 104 weeks.

(2) Not more than 40 hours in any seven consecutive days.

(3) Not less than 1,700 hours of supervised experience completed subsequent to the granting of the qualifying master's or doctor's degree.

(4) Not more than 1,300 hours of supervised experience obtained prior to completing a master's or doctor's degree.

The applicant shall not be credited with more than 750 hours of counseling and direct supervisor contact prior to completing the master's or doctor's degree.

(5) No hours of experience may be gained prior to completing either 12 semester units or 18 quarter units of graduate instruction and becoming a trainee except for personal psychotherapy.

(6) No hours of experience gained more than six years prior to the date the application for examination eligibility was filed, except that up to 500 hours of clinical experience gained in the supervised practicum required by subdivision (c) of Section 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d) of Section 4980.36 shall be exempt from this six-year requirement.

(7) Not more than a combined total of 1,250 hours of experience in the following:

(A) Direct supervisor contact.

(B) Professional enrichment activities. For purposes of this chapter, "professional enrichment activities" include the following:

(i) Workshops, seminars, training sessions, or conferences directly related to marriage and family therapy attended by the applicant that are approved by the applicant's supervisor. An applicant shall have no more than 250 hours of verified attendance at these workshops, seminars, training sessions, or conferences.

(ii) Participation by the applicant in personal psychotherapy, which includes group, marital or conjoint, family, or individual psychotherapy by an appropriately licensed professional. An applicant shall have no more than 100 hours of participation in personal psychotherapy. The applicant shall be credited with three hours of experience for each hour of personal psychotherapy.

(C) Client centered advocacy.

(8) Not more than 500 hours of experience providing group therapy or group counseling.

(9) Not more than 250 hours of experience administering and evaluating psychological tests, writing clinical reports, writing progress notes, or writing process notes.

(10) Not less than 500 total hours of experience in diagnosing and treating couples, families, and children. For up to 150 hours of treating couples and families in conjoint therapy, the applicant shall be credited with two hours of experience for each hour of therapy provided.

(11) Not more than 375 hours of experience providing personal psychotherapy, crisis counseling, or other counseling services via telemedicine in accordance with Section 2290.5.

(b) All applicants, trainees, and registrants shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of marriage and family therapy. Supervised experience shall be gained by interns and trainees either as an employee or as a volunteer. The requirements of this chapter regarding gaining hours of experience and supervision are applicable equally to employees and volunteers. Experience shall not be gained by interns or trainees as an independent contractor.

(1) If employed, an intern shall provide the board with copies of the corresponding W-2 tax forms for each year of experience claimed upon application for licensure.

(2) If volunteering, an intern shall provide the board with a letter from his or her employer verifying the intern's employment as a volunteer upon application for licensure.

(c) Supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting, as specified:

(1) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of client contact in each setting.

(2) An individual supervised after being granted a qualifying degree shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of client

contact is gained in each setting. No more than five hours of supervision, whether individual or group, shall be credited during any single week.

(3) For purposes of this section, "one hour of direct supervisor contact" means one hour per week of face-to-face contact on an individual basis or two hours per week of face-to-face contact in a group.

(4) Direct supervisor contact shall occur within the same week as the hours claimed.

(5) Direct supervisor contact provided in a group shall be provided in a group of not more than eight supervisees and in segments lasting no less than one continuous hour.

(6) Notwithstanding paragraph (3), an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld.

(7) All experience gained by a trainee shall be monitored by the supervisor as specified by regulation.

(d) (1) A trainee may be credited with supervised experience completed in any setting that meets all of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(C) Is not a private practice owned by a licensed marriage and family therapist, a licensed psychologist, a licensed clinical social worker, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(2) Experience may be gained by the trainee solely as part of the position for which the trainee volunteers or is employed.

(e) (1) An intern may be credited with supervised experience completed in any setting that meets both of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the intern's work at the setting meets the experience and supervision requirements set forth

in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(2) An applicant shall not be employed or volunteer in a private practice, as defined in subparagraph (C) of paragraph (1) of subdivision (d), until registered as an intern.

(3) While an intern may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration to interns.

(4) Except for periods of time during a supervisor's vacation or sick leave, an intern who is employed or volunteering in private practice shall be under the direct supervision of a licensee that has satisfied the requirements of subdivision (g) of Section 4980.03. The supervising licensee shall either be employed by and practice at the same site as the intern's employer, or shall be an owner or shareholder of the private practice. Alternative supervision may be arranged during a supervisor's vacation or sick leave if the supervision meets the requirements of this section.

(5) Experience may be gained by the intern solely as part of the position for which the intern volunteers or is employed.

(f) Except as provided in subdivision (g), all persons shall register with the board as an intern in order to be credited for postdegree hours of supervised experience gained toward licensure.

(g) Except when employed in a private practice setting, all postdegree hours of experience shall be credited toward licensure so long as the applicant applies for the intern registration within 90 days of the granting of the qualifying master's or doctor's degree and is thereafter granted the intern registration by the board.

(h) Trainees, interns, and applicants shall not receive any remuneration from patients or clients, and shall only be paid by their employers.

(i) Trainees, interns, and applicants shall only perform services at the place where their employers regularly conduct business, which may include performing services at other locations, so long as the services are performed under the direction and control of their employer and supervisor, and in compliance with the laws and regulations pertaining to supervision. Trainees and interns shall have no proprietary interest in their employers' businesses and shall not lease or rent space, pay for furnishings, equipment or supplies, or in any other way pay for the obligations of their employers.

(j) Trainees, interns, or applicants who provide volunteered services or other services, and who receive no more than a total, from all work settings, of five hundred dollars ($500) per month as reimbursement for expenses actually incurred by those trainees, interns, or applicants for services rendered in any lawful work setting other than a private practice shall be considered an employee and not an independent contractor. The board may audit applicants who receive reimbursement for expenses, and the applicants shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.

(k) Each educational institution preparing applicants for licensure pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her interns and trainees regarding the advisability of undertaking individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, the educational institution and supervisors are encouraged to assist the applicant in locating that counseling or psychotherapy at a reasonable cost.

SEC. 34. Section 4980.80 of the Business and Professions Code is amended to read:

4980.80. (a) This section applies to persons who apply for licensure between January 1, 2010, and December 31, 2013, inclusive.

(b) The board may issue a license to a person who, at the time of application, holds a valid license issued by a board of marriage counselor examiners, marriage therapist examiners, or corresponding authority of any state, if all of the following requirements are satisfied:

(1) The person has held that license for at least two years immediately preceding the date of application.

(2) The education and supervised experience requirements are substantially the equivalent of this chapter.

(3) The person complies with Section 4980.76, if applicable.

(4) The person successfully completes the board administered licensing examinations as specified by subdivision (d) of Section 4980.40 and pays the fees specified.

(5) The person completes all of the following coursework or training:

(A) (i) An applicant who completed a two semester or three quarter unit course in law and professional ethics for marriage and family therapists that included areas of study as specified in Section 4980.41 as part of his or her qualifying degree shall complete an 18-hour course in California law and professional ethics that includes, but is not limited to, the following subjects: advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous patients, psychotherapist-patient privilege, recordkeeping, patient access to records, requirements of the Health Insurance Portability and Accountability Act of 1996, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, and therapist disclosures to patients.

(ii) An applicant who has not completed a two semester or three quarter unit course in law and professional ethics for marriage and family therapists that included areas of study as specified in Section 4980.41 as part of his or her qualifying degree, shall complete a two semester or three quarter unit course in California law and professional ethics that includes, at minimum, the areas of study specified in Section 4980.41.

(B) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28 and any regulations promulgated thereunder.

(C) A minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 25 and any regulations promulgated thereunder.

(D) A minimum of 15 contact hours of training or coursework in alcoholism and other chemical substance dependency as specified by regulation.

(E) (i) Instruction in spousal or partner abuse assessment, detection, and intervention. This instruction may be taken either in fulfillment of other requirements for licensure or in a separate course.

(ii) A minimum of 15 contact hours of coursework or training in spousal or partner abuse assessment, detection, and intervention strategies.

(F) A minimum of a two semester or three quarter unit survey course in psychological testing. This course may be taken either in fulfillment of other requirements for licensure or in a separate course.

(G) A minimum of a two semester or three quarter unit survey course in psychopharmacology. This course may be taken either in fulfillment of other requirements for licensure or in a separate course.

(H) With respect to human sexuality, alcoholism and other chemical substance dependency, spousal or partner abuse assessment, detection, and intervention, psychological testing, and psychopharmacology, the board may accept training or coursework acquired out of state.

(c) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 35. Section 4982.2 of the Business and Professions Code is repealed.

SEC. 36. Section 4982.25 of the Business and Professions Code is amended to read:

4982.25. The board may deny an application, or may suspend or revoke a license or registration issued under this chapter, for any of the following:

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

(b) Revocation, suspension, or restriction by the board of a license, certificate, or registration to practice as a clinical social worker, professional clinical counselor, or educational psychologist shall also constitute grounds for disciplinary action for unprofessional conduct against the licensee or registrant under this chapter.

SEC. 37. Section 4984.6 of the Business and Professions Code is repealed.

SEC. 38. Section 4984.8 of the Business and Professions Code is amended to read:

4984.8. (a) A licensee may apply to the board to request that his or her license be placed on inactive status.

(b) A licensee on inactive status shall be subject to this chapter and shall not engage in the practice of marriage and family therapy in this state.

(c) A licensee who holds an inactive license shall pay a biennial fee in the amount of one-half of the standard renewal fee and shall be exempt from continuing education requirements.

(d) A licensee on inactive status who has not committed an act or crime constituting grounds for denial of licensure may, upon request, restore his or her license to practice marriage and family therapy to active status.

(1) A licensee requesting to restore his or her license to active status between renewal cycles shall pay the remaining one-half of his or her renewal fee.

(2) A licensee requesting to restore his or her license to active status, whose license will expire less than one year from the date of the request, shall complete 18 hours of continuing education as specified in Section 4980.54.

(3) A licensee requesting to restore his or her license to active status, whose license will expire more than one year from the date of the request, shall complete 36 hours of continuing education as specified in Section 4980.54.

SEC. 39. Section 4989.54 of the Business and Professions Code is amended to read:

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

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

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

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

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

shall be deemed to be a conviction within the meaning of this section.

(4) The board may order a license suspended or revoked, or may decline to issue a license when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty or setting aside the verdict of guilty or dismissing the accusation, information, or indictment.

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

(c) Administering to himself or herself a controlled substance or using any of the dangerous drugs specified in Section 4022 or an alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to himself or herself or to any other person or to the public or to the extent that the use impairs his or her ability to safely perform the functions authorized by the license. The board shall deny an application for a license or revoke the license of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing educational psychology.

(d) Failure to comply with the consent provisions in Section 2290.5.

(e) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

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

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

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

of the disciplinary action, decision, or judgment shall be conclusive evidence of that action.

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

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

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

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

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

(n) Engaging in sexual relations with a client or a former client within two years following termination of professional services, soliciting sexual relations with a client, or committing an act of sexual abuse or sexual misconduct with a client or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a licensed educational psychologist.

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

(p) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients.

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

(r) Performing, holding himself or herself out as being able to perform, or offering to perform any professional services beyond the scope of the license authorized by this chapter or beyond his

or her field or fields of competence as established by his or her education, training, or experience.

(s) Reproducing or describing in public, or in any publication subject to general public distribution, any psychological test or other assessment device the value of which depends in whole or in part on the naivete of the subject in ways that might invalidate the test or device. An educational psychologist shall limit access to the test or device to persons with professional interests who can be expected to safeguard its use.

(t) Aiding or abetting an unlicensed person to engage in conduct requiring a license under this chapter.

(u) When employed by another person or agency, encouraging, either orally or in writing, the employer's or agency's clientele to utilize his or her private practice for further counseling without the approval of the employing agency or administration.

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

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

(x) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(y) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(z) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of the examination as described in Section 123.

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

(ab) Permitting a person under his or her supervision or control to perform, or permitting that person to hold himself or herself out as competent to perform, professional services beyond the level of education, training, or experience of that person.

SEC. 40. Section 4990.02 of the Business and Professions Code is amended to read:

4990.02. "Board," as used in this chapter, Chapter 13 (commencing with Section 4980), Chapter 13.5 (commencing with Section 4989.10), Chapter 14 (commencing with Section 4991), and Chapter 16 (commencing with Section 4999.10) means the Board of Behavioral Sciences.

SEC. 41. Section 4990.12 of the Business and Professions Code is amended to read:

4990.12. The duty of administering and enforcing this chapter, Chapter 13 (commencing with Section 4980), Chapter 13.5 (commencing with Section 4989.10), Chapter 14 (commencing with Section 4991), and Chapter 16 (commencing with Section 4999.10) is vested in the board and the executive officer subject to, and under the direction of, the board. In the performance of this duty, the board and the executive officer have all the powers and are subject to all the responsibilities vested in, and imposed upon, the head of a department by Chapter 2 (commencing with Section 11150) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 42. Section 4990.18 of the Business and Professions Code is amended to read:

4990.18. It is the intent of the Legislature that the board employ its resources for each and all of the following functions:

(a) The licensure of marriage and family therapists, clinical social workers, professional clinical counselors, and educational psychologists.

(b) The development and administration of licensure examinations and examination procedures consistent with prevailing standards for the validation and use of licensing and

1 certification tests. Examinations shall measure knowledge and
2 abilities demonstrably important to the safe, effective practice of
3 the profession.
4 (c) Enforcement of laws designed to protect the public from
5 incompetent, unethical, or unprofessional practitioners.
6 (d) Consumer education.
7 SEC. 43. Section 4990.22 of the Business and Professions
8 Code is amended to read:
9 4990.22. (a) The Behavioral Sciences Fund shall be used for
10 the purposes of carrying out and enforcing the provisions of this
11 chapter and the chapters listed in Section 4990.12. All moneys in
12 the fund shall be expended by the board for the purposes of the
13 programs under its jurisdiction.
14 (b) The board shall keep records that reasonably ensure that
15 funds expended in the administration of each licensure or
16 registration category shall bear a reasonable relation to the revenue
17 derived from each category and report to the department no later
18 than May 31 of each year on those expenditures.
19 (c) Surpluses, if any, may be used by the board in a manner that
20 bears a reasonable relation to the revenue derived from each
21 licensure or registration category and may include, but not be
22 limited to, expenditures for education and research related to each
23 of the licensing or registration categories.
24 SEC. 44. Section 4990.30 of the Business and Professions
25 Code is amended to read:
26 4990.30. (a) A licensed marriage and family therapist, marriage
27 and family therapist intern, licensed clinical social worker,
28 associate clinical social worker, licensed professional clinical
29 counselor, professional clinical counselor intern, or licensed
30 educational psychologist whose license or registration has been
31 revoked, suspended, or placed on probation, may petition the board
32 for reinstatement or modification of the penalty, including
33 modification or termination of probation. The petition shall be on
34 a form provided by the board and shall state any facts and
35 information as may be required by the board including, but not
36 limited to, proof of compliance with the terms and conditions of
37 the underlying disciplinary order. The petition shall be verified by
38 the petitioner who shall file an original and sufficient copies of
39 the petition, together with any supporting documents, for the

members of the board, the administrative law judge, and the Attorney General.

(b) The licensee or registrant may file the petition on or after the expiration of the following timeframes, each of which commences on the effective date of the decision ordering the disciplinary action or, if the order of the board, or any portion of it, is stayed by the board itself or by the superior court, from the date the disciplinary action is actually implemented in its entirety:

(1) Three years for reinstatement of a license or registration that was revoked for unprofessional conduct, except that the board may, in its sole discretion, specify in its revocation order that a petition for reinstatement may be filed after two years.

(2) Two years for early termination of any probation period of three years or more.

(3) One year for modification of a condition, reinstatement of a license or registration revoked for mental or physical illness, or termination of probation of less than three years.

(c) The petition may be heard by the board itself or the board may assign the petition to an administrative law judge pursuant to Section 11512 of the Government Code.

(d) The petitioner may request that the board schedule the hearing on the petition for a board meeting at a specific city where the board regularly meets.

(e) The petitioner and the Attorney General shall be given timely notice by letter of the time and place of the hearing on the petition and an opportunity to present both oral and documentary evidence and argument to the board or the administrative law judge.

(f) The petitioner shall at all times have the burden of production and proof to establish by clear and convincing evidence that he or she is entitled to the relief sought in the petition.

(g) The board, when it is hearing the petition itself, or an administrative law judge sitting for the board, 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 his or her license or registration was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability.

(h) The hearing may be continued from time to time as the board or the administrative law judge deems appropriate but in no case

may the hearing on the petition be delayed more than 180 days from its filing without the consent of the petitioner.

(i) The board itself, or the administrative law judge if one is designated by the board, shall hear the petition and shall prepare a written decision setting forth the reasons supporting the decision. In a decision granting a petition reinstating a license or modifying a penalty, the board itself, or the administrative law judge, may impose any terms and conditions that the agency deems reasonably appropriate, including those set forth in Sections 823 and 4990.40. If a petition is heard by an administrative law judge sitting alone, the administrative law judge shall prepare a proposed decision and submit it to the board. The board may take action with respect to the proposed decision and petition as it deems appropriate.

(j) The petitioner shall pay a fingerprinting fee and provide a current set of his or her fingerprints to the board. The petitioner shall execute a form authorizing release to the board or its designee, of all information concerning the petitioner's current physical and mental condition. Information provided to the board pursuant to the release shall be confidential and shall not be subject to discovery or subpoena in any other proceeding, and shall not be admissible in any action, other than before the board, to determine the petitioner's fitness to practice as required by Section 822.

(k) The board may delegate to its executive officer authority to order investigation of the contents of the petition.

(*l*) 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 or the petitioner is required to register pursuant to Section 290 of the Penal Code. No petition shall be considered while there is an accusation or petition to revoke probation pending against the petitioner.

(m) Except in those cases where the petitioner has been disciplined for violation of Section 822, the board may in its discretion deny without hearing or argument any petition that is filed pursuant to this section within a period of two years from the effective date of a prior decision following a hearing under this section.

SEC. 45. Section 4990.38 of the Business and Professions Code is amended to read:

4990.38. The board may deny an application or may suspend or revoke a license or registration issued under the chapters it administers and enforces for any disciplinary action imposed by another state or territory or possession of the United States, or by a governmental agency on a license, certificate or registration to practice marriage and family therapy, clinical social work, educational psychology, professional clinical counseling, or any other healing art. The disciplinary action, which may include denial of licensure or revocation or suspension of the license or imposition of restrictions on it, constitutes unprofessional conduct. A certified copy of the disciplinary action decision or judgment shall be conclusive evidence of that action.

SEC. 46. Section 4992.36 of the Business and Professions Code is amended to read:

4992.36. The board may deny an application, or may suspend or revoke a license or registration issued under this chapter, for any of the following:

(a) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action imposed by another state or territory of the United States, or by any other governmental agency, on a license, certificate, or registration to practice clinical social work or any other healing art shall constitute grounds for disciplinary action for unprofessional conduct. A certified copy of the disciplinary action decision or judgment shall be conclusive evidence of that action.

(b) Revocation, suspension, or restriction by the board of a license, certificate, or registration to practice marriage and family therapy, professional clinical counseling, or educational psychology against a licensee or registrant shall also constitute grounds for disciplinary action for unprofessional conduct under this chapter.

SEC. 47. Article 3 (commencing with Section 4994) of Chapter 14 of Division 2 of the Business and Professions Code is repealed.

SEC. 48. Section 4996.17 of the Business and Professions Code is amended to read:

4996.17. (a) Experience gained outside of California shall be accepted toward the licensure requirements if it is substantially the equivalent of the requirements of this chapter.

