State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

July 27-29, 2011

Executive Committee	July 27	2:30 p.m. - 5:30 p.m.
Panel A	July 28	8:00 a.m. - 11:00 a.m.
Panel B	July 28	8:00 a.m. - 11:00 a.m.
Access to Care Committee	July 28	11:00 a.m. -12:00 p.m.
Full Board	July 28	1:00 p.m. - 3:30 p.m.
Tour of UCD Medical School	July 28	3:30 p.m. - 6:00 p.m.
Application Review Committee	July 29	8:30 a.m. - 9:00 a.m.
Full Board	July 29	9:00 a.m. - 3:00 p.m.

MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

Courtyard by Marriott – Cal Expo
1782 Tribute Road
Sacramento, CA 95815

July 27-29, 2011

Wednesday, July 27

- **2:30 p.m. – 5:30 p.m.** — **Executive Committee – Lake Tahoe Room**
  Medical Board Offices, 2005 Evergreen Street, Sacramento, 95815
  (Members: Yaroslavsky, Chang, Duruisseau, Levine, Salomonson)

Thursday, July 28

- **8:00 a.m. – 11:00 a.m.** — **Panel A – Golden State Room C/D**
  (Members: Duruisseau, Carreon, Diego, Salomonson, Yaroslavsky,)
- **8:00 a.m. – 11:00 a.m.** — **Panel B – Golden State Room A/B**
  (Members: Chang, Levine, Low, Moran, Schipske)
- **11:00 a.m. – 12:00 p.m.** — **Access to Care Committee – Golden State Room C/D**
  (Members: Schipske, Chang, Carreon, Duruisseau, Yaroslavsky)
- **1:00 p.m. – 3:30 p.m.** — **Full Board Meeting – Golden State Room C/D**
  (All Members)
- **3:30 – 6:00 p.m.** — **Tour of UC Davis Medical School**
  (All Members)

Friday, July 29

- **8:30 a.m. – 9:00 a.m.** — **Application Review Committee - Golden State Room C/D**
  (Members: Schipske, Diego, Low)
- **9:00 a.m. – 3:00 p.m.** — **Full Board Meeting – Golden State Room C/D**
  (All Members)

MEDICAL BOARD OF CALIFORNIA
Executive Office

MEMBERS OF THE BOARD
Barbara Yaroslavsky, President
Hedy Chang, Secretary
Jorge Carreon, M.D.
Silvia Diego, M.D.
Shelton Duruisseau, Ph.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

July 28-29, 2011

Courtyard by Marriott
Golden State Room C/D
1782 Tribute Road
Sacramento, CA 95815
916-929-7900 (directions only)

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

AGENDA

Thursday, July 28
1:00 p.m. – 3:30 p.m.

Friday, July 29
9:00 a.m. – 3:00 p.m.

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources.

ORDER OF ITEMS IS SUBJECT TO CHANGE

Thursday, July 28

1. 1:00 p.m. 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 May 6, 2011 meeting

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.

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4. Licensing Chief's Report – Mr. Worden
   A. Staffing
   B. Status of 7/1/11 Licensing for 2065/2066 Applicants
   C. Program Statistics
   D. Status of International Medical School Program

5. Licensing Outreach Report - Mr. Schunke

6. Midwifery Advisory Council Update and Consideration of Council Recommendations
   A. Midwifery Advisory Council Nominations and Approval – Mr. Worden
   B. Update – Ms. Ehrlich

7. Enforcement Chief's Report – Ms. Threadgill
   A. Approval of Orders Following Completion of Probation and Orders for License Surrender During Probation
   B. Expert Utilization Report
   C. Enforcement Program Update
      1) Staffing
      2) Program Statistics
      3) Probation Enhancements

8. Vertical Enforcement Program Report – Ms. Threadgill and Mr. Ramirez
   A. Status Report on VE Manual
   B. Statistics
   C. HQE Organization and Staffing

9. Legislation/ Regulation – Ms. Simoes
   A. 2011 Legislation
   B. 2012 Legislative Proposals
   C. Status of Regulatory Action – Mr. Schunke

10. Access to Care Update - Ms. Schipske

11. Physician Assistant Committee Update – Dr. Low

12. Federation of State Medical Boards Update - Ms. Chang

13. Health Professions Education Foundation Update – Ms. Yaroslavsky and Dr. Duruisseau

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Friday, July 29

14. 9:00 a.m. Call to Order / Roll Call

15. 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)]

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

17. President's Report - Ms. Yaroslavsky
    A. Committee Appointments

18. Executive Director's Report – Ms. Whitney
    A. Introduction of Deputy Director
    B. Staffing and Administrative Update
    C. Budget Overview – Ms. Kirchmeyer
    D. BreEZe Update – Ms. Kirchmeyer
    E. Board Meeting Dates and Locations
        1) Location of October 27-28, 2011 Meeting
        2) 2012 Board Meeting Dates and Locations

19. Adoption of Revised Emergency Contraception (EC) Protocol – Ms. Smith-Crowley, Ms. Besinque, PharmDn, and Ms. Herold

20. Status of the UC Medical School System – Dr. Nation

21. Consideration of Request for Recognition of American University of Antigua – Dr. Nuovo

22. Annual Report on the MBC / UCD Telemedicine Pilot Program – Dr. Nuovo

23. Consideration of Petition to Repeal Section 1349 of Title 16 of the California Code of Regulations Pertaining to Physician-Podiatrist Partnerships – Mr. Heppler

11:30 a.m. Break for Lunch

24. 12:00 (Noon) Presentation: CMA California Physician Workforce Report – Ms. Choong and Mr. Grafilo

25. Report on Health Care Reform in California – Ms. Minnifield

26. Election of Officers

27. Agenda Items for October 27-28, 2011 Meeting

28. Discussion and Possible Action on Draft Strategic Plan Presented by the Executive Committee and Strategic Plan Subcommittee – Dr. Levine and Ms. Yaroslavsky

29. Adjournment

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

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For additional information call (916) 263-2389.

NOTICE: The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Cheryl Thompson at (916) 263-2389 or cheryl.thompson@mbc.ca.gov or send a written request to Ms. Thompson. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

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MEDICAL BOARD OF CALIFORNIA
Executive Office

NOTICE
REVISION TO TIMING OF
ITEM #24
ON THE
FULL BOARD AGENDA

Please note, that due to unforseen circumstances,
Agenda Item #24 Presentation:
CMA California Physician Workforce Report
will move from the Friday, July 29
full Board agenda and time slot
to the
Thursday, July 28 full Board agenda
that will be held
between 1:00 p.m. to 3:30 p.m.

We apologize for any inconvenience this may cause.

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MEDICAL BOARD OF CALIFORNIA
Executive Office

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

May 6, 2011

MINUTES

Due to timing for invited guests to provide their presentations, the agenda items below are listed in the order they were presented.

Agenda Item 1 Call to Order/ Roll Call
Ms. Yaroslavsky called the meeting of the Medical Board of California (Board) to order on May 6, 2011 at 10:15 a.m. A quorum was present and notice had been sent to interested parties.

Members Present:
Barbara Yaroslavsky, President
Frank V. Zerunyan, J.D., Vice President
Hedy Chang, Secretary
Jorge Carreon, M.D.
Silvia Diego, M.D.
Shelton Duruisseau, Ph.D.
Eric Esrailian, 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.

Members Absent:
John Chin, M.D.

Staff Present:
Larry Bennett, Enforcement Investigator
Magda Castro, Enforcement Investigator
Catherine Hayes, Probation Manager
Kurt Heppler, Legal Counsel
Teri Hunley, Business Services Manager
Ross Locke, Business Services Staff
Regina Rao, Business Services Staff
Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel

DRAFT

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Jennifer Simoes, Chief of Legislation
Cheryl Thompson, Executive Assistant
Renee Threadgill, Chief of Enforcement
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:

Muzzafer Aslan, M.D., Member of the Public
Hilma Balaian, Kaiser Permanente
Yvonne Choong, California Medical Association (CMA)
Genevieve Clavreul, Member of the Public
Paul Costa, Department of Consumer Affairs
Long Do, CMA
Julie D'Angelo Fellmeth, Center for Public Interest Law
Karen Ehrlich, L.M., Midwifery Advisory Council
Dean Grafilo, CMA
Beth Grivett, California Academy of Physician Assistants
M. Hiltlke, Los Angeles Times
Tara Kittle, Member of the Public
Jason Lee, Member of the Public
Lucille Leong, M.D., City of Hope Cancer Center
John Marshall, Member of the Public
Stephen McDow, Orange County Medical Association
Cecilia Melendres, USC
Michele Monserratt-Ramos, Consumers Union Safe Patient Campaign
Robert Morgan, M.D., City of Hope
Paul Phinney, CMA
Lavonne Powell, Department of Consumer Affairs
Carlos Ramirez, Office of the Attorney General
Anna Robb-Rios, City of Hope
Rehan Sheikh, Member of the Public
Taryn Smith, Senator Office of Research
Peter Vakselis, Member of the Public
Kerry Weisel, Office of the Attorney General
Julie Zamoyski, UCLA
(Note: This list only identifies those who signed in at the meeting; staff was not available to record the names of all persons in attendance.)

Agenda Item 17 Presentation of Physician Humanitarian Awards

The Physician Humanitarian Award was created several years ago by the Board to recognize the demonstration of excellence by physicians who strive to improve access to health care for underserved populations. Ms. Yaroslavsky presented awards to this year's recipients: Dr. Richard Kammerman and Dr. Rodney Borger.

Dr. Kammerman is board certified in family medicine and is a past chair and current Clinical Professor of the UC Irvine Department of Family Medicine. Since the early 1960's, he has

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served countless hours in leadership positions within the Orange County Medical Association and other professional associations, hospital organizations and community groups. Dr. Kammerman has greatly impacted the lives of the uninsured and underinsured in Orange County. His tireless work and commitment to the poor resulted in the launching of CalOptima, the county's Medicaid managed system of care. He oversaw the program's research and design and was instrumental in forging a partnership among the county government, private physicians, hospitals and community clinics that continues to exist today.

Dr. Borger is board certified in emergency medicine and is the Director of the emergency room at Arrowhead Medical Center in Colton, CA. He has repeatedly demonstrated his commitment to public health and safety through the development of innovations to improve the operation of emergency departments. In addition to serving on the California Department of Public Health Advisory Committee, Dr. Borger also was instrumental in forming the San Bernardino County Medical Reserves Corps, a specialized component of Citizen Corps, a national network of volunteers dedicated to ensuring hometown security. He has traveled to Africa to provide basic health care for the people of Botswana, and to Thailand to provide medical care for missionaries and aid workers in remote locations.

Ms. Yaroslavsky called the meeting into recess in order to hold the Enforcement Committee meeting.

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Ms. Yaroslavsky called the meeting back into session at 11:15 a.m.

CLOSED SESSION

Agenda Item 21 **Pursuant to Government Code Section 11126(e)(1), the Board met in closed session to confer with its legal counsel regarding the following litigation: *Soderling v. Medical Board of California, et al.*, Sacramento County Superior Court; Case Number 2008-800000044**

RETURN TO OPEN SESSION

Agenda Item 2 **Public Comment on Items not on the Agenda**

Tara Kittle provided a list of suggestions for improving the medical system that are drawn from personal experience. These include the ability to audiotape conversations with physicians in order to provide accountability, a statement of patient rights and responsibilities, and abolishing hospital administration boards and insurance company physicians who deny the treating physician's orders. She suggested that the Board establish a compensation committee to review the financial compensation structure for physicians in order to improve patient coutcomes. Ms. Kittle requested that this item be placed on the agenda for a future meeting.

John Marshall described his negative experience with an independent medical examiner that his insurance company sent him to for a medical disability evaluation. He stated that the denial for his claim was based on tests and examinations that were never conducted by the reporting

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physician, an unlicensed technician was used to take X-rays, and the doctor illegally withheld his medical records. He stated the Medical Board did not investigate his complaint. Ms. Yaroslavsky stated it was her understanding that Mr. Marshall was in communication with staff regarding this issue.

Dr. Muzzafer Aslan addressed the Board regarding his petition to reinstate his physician's and surgeon's license. Mr. Heppler stated the Board no longer has jurisdiction over this matter and any future action would need to be addressed through the Superior Court of California.

Genevieve Clavreul requested clarification on the standard for doctors' written orders, stating she witnessed a doctor using the apothecary system; this created confusion for the nurses in calculating dosages. Mr. Heppler requested that Ms. Clavreul contact him directly with her concerns.

Agenda Item 23 Presentation / Discussion / Acceptance of the Proposed Written Guidance on the Transmission and Receipt of Electronic Controlled Substance Prescriptions

Ms. Whitney stated the proposed written guidance to pharmacies and prescribers on the transmission and receipt of electronic controlled substance prescriptions was developed pursuant to the Drug Enforcement Administration's Interim Final Rule (IFR). The Board of Pharmacy requested that the Board work with them in developing a simplified information booklet for physicians and pharmacists.

Kerry Weisel, Deputy Attorney General, reported the DEA's requirements for e-prescribing of controlled drugs is laid out in a 330 page document that is both detailed and highly technical in nature. Ms. Weisel and Deputy Attorney General Joshua Room created a guidance document in order to adequately inform California licensees about the requirements contained in the IFR. She referred members to the summary document included in their packets. Information for the written guidance document was derived from the IFR and materials provided by the DEA's Office of Diversion Control. She suggested that the Board may want to provide a link to these useful materials on its website. Many of the questions a physician might have about e-prescribing controlled substances can be answered by the providers of the application software.

Ms. Weisel stated that the summary document, which is proposed to be included on the Board's website, will be helpful to physicians, as many may not be aware that it is now acceptable for controlled substances to be electronically prescribed. The document, which will assist physicians in following the proper procedures, discusses the interaction between DEA regulations and California law.

Dr. Duruisseau made a motion to accept the guidance document and post it on the Board's website; s/Levine; motion carried.

Agenda Item 3 Approval of Minutes from the January 28, 2011 Meeting

Ms. Chang moved to approve the revised version of the minutes from the January 28, 2011 meeting; s/Levine; motion carried.

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Agenda Item 4 REGULATIONS - PUBLIC HEARING

Ms. Yaroslavsky opened the public hearing on the proposed regulations to adopt section 1327(a) of Title 16 of the California Code of Regulations as described in the notice published in the California Regulatory Notice Register and sent by mail to those on the Board's mailing list. For the record, Ms. Yaroslavsky stated the date was May 6, 2011.

Mr. Heppler reported the City of Hope petitioned the Board to amend Title 16, CCR, §1327 dealing with clinical training programs for foreign medical students and accreditation requirements. Due to the bylaws of the California Medical Association (CMA), which preclude accreditation by the Accreditation Council for Continuing Medical Education (ACCME), it is impossible for the City of Hope to become approved. The proposed regulation, in addition to making a few conforming changes, would allow a clinical training program, still subject to the filing of an application and approval by the Board, to be approved by *either* CMA *or* the ACCME.

Ms. Yaroslavsky noted that written comments were received from the City of Hope in support of the amendment. Mr. Heppler reported written comments were also received from Ross University School of Medicine regarding an issue in existing regulation unrelated to this rulemaking proceeding. The comments, therefore, need not be considered in this rulemaking procedure.

Mr. Worden added that the amendment, if approved by the Board, would provide the opportunity for the City of Hope and other hospitals in a similar situation to provide clinical training to students,

No public comment was offered. Ms. Yaroslavsky closed the hearing.

Dr. Salomonson made a motion to adopt the proposed amendments to Section 1327(a) of Title 16 CCR; the motion was seconded and carried.

Agenda Item 5 REGULATIONS -PUBLIC HEARING

Ms. Yaroslavsky opened the public hearing on the proposed regulations to adopt sections 1333, 1333.1, 1333.2, and 1333.3 of Title 16 of the California Code of Regulations as described in the notice published in the California Regulatory Notice Register and sent by mail to those on the Board's mailing list.

Ms. Scuri reported AB 2699, which was passed in 2010 and took effect in 2011, permits practitioners who are licensed in a state other than California to provide services at a health care event in California. The proposed regulations would implement the statute. No written comments were received on this item. Ms. Scuri directed members to the modified text that was distributed prior to the meeting and made available to the public. She provided an overview of the substantive changes to the text. The proposed regulations would define "a community based organization" and "out of state practitioner". Further, they would set forth the sponsoring entity registration and record keeping requirements. Section 1333.1(d), adds a "notice to consumers" type of notification requiring the sponsoring entity to place a notice visible to patients at every station where patients are seen by physicians stating that the physician is either licensed and

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regulated by the Medical Board of California or holds a current valid license from another state and has been authorized to provide healthcare services only at this specific health fair; the notice would include the Medical Board's contact information.