(b) The board may issue a license to any person who, at the time of application, holds a valid active clinical social work license issued by a board of clinical social work examiners or

corresponding authority of any state, if the person passes the board administered licensing examinations as specified in Section 4996.1 and pays the required fees. Issuance of the license is conditioned upon all of the following:

(1) The applicant has supervised experience that is substantially the equivalent of that required by this chapter. If the applicant has less than 3,200 hours of qualifying supervised experience, time actively licensed as a clinical social worker shall be accepted at a rate of 100 hours per month up to a maximum of 1,200 hours.

(2) Completion of the following coursework or training in or out of this state:

(A) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28, and any regulations promulgated thereunder.

(B) A minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 25, and any regulations promulgated thereunder.

(C) A minimum of 15 contact hours of training or coursework in alcoholism and other chemical substance dependency, as specified by regulation.

(D) A minimum of 15 contact hours of coursework or training in spousal or partner abuse assessment, detection, and intervention strategies.

(3) The applicant's license is not suspended, revoked, restricted, sanctioned, or voluntarily surrendered in any state.

(4) The applicant is not currently under investigation in any other state, and has not been charged with an offense for any act substantially related to the practice of social work by any public agency, entered into any consent agreement or been subject to an administrative decision that contains conditions placed by an agency upon an applicant's professional conduct or practice, including any voluntary surrender of license, or been the subject of an adverse judgment resulting from the practice of social work that the board determines constitutes evidence of a pattern of incompetence or negligence.

(5) The applicant shall provide a certification from each state where he or she holds a license pertaining to licensure, disciplinary action, and complaints pending.

(6) The applicant is not subject to denial of licensure under Section 480, 4992.3, 4992.35, or 4992.36.

(c) The board may issue a license to any person who, at the time of application, holds a valid, active clinical social work license issued by a board of clinical social work examiners or a corresponding authority of any state, if the person has held that license for at least four years immediately preceding the date of application, the person passes the board administered licensing examinations as specified in Section 4996.1, and the person pays the required fees. Issuance of the license is conditioned upon all of the following:

(1) Completion of the following coursework or training in or out of state:

(A) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28, and any regulations promulgated thereunder.

(B) A minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 25, and any regulations promulgated thereunder.

(C) A minimum of 15 contact hours of training or coursework in alcoholism and other chemical substance dependency, as specified by regulation.

(D) A minimum of 15 contact hours of coursework or training in spousal or partner abuse assessment, detection, and intervention strategies.

(2) The applicant has been licensed as a clinical social worker continuously for a minimum of four years prior to the date of application.

(3) The applicant's license is not suspended, revoked, restricted, sanctioned, or voluntarily surrendered in any state.

(4) The applicant is not currently under investigation in any other state, and has not been charged with an offense for any act substantially related to the practice of social work by any public agency, entered into any consent agreement or been subject to an administrative decision that contains conditions placed by an agency upon an applicant's professional conduct or practice, including any voluntary surrender of license, or been the subject of an adverse judgment resulting from the practice of social work that the board determines constitutes evidence of a pattern of incompetence or negligence.

(5) The applicant provides a certification from each state where he or she holds a license pertaining to licensure, disciplinary action, and complaints pending.

(6) The applicant is not subject to denial of licensure under Section 480, 4992.3, 4992.35, or 4992.36.

SEC. 49. Section 4996.23 of the Business and Professions Code is amended to read:

4996.23. The experience required by subdivision (c) of Section 4996.2 shall meet the following criteria:

(a) All persons registered with the board on and after January 1, 2002, shall have at least 3,200 hours of post-master's degree supervised experience providing clinical social work services as permitted by Section 4996.9. At least 1,700 hours shall be gained under the supervision of a licensed clinical social worker. The remaining required supervised experience may be gained under the supervision of a licensed mental health professional acceptable to the board as defined by a regulation adopted by the board. This experience shall consist of the following:

(1) A minimum of 2,000 hours in clinical psychosocial diagnosis, assessment, and treatment, including psychotherapy or counseling.

(2) A maximum of 1,200 hours in client-centered advocacy, consultation, evaluation, and research.

(3) Of the 2,000 clinical hours required in paragraph (1), no less than 750 hours shall be face-to-face individual or group psychotherapy provided to clients in the context of clinical social work services.

(4) A minimum of two years of supervised experience is required to be obtained over a period of not less than 104 weeks and shall have been gained within the six years immediately preceding the date on which the application for licensure was filed.

(5) Experience shall not be credited for more than 40 hours in any week.

(b) "Supervision" means responsibility for, and control of, the quality of clinical social work services being provided. Consultation or peer discussion shall not be considered to be supervision.

(c) (1) Prior to the commencement of supervision, a supervisor shall comply with all requirements enumerated in Section 1870 of Title 16 of the California Code of Regulations and shall sign under

penalty of perjury the "Responsibility Statement for Supervisors of an Associate Clinical Social Worker" form.

(2) Supervised experience shall include at least one hour of direct supervisor contact for a minimum of 104 weeks. For purposes of this subdivision, "one hour of direct supervisor contact" means one hour per week of face-to-face contact on an individual basis or two hours of face-to-face contact in a group conducted within the same week as the hours claimed.

(3) An associate shall receive an average of at least one hour of direct supervisor contact for every week in which more than 10 hours of face-to-face psychotherapy is performed in each setting in which experience is gained. No more than five hours of supervision, whether individual or group, shall be credited during any single week.

(4) Group supervision shall be provided in a group of not more than eight supervisees and shall be provided in segments lasting no less than one continuous hour.

(5) Of the 104 weeks of required supervision, 52 weeks shall be individual supervision, and of the 52 weeks of required individual supervision, not less than 13 weeks shall be supervised by a licensed clinical social worker.

(6) Notwithstanding paragraph (2), an associate clinical social worker working for a governmental entity, school, college, or university, or an institution that is both a nonprofit and charitable institution, may obtain the required weekly direct supervisor contact via live two-way videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is preserved.

(d) The supervisor and the associate shall develop a supervisory plan that describes the goals and objectives of supervision. These goals shall include the ongoing assessment of strengths and limitations and the assurance of practice in accordance with the laws and regulations. The associate shall submit to the board the initial original supervisory plan upon application for licensure.

(e) Experience shall only be gained in a setting that meets both of the following:

(1) Lawfully and regularly provides clinical social work, mental health counseling, or psychotherapy.

(2) Provides oversight to ensure that the associate's work at the setting meets the experience and supervision requirements set forth

in this chapter and is within the scope of practice for the profession as defined in Section 4996.9.

(f) Experience shall not be gained until the applicant has been registered as an associate clinical social worker.

(g) Employment in a private practice as defined in subdivision (h) shall not commence until the applicant has been registered as an associate clinical social worker.

(h) A private practice setting is a setting that is owned by a licensed clinical social worker, a licensed marriage and family therapist, a licensed psychologist, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(i) If volunteering, the associate shall provide the board with a letter from his or her employer verifying his or her voluntary status upon application for licensure.

(j) If employed, the associate shall provide the board with copies of his or her W-2 tax forms for each year of experience claimed upon application for licensure.

(k) While an associate may be either a paid employee or volunteer, employers are encouraged to provide fair remuneration to associates.

(*l*) An associate shall not do the following:

(1) Receive any remuneration from patients or clients and shall only be paid by his or her employer.

(2) Have any proprietary interest in the employer's business.

(3) Lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of his or her employer.

(m) An associate, whether employed or volunteering, may obtain supervision from a person not employed by the associate's employer if that person has signed a written agreement with the employer to take supervisory responsibility for the associate's social work services.

(n) Notwithstanding any other provision of law, associates and applicants for examination shall receive a minimum of one hour of supervision per week for each setting in which he or she is working.

SEC. 50. Section 4999.46 of the Business and Professions Code is amended to read:

4999.46. (a) To qualify for licensure, applicants shall complete clinical mental health experience under the general supervision of an approved supervisor as defined in Section 4999.12.

(b) The experience shall include a minimum of 3,000 postdegree hours of supervised clinical mental health experience related to the practice of professional clinical counseling, performed over a period of not less than two years (104 weeks) which shall include:

(1) Not more than 40 hours in any seven consecutive days.

(2) Not less than 1,750 hours of direct counseling with individuals or groups in a clinical mental health counseling setting using a variety of psychotherapeutic techniques and recognized counseling interventions within the scope of practice of licensed professional clinical counselors.

(3) Not more than 500 hours of experience providing group therapy or group counseling.

(4) Not more than 250 hours of experience providing counseling or crisis counseling on the telephone.

(5) Not less than 150 hours of clinical experience in a hospital or community mental health setting.

(6) Not more than a combined total of 1,250 hours of experience in the following related activities:

(A) Direct supervisor contact.

(B) Client centered advocacy.

(C) Not more than 250 hours of experience administering tests and evaluating psychological tests of clients, writing clinical reports, writing progress notes, or writing process notes.

(D) Not more than 250 hours of verified attendance at workshops, training sessions, or conferences directly related to professional clinical counseling that are approved by the applicant's supervisor.

(c) No hours of clinical mental health experience may be gained more than six years prior to the date the application for examination eligibility was filed.

(d) An applicant shall register with the board as an intern in order to be credited for postdegree hours of experience toward licensure. Postdegree hours of experience shall be credited toward licensure, provided that the applicant applies for intern registration within 90 days of the granting of the qualifying degree and is registered as an intern by the board.

(e) All applicants and interns shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of professional clinical counseling.

(f) Experience obtained under the supervision of a spouse or relative by blood or marriage shall not be credited toward the required hours of supervised experience. Experience obtained under the supervision of a supervisor with whom the applicant has had or currently has a personal, professional, or business relationship that undermines the authority or effectiveness of the supervision shall not be credited toward the required hours of supervised experience.

(g) Supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting.

(1) No more than five hours of supervision, whether individual or group, shall be credited during any single week.

(2) An intern shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of face-to-face psychotherapy is performed in each setting in which experience is gained.

(3) For purposes of this section, "one hour of direct supervisor contact" means one hour of face-to-face contact on an individual basis or two hours of face-to-face contact in a group of not more than eight persons in segments lasting no less than one continuous hour.

(4) Notwithstanding paragraph (3), an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable, may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld.

SEC. 51. Section 4999.57 is added to the Business and Professions Code, to read:

4999.57. (a) This section applies to a person who applies for examination eligibility or registration between January 1, 2011,

and December 31, 2013, inclusive, who does not hold a license described in subdivision (a) of Section 4999.58.

(b) Experience gained outside of California shall be accepted toward the licensure requirements if it is substantially equivalent to that required by this chapter, if the applicant complies with Section 4999.40, if applicable, and if the applicant has gained a minimum of 250 hours of supervised experience in direct counseling within California while registered as an intern with the board.

(c) Education gained while residing outside of California shall be accepted toward the licensure requirements if it is substantially equivalent to the education requirements of this chapter, if the applicant has completed the training or coursework required under subdivision (e) of Section 4999.32, and if the applicant completes, in addition to the course described in subparagraph (I) of paragraph (1) of subdivision (c) of Section 4999.32, an 18-hour course in California law and professional ethics that includes, but is not limited to, instruction in advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous clients, psychotherapist-client privilege, recordkeeping, client access to records, the Health Insurance Portability and Accountability Act, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, and therapist disclosures to clients.

(d) For purposes of this section, the board may, in its discretion, accept education as substantially equivalent if the applicant's education meets the requirements of Section 4999.32. If the applicant's degree does not contain the content or the overall units required by Section 4999.32, the board may, in its discretion, accept the applicant's education as substantially equivalent if the following criteria are satisfied:

(1) The applicant's degree contains the required number of practicum units under paragraph (3) of subdivision (c) of Section 4999.32.

(2) The applicant remediates his or her specific deficiency by completing the course content and units required by Section 4999.32.

(3) The applicant's degree otherwise complies with this section.

(e) This section shall become inoperative on January 1, 2014, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2014, deletes or extends that date.

~~SEC. 52. Section 4999.58 of the Business and Professions Code is amended to read:~~

~~4999.58. (a) This section applies to a person who applies for examination eligibility between January 1, 2011, and December 31, 2013, inclusive, who meets both of the following requirements:~~

~~(1) At the time of application, holds a valid license as a professional clinical counselor, or other counseling license that allows the applicant to independently provide clinical mental health services, in another jurisdiction of the United States.~~

~~(2) Has held the license described in paragraph (1) for at least two years immediately preceding the date of application.~~

~~(b) The board may issue a license to a person described in subdivision (a) if all of the following requirements are satisfied:~~

~~(1) The education and supervised experience requirements of the other jurisdiction are substantially the equivalent of this chapter, as described in subdivision (c) and in Section 4999.46.~~

~~(2) The person complies with subdivision (b) of Section 4999.40, if applicable.~~

~~(3) The person successfully completes the examinations required by the board pursuant to paragraph (3) of subdivision (a) of Section 4999.50.~~

~~(4) The person pays the required fees.~~

~~(c) Experience gained outside of California shall be accepted toward the licensure requirements if it is substantially equivalent to that required by this chapter. The board shall consider hours of experience obtained in another state during the six-year period immediately preceding the applicant's initial licensure by that state as a licensed professional clinical counselor.~~

~~(d) Education gained while residing outside of California shall be accepted toward the licensure requirements if it is substantially equivalent to the education requirements of this chapter, if the applicant has completed the training or coursework required under subdivision (c) of Section 4999.32, and if the applicant completes, in addition to the course described in subparagraph (I) of paragraph (1) of subdivision (c) of Section 4999.32, an 18-hour course in California law and professional ethics that includes, but is not limited to, instruction in advertising, scope of practice, scope of~~

~~competence, treatment of minors, confidentiality, dangerous clients, psychotherapist-client privilege, recordkeeping, client access to records, the Health Insurance Portability and Accountability Act, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, and therapist disclosures to clients.~~

~~(e) For purposes of this section, the board may, in its discretion, accept education as substantially equivalent if the applicant's education meets the requirements of Section 4999.32. If the applicant's degree does not contain the content or the overall units required by Section 4999.32, the board may, in its discretion, accept the applicant's education as substantially equivalent if the following criteria are satisfied:~~

~~(1) The applicant's degree contains the required number of practicum units under paragraph (3) of subdivision (c) of Section 4999.32.~~

~~(2) The applicant remediates his or her specific deficiency by completing the course content and units required by Section 4999.32.~~

~~(3) The applicant's degree otherwise complies with this section.~~

~~(f) This section shall become inoperative on January 1, 2014, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2014, deletes or extends that date.~~

SEC. 52. Section 4999.58 of the Business and Professions Code is amended to read:

4999.58. (a) This section applies to ~~persons who apply~~ *a person who applies* for examination eligibility between January 1, 2011, and December 31, 2013, ~~inclusive.~~ *inclusive, and who meets both of the following requirements:*

(1) At the time of application, holds a valid license as a professional clinical counselor, or other counseling license that allows the applicant to independently provide clinical mental health services, in another jurisdiction of the United States.

(2) Has held the license described in paragraph (1) for at least two years immediately preceding the date of application.

(b) The board may issue a license to a person ~~who, at the time of application, has held for at least two years, a valid license as a professional clinical counselor, or other counseling license that~~

~~allows the applicant to independently provide clinical mental health services, in another jurisdiction of the United States, if the~~ *described in subdivision (a) if all of the following requirements are satisfied:*

(1) The education and supervised experience requirements *of the other jurisdiction* are substantially the equivalent of this chapter, as described in subdivision (e) and in Section 4999.46~~, the~~.

(2) The person complies with subdivision (b) of Section 4999.40, if applicable~~, the~~.

(3) The person successfully completes the examinations required by the board pursuant to paragraph (3) of subdivision (a) of Section 4999.50~~, and the~~.

(4) The person pays the required fees.

(c) Experience gained outside of California shall be accepted toward the licensure requirements if it is substantially equivalent to that required by this chapter~~ and if the applicant has gained a minimum of 250 hours of supervised clinical experience in direct counseling within California while registered as an intern with the board~~. The board shall consider hours of experience obtained in another state during the six-year period immediately preceding the applicant's initial licensure by that state as a licensed professional clinical counselor.

(d) Education gained while residing outside of California shall be accepted toward the licensure requirements if it is substantially equivalent to the education requirements of this chapter, if the applicant has completed the training or coursework required under subdivision (e) of Section 4999.32, and if the applicant completes, in addition to the course described in subparagraph (I) of paragraph (1) of subdivision (c) of Section 4999.32, an 18-hour course in California law and professional ethics that includes, but is not limited to, instruction in advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous clients, psychotherapist-client privilege, recordkeeping, client access to records, the Health Insurance Portability and Accountability Act, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, and therapist disclosures to clients.

(e) For purposes of this section, the board may, in its discretion, accept education as substantially equivalent if the applicant's education meets the requirements of Section 4999.32. If the applicant's degree does not contain the content or the overall units required by Section 4999.32, the board may, in its discretion, accept the applicant's education as substantially equivalent if the following criteria are satisfied:

(1) The applicant's degree contains the required number of practicum units under paragraph (3) of subdivision (c) of Section 4999.32.

(2) The applicant remediates his or her specific deficiency by completing the course content and units required by Section 4999.32.

(3) The applicant's degree otherwise complies with this section.

(f) This section shall become inoperative on January 1, 2014, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2014, deletes or extends that date.

SEC. 53. Section 4999.59 is added to the Business and Professions Code, to read:

4999.59. (a) This section applies to a person who applies for examination eligibility or registration between January 1, 2011, and December 31, 2013, inclusive, who meets both of the following requirements:

(1) At the time of application, holds a valid license described in paragraph (1) of subdivision (a) of Section 4999.58.

(2) Has held the license described in paragraph (1) for less than two years immediately preceding the date of application.

(b) Experience gained outside of California shall be accepted toward the licensure requirements if it is substantially equivalent to that required by this chapter, if the applicant complies with Section 4999.40, if applicable, and if the applicant has gained a minimum of 250 hours of supervised experience in direct counseling within California while registered as an intern with the board. The board shall consider hours of experience obtained in another state during the six-year period immediately preceding the applicant's initial licensure in that state as a professional clinical counselor.

(c) Education gained while residing outside of California shall be accepted toward the licensure requirements if it is substantially equivalent to the education requirements of this chapter, if the

applicant has completed the training or coursework required under subdivision (e) of Section 4999.32, and if the applicant completes, in addition to the course described in subparagraph (I) of paragraph (1) of subdivision (c) of Section 4999.32, an 18-hour course in California law and professional ethics that includes, but is not limited to, instruction in advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous clients, psychotherapist-client privilege, recordkeeping, client access to records, the Health Insurance Portability and Accountability Act, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, and therapist disclosures to clients.

(d) For purposes of this section, the board may, in its discretion, accept education as substantially equivalent if the applicant's education meets the requirements of Section 4999.32. If the applicant's degree does not contain the content or the overall units required by Section 4999.32, the board may, in its discretion, accept the applicant's education as substantially equivalent if the following criteria are satisfied:

(1) The applicant's degree contains the required number of practicum units under paragraph (3) of subdivision (c) of Section 4999.32.

(2) The applicant remediates his or her specific deficiency by completing the course content and units required by Section 4999.32.

(3) The applicant's degree otherwise complies with this section.

(e) This section shall become inoperative on January 1, 2014, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2014, deletes or extends that date.

SEC. 54. Section 4999.90 of the Business and Professions Code is amended to read:

4999.90. The board may refuse to issue any registration or license, or may suspend or revoke the registration or license of any intern or licensed professional clinical counselor, if the applicant, licensee, or registrant has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

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

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

(c) Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022, or any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license, or the conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this subdivision, or any combination thereof. The board shall deny an application for a registration or license or revoke the license or registration of any person, other than one

who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing licensed professional clinical counseling services.

(d) Gross negligence or incompetence in the performance of licensed professional clinical counseling services.

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

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

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

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

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

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

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

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

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

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

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

(p) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

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

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

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

(t) Permitting a clinical counselor trainee or intern under one's supervision or control to perform, or permitting the clinical counselor trainee or intern to hold himself or herself out as competent to perform, professional services beyond the clinical counselor trainee's or intern's level of education, training, or experience.

(u) The violation of any statute or regulation of the standards of the profession, and the nature of the services being rendered, governing the gaining and supervision of experience required by this chapter.

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

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

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

(y) Repeated acts of negligence.

(z) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(aa) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of an examination as described in Section 123.

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

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Tracker II

Medical Board of California
Tracker II - Legislative Bills
4/22/2010

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 52	Portantino	Umbillical Cord Blood Collection Program	Sen. Health	06/24/09
AB 159	Nava	Perinatal Mood and Anxiety Disorders: task force	Asm. Approps - susp.	03/25/09
AB 417	Beall	Medi-Cal Drug Treatment Program: buprenorphine	Sen. Approps. - susp	03/15/10
AB 445	Salas	Use of X-ray Equipment: prohibition: exemptions	Asm. Health	
AB 452	Yamada	In-home Supportive Services: CA Independence Act of 2009	Asm, Hum. S.	
AB 456	Emmerson	Dentristry Diversion Program	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	Asm. Jud.	
AB 542	Feuer	Adverse Medical Events: expanding reporting	Sen. Health	06/18/09
AB 718	Emmerson	Electronic Prescribing Pilot Program	Sen. Rules	09/01/09
AB 721	Nava	Physical Therapists: scope of practice	Asm. B&P	04/13/09
AB 832	Jones	Ambulatory surgical clinics: workgroup	Asm. Approps.	05/05/09
AB 834	Solorio	Health Care Practitioners: peer review	Asm. B&P	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	Asm. Approps.	04/14/09
AB 950	Hernandez	Hospice Providers: licensed hospice facilities	Sen. Health	03/25/10
AB 1140	Niello	Diagnostic Imaging Services	Sen. Health	04/14/09
AB 1162	Carter	Health Facilities: licensure	Introduced	
AB 1168	Carter	Professions and Vocations (spot)	Introduced	
AB 1194	Strickland	State Agency Internet Web Sites: information	Asm. B&P	
AB 1458	Davis	Drugs: adverse effects: reporting	Asm. Approps.	05/05/09

Medical Board of California
Tracker II - Legislative Bills
4/22/2010

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1478	Ammiano	Written Acknowledgment: medical nutrition therapy	Asm. B&P	
AB 1487	Hill	Tissue Donation	Sen. Health	03/02/10
AB 1518	Anderson	State Government: Boards, Commissions, Committees, repeal	Sen. Rules	04/08/10
AB 1542	Health Comm.	Medical Records: centralized location	Sen. Health	07/01/09
AB 1659	Huber	State Government: agency repeals	Asm. Approps.	04/07/10
AB 1916	Davis	Pharmacies: prescriptions: reports	Asm. B&P	04/08/10
AB 1938	Fletcher	Dentistry	Asm. B&P	
AB 1940	Fletcher	Physician Assistants	Asm. B&P	04/05/10
AB 1994	Skinner	Hospital employees: presumption	Asm. Approps.	03/23/10
AB 2028	Hernandez	Confidentially of Medical Information: disclosure	Asm. Approps.	04/13/10
AB 2093	V. Manual Perez	Immunizations for Children: reimbursement of physicians	Asm. Approps.	
AB 2104	Hayashi	California State Board of Pharmacy	Asm. Approps.	04/08/10
AB 2130	Huber	Professions and Vocations: sunset review	Asm. Approps.	
AB 2254	Ammiano	Marijuana Control, Regulation, and Education Act	Asm. Pub. S.	
AB 2268	Chesbro	Alcohol and Drug Abuse	Asm. Floor	04/20/10
AB 2292	Lownethal	Pharmacy: clinics	Asm. Approps	
AB 2386	Gilmore	Armed Forces: medical personnel	Asm. Health	04/14/10
AB 2548	Block	Prescription Drug Monitoring Program	Asm. Approps.	
AB 2551	Hernandez	Health Professions Development: loan repayment	Asm. B&P	
AB 2667	Hill	Vehicles: child passenger restraint systems	Asm. B&P	
AB 2699	Bass	Healing Arts: licnensing exemption	Asm. Floor	04/14/10
AB 2707	Berryhill	Department of Consumer Affairs: regulatory boards	Introduced	

Medical Board of California
Tracker II - Legislative Bills
4/22/2010

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 58	Aanestad	Physicians and Surgeons: peer review	Sen. Approps.	05/19/09
SB 92	Aanestad	Health care reform	Sen. Health	03/11/09
SB 238	Calderon	Medical Information: prescription refil requirements	Sen. Health	04/23/09
SB 294	Negrete McLeod	Healing Arts	Asm. Floor	09/04/09
SB 341	DeSaulnier	Pharmaceuticals: adverse drug reactions	Sen. Approps.	05/14/09
SB 395	Wyland	Medical Practice	Sen Rules	
SB 442	Ducheny	Clinic Corporation: licensing	Asm. Health	01/12/10
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	Sen. G.O.	
SB 638	Negrete McLeod	Regulatory boards: operations	Sen. Rules	
SB 719	Huff	State Agency Internet Web Sites: information searchability	Sen. Approps.	
SB 761	Aanestad	Health Manpower Pilot Projects	Asm. Health	05/06/09
SB 810	Leno	Single-Payer Health Care Coverage	Sen. Approps.	01/13/10
SB 953	Walters	Podiatrists: liability for emergency services	Sen. Jud.	03/16/10
SB 1050	Yee	Osteopathic Medical Board of California: Naturopathic Medicine	Sen. Approps.	04/07/10
SB 1051	Huff	Emergency Medical Assistance: administration of disasters	Sen. Health	04/21/10
SB 1071	DeSauliner	Controlled Substance	Sen. Health	04/16/10
SB 1083	Correa	Health Facilities: licensure	Sen. Approps.	04/21/10
SB 1094	Aanestad	Healing Arts: peer review	Sen. B&P	
SB 1132	Negrete McLeod	Healing Arts	Sen. Rules	
SB 1171	Negrete McLeod	Regulatory boards: operations	Sen. Rules	04/05/10

Medical Board of California
Tracker II - Legislative Bills
4/22/2010

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 1246	Negrete McLeod	Naturopathic Medicine	Sen. Approps.	04/15/10
SB 1281	Padilla	Emergency Medical Services: defibrillators	Sen. Jud.	
SB 1390	Corbett	Prescription drug labels	Sen. Approps.	04/05/10
SB 1490	B&P Comm.	Professions and Vocations	Sen. Approps.	04/12/10
SB 1491	B&P Comm.	Professions and Vocations	Sen. Approps.	
SBX8 53	Calderon	Medical Marijuana Act	Sen. Rules	
SJR 14	Leno	Medical Marijuana	Asm. Health	
SJR 15	Leno	Public Health Laboratories	Asm. Health	08/17/09

State of California

Department of Consumer Affairs
Medical Board of California

Memorandum

To : Members, Medical Board

Date: April 8, 2010

From : Kevin A. Schunke, Licensing Outreach Manager

Subject: Licensing Outreach Program for 2010

Since 2001, the Medical Board has offered a licensing outreach program. The purpose of the program is to build improved working relationships with California's teaching hospitals, the Graduate Medical Education (GME) staff, and residents, but also with other future applicants who are be considered for faculty appointments or professional positions.

In the past, outreach has been achieved through two avenues: (1) presentations at new resident orientation or during grand rounds, and (2) participation in licensing workshops. Beginning Fall, 2009, I also have expanded my outreach to include hospital recruiters and credentialing staff to better explain the licensing process for faculty members and to discuss how their anticipated hiring dates might best dovetail with the Board's other obligations. And in the near future, I hope to broaden my outreach to medical groups, clinics, professional societies, etc., as well as developing a web-based seminar with CMA for their members and member societies.

Since I reported at the last Board meeting, I have attended the following licensing workshops:

February 18, Harbor/UCLA -- about 75 residents
March 9-10, UCLA and UCLA/Olive View -- about 100 residents
March 18 – UCD - over 100 residents
March 22-23 – UCSD, both the Hillcrest and LaJolla campuses (also with residents from the VA, Scripps Green, and Rady Children's hospitals) – about 100 residents

The following licensing workshops have been planned, and others may be added:

May 5 – Alameda County/Highland Hospital and UCSF-East Bay Surgery Program (Oakland)
May 6 – Children's Hospital Oakland
May 12 – various recruiters and hospital/clinic staff, Central Valley
May 13 – UCSF-Fresno
Aug. 24 – UCSF (with residents from the VA and San Francisco General hospitals) (day 1)
Aug. 26 – USC
Sept. 1 – UCSF (with residents from the VA and San Francisco General hospitals) (day 2)
Oct. 6 – Kaiser Permanent SF Bay Area (residents from the Oakland, San Francisco, and Santa Clara campuses) (day 1)
Oct. 13 -- Kaiser Permanent SF Bay Area (residents from the Oakland, San Francisco, and Santa Clara campuses) (day 2)
Oct. 15 – UC Irvine (also with residents from Long Beach Memorial and VA hospitals)
Oct. 28 – Children's Hospital Los Angeles
Oct. 29 – Kaiser Permanent Los Angeles (also with residents from some regional campuses)
Nov. 9 – Loma Linda University

I have been invited to participate in new resident orientation at the following teaching hospitals:

June 17 – UCLA
June 18 – UCSF
June 23 – UCSD, UCI, Loma Linda
June 30 – UCSD
July 1 – Loma Linda, UCI, and UCLA

In the past, I have visited California Pacific and St. Mary's hospitals, both in San Francisco. I will attempt to coordinate visits to these smaller hospitals into one day or tie in my visits with the licensing fairs being held at UCSF.

Cedars-Sinai has declined my numerous overtures encouraging them to host licensing fairs; however, they have expressed their interest in having me make a grand-rounds presentation sometime this fall, possibly in conjunction with visits to other hospitals in the Los Angeles area.

For the first time, an article on the Board's outreach program was included in the April, 2010 edition of the *Newsletter* (see attached). Within hours of the *Newsletter* being posted on line, I received several inquiries asking about the program, what outreach "services" were included and offered via the program, and general licensing questions.

I value the long-standing cooperation I have received from GME staff at some hospitals, for they have allowed me the opportunity to visit their campuses and work with the residents. But I also hope that I can expand my outreach visits to other hospitals that are not on this list; I would appreciate any introductions Board members can make for me, or any encouragement you could offer Administrators at teaching hospitals not on this list so they can benefit from our continued efforts to improve service to all our clients. Possible contacts I will consider in the expansion of outreach will include former Board members, medical consultants, and the Board's experts.

I look forward to discussing and receiving input about this outreach program at the Board meeting. In the meantime, if you have questions or are able to provide me with contact information for other hospitals, you may contact me at (916) 263-2368 or via email at kschunke@mbc.ca.gov.

Attachment

Medical Board expands licensing-application outreach

For 10 years, the Medical Board has offered a licensing-application outreach program. The purpose of the program is to build improved working relationships with California's teaching hospitals, the Graduate Medical Education (GME) staff, and residents, but also with other future applicants who are being considered for faculty appointments or professional positions.

In the past, GME outreach has been achieved through two avenues: (1) presentations at new-resident orientation and during grand rounds, and (2) participation in full-day licensing workshops. These licensing workshops are coordinated by the hospital and offer residents a "one-stop shopping" opportunity for Live Scan fingerprinting, notary, and photography services; Medical Board staff also is invited to attend, answering questions and assisting residents with the application process.

Beginning this year, the outreach has been expanded to include hospital recruiters and credentialing staff to better explain the licensing process for faculty members and to discuss how their anticipated hiring dates might best dovetail with the Board's licensing deadlines. The Board also would like to broaden its outreach to medical groups, clinics, professional societies, and county medical societies.

If you would like more information or to schedule an outreach event, please contact Kevin A. Schunke, Licensing Outreach Manager, at kschunke@mbc.ca.gov or (916) 263-2368.

LICENSING PROGRAM
CHIEF'S REPORT

WORKLOAD REPORT

as of March 31, 2010

AGENDA ITEM 19A
FISCAL YEAR 2009-10

AMBULATORY SURGERY CENTER APPROVALS FY 09/10*				
	Q1	Q2	Q3	Q4
Renewal Applications Received	0	4	n/a	
Renewal Applications Issued	0	4	n/a	

* Approval granted for three (3) years

CONSUMER INFORMATION UNIT FY 09/10				
	Q1	Q2	Q3	Q4
Total Calls Answered	27,117	22,049	23,579	
Calls Requesting Call Back	4,951	3,021	4,491	
Calls Abandoned	4,967	3,336	4,834	
Address Changes Completed	3,346	2,302	2,217	

PHYSICIAN & SURGEON DATA FY 09/10				
	Q1	Q2	Q3	Q4
Applications Received	1,651	1,555	1,274	
Initial Reviews Completed	n/a	n/a	1,658	
Applications Pending	n/a	n/a	6,716	
SR2 Applications Pending	n/a	n/a	73	
Licenses Issued	1,107	1,132	1,425	
Renewals Issued	14,883	15,668	15,447	

SPECIAL PROGRAMS FY 09/10																				
Permit Category	Applications Received				Applications Reviewed				Permits Issued				Permits Renewed				Total Pending		Total Backlog**	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q3	Q4	Q3	Q4
2111*	12	4	3		12	4	3		17	10	3		17	11	6		6		0	
2112	1	0	0		1	0	0		1	1	0		1	0	0		0		0	
2113	5	1	3		5	1	0		13	4	1		13	18	18		8		3	
2168	1	0	0		1	0	0		0	0	2		0	1	1		1		0	
2072	0	0	0		0	0	0		0	0	0		0	0	0		0		0	
1327	1	0	0		1	0	0		0	0	0		0	2	0		0		0	

*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

**Number of requests over the 10-working day regulatory timelines for reviewing an application
n/a - Not applicable

WORKLOAD REPORT

as of March 31, 2010

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 09/10				
	Q1	Q2	Q3	Q4
New Applications Received in Quarter	0	1	0	
Pending Assignment to Consultant in Previous Quarter	2	3	1	
Applications to Consultant in Current Quarter*	1	1	3	
Total Pending Applications**	3	4	4	

* Applications received in: March 2008, August 2008, January 2009, and October 2009

**Of the three pending applications currently with the consultant, two were reviewed and are awaiting the school's response

LICENSED MIDWIVES FY 09/10				
	Q1	Q2	Q3	Q4
Applications Received	2	0	10	
Applications Pending	n/a	1	0	
Licenses Issued	2	2	10	
Licenses Renewed	18	4	29	

OPTICAL REGISTRATIONS FY 09/10				
	Q1	Q2	Q3	Q4
Business Registrations Issued	19	60	8	
Pending Applications Business	n/a	n/a	82	
Out-of-State Business Registrations Issued	1	0	0	
Pending Applications Out of State Bus.	n/a	n/a	0	
Spectacle Lens Registrations Issued	56	18	71	
Pending Applications-Spectacle Lens	n/a	n/a	47	
Contact Lens Registrations Issued	36	11	26	
Pending Applications-Contact Lens	n/a	n/a	22	
Spectacle Lens Registrations Renewed	214	200	242	
Contact Lens Registrations Renewed	82	93	77	

RESEARCH PSYCHOANALYST (RP) FY 09/10				
	Q1	Q2	Q3	Q4
RP Applications Received	0	0	0	
RP Licenses Issued	0	1	0	

FICTITIOUS NAME PERMITS (FNP) FY 09/10				
	Q1	Q2	Q3	Q4
P&S - FNP Issued	276	227	210	
P&S - FNP Pending	n/a	n/a	242	
Podiatric FNP Issued	6	6	1	
Podiatric FNP Pending	0	0	1	

SPECIALTY BOARD APPLICATIONS FY 09/10				
	Q1	Q2	Q3	Q4
Applications Received (Emergency Medicine) *	0	0	0	

*Application received in 1999 and is incomplete

Licensing Program

Weekly Application Production

week ending -->	23-Jan	30-Jan	6-Feb	13-Feb	20-Feb	27-Feb	6-Mar	13-Mar	20-Mar	27-Mar	3-Apr	10-Apr
Number of Workdays -->	3	5	4	4	3	4	4	4	4	5	3	4
Applications Received												
US/CAN	67	101	62	73	22	68	56	46	28	82	46	137
IMG - License	10	31	23	8	22	32	13	8	19	26	17	5
IMG - PTAL	17	20	17	6	19	23	17	7	24	29	37	4
Total	***94***	***152***	***102***	***87***	***63***	***123***	***86***	***61***	***71***	***137***	***100***	***146***
Applications Completed (License or PTAL Issued)												
US/CAN	62	41	104	99	45	73	148	65	91	76	125	74
IMG - License	17	30	34	24	10	15	37	13	32	32	43	12
IMG - PTAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	11
Total	***79***	***71***	***138***	***123***	***55***	***88***	***185***	***78***	***123***	***108***	***168***	***97***
Applications Processed (Initial Review Completed)												
Application Complete Upon Initial Review (ready for licensure)												
US/CAN	15	20	13	11	14	6	6	12	8	1	5	11
IMG - License	0	0	0	0	0	0	0	0	0	1	0	0
IMG - PTAL	3	0	1	0	0	0	2	0	1	0	0	0
Subtotal	***18***	***20***	***14***	***11***	***14***	***6***	***8***	***12***	***9***	***2***	***5***	***11***
Initial Review (Application Deficient)												
US/CAN	66	94	87	54	67	71	68	109	88	24	31	49
IMG - License	18	23	12	10	10	18	19	16	15	10	12	16
IMG - PTAL	20	24	18	10	4	11	14	20	15	11	7	11
Subtotal	***104***	***139***	***117***	***74***	***81***	***100***	***101***	***133***	***118***	***45***	***50***	***76***
Total	***122***	***159***	***131***	***85***	***95***	***106***	***109***	***145***	***127***	***47***	***55***	***87***
Inventory Waiting Initial Review												
NEW: 0-30 days	307	408	401	405	432	450	418	405	455	438	453	439
AGING: 31-60 days	378	354	340	306	291	372	414	426	447	430	415	415
AGING: 61-90 days	228	168	146	174	170	133	131	48	12	117	185	193
BACKLOG: Over 90 days	0	0	0	0	0	0	0	0	0	0	0	0
Total	***913***	***930***	***887***	***885***	***893***	***955***	***963***	***879***	***914***	***985***	***1053***	***1047***
Date of Oldest Application Awaiting Initial Review	*11/10/09*	*11/18/09*	*11/25/09*	*12/03/09*	*12/10/09*	*12/19/09*	*12/28/09*	*01/04/10*	*12/28/09*	*01/25/10*	*01/25/10*	*01/25/10*
Days out of Compliance	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Age (in days) - Oldest Application Awaiting Review	*74*	*73*	*73*	*72*	*72*	*70*	*68*	*70*	*84*	*63*	*70*	*77*
Date of Oldest Pending Mail Awaiting Review						*01/25/10*	*02/10/10*	*02/23/10*	*02/26/10*	*03/09/10*	*03/09/10*	*03/12/10*
Age (in Days) - Oldest Pending Mail Awaiting Review						*33*	*24*	*18*	*22*	*18*	*25*	*28*

Note: Subtract from *Applications Received* 46 files (17 PTAL, 8 IMG, 21 US). They were added in last week manually.

Note: Added to *Applications Received 84* US files. Staff did not complete pathways prior to running of weekly report.

Note: Subtracted 1 file from *Inventory Over 90* and added it to *0-30 days* due to staffing error on input of application received date.