In Section 1333.2, the cost for the criminal records check makes it clear that the applicant shall pay the costs for furnishing the fingerprints and conducting the criminal history record check, which would only apply to the first application for authorization. Section 1333.2(c) includes mandatory grounds for denial of authorization to participate if the Board is unable to obtain a timely report of the results of the criminal history check. Section 1333.2(e) adds a notice to consumers similar to that which is required in 1333.1(d), but it applies to an individual practitioner, rather than a sponsoring entity, since events sponsored by a local government entity are not required to register with the Medical Board. Conforming changes have been made to the authorization form (901-B).

Ms. Yaroslavsky asked if the authorization form will be used by other health professions for providing services at the same kinds of events. Ms. Scuri responded that forms used by other health licensing boards will be very similar. The forms that were developed were to serve as templates, though modifications will be required to suit each licensing board's needs and requirements.

No public comment was offered. Ms. Yaroslavsky closed the hearing.

Dr. Levine made a motion to authorize the Board's Executive Director to adopt the modified language at the expiration of the 15-day comment period if there are no adverse comments; s/Chang; motion carried.

Agenda Item 6 Physician Responsibility in the Supervision of Affiliated Health Care Professionals Advisory Committee Update and Consideration of Possible Action on Committee Recommendations

Dr. Moran reported the Committee received an overview of the relevant rules and issues regarding the physician's oversight of allied health care professionals. This included an overview of the newly enacted Notice to Consumers law (AB 583) and a presentation on the corporate practice of medicine by Deputy Attorney General Russell Lee. In addition, the Committee heard a report on other states' definitions of a medical spa and availability. Ms. Scuri provided an overview of the standardized procedures regulations from the Board of Registered Nursing.

The Committee determined two action items for its next meeting: 1) identifying the need for legislation that may be lacking, possibly even re-attempting failed legislative efforts, and 2) identifying ways to educate the public and physicians on the nature of these oversight relationships / processes and what the laws dictate.

Ms. Schipske thanked Dr. Moran for chairing the Committee, stating it has been both instructive and enlightening on a number of issues. She suggested that the Board formally communicate with the Board of Registered Nursing on the many concerns that arose during the Committee's meetings. She thought this would be helpful and requested that it be placed as an action item on the Board's agenda.

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Ms. Yaroslavsky agreed and suggested that a written compilation be made of all the issues that were raised and possible solutions that were developed through the Committee's work. This compilation could then be disseminated to interested parties, included in the Board's newsletter, and distributed by other available means.

Agenda Item 7 Access to Care Update

Ms. Yaroslavsky reported the Access to Care Committee heard informative presentations on collaborative practice models in medicine from Eric Davydov, M.D., Medical Director of the Facey Medical Group, and Paula Verdette, M.D., Medical Director of Huntington Hospital.

Agenda Item 8 Licensing Committee Update and Consideration of Possible Action on Committee Recommendations

Dr. Salomonson reported Mr. Worden provided an update on the application processing status. Among applicants requiring licensure by July 1 in order to continue with their training, 361 still have not been licensed; 29 applied in April (though these individuals should still be licensed by the deadline); and 27 individuals have still not submitted an application. Kevin Schunke, Licensing Outreach Manager, will be contacting the training programs to report on the status of their applicants. The coordinated efforts of Mr. Worden and Mr. Schunke have been successful in licensing these individuals in a timely manner.

Updates were also given on the Business Process Re-engineering Project. The policy and procedure manual project was put on hold due to staffing shortages. Dr. Low and Mr. Worden provided an update on the international medical school approval process.

The Licensing Committee will not meet at the July 2011 Board meeting, but will be scheduled for the October 2011 meeting.

Hilma Balaian from Kaiser Permanente's GME Office in Los Angeles, commended the Licensing Committee for their efforts. She praised the Outreach Program and its success in streamlining the licensing process for residents and stated this was the first time in 12 years that all of their residents are already licensed, far before the deadline. Ms. Balaian expressed her appreciation for the work Mr. Schunke had done in communicating with the GME programs.

Agenda Item 12 Strategic Plan Subcommittee Update

Dr. Levine reported the Board is beginning its process of strategic planning. The prior strategic plan was completed in 2008 and is available on the Board's website. Janie Cordray is the consultant for the process; she has developed a Board member survey, a staff survey, and questions for former Board executive officers to begin creating a framework for the agenda for the strategic planning process. Board members will be surveyed and individually interviewed between now and the end of June 2011. A strategic planning meeting for Board members will be held on the afternoon of July 27, 2011 in Sacramento, prior to the scheduled Board meeting. Dr. Levine instructed the members that the survey does not have to be filled out, it is to prompt their thinking about what priorities the Board ought to be pursuing for the next several years.

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Agenda Item 9 Special Programs Committee Update and Consideration of Possible Action on Committee Recommendations

Ms. Chang reported the Committee has recommended that the "2112" fellowship application for training in a specialty or subspecialty field at a teaching hospital in California be approved pending a site visit to the hospital to determine if the hospital meets the minimum requirements of B&P Section 2112 and California Code of Regulations Section 1325.5.

Ms. Chang made a motion for the Board accept this report; s/Duruisseau; motion carried.

Agenda Item 10 Enforcement Committee Update and Consideration of Possible Action on Committee Recommendations

Dr. Low reported the Enforcement Committee received an update on probation practice monitors by Mr. Heppler. The update included information on the difficulty disciplined licensees may have in obtaining probation monitors. At the last Committee meeting, there was concern that licensed physicians may be reluctant to serve as monitors due to the fear of possible defamation lawsuits or legal action, however, an analysis by staff did not support this contention. Nevertheless, the Probation Program is revising the monitoring forms to recommend that a practice monitor seek and execute a "hold harmless" agreement with the disciplined physician. Legal staff believes no further action is warranted on the issue of civil immunity of practice monitors.

The Committee also heard a presentation on significant improvements that will provide practice monitors with a formal structure to perform chart review and site inspections, and a standardized report format to be used when preparing quarterly reports to the Board. These improvements will be put into place after legal approval.

Ms. Threadgill delivered a presentation to the Committee on expert reviewer utilization in the Central Complaint Unit (CCU) and District Offices. B&P Code §2220.08 requires that any complaint involving quality of care must be reviewed by one or more medical experts with pertinent education, training and expertise to evaluate the specific standard of care in order to determine if the case should be sent to the field for further investigation. Expert's qualifications and utilization figures were discussed. A database is available to help the CCU and investigative staff select a proper expert. The prospective field expert is interviewed in order to ensure the individual has the proper expertise. Once the expert packet of documents is prepared, it undergoes scrutiny by both the supervising investigator and the deputy attorney general to ensure that nothing is included that might bias the expert in his or her review. The current median time for an expert package to be reviewed for the field and finalized is 36 days; the goal is to reduce this to 30 days.

Enforcement process "data markers", for both the Central Complaint Unit and the District Offices, were discussed. Although the data is relatively limited at the present time, as more data comes in, it will be possible to identify the areas of delay and make improvements to efficiency.

Dr. Low stated the Enforcement Committee will not meet at the July 2011 meeting, but will reconvene in October 2011.

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Tara Kittle commended the Enforcement Committee for their work in improving efficiency. She expressed her concern that it only takes one expert to determine if a breach in the standard of care has occurred. She encouraged the Committee to consider requiring a minimum of two expert reviews, possibly from different parts of the state, in order to provide additional insight in making this determination.

Agenda Item 11 Executive Committee Update

Ms. Yaroslavsky reported the Executive Committee met to conduct an evaluation of the Executive Director.

Agenda Item 13 Physician Assistant Committee Update

Dr. Low reported the Physician Assistant Committee (PAC) created a Physician Assistant Education and Training Subcommittee which met on January 19, 2011. Topics discussed included PA training and education methods used by the PAC to approve paid training programs. Significant time was spent discussing the requirement that preceptors be licensed physicians whose practice is sufficient to adequately expose preceptees to a full range of experience. Initially, a preceptor cannot be assigned to supervise more than one preceptee at a time. At the following PAC meeting, direction was given to the subcommittee to focus on the education aspect and reassess the preceptor-to-preceptee ratio. Additionally, the PAC asked for a better definition of who can be a preceptor.

The PAC met on February 3, 2011. Committee members were notified of the numerous budget issues confronting the PAC and other state agencies. Reductions in travel, enforcement reimbursement, hiring freezes, and other adjustments are being made.

Two regulations are moving through the adoption process. The first regulation, "Notice to Consumers", contains language similar to what was adopted by the Board and is being finalized for the Department and the Office of Administrative Law (OAL). The second regulation implements enhancements to enforcement processes.

Dr. Low indicated the PAC has three legislative proposals that were submitted to the Department. The proposals involve reporting requirements, the elimination of international graduate programs, and the elimination of the provision in the law that allows a US medical school graduate to take the PA exam because the national examining agency only allows graduates of approved PA schools to take the exam.

Agenda Item 18 President's Report

Ms. Yaroslavsky reported her time as the Board's president is occupied by participating in conference calls, reading cases, attending meetings, and being available for input. She participates in a monthly roundtable call with the DCA Director along with all the DCA healing arts board presidents and executive officers. The calls provide an open forum with the opportunity to question and discuss areas of concern. A weekly call is also held with the Executive Director to review issues. Ms. Yaroslavsky stated she finds staff eager and receptive to any questions or comments she may have.

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Ms. Yaroslavsky expressed the Board's appreciation for staff who must function under reduced staffing levels, increased responsibilities, and limited resources. In spite of these constraints, licensing timelines are significantly reduced from the backlog that existed 18 months ago and outreach to teaching hospitals has been successful in licensing residents in a timely manner.

Legislation continues to take a priority in the public protection arena. Ms. Yaroslavsky thanked Jennifer Simoes, Chief of Licensing, for her efforts in ensuring the Board's bills are being heard. Ms. Yaroslavsky has met with several legislators in Sacramento to seek sponsorship of the Board's bills and explain the purpose of the legislation. In doing so, the legislators are educated on the Board's role and responsibilities.

Ms. Yaroslavsky, who serves as a member of the Midwifery Advisory Committee (MAC), stated she is pleased with the advancements that have been made.

As a member of the Health Professions Education Foundation, Ms. Yaroslavsky has attended meetings and participated in calls on committee work. She reported additional money will be spent this cycle in the Stephen Thompson Physician Loan Repayment Program. Dr. Duruisseau also sits on the HPEF Selection Committee for the Loan Repayment Program.

Ms. Yaroslavsky thanked Dr. Duruisseau for setting up conversations with Terry Leach, Interim Executive Director of the UC Center for Health Quality and Innovation, and Dr. Catherine Nation, UC Office of the President, to discuss the addition of creative programs around the state.

Ms. Yaroslavsky reminded members of the presentation made by Dr. Dowling at the April 2010 Board meeting where he shared UCLA's innovative program to place doctors who have graduated from World Health Organization medical schools in community based hospitals. She reported she was able to attend the graduation ceremony for these doctors as they began their post-graduate training throughout California.

In April 2011, Ms. Yaroslavsky attended the statewide Investigator's Conference and met with many dedicated staff. She thanked Renee Threadgill, Chief of Enforcement, and her staff for making the conference successful.

Ms. Yaroslavsky has been invited to participate in a statewide primary care workgroup, California Health Workforce Alliance. She attended a meeting of the group in Los Angeles.

The Federation of State Medical Board's Annual Meeting was held in Seattle on April 28-30, 2011. Ms. Yaroslavsky stated that the meeting was very informative. She reported that California has already dealt with issues that other states are just beginning to wrestle with. She looks forward to the opportunity for broader sharing of ideas and processes among boards that are similar in size or in the number of licensees. Ms. Yaroslavsky noted that boards are structured and operate differently throughout the nation. There are state boards that have only three public members, thereby limiting the influence of their vote. Some boards have the public present for the discussion of enforcement cases and outcomes. While the Board uses "clear and convincing evidence" as the standard for discipline, many other states use "a preponderance of the evidence" standard.

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She stated the importance of California participating in these discussions and forums. Ms. Yaroslavsky sits on the Bylaws Committee. Dr. Diego has been named to the Post Licensure Assessment System (PLAS) Committee. Ms. Chang has been elected to a three-year term of the FSMB Board of Directors. Dr. Moran serves on the Nominating Committee. Dr. Salomonson, sits on the Education Committee and attended a USMLE meeting in Philadelphia (at no expense to the Board) to develop questions for the USMLE exam.

Ms. Yaroslavsky announced that Dr. Hayes Bautista and Dr. Sergio Aguilar-Gaxiola will join the Board's Cultural and Linguistic Competency Workgroup.

Agenda Item 14 Federation of State Medical Boards Update

Ms. Chang reported that FSMB is addressing many of the same issues as the Board, including access to care and pending physician shortages, physician health and wellness, and telemedicine. The Federation and the National Board of Medical Examiners are working together to address the re-entry of physicians who have been out of practice for a period of time and the maintenance of licensure (MOL). They are looking for state boards to undertake a pilot project on MOL.

Ms. Chang serves on the Foundation of the Federation of State Medical Boards. The Foundation, along with the new chair of the FSMB, Janelle Rhyne, and the Administrators in Medicine (AIM) are working together on a project to develop a comprehensive system for measuring a state medical board's performance. The measurements will examine a manpower analysis, a measurement similar to the one used by the Public Citizen, and many other factors.

Agenda Item 16 Board Member Communications with Interested Parties

There were no communications disclosed by members.

Agenda Item 19 Executive Director's Report

A. Budget Overview

Ms. Whitney directed members to page 176 of their packets for the Analysis of the Fund Condition. Budget Year 2010-2011 shows a reserve of $26.7 million dollars, or a 5.7 month reserve. The fund condition for the Budget Year 2011-2012 drops to 2.9 months of reserve due to a proposed General Fund loan of $9 million dollars. In addition, the fund condition still shows $577,000 as a 2011-2012 proposed augmentation for Operation Safe Medicine (OSM); however, Ms. Whitney indicated this augmentation was unlikely to be approved this year. She expressed staff's disappointment with this outcome and noted that an augmentation request for the 2012-2013 fiscal year is being prepared for submission. It is hoped the new Administration will understand the need to continue this program on a permanent basis. Ms. Whitney has been in communication with the Deputy Director over administration about the possibility of shifting some positions to cover those in OSM.

Mr. Zerunyan expressed his desire for the public to understand the General Fund loan issue. The previous Administration borrowed $6 million dollars, which has not yet been returned. There is no date for the return of the proposed $9 million being borrowed by the current Administration. He has reviewed the conditions of the loans and stated that it appears there is no specific date or conditions set in place with respect to the return of the funds. Mr. Zerunyan stated this makes the return of funds completely discretionary, possibly allowing for the funds to never be returned to the Board.

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Ms. Whitney directed members to page 186 of the meeting packet for the language regarding the General Fund loan in the budget bill. It states "the Director of Finance shall order the repayment of all or a portion of this loan if he or she determines that either of the following circumstances exist: (a) the fund or account from which the loan was made has a need for the moneys, or (b) there is no longer a need for the moneys in the fund or account that received the loan. This loan shall be repaid with interest calculated at the rate earned by the Pooled Money Investment Account at the time of transfer." In essence, the Board would have to go back to the Legislature and let them know the Board is in need of those moneys in order to have them returned.

Page 177 of the packet lists the expenditures of the Board through the end of February 2011. The Board has expended approximately 62% of its authorization with 67% of the year being completed. Projecting this out, the Board will under-spend its authorization by approximately $1 million dollars, largely due to furloughs and the hiring freeze.

Dr. Paul Phinney, CMA Board of Trustees, stated CMA is aware of the proposed $9 million loan and the existing $6 million loan, as well as the lack of information in the statute on a date for repayment. CMA is concerned with the misuse of physician fees. In 2008 it sued the state to invalidate the loan, however, the courts have not been sympathetic with the suit. CMA remains committed to challenging the state's raid of physician's fees. It believes that balancing the state's budget with this sort of borrowing is a violation of the Medical Practice Act. The focus of the courts in evaluating the legality of borrowing from the contingent fund has been whether such borrowing hinders the performance of the Medical Board's regulatory function. Dr. Phinney stated there is reason to be concerned, referencing the recent LA Times article criticizing the Board's performance as a regulator, relating this failure to being "woefully understaffed and regularly robbed of budget funds." He asked how the proposed $9 million loan (combined with the already taken $6 million) will affect the Board's operation and its ability to carry out its regulatory function, both now and going into the future.

Ms. Whitney responded, stating the Department of Finance looks at the Board's fund condition in both the short and long term to make decisions on budget change proposals or augmentations. The augmentation for Operation Safe Medicine may be more difficult than anticipated with the $9 million loan from the Board's budget. The Board has anticipated the loan and it appears that there will still be sufficient funds to move forward; however, this does not address the Governor's other executive orders that limit personnel resources and individual employees' ability to perform their duties, such as attending meetings and conferences.

Ms. Yaroslavsky noted the difficulty is not just in the loan, but in the ability to spend the money that the Board has available.

Dr. Salomonson agreed, stating the Board is prohibited from spending the money in its account, thereby creating the appearance of a surplus while positions go unfilled. Therefore, because of the perceived surplus, it justifies moving more money out of the Board's fund.