Note: Effective 4/4/10, a report was created for initial/subsequent PTAL's issued

AGENDA ITEM 19A

GME Residents Needing Licensure

week ending -->	6-Feb	13-Feb	20-Feb	27-Feb	6-Mar	13-Mar	20-Mar	27-Mar	3-Apr	10-Apr	17-Apr	24-Apr
Number of Workdays -->	4	4	3	4	4	4	4	5	4	4	4	4
Pending Applications												
Applications Reviewed & Pending	626	610	688	691	656	660	638	647	638	521		
Applications Not Reviewed			177	162	162	151	109	111	94	163		
Applications Not Received			200	184	191	153	149	139	144	79		
Applications Not Reviewed and Not Received	327	346										
Total Pending	***953***	***956***	***1065***	***1037***	***1009***	***964***	***896***	***897***	***876***	***763***	***0***	***0***
Licenses Issued	539	577	641	671	741	786	824	838	863	1016		
Total Names Identified by GME Offices	***1492***	***1533***	***1706***	***1708***	***1750***	***1750***	***1720***	***1735***	***1739***	***1779***	***0***	***0***

Note: Week of March 20, 30 duplicate records were discovered and deleted.

AGENDA ITEM 19A

Licensing Program

Weekly Application Production

week ending -->	6-Feb	13-Feb	20-Feb	27-Feb	6-Mar	13-Mar	20-Mar	27-Mar	3-Apr	10-Apr	17-Apr	24-Apr
Number of Workdays -->	4	4	3	4	4	4	4	5	3	4	4	5
Applications Received												
US/CAN	62	73	22	68	56	46	28	82	46	53	63	41
IMG - License	23	8	22	32	13	8	19	26	17	5	22	19
IMG - PTAL	17	6	19	23	17	7	24	29	37	4	24	26
Total	***102***	***87***	***63***	***123***	***86***	***61***	***71***	***137***	***100***	***62***	***109***	***86***
Applications Completed (License or PTAL Issued)												56
US/CAN	104	99	45	73	148	65	91	76	125	74	89	56
IMG - License	34	24	10	15	37	13	32	32	43	12	19	18
IMG - PTAL	NA	NA	NA	NA	NA	NA	NA	NA	NA	11	11	20
Total	***138***	***123***	***55***	***88***	***185***	***78***	***123***	***108***	***168***	***97***	***119***	***94***
Applications Processed (Initial Review Completed)												
Application Complete Upon Initial Review (ready for licensure)												
US/CAN	13	11	14	6	6	12	8	1	5	11	9	13
IMG - License	0	0	0	0	0	0	0	1	0	0	1	0
IMG - PTAL	1	0	0	0	2	0	1	0	0	0	0	2
Subtotal	***14***	***11***	***14***	***6***	***8***	***12***	***9***	***2***	***5***	***11***	***10***	***15***
Initial Review (Application Deficient)												
US/CAN	87	54	67	71	68	109	88	24	31	49	89	121
IMG - License	12	10	10	18	19	16	15	10	12	16	25	17
IMG - PTAL	18	10	4	11	14	20	15	11	7	11	10	16
Subtotal	***117***	***74***	***81***	***100***	***101***	***133***	***118***	***45***	***50***	***76***	***124***	***154***
Total	***131***	***85***	***95***	***106***	***109***	***145***	***127***	***47***	***55***	***87***	***134***	***169***
Inventory Waiting Initial Review												
NEW: 0-30 days	401	405	432	450	418	405	455	438	453	439	505	437
AGING: 31-60 days	340	306	291	372	414	426	447	430	415	415	408	427
AGING: 61-90 days	146	174	170	133	131	48	12	117	185	193	152	136
BACKLOG: 0ver 90 days	0	0	0	0	0	0	0	0	0	0	0	0
Total	***887***	***885***	***893***	***955***	***963***	***879***	***914***	***985***	***1053***	***1047***	***1065***	***1000***
Date of Oldest Application Awaiting Initial Review	*11/25/09*	*12/03/09*	*12/10/09*	*12/19/09*	*12/28/09*	*01/04/10*	*12/28/09*	*01/25/10*	*01/25/10*	*01/25/10*	*02/04/10*	*02/16/10*
Days out of Compliance	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Age (in days) - Oldest Application Awaiting Review	*73*	*72*	*72*	*70*	*68*	*70*	*84*	*63*	*70*	*77*	*73*	*68*
Date of Oldest Pending Mail Awaiting Review				*01/25/10*	*02/10/10*	*02/23/10*	*02/26/10*	*03/09/10*	*03/09/10*	*03/12/10*	*03/16/10*	*03/26/10*
Age (in Days) - Oldest Pending Mail Awaiting Review				*33*	*24*	*18*	*22*	*18*	*25*	*28*	*33*	*29*

Note: Based on review of Exception Report added 3 apps to Initial Reviews *Apps w/Deficiences;* Removed 1 app from *Apps w/Def* and added it to *Apps Complete*

GME Residents Needing Licensure

week ending -->	6-Feb	13-Feb	20-Feb	27-Feb	6-Mar	13-Mar	20-Mar	27-Mar	3-Apr	10-Apr	17-Apr	24-Apr
Number of Workdays -->	4	4	3	4	4	4	4	5	4	4	4	4
Pending Applications												
Applications Reviewed & Pending	626	610	688	691	656	660	638	647	638	521	495	513
Applications Not Reviewed			177	162	162	151	109	111	94	163	77	46
Applications Not Received			200	184	191	153	149	139	144	79	73	64
Applications Not Reviewed and Not Received	327	346										
Total Pending	***953***	***956***	***1065***	***1037***	***1009***	***964***	***896***	***897***	***876***	***763***	***645***	***623***
Licenses Issued	539	577	641	671	741	786	824	838	863	1016	1061	1080
Total Names Identified by GME Offices	***1492***	***1533***	***1706***	***1708***	***1750***	***1750***	***1720***	***1735***	***1739***	***1779***	***1706***	***1703***

Note: Week of March 20, 30 duplicate records were discovered and deleted.

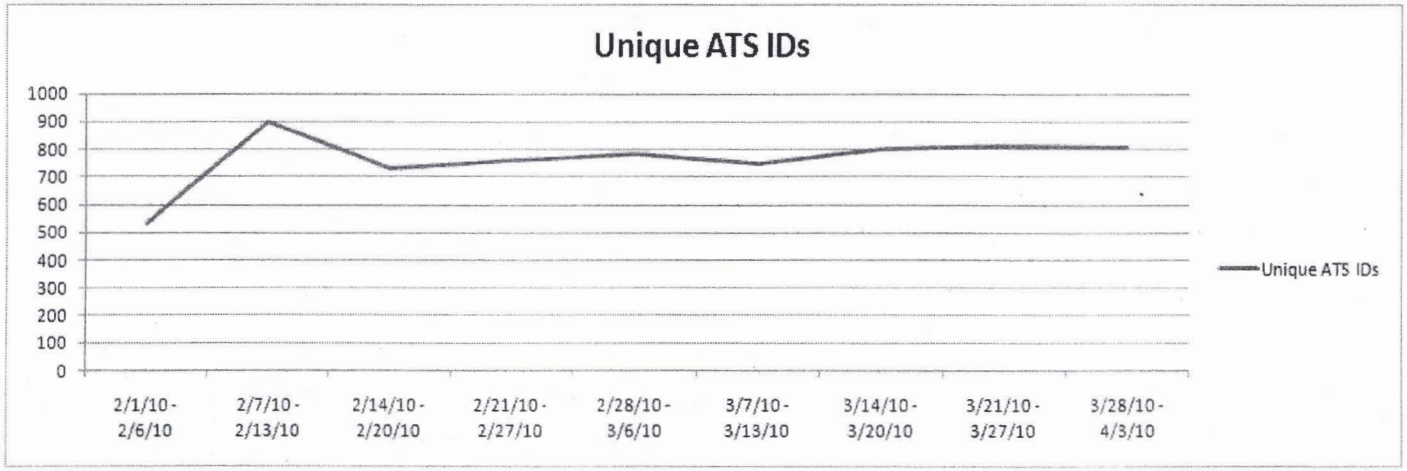
Note: Week of April 17 re: Total Names Identified by GME offices has been adjusted as a result of names being crossed off per the request of the GME office.

WEB APPLICANT ACCESS SYSTEM

Login Type	10-Feb	10-Mar
Successful Logins	6153	7949
Unique IP Addresses	2220	2262
Unique ATS IDs	1644	1782

The table above displays the total number of Successful Logins, the number of unique IP addresses for those logins, and the number of unique ATS IDs for those logins per month. In February 2010, there were 6,153 successful logins but all those logins were done to check only 1644 unique ATS IDs. Therefore, many are logging in multiple times per month, repeatedly checking their status. The table below, breaks down the unique ATS ID's by weeks.

Unique ATS IDs	2/1/10 - 2/6/10	2/7/10 - 2/13/10	2/14/10 - 2/20/10	2/21/10 - 2/27/10	2/28/10 - 3/6/10	3/7/10 - 3/13/10	3/14/10 - 3/20/10	3/21/10 - 3/27/10	3/28/10 - 4/3/10
	534	900	730	759	783	751	799	814	807



MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 21, 2010
DEPARTMENT: Licensing Operations
SUBJECT: Consideration of Midwifery Advisory Council (MAC) Recommendations
STAFF CONTACT: Abbie French

REQUESTED ACTION:

Address barriers to care experienced by Licensed Midwives.

STAFF RECOMMENDATION:

The MAC has voted to request the Board's permission to begin to address barriers to care experienced by Licensed Midwives, including the following:

- Form a task force to work with liability insurance carriers. The goal of this task force would be to work with the liability carriers to resolve issues in California for physicians and surgeons who wish to work with midwives. For example, if a physician or surgeon wants to hire a midwife for their practice it currently would cost them $18,000 a year for liability coverage vs. $1800 a year to hire a nurse practitioner.

- Form a task force to change the process to register live births. SB 1479 states, in part: "This bill would require a professionally licensed midwife in attendance at a live birth outside the hospital, where no physician is present, to prepare and register a birth certificate." The Bureau of Vital Records in most counties does not allow a midwife to fulfill the requirements they have by law. For example, in the past, Santa Cruz County allowed the midwives to fill out a birth certificate and send it in to register the birth of a baby. Santa Cruz County now requires the midwife, parents, and baby to physically come into the vital records office to show proof of residence. In addition, the registrar must be present to witness the signing of the birth certificate, by the midwife, prior to filing the birth certificate.

- Form a task force to identify key legislative and regulatory areas that need to be addressed to ensure the Licensed Midwife Practice Act (LMPA) is implemented the way the legislature envisioned it to be implemented. For example, the practice of midwifery authorizes the licensee, under the supervision of a licensed physician and surgeon, in active practice, to attend cases of normal childbirth, in a home, birthing clinic, or hospital environment. All clinics in the state run a comprehensive perinatal service program, but Licensed Midwives are not on the list of providers. Therefore, Licensed Midwives are unable to be hired by the clinics because clinic is unable to bill for the Licensed Midwife services.

EXECUTIVE SUMMARY:

Section 2509 of the Business and Professions Code authorizes, in part "that the Board create and appoint a Midwifery Advisory Council consisting of licensees of the Board in good standing, who need not be members of the Board, and members of the public who have an interest in midwifery practice. The council shall make recommendations on matters specified by the Board.

We have not determined priorities for these three initiatives as we feel each one of these is a priority. We understand some will take much longer to achieve then the others. We anticipate these could be accomplished over the next two years as some may require legislative action.

We bring these issues to you today and ask for permission from the Board to move forward.

FISCAL CONSIDERATIONS:

To be determined.

PREVIOUS MBC AND/OR COMMITTEE ACTION:

N/A

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 30, 2010
ATTENTION: Medical Board of California
DEPARTMENT: Licensing Operations
SUBJECT: Challenge Program Modification – Maternidad La Luz
STAFF CONTACT: Deborah Pellegrini, Chief

REQUESTED ACTION: Approve modification to the existing challenge program at Maternidad La Luz (MLL) and broaden the potential applicant category to include those who are Certified Professional Midwives.

STAFF RECOMMENDATION: Staff recommends that the Board approve modification to the existing challenge program and broadening the applicant category to include Certified Professional Midwives (CPMs) at MLL located in El Paso, Texas, as those changes are consistent with existing law.

EXECUTIVE SUMMARY: Business and Professions Code section 2513 states that an approved midwifery education program shall offer the opportunity for students to obtain credit by examination for previous midwifery education and clinical experience (see attached language). The Midwifery Education Accreditation Council (MEAC) approved the curriculum prior to Board approval of MLL's three year direct-entry midwife program. In the spring of 2004, the Medical Board also approved the application from MLL to add a challenge program to their previously board approved direct-entry midwife program. The challenge program in place at this time requires a midwife applicant to spend one year on-campus to allow the school to verify skills, educational, and practical knowledge prior to allowing the applicant to take the challenge examination.

In December 2009, MLL approached the Medical Board to modify its existing curriculum of the challenge program curriculum to allow midwife applicants to challenge its program by distance education and practical verification. In addition, MLL is requesting approval to broaden the applicant acceptance criteria to allow Certified Professional Midwives (CPMs) to take the challenge examination by distance. MLL has named this broadened category the "Prior Learning and Experience Program (PLEP)." (See the attached flow chart that displays how an applicant will move through the challenge program.)

MLL submitted a matrix with the statute and regulatory requirements that the program meets. It used the same template that was submitted in 2004 for the original approval of the challenge program and updated the information to reflect the changes that are being proposed (see attached MLL matrix). Medical Board staff reviewed the matrix and concur that MLL continues to meet all of the requirements for a challenge program. It is important to note that the quality of education would not be compromised for midwives enrolling in the challenge program as these programs are already in existence, time-tested, and functioning successfully through the midwifery programs offered by the National Midwifery Institute located in Bristol, Vermont.

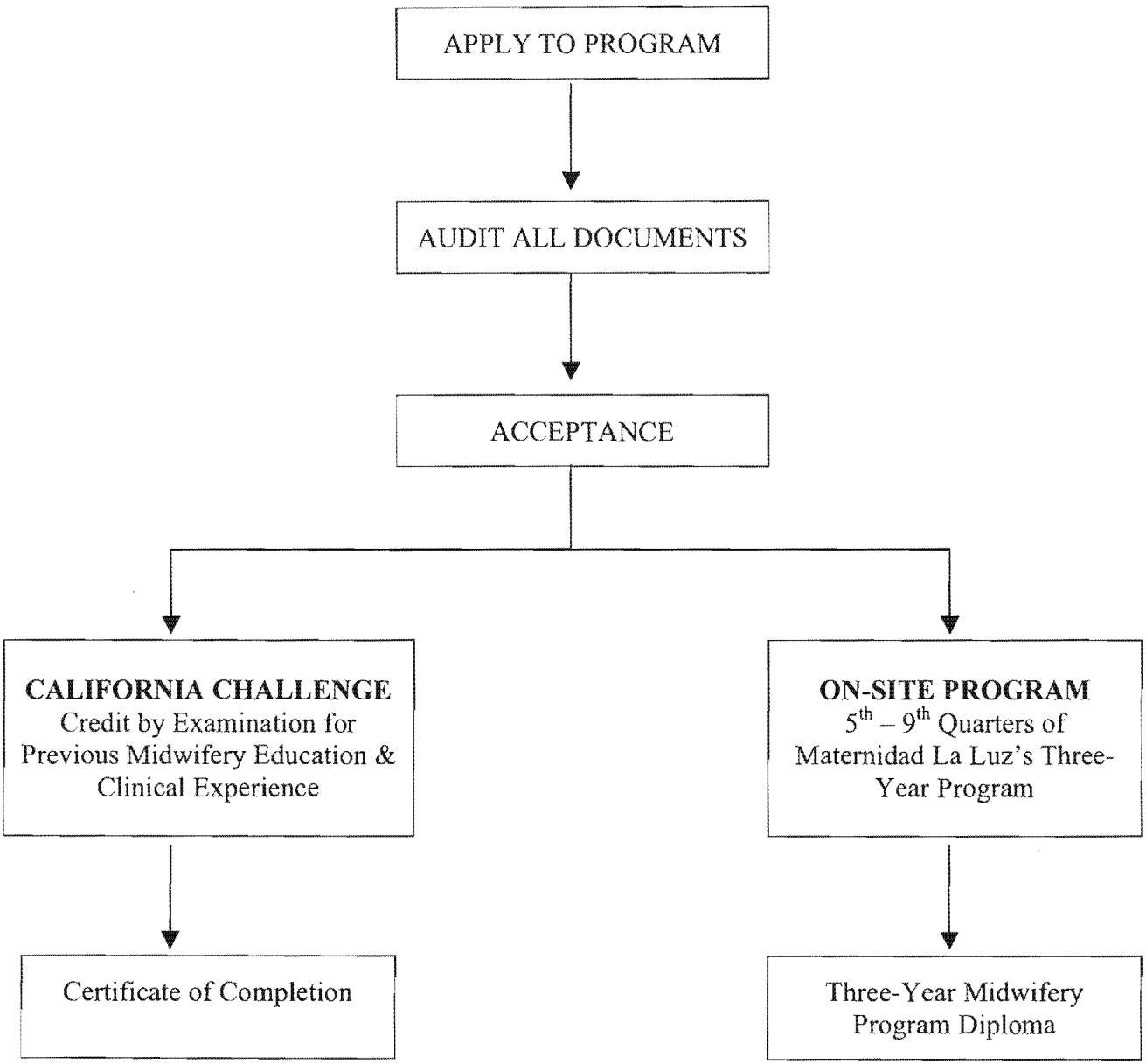
MLL's proposal mirrors NMIs midwife challenge programs. MLL is simply choosing to carve out additional programs from the current MEAC-approved challenge process, so that it may offer other avenues to licensure for those midwives who choose to practice their craft in California. MLL contacted MEAC and asked it if the changes in curriculum that are being proposed would be considered "substantive." MEAC advised MLL that it does not consider the proposed changes to be substantive, and MEAC approved MLL's three year direct-entry curriculum as well as the challenge program curriculum, prior to submission to the Board.

At this time, the National Midwifery Institute located in Bristol, Vermont, is the only other school in the United States that offers a challenge program. NMI is a board approved school and the challenge program is a distance learning and verification program. The Vermont school also accepts CPMs. MLL's proposed modification to its challenge program aligns this school's program with the Vermont program. The Board approval of the MLL proposed modification to its challenge program and applicant pool allows the program to be competitive in the midwifery market.

FISCAL CONSIDERATIONS:
None.

PREVIOUS MBC AND/OR COUNCIL ACTION:
In 2004, the Board approved MLL's three year direct-entry midwife program and approved its application to add a challenge program as well.

MATERNIDAD LA LUZ
PRIOR LEARNING AND EXPERIENCE PROGRAM



CALIFORNIA CODES
BUSINESS AND PROFESSIONS CODE
SECTION 2513.

2513. (a) An approved midwifery education program shall offer the opportunity for students to obtain credit by examination for previous midwifery education and clinical experience. The applicant shall demonstrate, by practical examination, the clinical competencies described in Section 2514 or established by regulation pursuant to Section 2514.5. The midwifery education program's credit by examination policy shall be approved by the board, and shall be available to applicants upon request. The proficiency and practical examinations shall be approved by the board.

(b) Completion of clinical experiences shall be verified by a licensed midwife or certified nurse-midwife, and a physician and surgeon, all of whom shall be current in the knowledge and practice of obstetrics and midwifery. Physicians and surgeons, licensed midwives, and certified nurse-midwives who participate in the verification and evaluation of an applicant's clinical experiences shall show evidence of current practice. The method used to verify clinical experiences shall be approved by the board.

(c) Upon successful completion of the requirements of paragraphs (1) and (2), the applicant shall also complete the licensing examination described in paragraph (1) of subdivision (a) of Section 2512.5.

MEDICAL BOARD OF CALIFORNIA
CHALLENGE MECHANISM AUDIT/SELF-ASSESSMENT MATRIX—MIDWIFERY PROGRAM
Maternidad La Luz (El Paso, Texas): Entry by One-Year MEAC-Accredited Program

Statutory Requirements		Maternidad La Luz Response	Does MLL's Program Satisfy California Regulatory Requirements?
B&P Code 2513(a)	"An approved midwifery education program shall offer the opportunity for students to obtain credit by examination for previous midwifery education and clinical experience."	Students with previous required midwifery education and clinical experience may "test out" of the first quarter at MLL. Students who complete the one-year program may challenge the three-year program through a practical and written examination per B&P Code 2513(a).	YES
B&P Code 2513.(a) and CCR 1379.30	The Challenge applicant shall demonstrate, by practical examination, the clinical competencies described in the statute.	See Appendix A, page 5.	YES
B&P Code 2513.(a)	The midwifery education program's credit-by-examination policy shall be approved by the Board, and shall be available to applicants upon request. Likewise, the proficiency and practical examinations shall be approved by the Board.	MLL's midwifery education program's credit-by-examination policy and proficiency and practical examinations were approved by the Board on…Applicants may request the application packet by mail, telephone, e-mail or through our website.	YES
B&P Code 2513(b)	Completion of clinical experiences shall be verified by a licensed midwife or certified nurse-midwife, <u>and</u> a physician and surgeon, all of whom shall be current in the knowledge and practice of obstetrics and midwifery.	MLL requires that all clinical experiences be verified by a licensed midwife or certified nurse-midwife <u>and</u> a physician, who signs a statement of intent and describes their current practice. The applicant obtains a copy of the license of the verifier	YES
B&P Code 2513(b)	Physicians and surgeons, licensed midwives, and certified nurse-midwives who participate in the verification and evaluation of an applicant's clinical experience shall show evidence of current practice.	MLL requires that verifiers/evaluators describe their current practice and sign a statement of intent and the applicant must obtain a copy of the verifier's current license.	YES
B&P Code 2513(b)	The method used to verify clinical experiences shall be approved by the Board.	The Board has approved MLL's method of verification for the One-Year Program, which consists of chart audit, direct observation,	YES

Statutory Requirements		Maternidad La Luz Response	Does MLL's Program Satisfy California Regulatory Requirements?
		verification of experience by telephone (e.g., talking with former clients, another midwife or someone else who was present at the birth).	
CCR 1379.15(b)	A person who applies for licensure as a midwife on or after January 1, 1998, who would rely on credit by examination for previous education and experience as his/her sole qualifications for taking the national written licensing exam *shall have obtained at least 50% of the experiences described in subsection (c) within five years immediately preceding the date of application.*	MLL states in Part I of its California Challenge Process Handbook: "At least 50 percent of the required clinical experiences having been obtained within five years of applying to the California Medical Board to either sit for the written exam or for initial licensure."	YES
CCR 1379.15(c)	An approved midwife education program shall verify the following number of clinical experiences.		
CCR 1379(c)	Statutorily required minimum number of clinical experiences: (1) 20 new antepartum visits clinical experiences; (2) 75 return antepartum visits; (3) 20 labor management experiences; (4) 20 deliveries; (5) 40 postpartum visits, within the first five days after birth; (6) 20 newborn assessments; (7) 40 postpartum/family planning/	MLL's requirements meet the CCR minimum requirements for the following clinical experiences: (1) MLL requires 20 new antepartum visits; (2) MLL requires 75 return antepartum visits; (3) MLL requires 20 labor management experiences; (4) MLL requires 20 deliveries; (5) MLL requires 40 postpartum visits within the first five days after birth; (6) MLL requires 20 newborn assessments; (7) MLL requires 40 postpartum/family planning/ gynecology visits	YES

Statutory Requirements		Maternidad La Luz Response	Does MLL's Program Satisfy California Regulatory Requirements?
	gynecology visits.		
CCR 1379.30	The midwifery education program shall prepare the midwife to practice as follows: (a) management of the normal pregnancy (b) management of normal labor and delivery in all birth settings, including the following when indicated. Statutorily required minimum number of clinical experiences:	(a) Please see the 1st – 9th Quarter Curriculum & Syllabus & Clinical Practice: Qtr 1-p 4; Qtr 2-p 1; Qtr 3-p 1; Qtr 4-p 1; Qtr 5-p 1; Qtr 6-p 4; 7th Qtr-p 1; 8th Qtr-p 1; Qtr 9-p 1 (b) Please see the 1st – 9th Quarter Curriculum & Syllabus & Clinical Practice	YES
CCR 1379.30	(1) Administration of intravenous fluids, analgesics, postpartum oxytocics, and RhoGAM; (2) Amniotomy during labor; (3) Application of external or internal monitoring devices; (4) Administration of local anesthesia, paracervical blocks, pudendal blocks, and local infiltration; (5) Episiotomy; (6) Repair of episiotomies and lacerations; (7) Resuscitation of the newborn (c) Management of the normal postpartum period; (d) Management of the normal newborn care, including administration of vitamin K and eye prophylaxis; and (Continued on next page)	(1) See 1st Qtr Cur/Syl: Basic Emergency Procedures, p 69; Hospital Procedures, p 75. 2nd Qtr Cur/Syl: Basic Suturing, p 86. Continued in Note 1, Appendix B, page 6 (2) See Note 2, Appendix B, page 6 (3) See 1st Qtr Cur/Syl: Hospital Procedures, p 75. Continued in Note 3, Appendix B, page 6. (4) See 1st Qtr Cur/Syl: Emergency Procedures, p 69; Hospital Procedures, p 75. Continued in Note 4, Appendix B, page 6. (5) and (6) See Appendix C, p. 7 (7) See Note 5, Appendix B, p 6. (c) See 1st Qtr Cur/Syl: Basic Neonatal Skills, p 60. Continued in Note 6, Appendix C, p. 7 (d) See 1st Qtr Cur/Syl: Basic Neonatal Skills, p 60. 2nd Qtr Cur/Syl: Normal Neonatal Adaptation, p 41; Newborn Issues, p 78. 4th Qtr Cur/Syl: Pharmacology, p 13. See Clinical Practice for Quarters 1-9.	
CCR	(e) Management of family planning and	(e) See 1st Qtr Cur/Syl: Principles of Community	

Statutory Requirements		Maternidad La Luz Response	Does MLL's Program Satisfy California Regulatory Requirements?
1379.30 (Continued)	routine gynecological care including methods of contraception, such as diaphragms and cervical caps.	Health & Well Woman Care, p 84; Physical Assessment, p 89; Family Planning, p 92; STDs, p 98; Breast Exam, p 43. Continued in Note 7, Appendix C, p 7.	YES
CCR 1379.31	Satisfactory evidence that an applicant has met the educational standards required for licensure as a midwife includes either (a) or (b). (a) a diploma is issued by a midwifery program approved by the Division; or (b) A notice of successful completion of the CHALLENGE Program (credit by examination) issued by a program approved by the Division.	Candidates must have earned a diploma from MLL before applying for the Challenge Program.	YES

APPENDIX A—CHALLENGE MECHANISM MATRIX

1. Evaluation of clinical competencies requires applicants to demonstrate entry-level midwifery clinical assessment and management skills through skills simulations. Midwifery skills will be assessed through the observation of care with client models from six of the following topics:
   1. Initial antepartum visit
   2. Routine prenatal follow-up visits
   3. Postpartum visits for mother
   4. Postpartum visits for baby
   5. Family planning visits
   6. Intrapartum skills:
      - Normal and/or complicated vertex delivery
      - Normal and/or complicated third stage
      - Infiltration and repair of perineal laceration
      - Newborn exam

   The level of proficiency of clinical skills is expected to be equivalent to the skill level of a student completing the 9th Quarter at MLL. The expected proficiency level is described in the study guide in the 9th Quarter Skills List.

   The clinical examination if based on the clinical competencies established by California midwifery regulations including:
   a) Management of the normal pregnancy
   b) Management of normal labor and delivery in all birth settings, including the following, when indicated:
      1. Administration of intravenous fluids, analgesics, postpartum oxytocics, and RhoGAM.
      2. Amniotomy during labor
      3. Application of external or internal monitoring devices
      4. Administration of local anesthesia, paracervical blocks, pudendal blocks, and local infiltration.
      5. Episiotomy
      6. Repair of episiotomies and lacerations
      7. Resuscitation of the newborn
   c) Management of the normal postpartum period
   d) Management of the normal newborn care, including administration of vitamin K and eye prophylaxis
   e) Management of family planning and routine gynecological care including barrier methods of contraception such as diaphragms and cervical caps.

APPENDIX B—NOTES

1. 4th Qtr Cur/Syl: IV Therapy, p 17; Pharmacology, p 13. See Cur/Syl for Qtrs 1-9: Clinical Practice & Emergency Skills (Qtr 1--p 155; Qtr 2-p 97; Qtr 3-p 24; Qtr 4-p 53; Qtr 5-p 15; Qtr 6-p 17; 7th Qtr-p 15; 8th Qtr-p 14; Qtr 9-p 13.)
2. See 1st Qtr Cur/Syl: Emergency Procedures, p 69; Hospital Procedures, p 75. 2nd Qtr Cur/Syl: Normal First Stage of Labor, p 25. See Cur/Syl for Qtrs 1-9: Emergency Skills & Clinical Practice.
3. See 2nd Qtr Cur/Syl: Fetal Heart Tones, p 21. See Cur/Syl for Qtrs 1-9: Emergency Skills & Clinical Practice.
4. See 2nd Qtr Cur/Syl: Normal 3rd & 4th Stage of Labor, p 32. 4th Qtr Cur/Syl: Pharmacology, p 13. See Cur/Syl for Qtrs 1-9: Emergency Skills & Clinical Practice.
5. See 2nd Qtr Cur/Syl: Neonatal Resuscitation, p 15. See Cur/Syl for Qtrs 1-9: Clinical Practice: Qtr 1-p 4; Qtr 2-p 1; Qtr 3-p 1; Qtr 4-p 1; Qtr 5-p 1; Qtr 6-p 4; 7th Qtr-p 1; 8th Qtr-p 1; Qtr 9-p 1 and Emergency Skills: Qtr 1--p 155; Qtr 2-p 97; Qtr 3-p 24; Qtr 4-p 53; Qtr 5-p 15; Qtr 6-p 17; 7th Qtr-p 15; 8th Qtr-p 14; Qtr 9-p 13.
6. See 2nd Qtr Cur/Syl: Normal Neonatal Adaptation, p 41; Newborn Issues, p 78. 4th Qtr Cur/Syl: Pharmacology, p 13. See Clinical Practice for Quarters 1-9.
7. See 1st Qtr Cur/Syl: Anatomy & Physiology Classes, pp 110-130. 2nd Qtr Cur/Syl: Normal Postpartum, p 38. 3rd Qtr Cur/Syl: Childbirth Education, p 14; Advanced Physical Assessment & Well Woman Care, p 17; 5th Qtr Cur/Syl: Advanced Physical Assessment & Principles of Preventive and Community Health in Well Woman Care. See Clinical Practice Qtrs 1-9.

Appendix C

Criteria 3.b.5. Episiotomy—Learning Objectives from Maternidad La Luz's Curriculum

Theory

From 1st Quarter Curriculum/Syllabus:

- Hospital Procedures, p 75
- Applied Anatomy & Physiology I: Reproductive System, p 116

From 2nd Qtr Curriculum/Syllabus:

- Basic Suturing, p; 86
- Normal 2nd Stage, p 28
- Postpartum Complications, p 91
- Normal Postpartum, p 38

From 4th Qtr Curriculum/Syllabus:

- Suturing II, p 27

See Clinical Practice for Quarters 1 – 9: Qtr 1-p 4; Qtr 2-p 1; Qtr 3-p 1; Qtr 4-p 1; Qtr 5-p 1; Qtr 6-p 4; 7th Qtr-p 1; 8th Qtr-p 1; Qtr 9-p 1

See Emergency Skills Classes for Quarters 1 – 9: Qtr 1--p 155; Qtr 2-p 97; Qtr 3-p 24; Qtr 4-p 53; Qtr 5-p 15; Qtr 6-p 17; 7th Qtr-p 15; 8th Qtr-p 14; Qtr 9-p 13.

On-Site Clinical

1. Students may observe a licensed midwife cutting an episiotomy in the birth center (It should be noted that midwives rarely perform episiotomies.)
2. During 2nd Stage of labor, midwives discuss with students why, when and how an episiotomy would be cut.
3. Students then learn how to cut mediolateral and midline episiotomies in normal second stage class
4. They observe a licensed midwife performing the procedure.
5. The student may perform episiotomies on clients under the direct supervision of a licensed midwife.
6. When students observe hospital births, they have additional learning opportunities for performing episiotomies and repair.

Criteria 3.b.6. Repair of Episiotomy & Lacerations—Learning Objectives from Maternidad La Luz's Curriculum

Theory

- See 1st Qtr Curriculum/Syllabus: Hospital Procedures, p 75; Applied Anatomy & Physiology I: Reproductive System, p 116
- See 2nd Qtr Curriculum/Syllabus: Basic Suturing, p 86; Normal 3rd & 4th Stage, p 32; Postpartum Complications, p 91; Normal Postpartum, p 38
- See 4th Qtr Curriculum/Syllabus: Suturing II, p 27; Pharmacology, p 13
- See Clinical Practice for Quarters 1 – 9
- See Emergency Skills Classes for Quarters 1 - 9

On-Site Clinical

At Maternidad La Luz, students go through a process to learn repair of lacerations and episiotomies:

1. They observe a licensed midwife performing sutures in the birth center
2. They learn basic suturing in class using beef hearts or chicken breasts and real suturing instruments and material, including Lidocaine
3. They assist the midwife in the birth center while she repairs lacerations or episiotomies.
4. The student has a more advanced suturing class in the 4th Quarter of studies to learn more complicated repairs.
5. The student may repair 1st and 2nd degree lacerations and episiotomies on clients under the direct supervision of a licensed midwife.

The midwives at Maternidad La Luz repair only 1st and 2nd degree lacerations and episiotomies as per protocol. Clients with more severe lacerations or extended episiotomy are referred to a physician.

MEDICAL BOARD OF CALIFORNIA
CHALLENGE MECHANISM AUDIT/SELF-ASSESSMENT MATRIX—MIDWIFERY PROGRAM
Maternidad La Luz (El Paso, Texas): Entry by Certified Professional Midwife (CPM) Credential

Statutory Requirements		Maternidad La Luz Response
B&P Code 2513(a)	"An approved midwifery education program shall offer the opportunity for students to obtain credit by examination for previous midwifery education and clinical experience."	Students who have a current Certified Professional Midwife (CPM) credential and are in good standing with the North American Registry of Midwives may challenge the three-year program through a practical and written examination per B&P Code 2513(a). We are using NARM's CPM obtained either via the PEP or MEAC-accredited graduate.
B&P Code 2513.(a) and CCR 1379.30	The Challenge applicant shall demonstrate, by practical examination, the clinical competencies described in the statute.	Students who have a current Certified Professional Midwife (CPM) credential and are in good standing with the North American Registry of Midwives may challenge the three-year program through a practical and written examination per B&P Code 2513(a).
B&P Code 2513.(a)	The midwifery education program's credit-by-examination policy shall be approved by the Board, and shall be available to applicants upon request. Likewise, the proficiency and practical examinations shall be approved by the Board.	MLL's midwifery education program's credit-by-examination policy and proficiency and practical examinations for students who complete the One-Year Program were approved by the Board. MLL will use the same policy and written and practical exams for applicants who enter the process with a CPM. Applicants may request the application packet by mail, telephone, e-mail or through our website.
B&P Code 2513(b)	Completion of clinical experiences shall be verified by a licensed midwife or certified nurse-midwife, <u>and</u> a physician and surgeon, all of whom shall be current in the knowledge and practice of obstetrics and midwifery.	MLL requires that all clinical experiences be verified by a licensed midwife or certified nurse-midwife <u>and</u> a physician, who signs a statement of intent and describes their current practice. The applicant obtains a copy of the license of the verifier. Applicants have also had clinical experiences verified by NARM.
B&P Code 2513(b)	Physicians and surgeons, licensed midwives, and certified nurse-midwives who participate in the verification and evaluation of an applicant's clinical experience shall show evidence of current practice.	MLL requires that verifiers/evaluators describe their current practice and sign a statement of intent and the applicant must obtain a copy of the verifier's current license.
B&P Code 2513(b)	The method used to verify clinical experiences shall be approved by the Board.	The Board has approved MLL's method of verification for the One-Year Program, which consists of chart audit, direct observation, verification of experience by telephone (e.g., talking with former clients, another midwife or someone else who

Statutory Requirements		Maternidad La Luz Response
		was present at the birth). MLL will use the same method to verify clinical experiences for CPMs.
CCR 1379.15(b)	A person who applies for licensure as a midwife on or after January 1, 1998, who would rely on credit by examination for previous education and experience as his/her sole qualifications for taking the national written licensing exam *shall have obtained at least 50% of the experiences described in subsection (c) within five years immediately preceding the date of application.*	MLL states in Part I of its California Challenge Process Handbook: "At least 50 percent of the required clinical experiences having been obtained within five years of applying to the California Medical Board to either sit for the written exam or for initial licensure."
CCR 1379.15(c)	An approved midwife education program shall verify the following number of clinical experiences.	
CCR 1379(c)	Statutorily required minimum number of clinical experiences: (1) 20 new antepartum visits clinical experiences; (2) 75 return antepartum visits; (3) 20 labor management experiences; (4) 20 deliveries; (5) 40 postpartum visits, within the first five days after birth; (6) 20 newborn assessments; (7) 40 postpartum/family planning/ gynecology visits.	MLL's requirements meet the CCR minimum requirements for the following clinical experiences: (1) MLL requires 20 new antepartum visits; (2) MLL requires 75 return antepartum visits; (3) MLL requires 20 labor management experiences; (4) MLL requires 20 deliveries; (5) MLL requires 40 postpartum visits within the first five days after birth; (6) MLL requires 20 newborn assessments; (7) MLL requires 40 postpartum/family planning/ gynecology visits
CCR 1379.30	The midwifery education program shall prepare the midwife to practice as follows:	In order to fulfill NARM requirements to be a CPM, applicants must have already satisfactorily and completely demonstrated ALL of the MANA Core Competencies and NARM Comprehensive Skills, Knowledge, And Abilities Essential For Competent Midwifery Practice. Following are the specifics enumerated by the

Statutory Requirements		Maternidad La Luz Response
	(a) management of the normal pregnancy	California Business and Professional Code: **MANA Core Competencies:** • MANA Guiding Principals of Practice • General Knowledge and Skills • Care During Pregnancy **NARM Skills:** • I. Midwifery Counseling, Education, and Communication A – J (1 – 9). • II. General Healthcare Skills A – D (3, 8, 9, 10, 13, 14, 15, 16, 19, 20, 22, 23, 24, 26, 27), F, G, J, L, M, N. • III. Maternal Health Assessment A – L.
	(b) management of normal labor and delivery in all birth settings, including the following when indicated.	**MANA Core Competencies:** • MANA Guiding Principals of Practice • General Knowledge and Skills • Care During Labor, Birth and Immediately Thereafter. **NARM Skills:** • I. Midwifery Counseling, Education, and Communication A – J (2, 6, 8, 10, 11). • II. General Healthcare Skills A – I, K, M.. • III. Maternal Health Assessment A, D, E, L. • IV. Labor, Birth, and Immediate Postpartum A – F.
CCR 1379.30	(1) Administration of intravenous fluids, analgesics, postpartum oxytocics, and RhoGAM;	MLL requires current certification in IV Therapy **MANA Core Competencies:** • Care During Labor, Birth and Immediately Thereafter H, K, M. **NARM Skills:** • General Healthcare Skills: K (1 – 6) • IV. Labor, Birth, and Immediate Postpartum E 7 e, h, I and F 6 b.
	(2) Amniotomy during labor;	**NARM Skills:** • II. General Healthcare Skills: D 1
	(3) Application of external or internal monitoring devices;	**NARM Skills:** • General Healthcare Skills D 8 - 9, L, M, N • IV. Labor, Birth, and Immediate Postpartum B 1 f, C 11 a.
	(4) Administration of local anesthesia, paracervical blocks, pudendal blocks, and local infiltration;	**NARM Skills:** • IV. Labor, Birth, and Immediate Postpartum E 6 c (2), F b.