Ms. Whitney reported a new executive order was issued on April 26, 2011 that places restrictions on travel. This, too, will impact the budget by reducing expenditures. The executive order allows for only mission critical travel, such as for enforcement and functions required by statute.

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Only a minimum number of employees are allowed to travel for mission critical trips. As an example, the normal number of staff to attend and effectively run a Board meeting is 20; Agency reduced the number allowed to attend the meeting to 12. This has had significant impact on staff and their ability to provide adequate coverage on all items on the agendas. This executive order impacts other work of the Board. Public outreach will be limited to locations where staff can drive via state vehicle and not require lodging or meals. Any public outreach in Southern California will be extremely limited and only provided by field office staff. The order applies to conferences, including those where staff has been invited to deliver presentations. Ms. Whitney will be seeking direction on travel for licensing outreach, as the Board considers this mission critical; she will keep members informed. As it relates to Board meetings, the July meeting scheduled in Sacramento will not be impacted. However, if the order is still in effect in October, Ms. Whitney requested permission to move the meeting to Sacramento.

Dr. Low made a motion to move the October 2011 meeting from San Diego to Sacramento contingent upon whether a waiver has been obtained within 3 months prior to the meeting; s/Chang.

Ms. Schipske opposed the motion, stating the Board needs to be very adamant with the Administration that the purpose of holding the meetings throughout the state is to allow access to the public and physician community who do not have the means to travel. She stated it was not in the best interests of consumers to limit the locations for public board meetings. Ms. Schipske indicated it was inappropriate for an agency funded by licensing fees to be put into the same category as agencies funded by General funds. The Board has a role and a mission, which includes being accessible to the public, and stated the Board should convey this message back to the Administration.

Dr. Salomonson stated she agreed with the comments being made, but also realizes the difficulties created for staff when the number of individuals allowed to travel to meetings is so limited. Dr. Low concurred, stating the importance of having the appropriate staff present in order to have an effective, quality meeting.

Dr. Duruisseau suggested that, should the Board attempt to obtain a waiver, it should be more than a letter to the Administration; he stated a delegation of the Board would be more effective in order to impress upon the Agency the significance of this issue. He indicated the burden should not be placed upon the staff to obtain a waiver, but the members should become involved.

Ms. Kittle stated her support for holding the meetings throughout the state in order to allow access to the public.

Michele Monserratt-Ramos, Consumers Union Safe Patient Campaign, indicated that at the November 2010 Board meeting she suggested adding a telecommunications component to the Board's proceedings. She stated this was even more pertinent now, given the travel and staffing restrictions. Ms. Monserratt-Ramos asked the Board to consider teleconferencing the meetings in order to allow both staff and consumers to participate.

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Ms. Clavreul expressed her concern with moving the meeting to Sacramento. As a consumer, she stated this would limit her right to address the Board.

Ms. Balaian stated that the Board's Outreach program saves time and money for both the Board and residents who are applying for licensure. Licensing fairs bring multiple resources together in one place and provide an opportunity for the residents to ask questions and have their applications checked by a representative of the Board for completeness and accuracy. She stated that limiting staff travel for outreach would be a tremendous error.

Mr. Heppler clarified the motion stating: if the executive order restricting travel is still in place *and* the Medical Board cannot get the necessary travel exemptions or waivers for a sufficient number of staff to attend the out-of-Sacramento meeting, then the meeting will be moved to Sacramento.

Ms. Yaroslavsky called for the vote; motion carried; Opposed – Schipske; Abstained – Yaroslavsky.

Ms. Whitney noted that the meeting in Sacramento on July 2011 had originally been scheduled to take place at the UC Davis School of Medicine; however, a lack of available conference rooms will require the meeting to be moved to another Sacramento location.

Returning to the issue of the loan to the General Fund, Dr. Phinney stated CMA is specifically concerned that the loan is in conflict with the Medical Practices Act. It places the funds in question into a different category. The Medical Practices Act statute specifically states that the funds are to be used *solely* for carrying out the activities of the Medical Board. The Act has additional specific language prohibiting transfer of Medical Board funds to the state. Dr. Phinney reported the courts circumvented this provision by stipulating that, because the loan is temporary, it does not constitute a transfer. CMA disagrees with this interpretation and is committed to continue this fight.

B. Staffing and Administrative Update

Ms. Whitney reported that, as of May 1, 2011, the Board had 45 vacancies. This number does not include the 16 CPEI positions that were authorized this year. There are 5 more known retirements in May, although a couple of these positions may be able to be filled with applicants from within the DCA. Four freeze waivers have been submitted for positions: Medical Consultant (Licensing), Medical Consultant (Enforcement), Supervisor I for field office enforcement positions, and Office Technician for the Cashier Unit, Call Center and front-end licensing support. The waivers are first sent to the DCA Fiscal Office, then to the DCA Director, next to the SCSA Secretary, then to the Department of Finance, and, finally, to the Governor's Office for approval. The first waiver was for the "Medical Consultant – Licensing" for 8 permanent intermittent positions; this was submitted before the executive order on February 14 and was resubmitted on March 14 under the newly defined waiver process. This waiver was approved by the Governor's Office on April 20, 2011. The "Medical Consultant – Enforcement" for 8 permanent intermittent positions was submitted on March 21, 2011 and is currently at the Department of Finance. Waivers were submitted on April 5, 2011 for 5 Supervisor I enforcement positions for the field offices; this waiver is currently at the DCA Director's Office.

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Six waivers were requested on April 20, 2011 for Office Technician positions in cashiering (which is income generating), the Call Center, and front end support for licensing; this request is currently at the DCA Fiscal Office. Investigator waiver requests should go to DCA next week.

Among the 45 existing vacancies, 4 are located in the Executive Office, 2 in Administrative Services, 1 in Business Services, 12.8 in the Licensing Program, 4 in the Central Complaint Unit, 1 in the Office of Standards and Training, 14 in the Enforcement Section, and 6 in the Probation Section. Ms. Whitney reiterated that these numbers do not include the 16.4 vacancies related to the CPEI. The retirement of the Board's Budget Analyst, Debbie Titus, in mid-June will be a great loss; Ms. Titus has served in this capacity since 1986. Staff is in the process of interviewing for her replacement and will examine the possibility of seeking a freeze waiver to hire Ms. Titus as a retired annuitant to train her replacement.

In March, the acting Director issued a policy statement prohibiting board members from serving as expert consultants in the licensure examination development process. Since the Board has a physician member who serves as an invited guest on the FSMB Exam Development Committee for the USMLE, Ms. Whitney asked for clarification from the Department. DCA responded that national examination development workshops are not included the scope of this new policy and, thus, will not impact Dr. Salomonson's ability to continue to serve on the USMLE committee.

Ms. Whitney reported that Jennifer Simoes, as the Board's acting Public Information Officer, has been busy responding to press requests. Staff is still trying to fill the position, but have had a very limited group of interested applicants as the position can only be filled internally due to the hiring freeze.

Ms. Whitney concluded by commending all of the Board's staff on their willingness to step up while dealing with significantly reduced staffing levels. She particularly thanked staff in attendance at the Board meeting who had to cover for those not allowed to attend by making other staff member's presentations or managing other's committee meetings. Ms. Whitney also expressed her appreciation to the enforcement staff for providing security at each of the meetings.

Ms. Kittle suggested hiring locally for services such as the sound system or security as a way to deal with the travel restrictions. She also expressed her support for a delegation to obtain a travel waiver for staff to attend distant Board meetings.

Ms. Chang stated that the Board may be reaching a point of near crisis with all the restrictions being placed on it. She suggested that the Board President have a discussion with the Executive Director in order to form a plan on how to address these issues.

Ms. Yaroslavsky stated this was an excellent idea. She also indicated that it would be reasonable to expect a faster turnaround from the Agency and Department on some of the waiver processes that were in place.

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Agenda Item 20 Legislation / Regulation

A. 2011 Legislation

Ms. Simoes directed members to the Legislative Packet. She noted that additional handouts providing an updated tracker sheet and updated analyses were distributed to members and made available to the public.

Board Sponsored Bills

- **AB 1127 (Brownley) – Physicians & Surgeons: Physician Interview** – This bill would make it a violation of unprofessional conduct for a physician and surgeon who is the subject of an investigation by the Medical Board to repeatedly fail, absent good cause, to attend and participate in an interview scheduled by mutual agreement of the physician and surgeon and the Board. The Board decided to sponsor this bill because it believes it will expedite the closure of disciplinary cases and significantly reduce case delays by providing an incentive for physicians to attend and participate in the interviews. This bill was recently amended to address concerns raised by CMA, which is now neutral on this bill. It recently passed out of the Assembly Appropriations Committee.

  Rehan Sheikh, member of the public, asked if the Board had obtained an opinion from a legal counselor from the Attorney General's Office on whether the bill violates the Fifth Amendment rights of physicians.

- **AB 1267 (Halderman) – Physicians & Surgeons: Misdemeanor Incarceration** – This Board-sponsored bill would authorize the Board to automatically place a physician's license on inactive status when a physician is incarcerated after the conviction of a misdemeanor for the period of incarceration. The bill originally imposed an automatic suspension, but was recently amended to an inactive status after meeting with CMA. This achieves the same goal; the physician is not allowed to practice medicine while incarcerated. The difference from the original concept is that this is not a disciplinary action and does not negatively affect the physician's licensing record. This would be an action that changes the license status to inactive while the physician is incarcerated. The bill would still require disclosure on the Board's website that the physician is incarcerated. CMA has taken a neutral position on the bill. The bill has passed out of both Assembly Business and Professions Committee and Assembly Appropriations on consent (indicating bipartisan support and no opposition).

- **SB 541 (Price) – Regulatory Boards: Expert Consultants** – The Board is co-sponsoring this bill along with the Contractor's State Licensing Board. The bill would enable all boards and bureaus in DCA to continue to utilize expert consultants in the same manner as in the past 25 plus years, without having to go through the formal contracting process. If the bill passes, all boards would be allowed to complete a simplified 2-page contract with expedited processing, including allowing delegation to the boards for contracting authority. The bill passed out of Senate B&P without any "no" votes. Many boards and bureaus support this bill.

  Dr. Levine made a motion to reaffirm the Board's sponsorship and support of SB 541; s/Zerunyan; motion carried.

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- **Omnibus Bill** – The Board has some technical changes to be included in an omnibus bill. Senate B&P Committee staff is reviewing language and will inform Ms. Simoes if the language will be amended into the omnibus bill.

Potential New Legislation

Ms. Whitney referenced Dr. Dowling's presentation on UCLA's International Medical Graduate Program at the April 2010 meeting. In his presentation, he mentioned that the individuals in the program were not allowed to do clinical work, only observerships, because they are already graduates of medical school. Dr. Dowling suggested changing a section of code to allow these individuals to participate in clinical training like medical students. Board staff was hesitant about doing this, and, thus, entered into conversations with the UC President's Office. It would like to examine the possibility of a pilot program that would enable these individuals to do a limited number of weeks in a clinical training-type program. Ms. Whitney proposed that the Board authorize staff to work with the UC system to develop language to allow for a pilot program at UCLA, for up to 5 years, for those individuals in the International Medical Graduate Program who meet specified requirements such as testing and language skills, etc., to engage in supervised clinical training of up to 10 to 20 weeks. If the language can be developed and support gained from interested parties (i.e., other medical schools and physician groups), then the Board would co-sponsor legislation with the UC System. If the language was developed and moved into the second house, this would occur before the next Board meeting, thus, approval by the Board is needed in order to proceed.

Dr. Duruisseau made a motion to proceed with the development of a pilot program; s/Levine; motion carried.

2011 Legislation

- **AB 352 (Eng) – Radiological Assistants** – This bill would enact the Radiologist Assistant Practice Act. The bill would require the Board to create and appoint a Radiologist Assistant Advisory Council (RAAC), which would make recommendations to the Board on the establishment of standards and issuance of approval for programs and the scope of practice for radiologist assistants (RAs). The bill would allow licensed RAs to perform medical services set forth by regulations of the Board when the services are rendered under the supervision of a qualified physician and surgeon. The Board would be required to issue licenses for RAs. The RAAC will result in minimal fiscal impact to the Board.

  According to the author's office, RA's are licensed and regulated in 29 other states, and similar approaches have been successfully adopted in 5 other states. Staff suggests a support position on the bill.

  Bryce Docherty, American Society of Radiologic Technologist addressed the Board, urging its support of the bill. He noted the bill has already been amended three times. He thanked Ms. Simoes for her efforts and Mr. Heppler for his technical assistance on the bill. Mr. Docherty stated the intent has always been to make the program wholly fee-supported, with licensure fees to be set by the Board.

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Sal Martino, CEO of the American Society of Radiologic Technologists, and Dr. Kenneth Chin, board certified intervention radiologist, also expressed their support of the bill.

Ms. Chang made a motion to support AB 352; s/Levine; motion carried.

AB 374 (Hayashi) – Athletic Trainers –This bill would enact the Athletic Trainers Practice Act effective January 1, 2013 and would establish the Athletic Trainer Licensing Committee (ATLC) with the Medical Board to license athletic trainers. The bill authorizes the ATLC to adopt regulations to implement this bill and requires the ATLC to approve education and training programs for athletic trainers. The Board believes this bill will result in significant fiscal impact to the Board, with licensing fees unlikely to cover costs. Staff suggests an oppose position on the bill unless it is amended to be placed in a more appropriate board like the Physical Therapy Board or is structured as a semi-independent board like the Physician Assistant Committee under the Department of Consumer Affairs. Further, the scope of practice must be more clearly defined and the grounds for denial of licensure must be added to the bill.

Mr. Zerunyan made a motion to oppose AB 374 unless it is amended; s/Levine; motion carried.

- **AB 415 (Logue) – Healing Arts: Telehealth** – This bill would repeal existing law related to telemedicine and replace this law with the Telehealth Advancement Act of 2011. The bill defines "telehealth" as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care while the patient is at the originating site and the health care provider is at the distant site.

Staff suggests that amendments are needed in order for the Board to support this bill. These include adding language that a violation of the telemedicine law constitutes unprofessional conduct, adding language from existing law related to not altering the scope of practice of any health care provider and the portion related to the delivery of services. In addition, language should be added to clarify that the physician is responsible for determining if treatment is appropriate for telehealth; this should not be decided by the payment policies that are required to be adopted by the health care service plans and health insurance companies.

Staff recommends a support if amended position on the bill. Ms. Simoes reported two of the suggested amendments have been taken. Staff can work with the author's office and the Assembly Health Committee on the third requested amendment, as they have agreed it is needed.

A motion was made to support AB 415 if amended; s/Duruisseau; motion carried.

- **AB 507 (Hayashi) – Pain Management** - The bill would make changes to existing law related to severe chronic intractable pain and would repeal existing law that allows the Department of Justice to employ physicians for interviewing and examining patients related to prescription possession and use of controlled substances. The bill would continue to allow

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physicians to refuse to prescribe opiate medication for patients who request the treatment for pain or a condition causing pain. However, the bill requires physicians to refer patients to physicians who treat pain or a condition causing pain, with methods that include the use of opiates. Board staff believes this is problematic because it *requires* a physician to refer the patient to another physician. The bill should be amended to be permissive, to provide exclusion for physicians who do not know of another physician to refer their patients to, or to provide a referral to a web site that would contain a list of physicians such as one or more of the American Board of Medical Specialties certified physician sites. The other changes in this bill are technical in nature. Staff suggests a support if amended position, with the amendment being for the bill to be permissive or flexible in referrals.

Dr. Low expressed disbelief that a physician would not know another physician to make a referral to. He stated there are pain clinics everywhere. He was not sure the amendment was necessary.

Dr. Salomonson supported the amendment.

Ms. Chang made a motion to support AB 507 if amended; s/Duruisseau; motion carried.

- **AB 536 (Ma) – Physicians and Surgeons: Expungement** – The bill would require the Board to remove misdemeanor or felony convictions posted by the Board on its Internet website within 90 days of receiving a certified copy of an expungement order from the licensee. As the Board strives to keep accurate information on its website, staff suggests a support position on this bill.

Ms. Scuri explained the difference between having a conviction expunged after being "good" for one year and being factually innocent of a charge. She stated it would be preferable if the bill could be amended to clarify that it does not mean the Board must purge its *files*, especially if the public document references the expunged conviction, but only requires removal of the information from the Internet.

Ms. Chang made a motion to support AB 536 with the amendment suggested by Ms. Scuri; s/Diego.

Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL), expressed CPIL's concerns with the bill. She noted the Board has been disclosing felony convictions on its Internet website since 1998 due to the passage of a bill creating B&P Code §2027. It is due to the posting of this information that the Board's website is ranked in the top 10 of all state medical board websites in the US by the Public Citizen. Most of the items required to be posted by B&P §2027 are also required to be removed in ten years, with two exceptions, one being felony convictions which must be posted indefinitely. Expungements do not necessarily mean that the physician did not commit the act that resulted in the felony conviction. If a felony conviction is expunged, she would prefer that the website state that the conviction was expunged, rather than removing it completely from the website. The Board's public disclosure laws have served it well in the past and she urged caution in supporting any changes.