Statutory Requirements		Maternidad La Luz Response
	(5) Episiotomy;	**MANA Core Competencies:** • Care During Labor, Birth and Immediately Thereafter K, M, N **NARM Skills:** • II. General Healthcare Skills D 17 • IV. Labor, Birth, and Immediate Postpartum C 11 c) (6) h.
	(6) Repair of episiotomies and lacerations;	**MANA Core Competencies:** • Care During Labor, Birth and Immediately Thereafter N **NARM Skills:** • General Healthcare Skills A – C, D 11, 16, 17, 21, K 1. • IV. Labor, Birth, and Immediate Postpartum F 5 – 6.
	(7) Resuscitation of the newborn	MLL requires a current NRP card. **MANA Core Competencies:** • Care During Labor, Birth and Immediately Thereafter K, L **NARM Skills:** • II. General Healthcare Skills D 2, 4, 7, E. • IV. Labor, Birth, and Immediate Postpartum D 8.
	(c) Management of the normal postpartum period;	**MANA Core Competencies:** • Postpartum Care **NARM Skills:** • Midwifery Counseling, Education, and Communication A, C, F, G, H, I, J-2, 4, 5, 6, 7, 8, 9, 10, 11 • V. Postpartum
	(d) Management of the normal newborn care, including administration of vitamin K and eye prophylaxis; and	**MANA Core Competencies:** • Newborn Care **NARM Skills:** • I. Midwifery Counseling, Education, and Communication A, F, G, H, I, J-10. • II. General Healthcare Skills D 14, 20, 22, 23; K 4. • IV. Labor, Birth, and Immediate Postpartum D 13. • VII. Well-baby Care
CCR 1379.30 (Continued)	(e) Management of family planning and routine gynecological care including methods of contraception, such as diaphragms and cervical caps.	**MANA Core Competencies:** • Well-woman Care and Family Planning **NARM Skills:** • II. General Healthcare Skills A – D 20, 27.

Statutory Requirements		Maternidad La Luz Response
		• III. Maternal Health Assessment A, B 12 – 14. • VI. Well Woman Care
CCR 1379.31	Satisfactory evidence that an applicant has met the educational standards required for licensure as a midwife includes either (a) or (b). (a) a diploma is issued by a midwifery program approved by the Division; or (b) A notice of successful completion of the CHALLENGE Program (credit by examination) issued by a program approved by the Division.	Candidates must have earned a CPM and be enrolled in MLL's Previous Learning and Experience Program before applying for the Challenge Program. Maternidad La Luz will send a copy of grades and a certificate to the successful candidate; Maternidad La Luz will send a copy of grades, certificate, and the L-12 form to the California Medical Board.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	April 8, 2010
ATTENTION:	Medical Board of California
SUBJECT:	Written Examination Passing Score
STAFF CONTACT:	Deborah Pellegrini, Chief

REQUESTED ACTION:

Establish by resolution that the Board accepts a scaled passing score of 75 as the minimum passing score on all three parts of the United States Medical Licensing Examination (USMLE).

STAFF RECOMMENDATION:

Staff recommends the adoption of the resolution attached to this staff proposal.

BACKGROUND:

Section 2177 of the Business and Professions (B&P) Code requires that the passing score required on the USMLE be "established by resolution of the Division of Licensing [Board]." Prior to 2007, the law did not limit the number of times that applicants may fail USMLE Step 3 and still qualify for licensure. Effective January 1, 2007, Section 2177 was amended to require applicants to pass Step 3 within four attempts, as recommended by the Federation of State Medical Boards. The amendment does not apply to failing scores obtained prior to January 1, 2007.

On March 1, 2010, in Y.M. v. the Medical Board of California, the Third Appellate District Court determined that the Board was required to establish by formal resolution the passing scores for the USMLE. When the Appellate Court made its decision, it was not privy to the information that the Board had fully complied with Section 2177 by establishing by resolution at the January 2008 Board meeting its acceptance of the FSMB's recommended passing score as the passing score on USMLE.

ANALYSIS:

As a result of a lawsuit brought by an applicant who had failed Step 3 four times, the California Court of Appeals directed the Board to establish its passing score for USMLE by resolution.

At the Board's meeting on January 30, 2009, the members voted unanimously to reaffirm the Board's past practice of accepting the passing score set by the Federation of State Medical Boards (FSMB) as its own passing score on all steps of the United States Medical Licensing Examination (USMLE). The FSMB maintains a scaled passing score of 75 as the minimum passing score on the USMLE. The FSMB reports each examination score in a two-digit and a three-digit format. The three-digit score is a statistical percentile, and the FSMB adjusts the minimum passing score on the three-digit scale periodically. However, 75 is always the minimum passing score on the two-digit scale.

Out of an abundance of caution to comply with the Court's ruling and clarify the provisions of Section 2177, legal counsel advises the Board to specifically adopt a scaled passing score of 75 as the minimum passing score.

FISCAL CONSIDERATIONS:
None.

MEDICAL BOARD OF CALIFORNIA
Executive Office

Medical Board of California
Resolution
Examination Passing Score

Be it resolved that, pursuant to Business and Professions Code Section 2177, the Medical Board of California hereby:

(1) Reaffirms its past practice of accepting the recommended scaled passing score of 75 set by the Federation of State Medical Boards (FSMB) as the board's own passing score on all steps of the USMLE, as expressed in its vote at the January 30, 2009 board meeting;

(2) Reaffirms its past practice of accepting a scaled passing score of 75 on all examinations listed in Title 16 CCR section 1328; and

(3) Adopts a scaled passing score of 75, or if a different recommended scaled passing score is set by the FSMB, adopts that score for each step of the USMLE administered henceforth.

Adopted on April 30, 2010

By

Barbara Yaroslavsky
President

DRAFT

AGENDA ITEM 23

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 22, 2010
ATTENTION: Medical Board of California
DEPARTMENT: Legislation/Regulatory Program
SUBJECT: SB 1441 Standards
STAFF CONTACT: Linda K. Whitney, Interim Executive Director

REQUESTED ACTION: No action required at this time to develop regulatory language to implement the standards.

STAFF RECOMMENDATION: Wait for SB 1172 to be enacted, but direct staff to development recommendations and time lines to implement those standards that do not require legislation or regulatory action.

EXECUTIVE SUMMARY:

The SB 1441 Substance Abuse Coordination Committee (SACC) met on April 6, 2010 to continues to discuss its recommendations and make modifications to a couple of those recommendations, mainly removing the "automatic suspension" concept and replacing it with "placed on inactive status." These changes have been incorporated into SB 1172, the 2010 legislation that is carrying the legislative recommendations from the SACC.

Below is a listing of each standard as presented at the January Board meeting and our evaluation of regulatory or legislative action. As noted, none will require regulatory action at this time, but should SB 1172 pass, then the Board will need to address implementation of some sections of that language via regulations.

Standard #1 states any licensee on probation who the board has reasonable suspicion has a substance abuse problem shall be required to undergo a clinical diagnostic evaluation at the licensee's expense. This standard is consistent with the Board's disciplinary guidelines. Staff will be reviewing the standard to make sure it coincides with all the Board's procedures.
This standard requires no regulatory or legislative action.

Standard #2 addresses practice restrictions. The standard would require placing licensees on inactive status if they are found to be abusing substances. This will require a revision to the Medical Practice Act or general provisions.
This standard is being addressed in SB 1172.

Standard #3 deals with specific requirements that govern the ability of the licensing board to communicate with the licensee's employer about the licensee's status or condition. This standard can be implemented by including it in a stipulation or order as long as the definition of "worksite" is resolved.
This standard requires no regulatory or legislative action.

Standard #4 addresses drug testing standards and would require 104 random drug tests per year; currently the Board orders 52 tests. Ms. Whitney stated this standard presents policy, cost, resource, and necessity issues for the Board. Ms. Scuri added the mandatory number of testings has the potential to reduce the number of stipulations that licensees are willing to enter into; this impact should be considered.
This standard is being re-examined by a sub-committee of the SACC.

Standards #5 and #6 do not apply to the Medical Board.

Standard #7 addresses worksite monitors. The Board's procedures may need to be revised.
This standard requires no regulatory or legislative action.

Standard #8 focuses on the procedures to be followed when a licensee tests positive for a banned substance. The standard calls for placing the licensee's license on inactive status which will require legislation.
This standard is being addressed in SB 1172.

Standard #9 does not apply to the Board as it is already a part of the Board's evaluation of a major violation.
This standard is being addressed in SB 1172.

Standard #10 deals with the specific consequences for major and minor violations. To implement the consequences included in the standard, the authority for inactivation of a license would need to be placed in law. Since the Board does not have a diversion program, the remainder of the consequences does not apply.
This standard is being addressed in SB 1172.

Standard #11 addresses the criteria that a licensee must meet in order to petition for return to practice on a full time basis. The Board would need the statutory authority for the practitioner to return to practice at the same time it obtains authority to remove the licensee from practice, as previously mentioned in Standards #2, #8, and #10.
This standard is being addressed in SB 1172.

Standard #12 lists the criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license. These criteria are already in existing law; the Board would generally follow this same process since it already exists. It appears the standard is looking at two different processes; the Board may need a statutory requirement to address the second process.
This standard is being addressed in SB 1172.

Standards #13, #14, and #15 do not apply to the Board.

Standard #16 addresses measurable criteria and standards to determine whether the Board's method of dealing with substance-abusing licensees protects patients from harm. The Board would need to develop a reporting mechanism to provide all of the specified data to DCA. ***This standard requires no regulatory or legislative action.***

FISCAL CONSIDERATIONS: None at this time.

PREVIOUS MBC AND/OR COUNCIL ACTION: Continued discussion of the implementation of SB 1441, Statutes of 2008, with the report due January 1, 2010.

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

April 1, 2010

SPECIALTY	Number of cases reviewed/ sent to Experts Jan-Mar 2010	Number of Experts used and how often utilized Jan-Mar 2010	Active List Experts Y-T-D Total = 1,155
ADDICTION			13 ↑
ALLERGY & IMMUNOLOGY (A&I)			10
ANESTHESIOLOGY (Anes)	2	2 LIST EXPERTS REVIEWED 1 CASE	96 ↑
COLON & RECTAL SURGERY (CRS)	1	1 LIST EXPERT	4 ↓
COMPLEMENTARY/ALTERNATIVE MEDICINE			18 ↑
CORRECTIONAL MEDICINE	8	6 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	29 ↑
DERMATOLOGY (D)	1	1 LIST EXPERT	14
EMERGENCY (EM)	4	4 LIST EXPERTS REVIEWED 1 CASE	60 ↑
Medical Toxicology (MT)			3
ETHICS	2	1 LIST EXPERT REVIEWED 2 CASES	5 ↑
FAMILY (FM)	20	14 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES	99 ↑
HAND SURGERY			25
HOSPICE & PALLIATIVE MEDICINE			9 ↑
INTERNAL (General Internal Med)	20	12 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES	221 ↑
Cardiovascular Disease (Cv)	7	5 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	33
[Interventional Cardiology (Intv Cd)]	6	6 LIST EXPERTS REVIEWED 1 CASE	19
[Non-Interventional Cardiology]	1	LIST EXPERT	21
Clinical Cardiac Electrophysiology (CCEP)			3
Critical Care Medicine (CCM)			18
Endocrinology, Diabetes and Metabolism (EDM)	1	LIST EXPERT	5

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

April 1, 2010

SPECIALTY	Number of cases reviewed/ sent to Experts Jan-Mar 2010	Number of Experts used and how often utilized Jan-Mar 2010	Active List Experts Y-T-D Total = 1,155
Gastroenterology (Ge)	1		21
Geriatric Medicine (Ger)			41
Hematology (Hem)			7
Hospice & Palliative Medicine (HPM)			1
Infectious Disease (Inf)			12
Medical Oncology (Onc)	4	2 LIST EXPERTS REVIEWED 2 CASES	15
Nephrology (Nep)			9
Pulmonary Disease (Pul)	2	2 LIST EXPERTS REVIEWED 1 CASE	23
Rheumatology (Rhu)			9
Sleep Medicine (SLP)			4
Sports Medicine (SM)			1
Transplant Hepatology (TH)			0
MIDWIFE REVIEWER			10 ↓
NEUROLOGICAL SURGERY (NS)	1	LIST EXPERT	16
NEUROLOGY (N)	4	4 LIST EXPERTS REVIEWED 1 CASE	22
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			5
NUCLEAR MEDICINE (NuM)			6
OBSTETRICS & GYNECOLOGY (ObG)	18	10 LIST EXPERTS REVIEWED 1 CASE 2 OFF LIST EXPERTS REVIEWED 1 CASE * 2 LIST EXPERTS REVIEWED 2 CASES 1 OFF LIST EXPERT REVIEWED 2 CASES *	88
*TWO OF THE THREE OB/GYN OFF LIST EXPERTS PARTICIPATED IN THE PROGRAM			
Gynecologic Oncology (GO)			7

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

April 1, 2010

SPECIALTY	Number of cases reviewed/ sent to Experts Jan-Mar 2010	Number of Experts used and how often utilized Jan-Mar 2010	Active List Experts Y-T-D Total = 1,155[1]
Maternal & Fetal Medicine (MF)	1	LIST EXPERT	10
Reproductive Endocrinology/ Infertility (RE)			8
OPHTHALMOLOGY (Oph)	6	4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	42 ↑
ORAL & MAXILLOFACIAL SURGERY			1
ORTHOPAEDIC SURGERY (OrS)	3	3 LIST EXPERTS REVIEWED 1 CASE	46 ↓
Surgery of the Hand (HS)			23
Orthopaedic Sports Medicine (OSM)			21
OTOLARYNGOLOGY (Oto)			31
Neurotology (ON)			5
Pediatric Otolaryngology (PO)			3
Plastic Surgery within the Head and Neck (PSHN)			1
Sleep Medicine (SLP)			1
PAIN MEDICINE (PM)	8	1 LIST EXPERT REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	28 ↑
PATHOLOGY (Path)			11
PEDIATRICS (Ped)	1	LIST EXPERT	62
Neonatal-Perinatal Medicine (NP)	1	LIST EXPERT	9
Pediatric Cardiology (Cd)			6
Pediatric Cardiothoracic Surgery			2
Pediatric Critical Care Medicine (CCM)			2
Pediatric Emergency Medicine (PEM)			2
Pediatric Gastroenterology (Ge)			3
Pediatric Hematology-Oncology (HO)			5
Pediatric Infectious Diseases (Inf)			7*

**OF THE SEVEN ACTIVE LIST EXPERTS , ONLY THREE HAVE THE ADDED BOARD CERTIFICATION IN THIS SUB-SPECIALTY*

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
April 1, 2010

SPECIALTY	Number of cases reviewed/ sent to Experts Jan-Mar 2010	Number of Experts used and how often utilized Jan-Mar 2010	Active List Experts Y-T-D Total = 1,155
Pediatric Nephrology (Ne)			2
Pediatric Pulmonology (Pul)			1
PHYSICAL MEDICINE & REHABILITATION (PMR)	1	LIST EXPERT	9 ↑
PLASTIC SURGERY (PIS)	12	6 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES *	50 ↓
**FLAGGED FOR 2010 – WILL NOT USE AGAIN FOR NEW CASES(UNTIL NEXT YEAR)WITHOUT PRIOR APPROVAL FROM THE DEPUTY CHIEF*			
Surgery of the Hand (HS)			6
PREVENTIVE MEDICINE (PrM)			5
Occupational Medicine			7
Public Health and General Preventive Medicine			5
Medical Toxicology (MT)			1
Undersea & Hyperbaric Medicine (UM; UHM)			0
PSYCHIATRY (Psyc)	13	6 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	112 ↓
Addiction Psychiatry (AdP)	1		27
Child & Adolescent Psychiatry (ChAP)			26
Clinical Neurophysiology (C/NPh)			0
Forensic Psychiatry (FPsy)			54
Geriatric Psychiatry (GPsyc)			29
Pain Medicine (PM)	1	LIST EXPERT	13
Psychosomatic Medicine (PsychoMed)			16
Sleep Medicine (SLP)			1
RADIOLOGY (Rad)	3	1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	39 ↑
Diagnostic Radiology (Rad DR)			34

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

April 1, 2010

SPECIALTY	Number of cases reviewed/ sent to Experts Jan-Mar 2010	Number of Experts used and how often utilized Jan-Mar 2010	Active List Experts Y-T-D Total = 1,155
Radiation Oncology (Rad RO)			4
Radiologic Physics (RP)			0
Neuroradiology (NRad)			17
Nuclear Radiology (NR)			2
Pediatric Radiology (PR)			8
Vascular/Interventional Radiology (VIR)			4
SLEEP MEDICINE (S)	1	LIST EXPERT	8
SPINE SURGERY (SS)			1
SURGERY (S)	6	6 LIST EXPERTS REVIEWED 1 CASE	55 ↓
Pediatric Surgery (PdS)			4 ↑
Surgery of the Hand (HS)			0
Surgical Critical Care (SCC)			2
Vascular Surgery (VascS)			14 *
**OF THE 14 ACTIVELIST EXPERTS, ONLY 8 HAVE THE ADDED BOARD CERTIFICATION IN THIS SUB - SPECIALTY*			
THORACIC SURGERY (TS)			19
(MEDICAL) TOXICOLOGY			4
UROLOGY (U)	4	4 LIST EXPERTS REVIEWED 1 CASE	13 ↓
WORKERS' COMP/QME/IME			26

/Susan (4/1/10)

Expert Reviewers are desired in the following Specialty/Sub-specialty areas:

- Addiction
- Colon & Rectal Surgery
- Dermatology
- Interventional Cardiology
- Endocrinology
- Gastroenterology
- Medical Oncology
- Midwifery
- Neurological Surgery
- Neurology
- Obstetrics & Gynecology
- Reproductive Endocrinology & Infertility
- Orthopaedic Surgery
- Pain Medicine
- Pathology
- Pediatric Cardiology
- Pediatric Cardiothoracic Surgery
- Pediatric Gastroenterology
- Plastic Surgery
- Psychiatry
- Spine Surgery
- Thoracic Surgery
- Toxicology
- Urology

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

Memorandum

Date: April 6, 2010

To: Renee Threadgill

From: Valerie Moore

Subject: Redistribution of Cases for Panel Review

A couple of weeks ago, Ms. Chang contacted staff in the DCU and expressed concerns that there may be a disparity in the number of cases reviewed by Panel B than those reviewed by Panel A.

A review of the statistical data of the cases presented to the panels from January 2008 to March 2010 revealed the following:

PANEL STATISTICS

Panel	2008	2009	2010*
A (A-J)	90 (39%)	114 (42%)	23 (29%)
B (K-Z)	143 (61%)	156 (58%)	55 (71%)
Total	233	270	78

*through March 31, 2010

As of April 1, 2010, there are 407 open cases being monitored by the DCU analysts. Although we have no way of determining how many of these cases will proceed to hearing or settlement this year, the number of cases reviewed by Panel B during the first quarter of 2010 indicate Ms. Chang's concerns are valid. Based solely on the number of open cases, I recommend the alpha assignments be redistributed. I propose that Letters K and L be reassigned from Panel B to Panel A. The new alpha assignments would be as follows:

Panel A, A-**L**, which is 197, i.e., 48%, of the total number of open cases.
Panel B, **M**-Z, which is 210, i.e., 52%, of the total number of open cases.