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Ms. D'Angelo Fellmeth indicated misdemeanors have only been posted on the Board's website for the last two to three years, and they are only posted if they are the basis of an accusation or disciplinary action. She would have the same concerns about removing misdemeanor expungements, but is more concerned about removing felony convictions.

Mr. Heppler noted that case law suggests that even if a conviction is expunged, that does not render it a legal nullity. The purpose of Penal Code Section 1203.4 is to "promote good behavior" while on probation. If an applicant applies for licensure after having a conviction expunged, it must still be disclosed on the application for any state license.

Lavonne Powell, DCA, stated the Department is opposed to any bill that will make it more difficult for consumers to access public information. She noted that expungements are easy to obtain. Sometimes the licensees still owes their licensing authority money (for example, for cost recovery) when a judge gives them an expungement order. She also urged caution in supporting changes.

Ms. Chang withdrew her motion and made a new motion to oppose AB 536; s/ Diego.

Ms. Yaroslavsky suggested that it might be wiser to take a position of "oppose unless amended" so the Board can work with the author's office and other stakeholders on the direction of the bill.

Ms. Scuri suggested that the "oppose unless amended" position reflect that the conviction is expunged and the date of expungement be posted on the Board's website, in addition to the posting of the conviction.

Ms. Chang withdrew her motion and made a new motion to oppose AB 536 unless amended to require the posting of the fact of the expungement rather than the removal of the conviction; s/Diego; motion carried.

- **AB 589 (Perea) – Medical School Scholarships** – This bill would create the Steven M. Thompson Medical School Scholarship Program (STMSSP) within the Health Professions Education Foundation. STMSSP participants must commit in writing to three years of full-time professional practice in direct patient care in an eligible setting. The maximum amount per total scholarship is $105,000 to be distributed over the course of medical school. The STMSSP would be funded by funds transferred from the Managed Care Administrative Fines and Penalties Fund. The author's office believes the bill will help to address physician shortages in medically underserved areas. Staff suggests a support position.

Dr. Duruisseau made a motion to support AB 589; s/Esrailian; motion carried.

- **AB 783 (Hayashi) – Professional Corporations: Licensed PTs** – This bill would add licensed physical therapists and occupational therapists to the list of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation. Since 1990, the Physical Therapy Board has allowed physical therapists to be employed by medical corporations. On September 29, 2010, the California Legislative

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Counsel issued a legal opinion that concluded a physical therapist may not be employed by a professional medical corporation and stated that only professional physical therapy corporations or naturopathic corporations may employ physical therapists.

Currently, many physical therapists are employed by medical corporations. According to the author's office, this bill was introduced to prevent the unnecessary loss of employment by allowing medical and podiatric medical corporations to continue to employ physical therapists as they have done for over 21 years. Board staff suggests a support position on the bill.

Dr. Levine made a motion to support AB 783; s/Chang; motion carried.

- **Direct Employment Bills**:

AB 824 (Chesbro) – Rural Hospitals: Physician Services
AB 926 (Hayashi) – Physicians & Surgeons: Direct Employment
AB 1360 (Swanson) – Physicians & Surgeons: Employment
These bills have recently become 2-year bills; no position was taken by the Board.

- **AB 895 (Halderman) – Personal Income Tax: Physicians: Qualified Medical Services** - This bill would provide a tax credit for physicians of up to $5,000 for providing medical services or emergency medical services free of charge or at a reduced rate at a local community clinic or in an emergency department of a hospital. Board staff suggests a support position.

Karen Ehrlich, Midwifery Advisory Council, requested that the Board consider adding allied health professionals into those who would qualify for the tax credit for free services. Ms. Yaroslavsky suggested that Ms. Ehrlich contact the author's office with her request.

Ms. Chang made a motion to support AB 895; s/Diego; motion carried.

- **AB 958 (Berryhill) – Regulatory Boards: Statutes of Limitations** – This bill has become a two year bill; no position was taken by the Board.

- **SB 100 (Price) – Healing Arts: Outpatient Settings** - The Board took a support if amended position on this bill at its January 2011 meeting. The bill has been significantly amended to remove all provisions regarding licensing of outpatient settings by the California Department of Public Health (CDPH), and to remove all provisions related to advertising. New requirements are added for accreditation agencies, outpatient settings, and the Board. The Board would be allowed to adopt regulations to specify procedures that should be performed in accredited settings for facilities or clinics that are outside the definition of an outpatient setting. The bill requires that the accreditation agencies provide information on all outpatient settings that are accredited and requires the Board to maintain and post this information on its website. The bill also sets up a process for the correction of identified deficiencies in the outpatient setting.

The bill requires the Board to investigate all complaints upon discovery that an outpatient setting is operating without accreditation. Currently, this type of complaint would be

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forwarded to the District Attorney's Office. This provision would add to the Board's workload. Such information would be relayed to the Operation Safe Medicine Unit, but, as discussed earlier, the funding for this unit may not be extended. Board staff suggests a support if amended position on the bill. Technical amendments are needed to make only the final inspection reports available to the public and to specify that inspections should be physical inspections.

Ms. Chang made a motion to support SB 100 if amended; s/Moran.

Mr. Heppler suggested that the provision requiring the Board to bring an injunction if it determines that an outpatient setting is not in compliance should be permissive instead of mandatory, as it may be possible to gain compliance in other ways.

He also noted that when the Board receives Public Records Act requests, it does not provide information on complaints or investigations [Government Code §6254(f)] since it is acting in its role as a state licensing agency investigating its own licensees. This would not be the case with outpatient settings since these are not the Board's licensees. Mr. Heppler requested that the coverage for exemption of disclosure, specifically of inspection or investigation reports, be extended to investigations the Board would conduct on outpatient settings.

Mr. Heppler also noted the bill would amend B&P §2023.5 to require the Board to adopt regulations regarding physician availability for the use of laser or intense pulse light devices. He stated it was his understanding that the Board did hold forums on this topic and determined that no regulations were necessary, but, rather, existing laws needed to be enforced.

Dr. Salomonson expressed concern that the Board, in supporting the bill, would be signing on to become the inspector for outpatient settings.

Ms. Yaroslavsky called for the vote; the motion to take a support if amended position on SB 100 carried.

- **SB 233 (Paley) – Emergency Services and Care: Physician Assistants** – This bill would explicitly clarify that a physician assistant (PA) can provide treatment and consultation in an emergency care setting. Board staff suggests a support position on the bill.

Dr. Low made a motion to support SB 233; s/ Moran; motion carried.

- **SB 380 (Wright) – Continuing Education: Nutrition Course** – A handout update on this bill was provided to members and made available to the public. The bill originally dealt with mandated continuing medical education (CME); it was recently changed to address opposition and concerns. The bill authorizes the Board to set content standards for any educational activity concerning a chronic disease that includes appropriate information on the impact, prevention, and cure of the chronic disease by the application of changes in nutrition and lifestyle behavior. The bill only provides authority for the Board to set content standards, but does not *require* that it do so. Staff suggests a neutral position on the bill.

Ms. Chang made a motion to take a neutral position on the bill; no second was offered. The Board did not take a position on SB 380.

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- **SB 544 (Price) – Consumer Health Protection Enforcement Act** – This bill has become a two year bill; no position was taken by the Board.

- **SB 747 (Kehoe) – Continuing Education: Lesbian, Gay, Bisexual & Transgender Patients** – This bill would require physicians and surgeons, registered nurses, licensed vocational nurses, psychologists, physician assistants, psychiatric technicians, marriage and family therapists, and clinical social workers to complete a one-time continuing education course that provides instruction on cultural competency, sensitivity, and best practices for providing adequate care to lesbian, gay, bisexual and transgender (LGBT) persons. According to the sponsor, the LGBT community has specific medical needs and concerns and it is critical that health care professionals receive necessary training to understand those needs and provide improved patient care. Although the Board usually opposes mandated CME, Ms. Simoes stated that, because of the Board's interest in preventing and addressing health disparities and promoting cultural competency, Board staff suggests a neutral position.

No motion was offered; the Board did not take a position on SB 747.

- **SB 824 (Negrete McLeod) – Opticians: Change of Ownership** – The bill would require a registered dispensing optician (RDO) acquiring ownership of a business to file the notice with the Board within 10 days of the completion of the transfer of ownership. It would also make the RDO selling or transferring the ownership interest subject to the same 10 day timeline and be responsible for complying with all laws relating to the place of business until the cancellation notice is received by the Board. According to the sponsors, the requirement that the certificate be posted is hard to comply with during a change of ownership, as the registration documents must be furnished to the Board. They believe the bill will provide a process that allows the RDO to remain open while the documents are being processed. The Board believes that putting a 10 day timeline on both parties to get their required paperwork to the Board will make this process run more smoothly and effectively. Board staff suggests a support position on the bill.

Ms. Chang made a motion to support SB 824; the motion was seconded; motion carried.

Ms. Simoes directed members to the Tracker II listing of bills in the back of their Legislative Packet for their individual review.

B. Status of Regulatory Action

Ms. Simoes referred members to the Status of Regulatory Action matrix located on page 188 in their packets for information on pending regulations. She reported that the regulatory file for Abandonment of Application Files was sent to the Secretary of State's Office on April 26, 2011.

Agenda Item 22 12:00 (Noon) Presentation: CMA California Physician Workforce Report

Ms. Yaroslavsky indicated that the presentation by CMA would be held over for the July 2011 meeting. She thanked CMA for their flexibility.

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Agenda Item 24 Licensing Chief's Report

A. Licensing Program Update

Mr. Worden praised staff for their hard work in maintaining licensing timelines in light of the many vacancies in the Licensing Program. As of the week of May 2, 2011, the initial review date for US files is 36 days and 30 days for international files; review of pending mail is at 7 days.

The next Special Faculty Permit Review Committee is scheduled for June 16, 2011; however, no applications have been received at this time. If no applications are received by May 9, 2011, the meeting will be canceled.

Inquiries have been received from several international medical schools interested in applying for recognition by the Board; there is one pending application that has just started the recognition process. Mr. Worden reported there is one pending specialty board application and an inquiry from another specialty board regarding the process for recognition. The Polysomnographic Technologist Program is drafting the Final Statement of Reasons for its regulations.

B. Status of Implementation of AB 2386 (Armed Forces Medical Personnel)

The application form implementing AB 2386 (Training Registration of US Armed Forces Military Medical Physician and Surgeon Personnel in California Hospital Facilities) has been approved and is posted on the Board's website. A sample of the form is located on page 231 of the meeting packet.

Agenda Item 25 Midwifery Advisory Council Update and Consideration of Council Recommendations

A. Update on the Licensed Midwife Annual Report

Ms. Ehrlich reported the Board's Information Systems Branch and OSHPD have worked hard to help prevent reporting errors in the Licensed Midwife Annual Report for electronic filers. The Midwifery Advisory Council (MAC) is exploring the option of working with the Midwives Alliance of North America Statistic's Project to allow for prospective reporting of data.

B. Update on Physician Supervision

At the April 7, 2011 MAC meeting, Dr. Ruth Haskins presented a Collaborative Practice Statement issued by the American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse-Midwives (ACNM). Ms. Ehrlich directed members to page 249 of their packets for a copy of the statement. The joint statement is part of an on-going initiative to promote collaborative practice between obstetrician-gynecologists and certified nurse-midwives and/or certified midwives. Ms. Ehrlich stated the midwifery community is gratified and pleased with efforts of ACOG and ACNM to move toward collaboration. Licensed midwives look forward to further discussions so that, together, a framework for collaborative practice can be crafted that will benefit California's ob-gyns, licensed midwives, and the families they serve.

B&P §2507(f) requires that the Board adopt regulations defining the level of supervision required for the practice of midwifery. All previous attempts to do so, however, have resulted in an impasse due to widely differing views among the medical, midwifery, and insurance professions on the appropriate level of supervision. With the issuance of ACOG's Collaborative Practice Statement and the Board's previous authorization allowing the MAC to address this issue, the

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MAC will rekindle previous efforts to define physician supervision and perhaps introduce the concept of collaborative practice via regulation.

C. Recommendation to Pursue Regulations to Ensure that Midwifery Practice and Educationals Requirements (16 CCR 1379.30) Are Consistent

Current regulations spell out the educational requirements for midwifery education programs. The education program must prepare the midwife for the management of the normal pregnancy, labor, and delivery, including the administration of intravenous fluids, postpartum oxytocics, RhoGAM, local anesthesia, and vitamin K and eye prophylaxis, among others. However, the current regulations do not specifically authorize a licensed midwife to incorporate these requirements into her practice. As such, midwives often face difficulty in securing supplies such as oxygen, anesthetics, and oxytocics in order to practice safely and effectively. In an effort to address this barrier to care as previously authorized by the Board, the MAC would like to propose that staff move forward to develop regulations to ensure that midwifery practice and educational requirements are consistent. The MAC would like to see a regulation that specifically states that licensed midwives have the authority to use these resources that they have been educated for.

Ms. Schipske made a motion to direct staff to work on regulations to ensure consistency between midwifery practice and educational requirements; s/Low; motion carried.

D. Request for Board Authorization to Consider Modifying the Size and/or Composition of the Midwifery Advisory Council.

Ms. Ehrlich reported the current council, as determined by the Medical Board at its inception, is composed of six members; by law, half must be licensed midwives. Two obstetricians sit on the MAC, as does Ms. Yaroslavsky as a public member and representative of the Board. The midwifery community has always desired representation by citizens who have personally experienced midwifery care. She requested that the Board consider the addition of two additional positions to the council, one for a parent who has been served by a licensed midwife, and an additional midwife in order to keep within the mandate of the law. Ms. Ehrlich stated that she would like to see a licensed midwife from Southern California added to the MAC, as the three midwives currently serving on the Council are all from Northern California.

With regard to adding members to the MAC, Ms. Yaroslavsky asked if the Council had, in fact, voted to add members. Mr. Heppler clarified that, at its April 2011 meeting, the MAC made a motion to request authorization from the Board to study the issue of expanding the allocation of members to the MAC and the composition thereof.

Dr. Duruisseau made a motion to authorize the MAC to study the issue of adding members to the Council; s/Chang; motion carried.

Agenda Item 26 Enforcement Chief's Report

A. Approval of Orders Following Completion of Probation and Orders for License Surrender During Probation

Ms. Threadgill requested approval of 9 orders to restore licenses to full status following satisfactory completion of probation and 4 orders for license surrender during probation or administrative action.

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Dr. Duruisseau made a motion to approve the orders; s/Chang; motion carried.

B. Expert Utilization Report

Ms. Threadgill directed Members to page 251 of the packets for a chart reflecting the use of 140 experts to review 180 cases by specialty during the past quarter. The number of experts in the Enforcement Program's database is currently 1,262.

C. Enforcement Program Update

The District Office vacancy rate for investigators is currently hovering around 9%. However, the vacancy rate for Supervising Investigators has reached 29%. Staff is seeking hiring freeze exemptions for these vacancies; the investigator request will be finalized this week.

Since the "Notice to Consumers" posting became effective, the volume of complaints received by the Board has increased an average of 60 complaints per month. The Central Complaint Unit is experiencing an unprecedented number of vacancies as a result of retirements and promotions. With professional staff vacancies anticipated to reach 30% over the next two months, the Enforcement Program must reexamine where resources are expended by staff in the Complaint Unit and adjust accordingly.

Recruitment efforts to fill the vacant enforcement positions have been affected by the recent hiring freeze as the recruitment pool is limited to existing DCA employees. Staff is continuing to seek hiring freeze exemptions. However, while faced with diminishing resources, the Enforcement Program will not be able to pursue complaints such as advertising violations, fictitious name permit issues, fee splitting (e.g., coupons containing offers for medical services), HIPAA violations, or complaints involving testimony as a medical expert. These types of complaints can be closed with a disposition code reflecting "lack of resources" which can be retrieved and reopened as the staffing issues are resolved.

Ms. Threadgill acknowledged the work done in the Citation and Fine Program by Anthony Salgado who was recently promoted to a manager position with the Licensing Program. At the present time, there are no alternatives for absorbing the workload associated with this program.

Ms. Threadgill reported that some of the data markers for enforcement timelines were presented during the Enforcement Committee meeting. Although the data was too limited to make program changes at this time, staff will be examining the markers as additional information comes in to determine if policy changes are necessary in order to improve case processing timelines. Despite the furloughs, staffing shortages, and the inability to replace vacant staff investigator positions, investigators reduced the time it takes to resolve a case by 28 days between FY 08-09 and FY 10-11. With adequate resources and the removal of limitations such as furloughs, Ms. Threadgill stated the improvement could be even more pronounced.

Agenda Item 27 Vertical Enforcement Program Report

Ms. Threadgill directed members to page 255 of the packet for information on the Vertical Enforcement (VE) statistics. She noted there is a slight change in the presentation of this data. All of the Board's cases are now in the VE model and are being reported in the "All" category.

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In April 2011, a statewide investigator and inspector training were held. The training included an hour specialty presentation by Dr. Moran. Ms. Threadgill thanked Dr. Moran for her presentation and expressed appreciation for the assistance and participation provided by Ms. Yaroslavsky and Ms. Whitney. The training also included a presentation regarding defense attorney techniques, an asset forfeiture presentation by the DEA, and much more. Part of the investigator training included the attendance of Deputies from the Health Quality Enforcement (HQE) Section on medical records acquisition. This training with HQE was jointly prepared and presented. The feedback from this invaluable experience has been very positive. Ms. Threadgill reported this was the first time MBC Investigative Staff and HQE staff have jointly participated in a statewide training project. In fact, this was the first time HQE staff have had an opportunity to meet their colleagues from around the state.

Carlos Ramirez, Senior Assistant Attorney General, directed members to page 256 of the packet for a summary of HQE times frames for VE for 2010. Following the compilation of these statistics, an inventory was made of all Board cases within HQE in which an accusation had not been filed and notices of defense and requests for hearings had not been sent. Mr. Ramirez then issued a directive to HQE staff that all these Board cases, notices and requests should be filed and sent by March 25, 2011. He reported that, with the exception of two cases, this deadline was met.

HQE has continued to monitor the progress of cases, both in the filing of accusations and requests to set hearings. On April 21, 2011, there were 11 cases that had not been filed; since then, 8 of these cases have now been filed. Mr. Ramirez will continue to report on the progress at future meetings.

Ms. Yaroslavsky thanked Mr. Ramirez for providing the statistics as she found them very helpful.

Mr. Zerunyan stated the matrix that is being developed to show enforcement timelines will be very helpful as this will highlight specific areas that need to be addressed. He clarified that the statistics Mr. Ramirez provided only show cases opened in 2010; these numbers are different from those provided by Ms. Threadgill as her statistics include *all* open cases. It is unclear if the Board's statistics can be accurately compared with HQE's statistics until further analysis is undertaken.

Mr. Zerunyan stated his expectation that the Enforcement Program and HQE will work together to arrive at an agreement on how the numbers are to be reported in order to allow a fair and accurate assessment and comparison.

Agenda Item 28 SB 1441 Task Force Update: Standard #4

Ms. Whitney reported SB 1441 required the creation of the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees. These standards were adopted in early 2010 with an outstanding issue related to the standards governing aspects of biological fluid testing (Standard #4). The Substance Abuse Coordination Committee recently reviewed these standards and discussed the frequency of testing. She directed members to page 259 of the packet for information on the Testing Frequency Schedule. Previously, the standard had been 104 required

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tests per year. This standard has been changed to 52-104 tests per year. In addition, a second level was added for licensees in the second year of probation or diversion and each year thereafter, up to five years. The minimum number of tests in Level II is 36-104 tests per year. Beyond five years, the tests may be administered one time per month if there have been no positive drug tests in the previous five consecutive years of probation or diversion. This change was requested by the Board and adopted by the Committee. The Uniform Standards are now complete.

Agenda Item 29 Department of Consumer Affairs Update

A. Governor's Executive Orders

Lavonne Powell, DCA Representative, praised the Board's staff for its preparation and handling of the meeting with only half the number of those expected to be in attendance.

Ms. Yaroslavsky thanked Ms. Powell, but added that the impact of the restrictions on staff at the meeting will carry over as staff returns to the office to work on actions, minutes, and other items from the meeting.

Ms. Powell indicated that a budget letter will be sent out that contains additional details on travel restrictions. She noted that DCA is particularly challenged by this Executive Order.

B. Consumer Protection Enforcement Initiative (CPEI)

No update.

C. BreEZe Update

Ms. Powell directed members to page 267 for an update on the BreEZe project status. She reported that the Department is in negotiations with the bidder to secure a feasible contract for the project to move forward.

D. Other Administrative Updates

Ms. Powell stated she was impressed with the Board's practice monitor enhancements. She anticipates hearing of the results and sharing these enhancements with other boards that have practice monitors or are considering them.

Ms. Yaroslavsky thanked Ms. Powell for her report. She asked the Department to provide the Board with discretion and flexibility in dealing with the constraints placed upon it, and asked that there might be transparency and accountability from the Department.

Agenda Item 30 Agenda Items for July 28-29, 2011 Meeting in Sacramento, CA

Dr. Carreon stated that the maternal mortality rate in California is highest in the nation. In addition, he indicated that the recreational use of prescription drugs belonging to another person has become a problem throughout the country. As leaders in public protection, he would like the Board to discuss how it can work with other agencies to address these two issues.

Ms. Yaroslavsky suggested that these issues might be best addressed in the Education Committee with an update on the programs that exist with regard to prescription drugs or a presentation on the reporting and oversight of prescription drugs.

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Ms. Schipske requested that a presentation by Toni Sullivan, author of *Collaboration: A Health Care Imperative,* be made at the July meeting. She asked that copies of this book be distributed to members, particularly to those on the Access to Care Committee.

Ms. Yaroslavsky agreed and stated she would like to see a year-long program of presentations on the topic of collaborative care.

Agenda Item 31 Adjournment

There being no further business, Ms. Chang made a motion to adjourn. The meeting was adjourned at 3:32 p.m.

DRAFT

_____

Barbara Yaroslavsky, President

_____

Hedy Chang, Secretary

_____

Linda K. Whitney, Executive Director

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2065/2066 GME OUTREACH STATISTICS

As of July 1, 2011

Hospitals Participating	43 (2010 – 38) (10 New Participants)
Applicants Submitted by Hospital	1225*
Applications Received	1186**
Applications Reviewed	1185
Licenses Issued	1034
PTAL's Issued	41
IMG applicants	189
* 50 Applicants removed from programs/matrix (11 Applications were received & reviewed prior to being removed)	

** Includes applicants from out of state that needed a PTAL or License prior to starting.

WORKLOAD REPORT

as of June 30, 2011

CONSUMER INFORMATION UNIT FY 10/11					
	FY 10/11	*Q1	Q2	Q3	Q4
Total Calls Answered	***100,626***	26,974	22,484	24,592	26,576
Calls Requesting Call Back	***11,751***	3,792	2,463	2,576	2,920
Calls Abandoned	***13,698***	5,544	2,853	2,478	2,823
Address Changes Completed	***10,732***	3,120	2,277	2,822	2,513

* 1.5 days phone outage; technical issues w/dropped calls.

CONSUMER INFORMATION UNIT FY 9/10					
	FY 09/10	Q1	Q2	Q3	Q4
Total Calls Answered	***97,450***	27,117	22,049	23,579	24,705
Calls Requesting Call Back	***16,318***	4,951	3,021	4,491	3,855
Calls Abandoned	***17,248***	4,967	3,336	4,834	4,111
Address Changes Completed	***9,700***	3,346	2,302	2,217	1,835

PHYSICIAN & SURGEON DATA FY 10/11					
	FY 10/11	Q1	Q2	Q3	*Q4*
Applications Received	***5,914***	1,503	1,505	1,543	1,363
Initial Reviews Completed	***5,984***	1,208	1,892	1,464	1,420
Total Pending	***N/A***	5,291	5,038	4,295	3,992
Reviewed	***N/A***	4,460	4,532	3,933	3,461
Not Reviewed	***N/A***	831	506	362	531
(SR2s Pending)	***N/A***	98	83	82	98
Licenses Issued	***5,272***	1,447	1,248	1,277	1,300
Renewals Issued	***62,656***	16,168	15,377	15,087	16,024

PHYSICIAN & SURGEON DATA FY 09/10					
	FY 09/10	Q1	Q2	Q3	*Q4*
Applications Received	***5,645***	1,658	1,573	1,211	1,203
Initial Reviews Completed	***3,530***	n/a	n/a	1,658	1,872
Total Pending	***N/A***	n/a	n/a	6,716	5,772
Reviewed	***N/A***	n/a	n/a	n/a	5,386
Not Reviewed	***N/A***	n/a	n/a	n/a	386
(SR2s Pending)	***N/A***	n/a	n/a	73	65
Licenses Issued	***5,110***	1,107	1,132	1,424	1,447
Renewals Issued	***60,814***	14,883	15,668	15,447	14,816

WORKLOAD REPORT

as of June 30, 2011

SPECIAL PROGRAMS FY 10/11																				
Permit	Applications Received				Applications Reviewed				Permits Issued				Permits Renewed				Total Pending			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2111	19	9	2	3	18	4	2	3	16	4	2	2	13	7	2	14	4	14	1	2
2112	0	1	0	1	0	0	0	1	0	0	1	0	0	0	0	0	0	1	1	1
2113	7	1	7	9	5	3	7	6	4	4	1	5	20	15	12	10	6	3	6	13
2168	0	0	0	0	0	0	0	0	0	0	0	0	3	1	1	3	1	0	0	1
2072	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1327	1	0	0	1	1	0	0	1	0	0	0	1	0	0	0	1	1	0	0	0

SPECIAL PROGRAMS FY 09/10																				
Permit	Applications Received				Applications Reviewed				Permits Issued				Permits Renewed				Total Pending			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2111	12	4	3	16	12	4	3	16	17	10	3	7	17	11	6	8	6	0	0	0
2112	1	0	0	1	1	0	0	1	1	1	0	0	1	0	0	0	0	1	0	0
2113	5	1	3	11	5	1	0	11	13	4	1	9	13	18	18	22	8	0	3	0
2168	1	0	0	0	1	0	0	0	0	0	2	0	0	1	1	1	1	1	0	0
2072	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1327	1	0	0	0	1	0	0	0	0	0	0	0	0	2	0	1	0	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

WORKLOAD REPORT
as of June 30, 2011

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 10/11					
	FY 10/11	Q1	Q2	Q3	Q4
New Applications Received	***9***	0	1	1	7
Total Pending Applications	***N/A***	0	6	5	7

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 09/10					
	FY 09/10	Q1	Q2	Q3	Q4
New Applications Received	***3***	0	1	0	2
Total Pending Applications	***6***	3	4	4	6

LICENSED MIDWIVES FY 10/11					
	FY 10/11	Q1	Q2	Q3	Q4
Applications Received	***41***	12	11	6	12
Applications Pending	***2***	4	1	2	2
Licenses Issued	***40***	9	13	5	13
Licenses Renewed	***98***	30	17	20	31

LICENSED MIDWIVES FY 09/10					
	FY 09/10	Q1	Q2	Q3	Q4
Applications Received	***16***	2	0	10	4
Applications Pending	***2***	N/A	1	0	2
Licenses Issued	***19***	2	2	10	5
Licenses Renewed	***74***	18	4	29	23

RESEARCH PSYCHOANALYST FY 10/11					
	FY 10/11	Q1	Q2	Q3	Q4
RP Applications Received	***7***	3	3	1	0
RP Licenses Issued	***8***	2	4	1	1

RESEARCH PSYCHOANALYST FY 09/10					
	FY 09/10	Q1	Q2	Q3	Q4
RP Applications Received	***4***	0	0	0	4
RP Licenses Issued	***3***	0	1	0	2

WORKLOAD REPORT

as of June 30, 2011

FICTITIOUS NAME PERMITS FY 10/11					
	FY 10/11	Q1	Q2	Q3	*Q4*
P&S - FNP Issued	***1,266***	310	317	291	348
P&S - FNP Pending	***89***	66	62	129	89
Podiatric FNP Issued	***22***	7	2	5	8
Podiatric FNP Pending	***N/A***	1	0	1	0

FICTITIOUS NAME PERMITS FY 09/10					
	FY 09/10	Q1	Q2	Q3	*Q4*
P&S - FNP Issued	***1,100***	276	227	210	387
P&S - FNP Pending	***86***	N/A	N/A	242	86
Podiatric FNP Issued	***18***	6	6	1	5
Podiatric FNP Pending	***1***	0	0	1	1

SPECIALTY BOARD APPLICATIONS FY 10/11					
	FY 10/11	Q1	Q2	Q3	*Q4*
Applications Received	***0***	0	0	0	0
Applications Pending	***1***	1	1	1	1

SPECIALTY BOARD APPLICATIONS FY 09/10					
	FY 09/10	Q1	Q2	Q3	*Q4*
Applications Received	***0***	0	0	0	0
Applications Pending	***1***	1	1	1	1

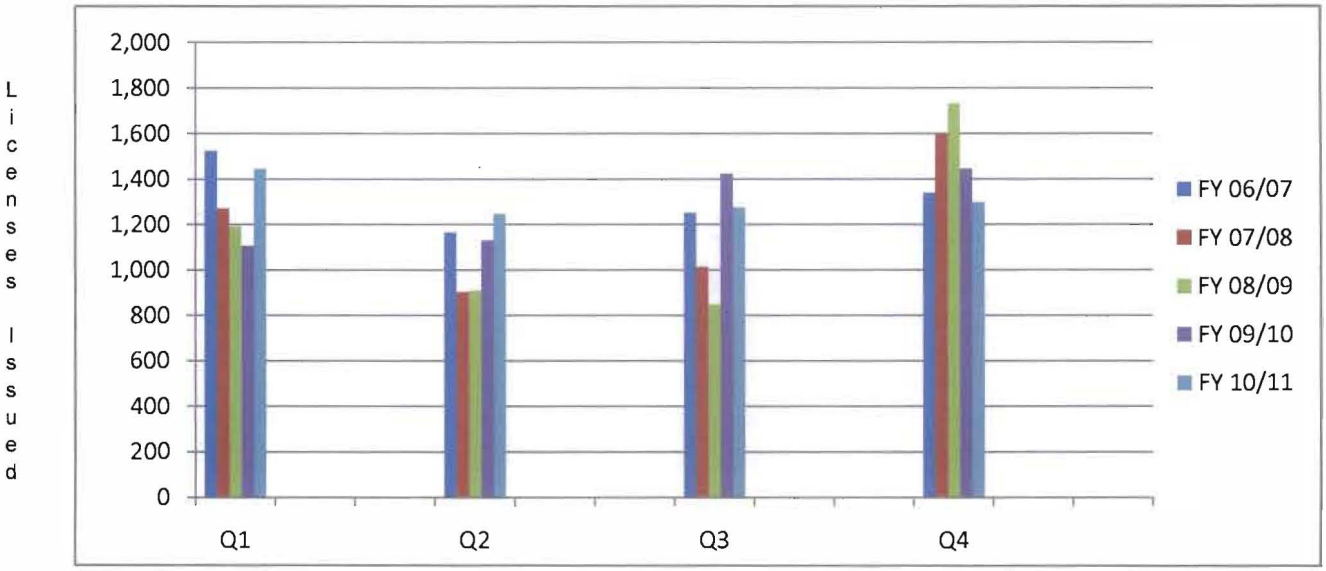
OPTICAL REGISTRATIONS FY 10/11					
	FY 010/11	Q1	Q2	Q3	Q4
Business Registrations Issued	***69***	16	21	17	15
Pending Applications Business	***17***	25	21	22	17
Out-of-State Business Registrations Issued	***0***	0	0	0	0
Pending Applications Out of State Bus.	***0***	0	0	0	0
Spectacle Lens Registrations Issued	***196***	42	55	53	46
Pending Applications-Spectacle Lens	***64***	62	37	49	64
Contact Lens Registrations Issued	***73***	19	17	23	14
Pending Applications-Contact Lens	***22***	20	11	14	22
Spectacle Lens Registrations Renewed	***870***	200	238	201	231
Contact Lens Registrations Renewed	***384***	81	116	106	81