Please let me know whether we should proceed with the redistribution of the alpha assignments.

cc: Susan Cady, SSM II

BREAKDOWN OF CASES REVIEWED BY PANELS

2008	
A-J Discipline Cases	82
A-J Reconsiderations	3
A-J Probation Cases	4
A-J Reconsiderations	1
K-Z Discipline Cases	121
K-Z Reconsiderations	9
K-Z Probation Cases	13
K-Z Reconsiderations	0
Total	233

2009	
A-J Discipline Cases	97
A-J Reconsiderations	6
A-J Probation Cases	11
A-J Reconsiderations	0
K-Z Discipline Cases	126
K-Z Reconsiderations	6
K-Z Probation Cases	22
K-Z Reconsiderations	2
Total	270

2010 (thru March 31, 2010)	
A-J Discipline Cases	21
A-J Reconsiderations	0
A-J Probation Cases	2
A-J Reconsiderations	0
K-Z Discipline Cases	51
K-Z Reconsiderations	1
K-Z Probation Cases	3
K-Z Reconsiderations	0
Total	78

ALPHA ASSIGNMENT OF AS APRIL 2010

A = 16
B = 28
C = 22
D = 18
E = 8
F = 13
G = 19
H = 22
I = 3
J = 7
K = 20
L = 21
M = 42
N = 7
O = 4
P = 30
Q = 1
R = 24
S = 36
T = 9
U = 4
V = 10
W = 24
X = 0
Y = 14
Z = 5
Total 407

Proposed

AGENDA ITEM 25C

STATE AND CONSUMER SERVICES AGENCY - Department of Consumer Affairs

ARNOLD SCHWARZENEGGER, Governor

MEDICAL BOARD OF CALIFORNIA
Discipline Coordination Unit
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

PETITION FOR PENALTY RELIEF

INSTRUCTIONS: Please type or print neatly. All blanks must be completed; if not applicable enter N/A. If more space is needed attach additional sheets. Attached to this application should be a "Narrative Statement" and two verified recommendations from a physician and surgeon licensed in any state who has personal knowledge of the reasons for the disciplinary action taken against your license.

I. TYPE OF PETITION [Reference Business and Professions Code sections 2221(b) and 2307]

☐ Reinstatement of Revoked/Surrendered Certificate ☐ Modification of Probation ☐ Termination of Probation

NOTE: A Petition for Modification and/or Termination of Probation can be filed together. If you are requesting Modification you must specify in your "Narrative Statement," which terms and conditions of your probation you want reduced or modified and provide an explanation. Please check all boxes above that apply.

II. PERSONAL INFORMATION

NAME: First Middle Last

HOME ADDRESS: Number & Street City State Zip

HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	CELL NUMBER
( )	( )	( )

CA Physician and Surgeon Certificate Number	Driver's License Number and State of Issuance

Current or prior medical licenses in other states or countries (please include license number(s), issue date(s), and status of license(s)):

III. ATTORNEY INFORMATION (If Applicable)

Will you be represented by an attorney? ☐ No ☐ Yes (If "Yes," please provide the following information)

NAME:

ADDRESS:

PHONE:

IV. DISCIPLINARY INFORMATION

Provide a brief explanation in your "Narrative Statement" as to the cause for the administrative action (e.g., prescribing without prior exam, gross negligence, self use of drugs, sexual misconduct, conviction of a crime, etc.)

Do you have any prior or current discipline or license denial in any other state or country? ☐ No ☐ Yes
(If Yes, give brief cause for administrative action or license denial in your "Narrative Statement" section, including dates and penalty order (e.g., 5 years probation).

V. MEDICAL BACKGROUND

Total number of years in medical practice:

Medical Specialty, if applicable:

Board Certified? ☐ No ☐ Yes If Yes, year certified:

Current field of medicine: (e.g., GP, OB/GYN, ENT, IM, etc.)

Current type of practice: (e.g., solo, group, HMO, Govt, etc.)

Name and location of practice:

List hospital privileges:

VI. CURRENT OCCUPATION OTHER THAN PHYSICIAN AND SURGEON

(answer only if currently not practicing medicine)

List employer, address, e-mail address, phone number, job title, and duties:

VII. EMPLOYMENT HISTORY (list for the past 5 years only)

Provide the company name, address, phone number, contact person and dates of employment:

VIII. REHABILITATION

Describe any rehabiliative or corrective measures you have taken since your license was disciplined to support your petition. List dates, nature of programs or courses, and current status. You may include any community service or volunteer work

IX. POST-ADMINISTRATIVE COMPLIANCE

Have any of the following situations occurred since the effective date of the Medical Board of California's administrative action? (This includes if you surrendered your license while under investigation or charges pending.)

1. Been placed on criminal probation or parole? ☐ Yes ☐ No
2. Been charged in any pending criminal action? ☐ Yes ☐ No
3. Been convicted of any criminal offense? (A conviction includes a no contest plea, disregard traffic offenses with a $100 fine or less) ☐ Yes ☐ No
4. Been required to register as a sex offender in any state? (Attach the court order) ☐ Yes ☐ No
5. Been charged or disciplined by any other medical board? ☐ Yes ☐ No
6. Surrendered your license to any other medical board? ☐ Yes ☐ No
7. Had your staff privileges disciplined by any hospital? ☐ Yes ☐ No
8. Had any civil malpractice claims filed against you? ☐ Yes ☐ No
9. Become addicted to the use of narcotics or controlled substances? ☐ Yes ☐ No
10. Become addicted to or received treatment for the use of alcohol? ☐ Yes ☐ No
11. Been hospitalized for alcohol or drug problems or for mental illness? ☐ Yes ☐ No

NOTE: If you answer "Yes" to any of the above questions, please explain in the "Narrative Statement."

X. DECLARATION

Executed on _____ 20 _____, at _____, _____.
(City) (State)

I declare under penalty of perjury under the laws of the State of Calfiornia that the foregoing is true and correct and that all statements and documents attached in support of this petition are true and correct.

_____ _____
Petitioner (Print Name) Signature

The information in this document is being requested by the Medical Board (Board) pursuant to Business and Professions Code sections 2221(b) and 2307. In carrying out its licensing or disciplinary responsibilities, the Board requires this information to make a determination on your Petition for Penalty Relief. You have a right to access our records containing non-confidential information as defined in Civil Code section 1798.3. The Custodian of Records is the Licensing Program Manager or Chief of Enforcement at the address shown on the first page.

INSTRUCTIONS FOR COMPLETING A MEDICAL BOARD OF CALIFORNIA PETITION FOR PENALTY RELIEF

Prior to completing the Petition package ensure that you qualify to submit a Petition at this time. Review the time frames for the three different types of Petitions below. If you do qualify to Petition, please read all of these instructions thoroughly. Type or print your answers clearly, if an item does not apply enter "N/A." Attach a separate sheet of paper if additional space is needed to answer a question. Petitions that are not legible, fully completed, or not prepared in accordance with these instructions will be returned. A background investigation will be conducted on any accepted Petition for Penalty Relief.

(1) **Petition for Reinstatement** – A person may file a Petition after a period of at least three years has elapsed from the effective date of the surrender or revocation for unprofessional conduct. If the reinstatement is due to a license surrender or revocation for mental or physical illness, you can Petition after one year has elapsed from the effective date of the disciplinary action.
(2) **Petition for Early Termination of Probation** – A person may file a Petition when at least two years has elapsed from the effective date of the administrative action for probation of three years or more. If the period of probation is less than three years, the Petition can be filed after one year has elapsed from the effective date of the disciplinary action.
(3) **Petition for Modification** – A person may file a Petition when at least one year has elapsed from the effective date of the disciplinary action.

If you meet any one of the criteria described above, your Petition package must specify the facts and be accompanied by at least two verified recommendations[1] from physicians and surgeons licensed in any state who have personal knowledge of your activities since the disciplinary penalty was imposed. You must also provide a narrative statement with your Petition (see instructions below).

Exclusions to being able to submit a Petition are the following:

(1) No Petition shall be considered while you are under sentence for any criminal offense, including any period during which you are on court-imposed probation or parole.
(2) No Petition shall be considered while there is an accusation or petition to revoke probation pending against you.

The Board may deny without a hearing or argument any Petition within a period of two years from the effective date of the prior decision following the Petition hearing.

Letters of Recommendation

Attach at least two verifiable letters of recommendation from physicians licensed in any state who have personal knowledge of your activities since the disciplinary penalty was imposed. Letters cannot be more than 6 months old from the date you sign your Petition. Instruct your colleagues to verify their letter of recommendation by including the following declaration above the signature line.

"I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct."

The letters of recommendation are considered direct evidence at hearing to support your rehabilitation. In

1. For Petitioners that are licensed by 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 since the date the disciplinary action was imposed.

order for the letters to come in as direct evidence at the hearing, either the author must testify, or sign a declaration, or sign their letter under penalty of perjury. If there is no signature under penalty of perjury, then the letter is considered pure hearsay and cannot be a basis for the Administrative Law Judge to grant the Petition or a finding of rehabilitation. Letters of recommendation containing mere conclusions and few facts are of little persuasion (e.g., I think he is a fine doctor and a credit to the profession). It is more effective when letters from colleagues, who are aware of your administrative action against your license, provide personal information about the way in which you have changed since the administrative action was taken. Be sure to submit the original letters, copies will not be accepted. Letters should be part of the original package and not submitted separately. All letters of recommendation are verified by the Board. Therefore, they must contain the physician's current address and a valid phone number where the physician can be contacted.

Narrative Statement Sheet

The Petition package must include a brief and concise narrative sheet attached on a separate sheet of paper to the Petition. In the narrative statement tell the Board what you want and the reasons why your request should be granted. Give a brief factual description of the offense that was the basis of your action. If applicable, give the history of prior action and the history of prior petitions. Give details (schools, class names, credit hours, certificates, dates) and copies (with appropriate back-up documentation) of your continuing medical education, training programs, seminars or educational courses as well as what medical journals you read on a regular basis. Give details and documented proof of your rehabilitative efforts and results, including programs, psychotherapy, and medical treatment and their duration.

Attach any appropriate supervisor's performance evaluations pertaining to your current assignments with the medical field, laboratory studies, and teaching assignments. Finally, attach a copy of your current resume/curriculum vitae.

If your **Petition is for Reinstatement** include in your narrative statement responses to these questions: During the period of time that your license has been revoked or surrendered, how have you earned a living? What aspect of your rehabilitation do you feel will protect against the recurrence of your prior conduct? What are your plans if your license is reinstated? Where will you practice? At a particular hospital, medical group, clinic, urgent care facility, HMO, etc.? What type of practice?

For reinstatements fingerprints must be obtained and submitted as follows:

- If you reside in California, you must complete a "Request for Live Scan Service." The request must be completed by a transmitting agency. A list of transmitting agencies is included with these instructions. After the transmitting agency has signed and completed the request, a copy must be returned with your Petition.

- If you reside outside of California, you must complete and return the enclosed fingerprint cards. Both cards must be taken to any law enforcement agency for completion. Your Petition cannot be processed without two completed fingerprint cards. **DO NOT STAPLE THE CARDS TO THE PETITION. DO NOT PHOTOCOPY THE CARDS.**

Administrative Hearing

An administrative hearing is held for all three types of Petitions. Below is some general information regarding the hearing.

- Approximately 120 days after your Petition has been filed and processed by the appropriate Attorney General's Office, their staff will contact you with a written notice of the time, date, and place of the Petition hearing. Hearings are scheduled in cities in Southern and Northern California on a rotating basis.

- You should be present a half hour before your appointed time. Most cases are set for one hour. You may appear with or without an attorney.

- An Administrative Law Judge (ALJ) sitting alone will preside over the hearing. You will be asked questions under oath. You should apprise the ALJ of any circumstances that have changed since you filed your Petition.

- Emphasis should be put on Evidence of Rehabilitation, rather than a discussion of the merits of the previous case that resulted in the disciplinary action. California Code of Regulation, Title 16, Section 1360.2 states the board or panel shall evaluate evidence of rehabilitation considering the following: nature and severity of the act(s) or crime; evidence of any act(s) or crime(s) committed subsequently; the time that has elapsed since the commission of the act; and the evidence, if any, of rehabilitation submitted by the applicant.

Proposed Decision

After the hearing, the ALJ is permitted 30-days to render a decision, upon which the Board will act. The proposed decision in your case will be mailed approximately 60-days after the hearing. The decision will not be announced orally at the hearing.

PLEASE NOTE: The ALJ's proposed decision is not binding on the Board and can be changed by the Board members through the appropriate actions provided in the law.

The entire Petition process takes approximately one year from the date the completed Petition is received by the Board until the Board renders a final decision in the matter.

Submitting the Petition

- Complete and assemble the original Petition, which includes the original letters of recommendation and narrative statement.

- Make two photocopies of the package. Once you submit the two packages to the Board, you cannot submit any additional information until you attend the administrative hearing.

- Staple each package (do not bind).

- If this is for a Petition for Reinstatement include the fingerprints.

- Mail the Petition and copies to:

MEDICAL BOARD OF CALIFORNIA
Attention: Discipline Coordination Unit
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

- Direct any questions you have regarding your Petition package to the Petition for Penalty Relief Coordinator at (916) 263-2520.

Medical Board of California
Investigation & Prosecution Timeframes*

	2005	2006		2007		2008		2009		Q1 2010	
	Prior to 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	383	381	329	329
Median	252	285	134	304	269	335	324	346	346	291	291
Record Count	827	703	192	648	539	609	588	673	672	161	161
Calendar Day Age from Request to Suspension Order Granted											
Average	51	44	4	34	38	19	19	52	39	18	18
Median	17	3	2	22	23	10	10	23	23	23	23
Record Count	24	21	11	17	13	21	17	17	16	3	3
Calendar Day Age from Request to Receipt of Medical Records											
Average	58	53	37	59	57	63	58	73	73	80	80
Median	32	31	26	31	31	28	28	32	32	31	31
Record Count	475	376	228	264	259	256	252	243	243	50	50
Calendar Day Age from Request to Physician Interview Completed											
Average	48	51	43	52	50	63	63	52	52	46	46
Median	36	42	38	37	36	41	42	37	37	31	31
Record Count	597	453	172	406	371	473	466	696	696	117	117
Calendar Day Age from Request to Receipt of Expert Opinion											
Average	51	47	35	51	43	50	50	48	48	47	47
Median	41	35	31	36	35	39	38	36	35	39	39
Record Count	519	424	82	344	270	374	359	426	424	93	93
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed											
Average	556	554	140	543	340	565	493	584	578	608	608
Median	525	504	120	523	339	541	486	575	569	637	637
Record Count	187	149	17	198	95	157	131	189	186	54	54
Calendar Day Age from Accusation Filed to Disciplinary Outcome**											
Average	608	602	85	576	188	561	243	173	339	442	327
Median	526	466	99	426	182	384	238	351	309	340	320
Record Count	212	195	3	226	29	203	80	198	145	39	33

*Excludes Out of State and Headquarters Cases
**Excludes Outcomes where no Accusation Filed

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

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Board Member and Advisory Committee Member Training Day
Tuesday, July 27, 2010
Sacramento Public Library

9:00 AM - 9:15 AM	**Welcome & Introductions** - Brian Stiger, Director, Department of Consumer Affairs
9:15 AM - 9:45 AM	**Opening Remarks** - Bill Leonard, Secretary, State and Consumer Services Agency
9:45 AM - 10:30 AM	**Status of Consumer Protection Initiative** - Paul Riches, Deputy Director, Enforcement and Compliance & Luis Portillo, Assistant Deputy Director, Legislative and Policy Review
10:30 AM - 10:45 AM	**Break**
10:45 AM - 11:15 AM	**DCA's Role in Job Creation** - Brian Stiger, Deputy Director, Enforcement and Compliance & Bill Young, Chief Deputy Director, Department of Consumer Affairs
11:15 AM - Noon	**Performance Measurement for Enforcement and Licensing** - Bev Augustine, Deputy Director, Strategic, Organizational Leadership & Individual Development & Kim Kirchmeyer, Deputy Director, Board and Bureau Support
Noon - 1:15 PM	**Break**
1:15 PM - 2:30 PM	**Board and Advisory Committee Members Roles & Responsibilities** - Kim Kirchmeyer, Deputy Director, Board and Bureau Support
2:30 PM - 2:45 PM	**Break**
2:45 PM - 3:00 PM	**Continuing Competency** – David Swankin, President and CEO, Citizen Advocacy Center
3:00 PM - 3:45 PM	**Process Improvement for Enforcement & Licensing** - Bev Augustine, Deputy Director, Strategic, Organizational Leadership & Individual Development
3:45 PM - 4:00 PM	**Wrap Up & Closing Remarks** - Thomas Sheehy, Undersecretary, State and Consumer Services Agency

DRAFT

California Department of Consumer Affairs

2008 – 2012 Strategic Plan

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Preface

To All Stakeholders:

I am pleased to present the updated Department of Consumer Affairs *Strategic Plan for 2008 – 2012*. The Department and the State of California face enormous challenges in the years ahead, and I am proud of our staff's commitment to excellence in consumer protection. We are steadfast in our belief that the interests of consumers must be the guiding principle in all that we do. Our mission, vision, values goals and objectives clearly reflect that belief.

While many important themes and goals from our *2008 – 2010 Strategic Plan* remain in this updated version – process improvement, customer service, efficient and timely licensing and regulation – some of the content is new. For example, the department has embarked on a Consumer Protection Enforcement Initiative, aimed at reducing the cycle time for our investigations. We have also taken steps to quickly reduce our licensing backlogs, in support of the Administration's job creation efforts.

We are committed to transparency and accountability. To that end, this version of the Strategic Plan contains a description of how we plan to measure our progress and success. Progress on most of the measures will be reported quarterly on the Department's website beginning in July 2010. In addition, we describe significant completed objectives from the Plan's *2008 -2010* version.

We recognize the ambitiousness of many of the *2008 - 2012 Strategic Plan's* goals and objectives. We challenge ourselves to reach for them because we believe they will result in the level and quality of service that our customers – California consumers and licensees – want and deserve.

Sincerely,

BRIAN J. STIGER
Director
California Department of Consumer Affairs

What Do We Want to Achieve?

Our Mission
To protect and serve the interests of California consumers.

Our Vision
California consumers make informed choices and have access to competent and ethical service providers.

Our Values
As a government agency dedicated to serving the interests of California consumers, the Department of Consumer Affairs (DCA) values:

Accountability – We are accountable to the people of California and each other as stakeholders. We operate transparently and encourage public participation in our decision-making whenever possible.

Efficiency – We diligently identify the best ways to deliver high-quality services with the most efficient use of our resources.

Effectiveness – We make informed decisions that make a difference and have a positive, measurable impact.

Integrity – We are honest, fair, and respectful in our treatment of everyone.

Customer Service – We acknowledge all stakeholders as our customers, listen to them, and take their needs into account.

Employees – We are an employer of choice and strategically recruit, train, and retain employees. We value and recognize employee contributions and talent.

Unity – We draw strength from our organizational diversity as well as California's ever-changing cultural and economic diversity.

How Will We Achieve It?

Goals and Objectives

Goal 1
California is the recognized national leader in enforcement.

Objective 1.1
Set and maintain model professional standards in enforcement by December 31, 2012.

Major Activities for Objective 1.1
Establish and track monthly Enforcement Improvement Plans for each board, bureau and program.

Institute a mandatory Enforcement Academy for all sworn and non-sworn enforcement staff members.

Reduce Division of Investigation case cycle time to six months.