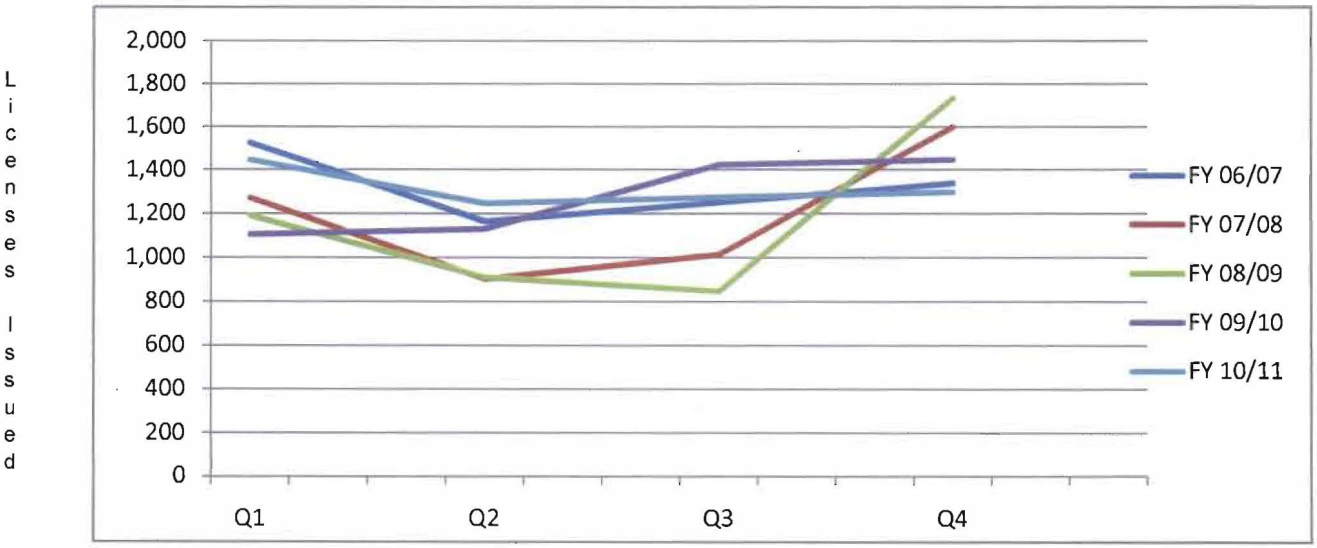
OPTICAL REGISTRATIONS FY 09/10					
	FY 09/10	Q1	Q2	Q3	Q4
Business Registrations Issued	***142***	19	60	8	55
Pending Applications Business	***30***	N/A	N/A	82	30
Out-of-State Business Registrations Issued	***1***	1	0	0	0
Pending Applications Out of State Bus.	***0***	N/A	N/A	0	0
Spectacle Lens Registrations Issued	***221***	56	18	71	76
Pending Applications-Spectacle Lens	***38***	N/A	N/A	47	38
Contact Lens Registrations Issued	***98***	36	11	26	25
Pending Applications-Contact Lens	***7***	N/A	N/A	22	7
Spectacle Lens Registrations Renewed	***906***	214	200	242	250
Contact Lens Registrations Renewed	***366***	82	93	77	114

WORKLOAD REPORT

as of June 30, 2011

PHYSICIAN'S AND SURGEON'S LICENSES ISSUED - FIVE FISCAL YEARS HISTORY					
Fiscal Year	**QTR 1**	**QTR 2**	**QTR 3**	**QTR 4**	**TOTAL**
FY 10/11	1,447	1,248	1,277	1,300	5,272
FY 09/10	1,107	1,132	1,424	1,447	5,110
FY 08/09	1,192	912	849	1,735	4,688
FY 07/08	1,271	904	1,014	1,598	4,787
FY 06/07	1,525	1,166	1,253	1,340	5,284

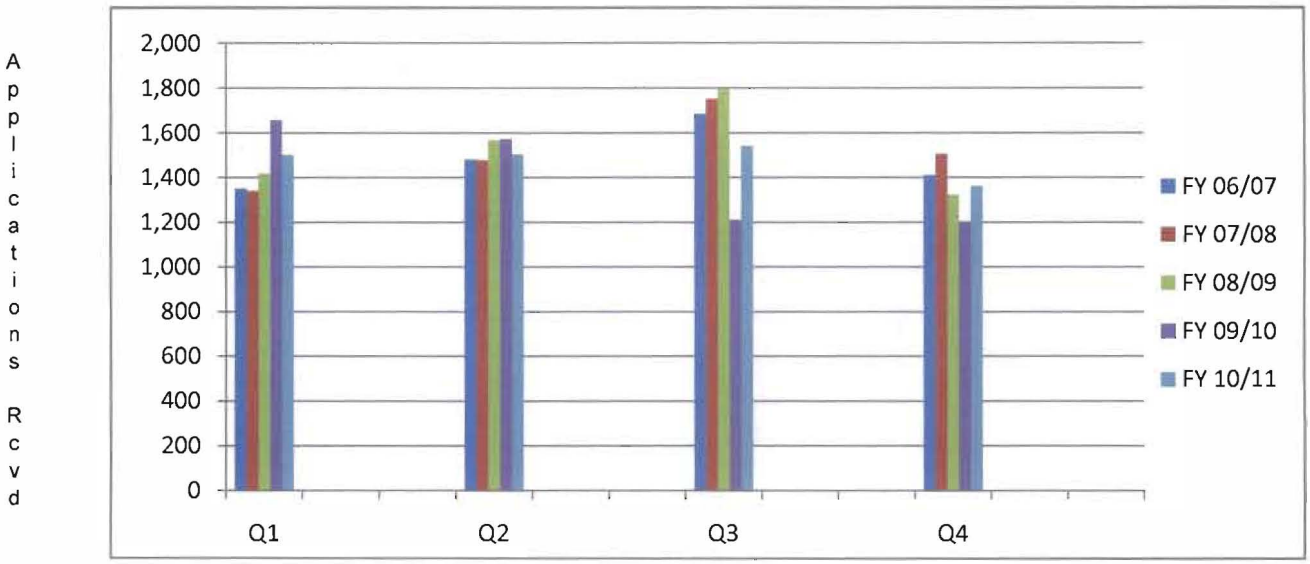


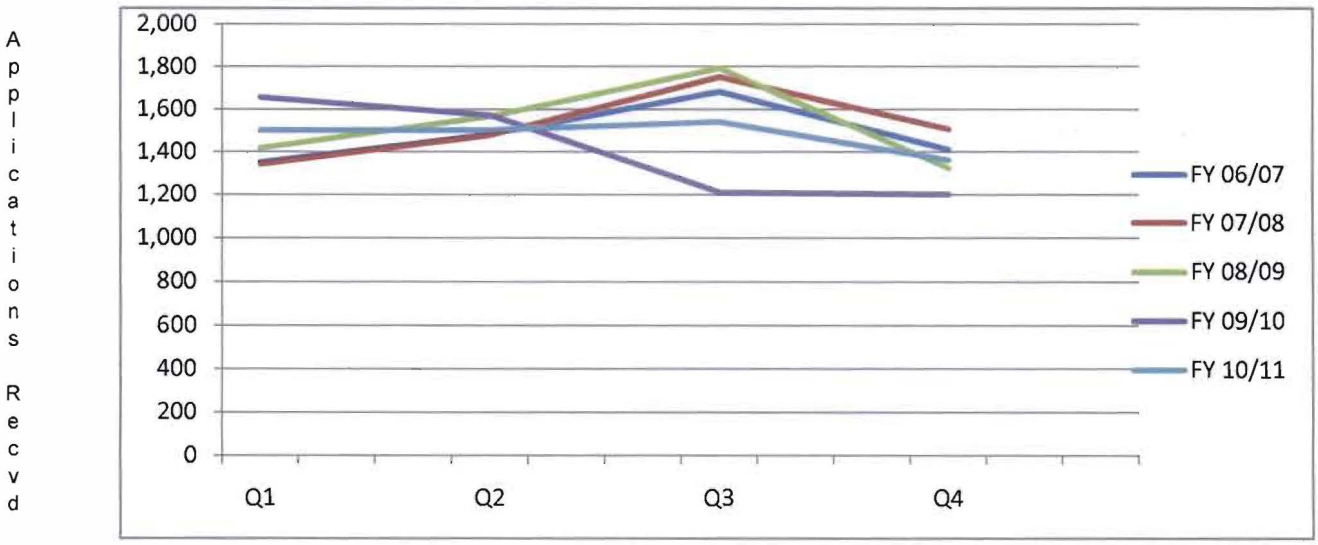


WORKLOAD REPORT

as of June 30, 2011

PHYSICIAN'S AND SURGEON'S LICENSE AND PTAL APPLICATIONS RECEIVED FIVE FISCAL YEARS HISTORY					
Fiscal Year	**QTR 1**	**QTR 2**	**QTR 3**	**QTR 4**	**TOTAL**
FY 10/11	1,503	1,505	1,543	1,363	5,914
FY 09/10	1,658	1,573	1,211	1,203	5,645
FY 08/09	1,420	1,568	1,794	1,325	6,107
FY 07/08	1,341	1,478	1,751	1,506	6,076
FY 06/07	1,352	1,483	1,685	1,412	5,932





Licensing Program

Weekly Application Production

Week Ending -->	16-Apr	23-Apr	30-Apr	7-May	14-May	21-May	28-May	4-Jun	11-Jun	18-Jun	25-Jun	2-Jul	9-Jul
Number of Workdays -->	5	5	5	5	5	5	5	4	5	5	5	5	4
Applications Received													
US/CAN	95	47	84	31	71	44	145	36	37	61	47	53	36
IMG - License	22	19	23	10	19	12	21	13	17	16	12	20	14
IMG - PTAL	24	23	22	25	25	22	26	22	24	24	31	0	24
Total	***141***	***89***	***129***	***66***	***115***	***78***	***192***	***71***	***78***	***101***	***90***	***106***	***74***
Applications Completed (License or PTAL Issued)													
US/CAN - Licensed	84	49	55	116	62	55	56	89	70	60	40	78	20
IMG - Licensed	23	15	19	39	21	24	11	29	24	30	22	48	14
Total - Licensed	**107**	**64**	**74**	**155**	**83**	**79**	**67**	**118**	**94**	**90**	**62**	**126**	**34**
Total - PTAL's Issued	***15***	***16***	***24***	***22***	***27***	***22***	***18***	***16***	***37***	***45***	***40***	***42***	***23***
Applications Processed (Initial Review Completed)													
Application Complete Upon Initial Review (ready for licensure)													
US/CAN	9	10	6	6	3	1	2	3	4	4	3	1	2
IMG - License	0	0	1	0	1	1	0	0	0	0	0	0	0
IMG - PTAL	0	1	0	0	1	0	2	0	1	0	0	0	0
Subtotal	***9***	***11***	***7***	***6***	***5***	***2***	***4***	***3***	***5***	***4***	***3***	***1***	***2***
Initial Review (Application Deficient)													
US/CAN	86	78	104	58	68	25	52	39	62	52	33	51	74
IMG - License	22	22	21	15	12	24	14	13	21	15	20	10	18
IMG - PTAL	24	22	32	28	28	30	14	23	15	25	21	29	14
Subtotal	***132***	***122***	***157***	***101***	***108***	***79***	***80***	***75***	***98***	***92***	***74***	***90***	***106***
Total	***141***	***133***	***164***	***107***	***113***	***81***	***84***	***78***	***103***	***96***	***77***	***91***	***108***

Inventory Awaiting Initial Review - Current as of: -->	19-Apr	26-Apr	3-May	10-May	17-May	24-May	31-May	7-Jun	14-Jun	21-Jun	28-Jun	6-Jul	12-Jul
NEW: 0-30 days	442	398	392	374	392	373	413	463	427	449	362	346	370
AGING: 31-60 days	33	66	44	33	14	22	88	29	34	48	148	167	96
AGING: 61-90 days	0	0	0	0	0	0	0	0	0	0	0	0	0
BACKLOG: Over 90 days	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	***475***	***464***	***436***	***407***	***406***	***395***	***501***	***492***	***461***	***497***	***510***	***513***	***466***
Date of Oldest US Appl Awaiting Initial Review-->	*03/14/11*	*03/24/11*	*03/29/11*	*04/06/11*	*04/14/11*	*04/21/11*	*04/27/11*	*05/02/11*	*05/10/11*	*05/13/11*	*05/24/11*	*05/24/11*	*05/26/11*
Number of calendar days for US Initial Reviews	*37*	*34*	*36*	*35*	*34*	*34*	*35*	*37*	*36*	*40*	*36*	*44*	*48*
Date of Oldest IMG Appl Awaiting Initial Review-->	*03/15/11*	*03/28/11*	*04/04/11*	*04/11/11*	*04/18/11*	*04/25/11*	*05/02/11*	*05/09/11*	*05/13/11*	*05/20/11*	*05/27/11*	*06/03/11*	*06/08/11*
Number of calendar days for IMG Initial Reviews	*36*	*30*	*30*	*30*	*30*	*30*	*30*	*30*	*33*	*33*	*33*	*34*	*35*
Date of Oldest US Pending Mail Awaiting Review-->	*04/13/11*	*04/20/11*	*04/27/11*	*05/04/11*	*05/11/11*	*05/18/11*	*05/25/11*	*06/01/11*	*06/08/11*	*06/13/11*	*06/22/11*	*06/29/11*	*07/06/11*
Number of calendar days for US Pending Mail	*7*	*7*	*7*	*7*	*7*	*7*	*7*	*7*	*7*	*9*	*7*	*8*	*7*
Date of Oldest IMG Pending Mail Awaiting Review-->	*04/13/11*	*04/20/11*	*04/27/11*	*05/04/11*	*05/11/11*	*05/18/11*	*05/23/11*	*05/31/11*	*06/08/11*	*06/15/11*	*06/22/11*	*06/28/11*	*07/06/11*
Number of calendar days for IMG Pending Mail	7	7	7	7	7	7	9	8	7	7	7	9	7

***Note:** Live data numbers are subject to change depending on the date that they are ran. All data on the report is ran weekly reflecting a Sunday through Saturday reporting period with the exception of the *Inventory Awaiting Initial Review* section. The data in the *Inventory Awaiting Initial Review section* reflects current data when the report is ran on the following Tuesday.

LICENSING PROGRAM

Monthly Application Production

Fiscal Year - 2010/2011

2010 - 2011 -->	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	TOTALS
Applications Received													FY 10/11
US/CAN	273	271	355	342	350	364	404	338	362	342	291	181	3873
IMG - License	72	82	48	52	64	76	98	83	69	106	62	58	870
IMG - PTAL	141	128	133	124	65	68	61	61	67	124	98	101	1171
TOTAL	**486**	**481**	**536**	**518**	**479**	**508**	**563**	**482**	**498**	**572**	**451**	**340**	**5914**
Applications Completed (License & PTAL)													
TOTAL - Licenses Issued	**616**	**396**	**435**	**396**	**406**	**446**	**402**	**433**	**442**	**493**	**384**	**423**	**5272**
TOTAL - PTAL's Issued	**170**	**138**	**164**	**157**	**143**	**117**	**88**	**79**	**94**	**79**	**89**	**138**	**1456**
Applications Awaiting Initial Review													
TOTAL	**554**	**605**	**826**	**588**	**598**	**496**	**436**	**577**	**561**	**436**	**501**	**510**	**510**

Fiscal Year - 2009/2010

2009 - 2010 -->	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS
Applications Received													FY 09/10
US/CAN	N/A	N/A	N/A	N/A	*224	236	333	225	212	203	341	151	N/A
IMG - License	N/A	N/A	N/A	N/A	*36	55	80	85	66	63	71	60	N/A
IMG - PTAL	N/A	N/A	N/A	N/A	*42	66	68	65	77	91	120	103	N/A
TOTAL	N/A	N/A	N/A	N/A	***302**	**357**	**481**	**375**	**355**	**357**	**532**	**314**	N/A
Applications Completed (License & PTAL)													
TOTAL - Licenses Issued	**463**	**322**	**322**	**318**	**353**	**461**	**446**	**404**	**574**	**479**	**494**	**474**	**5110**
TOTAL - PTAL's Issued	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	****42***	***113***	***146***	N/A
Applications Awaiting Initial Review													
TOTAL	N/A	N/A	N/A	N/A	***1630**	**1182**	**930**	**955**	**985**	**1000**	**684**	**488**	**488**

Notes: The data used for this report is ran on a weekly basis, therefore, the monthly totals are based on a 4-week period, not exact dates.
The data for the *Inventory Awaiting Initial Review* is obtained from the last week reporting period of the month.
*11/8/09 - Start of production statistics reports.
**4/4/10 - Start of *PTAL's Issued* statistics.

Agenda Item 4D

Status of International Medical School Program

will be sent under separate cover

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

Memorandum

Date: July 8, 2011

To: Board Members

From: Kevin A. Schunke,
Licensing Outreach Manager

Subject: Licensing Outreach Plans – Fall, 2011

HISTORY OF THE MEDICAL BOARD'S LICENSING OUTREACH PROGRAM:

In 2001, the Board created 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 applicants who need a license to move forward with their postgraduate training or fellowship. The outreach program has been expanded across all geographic regions of the state, including small and large hospitals, private and public hospitals, and those governed by the University of California, Office of the President.

Beginning Fall, 2009, outreach was expanded to include hospital recruiters and credentialing staff to better explain the licensing process for those hiring faculty or other professional positions; the intent is to demystify the licensing process and to discuss how their anticipated hiring dates might best dovetail with the Board's other obligations. About that same time, outreach was broadened to include medical groups, community clinics and health centers, professional societies, etc.

The outreach program mainly is achieved through two avenues at teaching hospitals: (1) participation in licensing workshops, and (2) presentations at resident orientation and/or during grand rounds. Then, when Board staff is planning to be in a certain geographic area, contact is made with other near-by entities that could benefit, and visits to those multiple sites are included. It has been a long-standing policy of the Board that if the proposed audience was minimal, visits to individual hospitals could not be planned unless other visits at near-by hospitals could be coordinated during the same trip.

In past years, the Board has experienced a cyclical backlog of applications for physician's and surgeon's licenses. The most severe backlog was experienced during the last 12 to 24 months. This backlog was unacceptable to the Board as it delayed physicians' ability to practice medicine and it limits access to care for patients. While some of the causes were beyond the Board's control – across-the-board budget cuts, the on-going furlough program which caused a 12 percent loss in productivity, a steadily-increasing number of license applications—the Board also implemented numerous "outside the box" operational changes to eliminate that backlog and ensure it does not occur again.

In 2010, with the encouragement of the Board members, the Board's Executive Officer elevated the Licensing Outreach Program to an executive-level function of the Board. It is critical that this function of the Board continue as it has vastly improved the process of getting applicants licensed before their statutory deadline and has significantly reduced the backlog of processing applications.

TWO BRANCHES OF THE MEDICAL BOARD'S LICENSING EDUCATION PROGRAM

1. Licensing workshops or "licensing fairs"

Without these outreach events, applicants do not have the impetus to start the application process and submit the required material in a timely manner. Realistically, human nature is to procrastinate, and residents already are overwhelmed by lengthy work-related obligations: the number of work-hours generally comprises of 80 hours a week, additional overnight call scheduled for every third day, and only 10 hours off between each exhausting shift. In addition to facing a plethora of paperwork they want to avoid or delay, the residents would have to make time in their already-busy schedule to get photos taken for the application, make an appointment to have their fingerprints scanned at a remote site, package and ship their diplomas to the Board, and pay for the services of a notary.

The Board has been instrumental in encouraging hospitals to coordinate these events. While the Board's participation is important to the success of the event, staff gives credit to the hospitals for being the sponsor. At these events, the hospital hires a notary, a mobile fingerprinting service (directly tied in with the California Department of Justice's Live Scan service), copying machine to copy and/or reduce the diploma, and a photographer--everything that is needed for the standard application process. This is a "one-stop shopping" opportunity for applicants to complete much of the application process; if there are no unusual circumstances, residents can complete the entire paperwork in less than 45 minutes.

During past years, there has been a significant increase of applicants for whom the review process was problematic. As with society in general, our applicants are showing an increasing evidence of criminal histories, substance abuse problems, mental health issues, problems during their medical school or postgraduate careers, etc. While staff strictly has been directed by legal counsel not to discuss the specifics of these cases, the applicants often seek advice from staff about what types of documentation, evidence of rehabilitation, etc, are needed to continue in the application process. Naturally, most applicants are not comfortable discussing these issues in front of their colleagues, so the outreach staff will spend extra time in a private setting to discuss the process.

To conserve resources, since the program's inception, staff always strives to coordinate visits to a geographic region by visiting near-by hospitals in one multi-day trip. At UCSD and the UCLA, their residents also work at numerous facilities. However, their internal operations allow for the coordination of visits to these campuses in one trip spread over two consecutive days. (A visit to UCSD will cover the main hospital in San Diego/Hillcrest one day and the second day will cover the La Jolla campus, while also inviting residents from the Veteran's Administration, Scripps Green, Rady Children's Hospital, etc. A visit to UCLA will cover the main Ronald Reagan Medical Center and Mattel Children's Hospital in Westwood one full day and the morning of the next day, then reaching out to the affiliated Olive View in Sylmar in the San Fernando Valley that afternoon.

Conversely, at UCSF, not only do they have a tremendously large number of residents who need to start the licensing process each year, their residents are assigned to a number of affiliated facilities spread across the Bay Area. It is a physical and logistical impossibility to meet with the full contingent of applicants in one day. Thus, UCSF always has requested that the licensing fair be split into two days in two different months.

For these fairs, the licensing outreach manager spends an entire day at a teaching hospital, sometimes starting as early as 7:30 am or going as late as 6:00 pm. The actual times are

determined by the number of residents at the hospital and, just as importantly, the hospital's operational needs. An all-day event can capture over 125 residents, but this often only allows for a four- to five-minute consultation with each resident by the outreach staff during a 10-hour day.

During 2011: Staff has been invited to participate in the following licensing workshops:

August 11-12: UCSD-Hillcrest, Scripps Mercy, UCSD-LaJolla, SD Veteran's Administration Hospital, Rady Children's Hospital of San Diego, Scripps Green, and affiliated medical centers

August 18: (Day 1) UCSF, SF General Hospital, the San Francisco Veteran's Administration Hospital, and other affiliated medical centers

August 24 – 25: Huntington Hospital (Pasadena) and USC+LA County Hospital

August 30: Loma Linda Medical University and other affiliated medical centers

September 7: (Day 2) UCSF, SF General Hospital, the San Francisco Veteran's Administration Hospital, and other affiliated medical centers

October 5-6: California Pacific Medical Center (including the Pacific, Davies, and California medical centers) and St. Mary's Medical Center (both in San Francisco)

October 12-13: UCLA (the main Ronald Reagan Medical Center and the Mattel Children's Hospital in Westwood, and affiliated regional medical centers), then driving to Sylmar, San Gabriel Valley to visit the UCLA – Olive View Medical Center

October 21 – UCI Medical Center, Long Beach Memorial Hospital, Children's Hospital of Orange County, and affiliated medical centers

November 2-3: Kaiser Permanente-Los Angeles, including from various regional Kaiser Hospitals and affiliated medical centers, and Children's Hospital-Los Angeles

However, after these outreach trips were planned and scheduled, the Governor's Executive Order, #B-06-11 ("Travel Restrictions") was issued April 26, 2011, curtailing all discretionary travel which was not mission-critical. Because the Governor's Executive Order regarding travel restrictions still is in effect, the Board still must received approval for this travel. The Department of Consumer Affairs advised staff a decision would be delayed until after the Budget was signed. Since the budget now has been signed, staff has resubmitted the request for this travel and is anxiously awaiting the authorization to continue with this outreach program. This exemption request covers only nine planned overnight trips.

2. Participation at "New Resident Orientation" and during grand rounds.

Medical school students generally graduate in May or June of each year; the postgraduate training year runs from July 1 of one year to June 30 of the following year. As part of a teaching hospital's new resident orientation held in mid June to early July, the Board's outreach manager is one of several guest speakers; staff offers an introduction to the Board and its mission and roles, outlines the licensing process, and offers a notice about licensing deadlines and requirements.

These new medical school graduates (in the past, often referred to as "interns;" now generally called "first year postgraduate residents" or "PGY1s") assume that once they have graduated from medical school, they are officially a fully-functioning physician and surgeon; they are unaware of the other statutory requirements they must meet before a license can be granted. Further, most are unaware of the deadlines for licensure and the ramifications of failing to meet those deadlines—at a minimum, they must cease and desist all clinical training, and to the extreme, they are subject to termination of employment. Either option is an extreme hardship to the teaching hospitals, which suddenly would be faced with a vacancy in the training program and in the provision of health care services. Professionalism, ethics, etc., are topics covered in the presentation.

During 2011: Staff had been invited to attend, and was scheduled to present at, the following orientation sessions:

For New First-Year Residents:

June 17:	UC-San Francisco
June 21:	Kaiser Permanente – Santa Clara
June 22:	Loma Linda Medical Center
	UC-Los Angeles
	Kaiser Permanente – Los Angeles
June 23:	Huntington Hospital (Pasadena)
	UC-San Diego
June 24:	UC-Irvine

For New Upperclass Residents and Fellows:

June 30:	UCSF
July 1:	Loma Linda Medical Center
	UC-Irvine
	UC-Los Angeles

The Board requested an exemption from the Governor's Executive Order regarding travel restrictions for these orientation sessions, but it was denied by the Department of Consumer Affairs. This decision was made even though the Medical Board is a special fund agency not supported by any General Fund revenue.

Because of the proximity of the teaching hospital to Sacramento, staff was able to attend both orientation sessions at UC-San Francisco and made tele-conference presentations for the orientation sessions at Loma Linda. However, for the remaining incoming residents and fellows (approximately 1,000 trainees at the other mentioned hospitals), this opportunity has been lost.

CONCLUSION:

This outreach (reviewing applications before they are submitted, providing an explanation of what other criminal-history, training, educational, etc, related documents are needed, etc.) is preventative in nature and helps keep the workload of the Board's staff consistent. Although we do not have quantifiable statistics to underscore this claim, comments from the senior licensing staff and the long-term GME staff at the hospitals indicate that there have been significantly fewer mistakes and problems since the outreach program began. Also, with the convenience of having all services provided at the licensing fair, it seems that many residents are applying earlier in the year, thus getting licensed earlier. This can only be seen as an advantage for the operational needs of the Board's Licensing Program staff, the teaching hospitals, and other health care facilities.

In past years, the Board has had to perform numerous hours of overtime in the spring and early-summer months in order to meet the June 30 deadline. The reason for this overtime in part was due to the fact that applicants submitted their applications late in the Fiscal Year and, therefore, there was a significant increase in applications, which staff was unable to process. In the last year, due to the extensive outreach in 2010, applicants the number of applications has remained constant and therefore staff has been able to complete the reviews in a timely manner. **For the first time in several years the Board did not have to perform any overtime hours to ensure that those needing licensure were licensed by June 30**. Again, the Board equates this to 1) the significant education of staff and applicants at health care facilities and 2) the availability of the Board's program manager to attend licensing events at which applications are reviewed, questions were answered, applicants were informed of the need for timely submittal of applications, etc.

Simply stated, the costs of supporting this education program are significantly less than the costs of the overtime hours spent in past years by the Board's Licensing Program.

As illustrated in the FY 2010/11 licensing statistics provided to the Board during the past year, more applications are submitted in the first quarter of the year, with the remaining quarters being fairly constant, keeping staff's workflow at a level to allow for earlier and timely licensure.

If you have any questions, please feel free to contact me at (916) 263-2368 or via email at kevin.schunke@mbc.ca.gov.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 12, 2011
ATTENTION:	Medical Board of California (Board)
DEPARTMENT:	Licensing Program
SUBJECT:	Midwifery Advisory Council (MAC) Vacancies
STAFF CONTACT:	Curt Worden, Chief
REQUESTED ACTION:	Appoint two members to the MAC.
STAFF RECOMMENDATION:	Reappoint Carrie Sparrevohn, L.M., and Board Member Barbara Yaroslavsky to the MAC for three-year terms.

EXECUTIVE SUMMARY:

The MAC was established in 2007 to make recommendations to the Board on issues related to the practice of midwifery in California. The MAC consists of six members and is currently comprised of three California licensed midwives in good standing and three members of the public that include one Board member and two California licensed obstetrician/ gynecologists. At least half the members must be licensed midwives.

The term of each position is three years. Staggered term expirations were established at the creation of the MAC. The two positions that expired on January 31, 2011 include one licensed midwife position, held by Carrie Sparrevohn, L.M., and one public member position, held by Board member Barbara Yaroslavsky. Lacking a formally adopted policy on term expirations, Ms. Sparrevohn and Ms. Yaroslavsky have continued to serve on the Council until replaced or reappointed by the Board.

Carrie Sparrevohn has been a Licensed Midwife since January 1997. She has been a home birth midwife for 15 years, working primarily in clinics serving underserved pregnant women. Ms. Sparrevohn is one of the original members of the MAC, initially appointed to a one year term in January 2007 and then reappointed to a 3-year term in February 2008. She would like to continue to serve on the Council.

Ms. Yaroslavsky is also one of the original members of the MAC, initially appointed to a one year term in February 2007 and reappointed to a 3-year term in February 2008. She is currently the President of the Medical Board of California. Ms. Yaroslavsky has served as a liaison between the MAC and the full Board and would like to continue to serve in this capacity.

In March 2011, a Midwifery Advisory Council Member Interest Form was mailed to all California licensed midwives and individuals on the interested parties mailing list. Five applications for the licensed midwife position were received; four applications for the public member position were received. At the April 7, 2011 MAC meeting, applicants were given the opportunity to address the Council. Upon learning of Ms. Sparrevohn's and Ms. Yaroslavsky's desire to continue their service on the MAC, the applicants who were present at the meeting withdrew their applications and endorsed Ms. Sparrevohn's and Ms. Yaroslavsky's candidacy.

The MAC voted to recommend to the full Board that Ms. Sparrevohn and Ms. Yaroslavsky be reappointed to the Midwifery Advisory Council.

FISCAL CONSIDERATIONS:
None.

PREVIOUS MBC AND/OR COUNCIL ACTION:
Not applicable.

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

July 1, 2011

SPECIALTY	Number of cases reviewed	Number of Experts used and how often utilized	Active List Experts Y-T-D: 1,223 ↓
ADDICTION	5	**4 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	15 ↓
ALLERGY & IMMUNOLOGY (A&I)			6 ↓
ANESTHESIOLOGY (Anes)	6	**6 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE	98 ↓
COLON & RECTAL SURGERY (CRS)	1	**1 EXPERT** 1 LIST EXPERT	4
COMPLEMENTARY/ALTERNATIVE MEDICINE	2	**1 EXPERT** 1 LIST EXPERT REVIEWED 2 CASES	27 ↑
CORRECTIONAL MEDICINE			45 ↑
DERMATOLOGY (D)	10	**3 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 6 CASES * (*involved companion cases)	15 ↓
EMERGENCY (EM)	15	**11 EXPERTS** 7 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES	60 ↓
ETHICS	1	**1 EXPERT** 1 LIST EPERT	6
FAMILY (FM)	56	**32 EXPERTS** 18 LIST EXPERTS REVIEWED 1 CASE 8 LIST EXPERTS REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES	60 ↓
HAND SURGERY			22 ↓
HOSPICE & PALLIATIVE MEDICINE			12 ↑
INTERNAL (General Internal Med)	49	**33 EXPERTS** 23 LIST EXPERTS REVIEWED 1 CASE 6 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES	243↓
Cardiovascular Disease (Cv)	14	**12 EXPERTS** 9 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	35 ↓

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY

July 1, 2011

SPECIALTY	Number of cases reviewed	Number of Experts used and how often utilized	Active List Experts Y-T-D: 1,223 ↓
Endocrinology, Diabetes and Metabolism (EDM)	[1]		10
Gastroenterology (Ge)	[1]		24
Medical Oncology (Onc)	5	**5 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE	15 ↓
Nephrology (Nep)	[1]		11
MIDWIFE REVIEWER	3	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	11 ↑
NEUROLOGICAL SURGERY (NS)	4	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	12 ↑
NEUROLOGY (N)	4	**4 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE	32
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			5
NUCLEAR MEDICINE (NuM)			6
OCCUPATIONAL MEDICINE	1	**1 EXPERT** 1 LIST EXPERT	10 ↑
OBSTETRICS & GYNECOLOGY (ObG)	72	**34 EXPERTS** 20 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES 4 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES 2 LIST EXPERTS REVIEWED 7 CASES* (* involved companion cases)	97 ↓
Maternal & Fetal Medicine (MF)	[2]		10
OPHTHALMOLOGY (Oph)	12	**10 EXPERTS** 2 OFF LIST EXPERTS REVIEWED 1 CASE 6 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	40 ↓
ORTHOPAEDIC SURGERY (OrS)	12	**10 EXPERTS** 8 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	38 ↓

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
USE OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
July 1, 2011

SPECIALTY	Number of cases reviewed	Number of Experts used and how often utilized	Active List Experts Y-T-D: 1,223 ↓
OTOLARYNGOLOGY (Oto)	9	**6 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 4 CASES	29 ↓
PAIN MEDICINE (PM)	27	**14 EXPERTS** 7 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 4 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	28 ↓
PATHOLOGY (Path)	6	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 2 CASES	13
PEDIATRICS (Ped)	5	**4 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	58 ↓
Neonatal-Perinatal Medicine (NP)	3	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	6 ↓
Pediatric Cardiology (Cd)	1	**1 EXPERT** 1 LIST EXPERT REVIED 1 CASE	7
PHYSICAL MEDICINE & REHABILITATION (PMR)	1	**1 EXPERT** 1 LIST EXPERT REVIEWED 1 CASE	11
PLASTIC SURGERY (PIS)	19	**14 EXPERTS** 12 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 5 CASES	59 ↓
PSYCHIATRY (Psyc)	56	**26 EXPERTS** 9 LIST EXPERTS REVIEWED 1 CASE 9 LIST EXPERTS REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES 5 LIST EXPERTS REVIEWED 4 CASES	115 ↓
Addiction Psychiatry (AdP)	2	**1 EXPERT** 1 LIST EXPERT REVIEWED 2 CASES	30
RADIOLOGY (Rad)/ Diagnostic Radiology (Rad DR)	8	**7 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	40
Radiation Oncology (Rad RO)	1	**1 EXPERT** 1 OFF 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

July 1, 2011

SPECIALTY	Number of cases reviewed	Number of Experts used and how often utilized	Active List Experts Y-T-D: 1,223 ↓
SURGERY (S)	17	**12 EXPERTS** 9 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES	60 ↓
Pediatric Surgery (PdS)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	3 ↓
Vascular Surgery (VascS)	4	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	16
THORACIC SURGERY (TS)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	19
TOXICOLOGY (MEDICAL)	1	**1 EXPERT** 1 LIST EXPERT	3
UROLOGY (U)	15	**9 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 5 CASES	19
WORKERS' COMP/QME/IME			30