Institute a Best Practices Committee to research and identify internal and external best enforcement practices.

Implement efficient department-wide uniform guidelines for: intake and complaint handling, anonymous complaint handling, electronic mail ballots for board members, and complaint prioritization.

Facilitate a data exchange procedure with the Attorney General's office.

Introduce an enforcement audit program.

Create an Unlicensed Activity Initiative to address unlicensed activity violations.

Develop standard procedures for contracting with subject matter experts.

Hire health care consultants.

Enable parallel investigations for the Division of Investigation.

Establish an Enforcement Managers Roundtable to improve communications and exchange best practices.

Establish a contract with a collection agency to collect outstanding licensee fees.

Objective 1.2

Update and optimize enforcement related operating systems, equipment, and software by December 31, 2012.

Major Activities for Objective 1.2

Implement the Enforcement Activity Report.

Redesign the department's computer coding system for intake, complaint resolution, investigations, and discipline.

Utilize webcasting to broadcast the Director's enforcement message at Board, Bureau, and Program meetings.

Implement enforcement fingerprinting regulations for new and retro-active licensees.

Research, design, and apply a superior IT system.

Objective 1.3

Update current and introduce new legislation and regulations to more effectively conduct enforcement activities by December 31, 2010.

Major Activities for Objective 1.3

Delegate subpoena authority to board executive officers to expedite investigation cycles.

Develop new legislation for all healing arts programs to adopt more effective enforcement capabilities.

Implement uniform standards for substance-abusing healing arts licensees within all healing arts programs.

Develop new legislation for all non-healing arts programs to adopt more effective enforcement capabilities.

Objective 1.4

Identify and obtain the resources needed to implement objectives 1.1 – 1.3 by June 30, 2010.

Major Activities for Objective 1.4

Generate a Budget Change Proposal for additional non-sworn investigators, training for non-sworn investigators, and hiring and training additional complaint intake staff.

Generate a Budget Change Proposal to increase enforcement resources for non-healing arts boards.

Goal 2

Support the Administration's job-creation initiative by enabling individuals and/or businesses to expeditiously enter California's workforce and contribute to California's job growth.

Objective 2.1

Reduce our pending applications for licensure by fifty percent by July 1, 2010, allowing approximately 36,300 individuals and/or businesses to enter the workforce.

Major Activities for Objective 2.1

Identify resources needed (overtime, temporary help).

Obtain Department of Finance approval to utilize needed resources.

Hire temporary staff to work on reducing the backlog.

Goal 3

California is the recognized national leader in professional licensing, and contributes effectively to job growth in California.

Objective 3.1

Evaluate the licensing process for efficiency by September 30, 2010.

Major Activities for Objective 3.1

Evaluate the process for issuing licenses; identify process improvements and identify and eliminate redundancies and bottlenecks in the process.

Evaluate the process for issuing renewal applications; identify process improvement, and identify and eliminate redundancies and bottlenecks in the process.

Ensure that all Boards and Bureaus have current licensing procedures and desk manuals available to licensing staff.

Research, design, and apply a superior IT system.

Objective 3.2

Evaluate the computer-based licensure examination process for efficiency by May 30, 2011.

Major Activities for Objective 3.2

Evaluate the computer-based licensure examination process, to identify process improvements.

Evaluate the effectiveness of the on-line occupational analyses for updating licensure examinations.

Objective 3.3

Evaluate and modify the minimum qualifications for licensure for efficiency, defensibility, and accessibility by June 30, 2012.

Major Activities for Objective 3.3

Evaluate the minimum qualifications for licensure to ensure that they remain relevant and consistent with the standard of practice.

Seek legislative amendments, if necessary, to modify minimum qualifications.

Goal 4

DCA's effective communication and outreach efforts provide consumers and licensees with relevant, timely, up-to-date information.

Objective 4.1

Measure the effectiveness of existing consumer education campaigns by February 28, 2011.

Major Activities for Objective 4.1

Develop and implement consumer surveys for evaluating the effectiveness of the department's consumer education campaigns (Take Charge California; Drive Healthy; and Inquire Before You Hire).

Analyze survey results and modify the campaigns as necessary.

Objective 4.2

Ensure that Consumer Information Call Center and staff are optimally equipped to respond effectively to consumer and licensee inquiries. Continuous, beginning April 2010.

Major Activities for Objective 4.2:

Update the Consumer Information Center's Interactive Voice Recording system.

Provide Consumer Information Center staff (Call Center and Correspondence Unit staff) with continuous team-building, and customer service and subject matter training, to ensure the information they provide to consumers and licensees is accurate and conveyed courteously and professionally.

Objective 4.3
Continuously provide information to licensees about current laws, regulations, and standards, beginning July 1, 2010.

Major Activities for Objective 4.3:
Distribute information described above to all DCA licensees.

Facilitate a roundtable discussion with professional associations no less than annually.

Objective 4.4
Develop partnerships with licensees to promote general consumer education by December 31, 2010.

Major Activities for 4.4:
Partner with professional associations to disseminate consumer protection information to their members.

Objective 4.5
Provide opportunities for board members to learn and share best practices with each other by July 31, 2010.

Major Activities for Objective 4.5:
Conduct at least one training day each year for board members.

Goal 5
DCA is "THE" state employer of choice in California.

Objective 5.1
Develop programs and tools by November 30, 2010 that will enhance employee's professional development and help ensure a workforce that meets the Department's strategic objectives and succession needs.

Major Activities for Objective 5.1
Develop and implement an internal job rotation program on a pilot basis to enhance employee training opportunities and development.

Evaluate the success of the supervisors'/managers' pilot mentoring program.

If pilot is successful, expand the program to include mentoring for Executive Officers and line staff.

Complete the Knowledge Management Center and ensure that all boards, bureaus, and programs have plans to continuously update their procedures and desk manuals.

Objective 5.2

Provide opportunities for all employees to learn and share with one another and with management. (Internal communication program to begin July 1, 2010.)

Major Activities for Objective 5.2

DCA Director will hold town hall meetings no less than quarterly for employees to share their opinions and suggestions.

Develop a formal departmental internal communications program, which includes the internal *Did You Know* newsletter.

Goal 6

DCA provides excellent customer service to its external and internal stakeholders by adhering to the 7Cs of Customer Service – Complete, Concise, Correct, Concerned, Committed, Courteous, and Clear.

Objective 6.1

Evaluate customer service levels to external stakeholders and make improvements where necessary by July 30, 2011.

Major Activities for Objective 6.1

Design and implement methods (e.g., surveys) and performance measures to continuously measure satisfaction of DCA's external customers (primarily, licensees and consumers).

Evaluate feedback to determine the feasibility and viability of changing work practices to better meet licensees' and consumers' needs.

Implement major recommendations.

Objective 6.2

Evaluate customer service levels to DCA's client boards, bureaus, and programs by July 31, 2010.

Major Activities for Objective 6.2

Conduct internal client customer service surveys to ensure that DCA's divisions are providing good customer service to boards, bureaus, and programs.

Evaluate feedback to determine the feasibility and viability of changing work practices to better meet employees' needs.

Implement major recommendations.

Objective 6.3

SOLID staff and the Process Improvement Team will conduct three process improvement projects by January 30, 2011, to ensure that internal business processes are as efficient as possible.

Major Activities for Objective 6.3

Complete the Human Resources Process Improvement Project, which includes an interactive Intranet tool and electronic versions of all human resource forms.

Conduct process improvement for the DCA's contracting process.

Conduct process improvement for the Correspondence Unit.

Goal 7

DCA will keep abreast of and utilize the latest technological advances to better serve its stakeholders.

Objective 7.1

Implement technology to enhance customer service for external and internal customers by December 31, 2012.

Major Activities for Objective 7.1

Implement BreEZe, the Customer Service Center Web portal, ad-hoc reporting tool, and improved imaging capability.

Promote the use of social media tools (Facebook, Twitter, and YouTube) as supported by the office of the State Chief Information Officer, to enhance customer service and communication with external stakeholders.

Replace the department's Lotus Notes e-mail system with Outlook.

How Will We Measure It?

The following performance measures and targets apply to our three main business functions: enforcement, licensing, and consumer/industry education. The measures assess:

- Volume – the number of inputs we receive and outputs we produce (e.g., number of complaints received; number of licenses issued; number of enforcement cases worked).
- Cycle Time – the number of days or weeks we spend on tasks;
- Efficiency (Cost) – the cost to produce outputs;
- Customer Service – the level of consumer and licensee satisfaction with our customer service
- Public Awareness — the level of public awareness of DCA services; and
- Employee Satisfaction – the level of DCA employee satisfaction in areas such as internal communication and opportunities for learning and growth.

MEASURE TYPE/NAME	BUSINESS FUNCTION	RELATED GOAL	TARGET	DESIRED OUTCOME
PM 1: Volume Number of complaints received	Enforcement	Goal 1	N/A	Long-Term: Improved understanding of the efficiency of enforcement services
PM 2: Cycle Time Average number of days to complete complaint intake	Enforcement	Goal 1	TBD by individual boards/ bureaus	Short-Term: Consumer and licensee satisfaction Long-Term: Increased consumer safety
PM 3: Cycle Time Average number of days to complete closed cases not resulting in formal discipline	Enforcement	Goal 1	TBD	Short-Term: Consumer and licensee satisfaction Long-Term: Increased consumer safety

MEASURE TYPE/NAME	BUSINESS FUNCTION	RELATED GOAL	TARGET	DESIRED OUTCOME
PM 4: Cycle Time Average Number of Days to Complete Cases Resulting in Formal Discipline	Enforcement	Goal 1	12 – 18 months	Short-Term: Consumer and licensee satisfaction Long-Term: Increased consumer safety
PM 5: Efficiency (Cost) Average cost of intake and investigation for complaints not resulting in formal discipline	Enforcement	Goal 1	To be developed by individual boards/ bureaus	Long-Term: Reduction in costs to conduct intake and investigations
PM 6: Efficiency (Cost) Average cost of the intake, investigation, and formal discipline (for cases resulting in formal discipline	Enforcement	Goal 1	To be developed by individual boards/ bureaus	Long-Term: Increased consumer safety
PM 7: Customer Satisfaction Consumer satisfaction with the service received during the enforcement process	Enforcement	Goals 1 and 6	To be developed	Short-Term: Increased consumer satisfaction Long-Term: Improved micro-processes

MEASURE TYPE/NAME	BUSINESS FUNCTION	RELATED GOAL	TARGET	DESIRED OUTCOME
PM 8: Cycle Time Average number of days from the date a probation monitor is assigned to the date the monitor makes first contact	Enforcement	Goals 1 and 6	To be developed	Short-Term: Increased customer satisfaction Long-Term: Increased consumer safety
PM 9: Cycle Time Average number of days from the time a violation is reported to the program to the time the probation monitor responds	Enforcement	Goals 1and 6	To be developed	Short-Term: Increased customer satisfaction Long-Term: Increased consumer safety
PM 10: Volume Number of licenses or registrations issued	Licensing	Goals 2 and 3	Not applicable	Long-Term: Improved understanding of the efficiency of licensing services
PM 11: Volume Number of licenses or registrations renewed	Licensing	Goals 2 and 3	Not applicable	Long-Term: Improved understanding of the efficiency of licensing services

MEASURE TYPE/NAME	BUSINESS FUNCTION	RELATED GOAL	TARGET	DESIRED OUTCOME
PM 12: Cycle Time Average processing time from receipt of application to license or registration issued	Licensing	Goals 2, 3, and 6	To be developed by individual boards/ bureaus/ programs	Short-Term: Increased licensee satisfaction Long-Term: Increased consumer safety and choice; for some licensing categories, positive impact on California's economy by creating jobs
PM 13: Cycle Time Average processing time from receipt of renewal application to license or registration renewed	Licensing	Goals 2, 3, and 6	To be developed by individual boards/ bureaus/ programs	Short-Term: Increased licensee satisfaction Long-Term: Increased consumer safety
PM 14: Efficiency (Cost) Average cost to issue a license or registration	Licensing	Goals 2, 3, and 6	To be developed by individual boards/ bureaus /programs	Short-Term: Increased licensee satisfaction Long-Term: Positive impact on California's economy by ensuring that costs to enter a profession or industry are reasonable

MEASURE TYPE/NAME	BUSINESS FUNCTION	RELATED GOAL	TARGET	DESIRED OUTCOME
PM 15: Efficiency (Cost) Average cost to issue a renewal license or registration	Licensing	Goals 3 and 6	To be developed	Short-Term: Increased licensee satisfaction
PM 16: Customer Service Licensee satisfaction with the license or certification application process	Licensing	Goals 3 and 6	To be developed	Short-Term: Increased licensee satisfaction Long-Term: Improved micro-processes
PM 17: Customer Service Licensee satisfaction with the license or certification renewal application process	Licensing	Goals 3 and 6	To be developed	Short-Term: Increased licensee satisfaction Long-Term: Improved micro-processes
PM 18: Volume Number of inquiries (calls, correspondence, etc.) received by the Consumer Information Center	Consumer Education	Goal 3	Not applicable	Long-Term: Improved understanding of workload volume

MEASURE TYPE/NAME	BUSINESS FUNCTION	RELATED GOAL	TARGET	DESIRED OUTCOME
PM 19: Cycle Time Average wait time for consumer and licensees calling the Consumer Information Center	Consumer Education	Goal 4	Overall Average Wait Time: 1 minute, 30 seconds	Short-Term: Increased customer satisfaction
PM 20: Customer Service Consumer and licensee satisfaction with the information provided by Consumer Information Center (call center, correspondence unit, and outreach unit)	Consumer Education	Goal 4	To be developed	Short-Term: Increased customer satisfaction Long-Term: Improved micro processes
PM 21: Public Awareness Levels Number of audience members reached by the BAR's Drive Healthy campaign	Consumer Education	Goal 4	(To be obtained from BAR)	Short-Term: Assurance that paid media campaign is reaching the maximum number of people with paid advertising and other campaign methods

MEASURE TYPE/NAME	BUSINESS FUNCTION	RELATED GOAL	TARGET	DESIRED OUTCOME
PM 22: Public Awareness Levels Percentage of survey takers who are aware of DCA and the services it provides	Consumer Education	Goal 4	85% overall public awareness levels; levels for subpopulations such as seniors, Spanish speakers, etc. to be determined. (Baseline data from public awareness survey conducted in 2005 = 76% of survey takers had heard of DCA and its services)	Short-Term: DCA gains data on the public's awareness levels Long-Term: Information and outreach efforts are modified
PM 23: Employee Satisfaction Levels Employee satisfaction with areas such as opportunities for learning, advancement, and internal communication methods	Employee Satisfaction	Goal 5	To be determined	Short-Term: DCA gains information on how to improve internal communication methods and employee services Long-Term: Services are modified

What Have We Accomplished?

This section describes the objectives DCA accomplished since our last Strategic Plan was issued in 2008.

Enforcement Enhancement and Improvement. DCA embarked on an ambitious Consumer Protection Enforcement Initiative. The initiative takes a three-pronged approach at improving the department's enforcement function through legislation, internal process improvement, and enhanced resources. Program objectives are listed under Goal 1 of this plan. Some of the objectives have already been completed: the development of an internal tracking system for enforcement case monitoring; a first-time Enforcement Academy for middle managers; and the development of performance measures, discussed below.

Job Creation. We recognize that DCA's licensing business function plays a critical role in the creation of jobs in California. To that end, in early 2010 we began another ambitious project, the Job Creation Initiative, aimed at quickly reducing our pending license application workload. Program objectives are listed under Goal 2 of this plan.

Process Improvement. We created the Strategic Organization, Leadership, and Individual Development (SOLID) unit in 2008. This unit is responsible for organizational development and strategic planning. Unit staff began implementing a process improvement project for the Office of Human Resources, which will be completed in April 2010. SOLID will perform process improvement work for DCA's contracting and correspondence functions as well in 2010.

Performance Measures. In 2009, SOLID staff, working with executives, middle managers, and line staff, developed a set of nine performance measures for enforcement (pages 13 – 14), and is leading the effort to streamline and modernize DCA's thirty-year old data base coding system for reporting progress on cycle times, cost, and volume. SOLID has since proposed performance measures for DCA's licensing and education business functions, as well as employee satisfaction (pages 14 – 18). These performance measures will be used to assess the progress of each board, bureau, and program toward meeting targets. DCA will begin publicly reporting on the measures in October 2010, through the use of a balanced scorecard reporting method and report-card like displays on each board/bureau/program website.

Best Practices. SOLID Training Solutions formed an Enforcement Best Practices committee, which researched best practices for complaint intake, investigations, and probation monitoring. The committee presented its findings to executive leadership in February 2010.

Consumer and Board Member Education. DCA developed a department-wide consumer education campaign titled *Take Charge California.* The goals of the campaign are to educate Californians about the importance of protecting themselves in the

marketplace; provide information, resources, and assistance needed to make informed and appropriate choices; and compel consumers to improve their marketplace skills. DCA is partnering with local, state, and federal level agencies, community based organizations, and public libraries in this campaign to spread the word.

To spread the word about the perils of unlicensed activity, we created a consumer and licensee education campaign titled *Inquire Before You Hire.* The campaign urges consumers to check that practitioners are licensed before hiring them and potential licensees to obtain licensure. DCA partners with other state agencies and businesses in this effort. For example, we partner with the Board of Equalization to conduct regional sweeps for unlicensed activity

We held the 2008 PACT (Professionals Achieving Consumer Trust) Summit in November 2008, as a learning and networking event for our 300 regulatory board members. Board members were provided with training on ethics, board governance, demographic and regulatory trends, and consumer protection issues. Conference participants rated their experience very highly.

We also held a Healing Arts Roundtable in 2009 with the Office of Statewide Health Planning Development. The Roundtable served as a forum for healing arts board chairpersons and their executive officers to discuss workforce shortage issues

Organizational and Employee Development. To help DCA evolve into THE employer of choice (Goal 3 in the previous plan), SOLID created and/or facilitates the following successful internal employee and leadership programs.

- Executive Leadership Forum – held bi-monthly, this forum is an opportunity for board and bureau leadership to meet with the department's Director and other executive staff to hear updates, raise issues, and share accomplishments.
- Managers' Roundtables – held quarterly, the roundtables are an opportunity for the department's middle management to meet with the Director and other executive staff to hear updates, raise issues, and share accomplishments.
- Mentor Program – a pilot for supervisors and managers was implemented in 2009, and will be evaluated for expansion in 2010.
- Customer Service Program – this program consists of a customer service model for DCA, titled the 7Cs of Customer Service; new and improved customer service training, and a quarterly Customer Service Newsletter. Managers are encouraged to use the 7Cs in employee evaluations and considerations for promotion.
- New Employee Welcome and Orientation sessions.
- Employee Suggestion Box – SOLID staff respond to anonymous suggestions and complaints through this mechanism.

- Employee of the Year Award .
- Employee Appreciation Days (held annually in both Northern and Southern California).
- New Employee Survey and Employee Exit Survey. The data from these surveys are shared with executive leadership and middle management to help them understand the demographics of employees who are attracted to DCA, as well as the reasons they seek other employment.
- Management Academy and Enforcement Management Academy – the training unit within SOLID oversees and implements these first-ever DCA academies for middle managers.

Technology. We created a Technology Governance Committee. In addition, we began work on the BreEZe IT system. The DCA plans to acquire a new, integrated, enterprise-wide enforcement and licensing system (BreEZe) that will support the DCA's needs for applicant tracking, licensing, renewal, enforcement, monitoring, cashiering, and data management. BreEZe will replace the existing CAS, ATS, and multiple "workaround" systems with an integrated system for use by all DCA organizations. The BreEZe project was approved by the Office of the State Chief Information Officer (OCIO) in November 2009, and the Request For Proposal (RFP) for a solution vendor is currently under development. The system implementation date is anticipated in December 2012.