1,223 Active List Experts to date
Utilized 283 Experts - Calendar Year to date (280 List Experts; 3 Off List Experts)
Total Cases Reviewed Calendar Year to Date = 444

/susan (6/30//11)

CLINICAL ASSESSMENT PROGRAM COMPARISONS (July 2011)

	PACE	Florida CAP	Upstate NY at Albany	KSTAR Texas	CPEP Colorado
Assessment Components (Phase I)					
Intake Interview/Practice Profile	X				X
PLAS (Post Licensure Assessment System)	X	X	X	X	X
CCS (computer-based case simulation)	X		X	X	
TSR (transaction stimulated recall)	X		X	X	
360° PULSE Survey	X				
Oral/clinical exam	X				X
Chart Audit using sample of Dr.'s records	X			X	X
History & physical skills exam-performed on mock patient	X	X (mechanical dummy)		X	X
Physician physical exam *Requires a physical exam by Bd approved MD	X	*	*	*	*
Cognitive function screening using Microcog	X		X	Optional at added cost	X
Exit Interview (valuable)	X				
Other assessment factors:					
Can physician "fail" assessment program?	Yes	Yes	No-conclude no practice until trained, or restrict area of practice	No	No
Will MD make a determination of safe to practice	Yes	Yes	No	Yes-refer to mini-residency	No-refer to supervised educational experience
Will MD provide written assessment findings?	Yes	Yes	Yes	Yes	Yes
Will MD testify in CA re assessment findings?	Yes	Yes	Yes	Yes	Yes
Length of Assessment	2 days	2 days	1-2 days	2 days	2 days
Cost	$8500	$8500	$6500	$8000-$13000	$6500-$9750
Remediation or Retraining (Phase II)	Yes	No	Varies	No	Yes
Tailored to address identified deficiencies	Yes			Yes	
Clinical education program offered (at additional cost)	40 hrs	Refer to 1 yr residency		3 month residency @ John Peter Smith in Ft. Worth, TX	Residency like setting

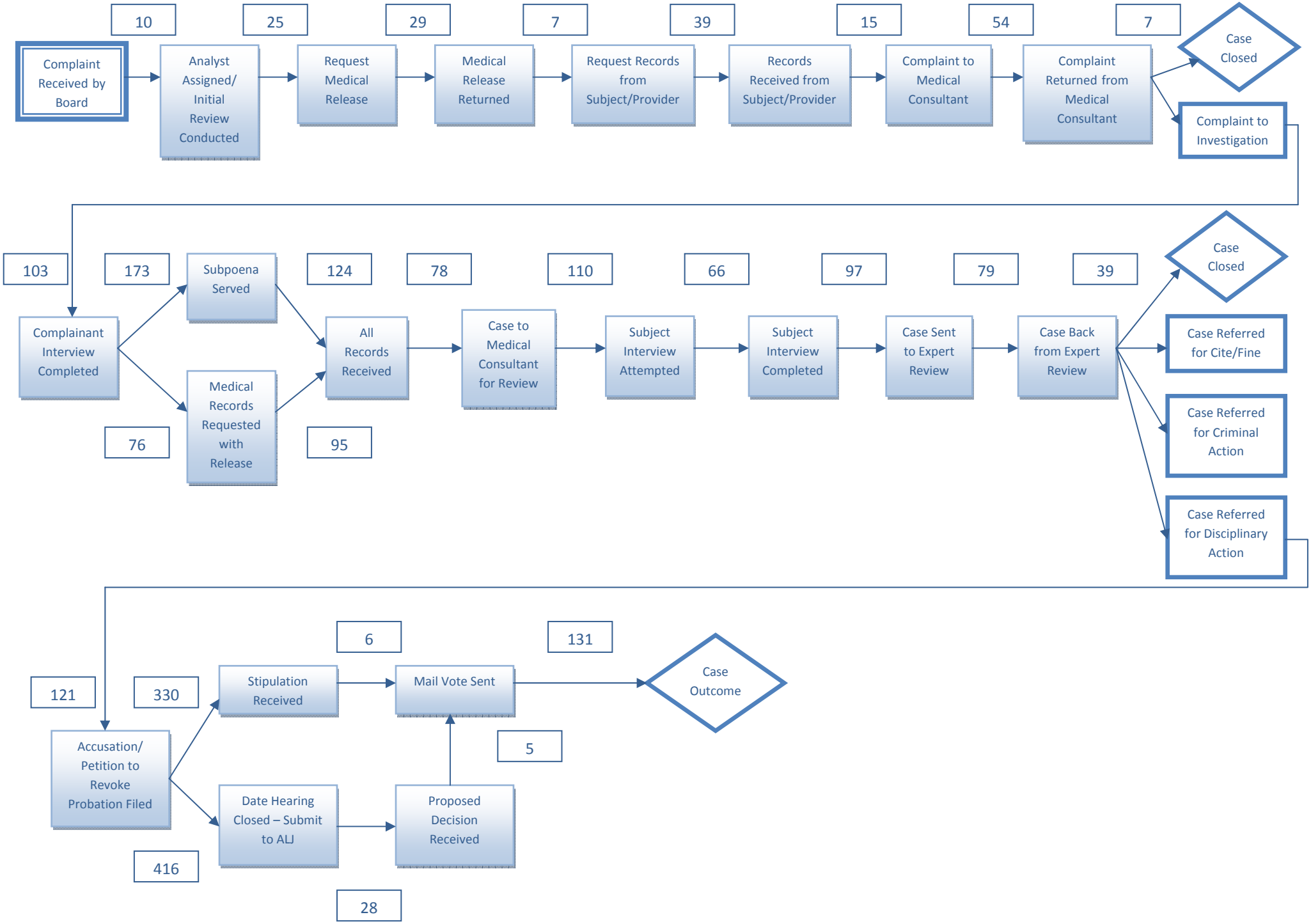
Enforcement Data Markers
All Case Types
July 2011 Board Meeting

Data represents average days to complete Complaint and Investigation processes for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011	
	All Case Types	Number of Records	All Case Types	Number of Records	All Case Types	Number of Records
Complaint Processes						
Complaint Received by Board → Analyst Assigned/Initial Review Conducted	10	6761	11	6869	9	7513
Analyst Assigned/Initial Review Conducted → Request Medical Release	25	1216	24	1360	28	1567
Request Medical Release → Medical Release Returned	29	1044	26	1166	25	1321
Medical Release Returned → Request Records from Subject/Provider	7	687	7	802	11	888
Request Records from Subject/Provider → Records Received from Subject/Provider	39	1759	38	1879	35	1906
Records Received from Subject/Provider → Complaint to Medical Consultant	15	1617	16	1865	17	1768
Complaint to Medical Consultant → Complaint Returned from Medical Consultant	54	1934	54	2120	52	2129
Complaint Returned from Medical Consultant → Case Closed/Complaint to Investigation	7	1932	4	2114	5	2126
Investigative Processes						
Complaint to Investigation → Complainant Interview Completed	103	349	102	424	110	490
Complainant Interview Completed → Subpoena Served	173	42	237	43	172	44
Complainant Interview Completed → Medical Records Requested with Release	76	141	88	170	59	194
Subpoena Served → All Records Received	124	120	100	178	88	166
Medical Records Requested with Release → All Records Received	95	372	92	406	85	420
All Records Received → Case to Medical Consultant for Review	78	227	84	318	70	369
Case to Medical Consultant for Review → Subject Interview Attempted	110	374	109	488	77	558
Subject Interview Attempted → Subject Interview Completed	66	712	53	880	53	961
Subject Interview Completed → Case Sent to Expert Review	97	412	81	511	72	580
Case Sent to Expert Review → Case Back from Expert Review	79	510	72	601	63	658
Case Back from Expert Review → Case Closed or Referred for Action	39	495	31	585	30	656

Enforcement Data Markers
All Case Types
July 2011 Board Meeting

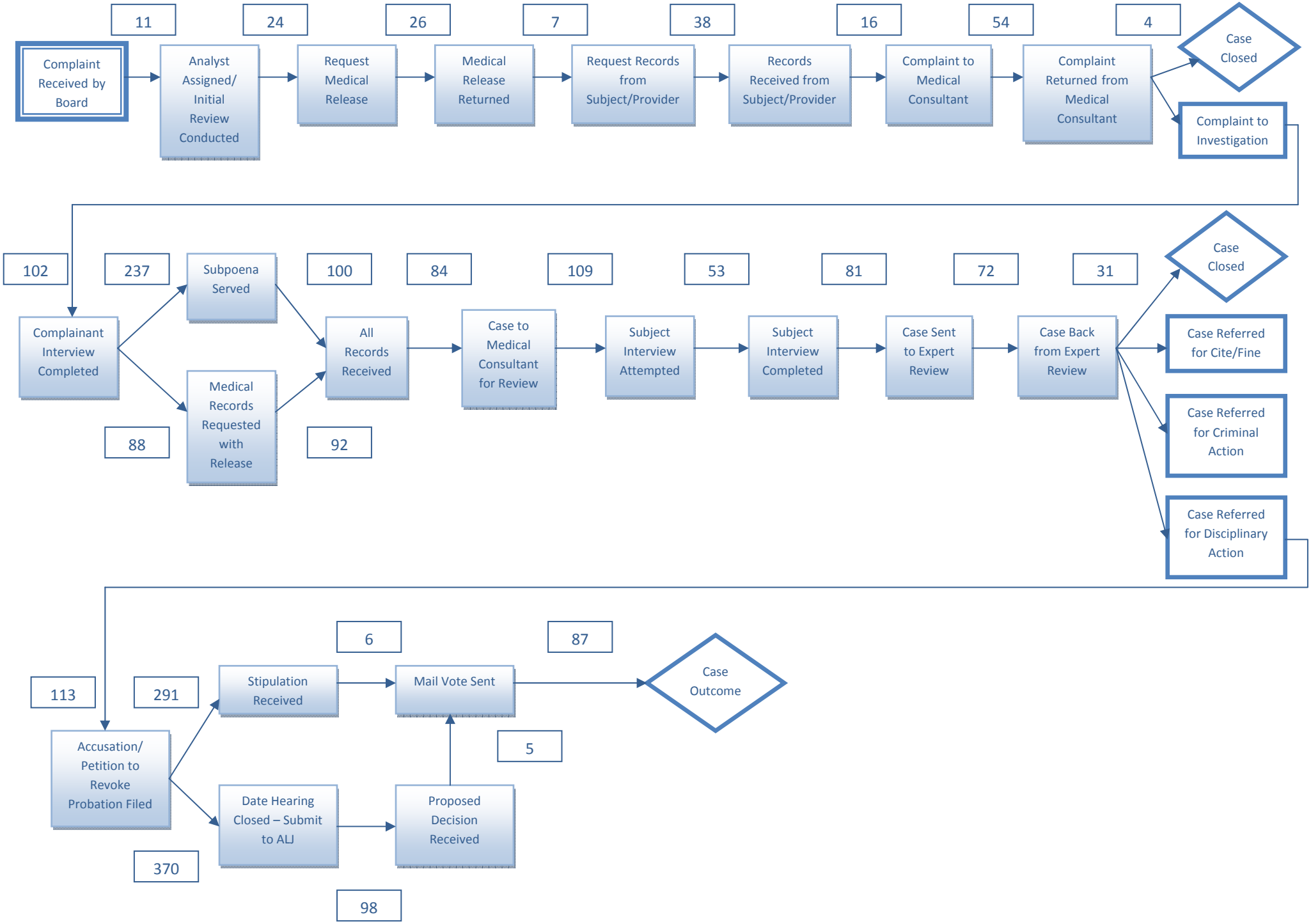
Data represents average days to complete Disciplinary processes for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011	
	All Case Types	Number of Records	All Case Types	Number of Records	All Case Types	Number of Records
Case Referred for Action → Accusation/Petition to Revoke Probation Filed	121	239	113	237	103	219
Accusation/Petition to Revoke Probation Filed → Stipulation Received	330	159	291	173	318	142
Stipulation Received → Mail Vote Sent	6	136	6	132	4	124
Accusation/Petition to Revoke Probation Filed → Date Hearing Closed - Submit to ALJ	416	25	370	30	393	44
Date Hearing Closed - Submit to ALJ → Proposed Decision Received	28	35	98	43	39	58
Proposed Decision Received → Mail Vote Sent	5	54	5	53	6	60
Mail Vote Sent → Case Outcome	131	206	87	208	111	205

Data represents overall average days from Receipt to Closure for records closed during reported time frames.	FY 2008/2009		FY 2009/2010		FY 2010/2011	
	All Case Types	Number of Records	All Case Types	Number of Records	All Case Types	Number of Records
Complaint Received → Closure in Complaint Unit	84	5278	84	5247	80	5755
Complaint Received → Closure at Field/Referred for Administrative or Criminal Action/Citation Issued	467	1585	464	1747	453	1861



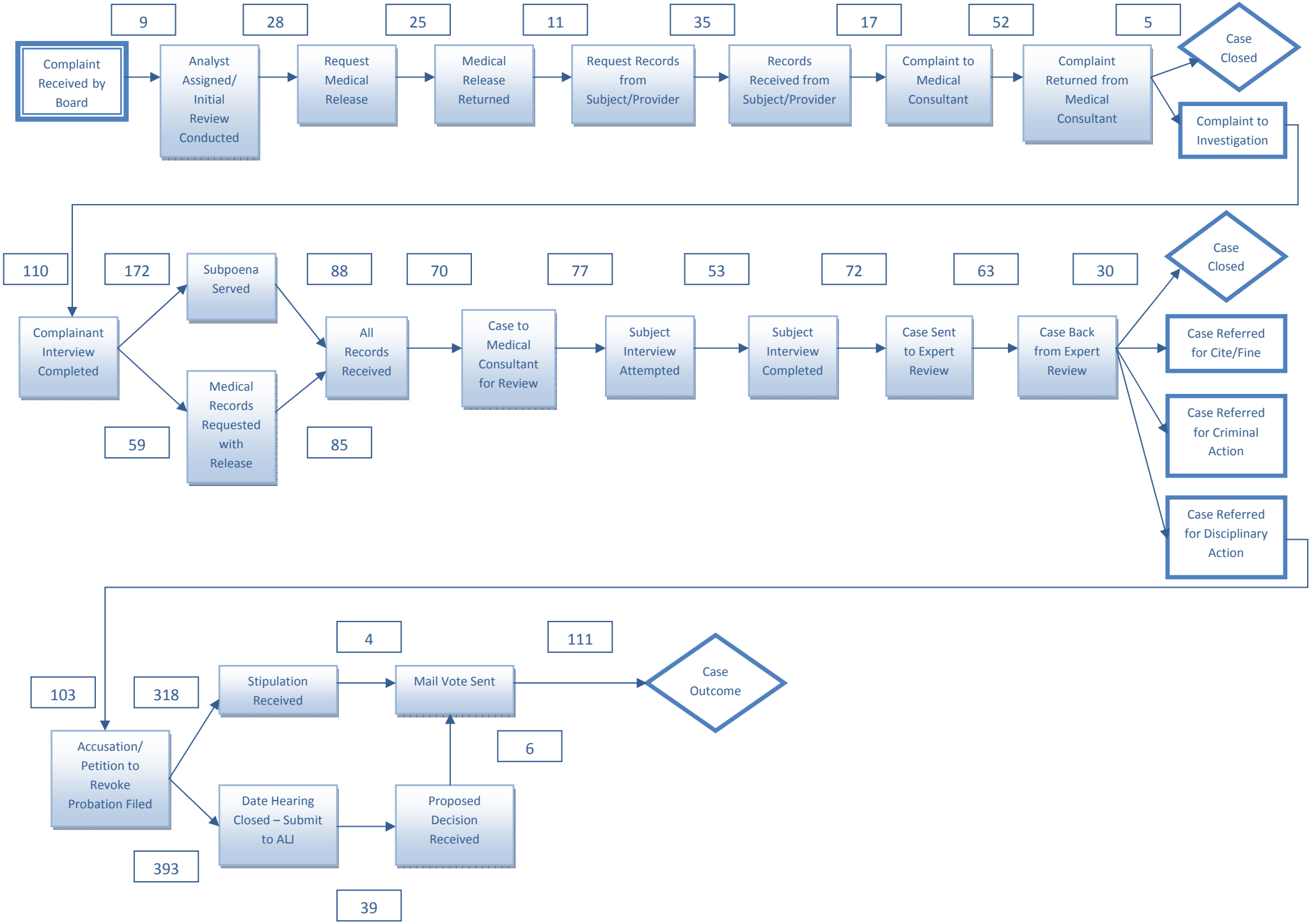
All Case Types – FY 2008/2009

Data represents average days to complete process for records closed during timeframe.



All Case Types – FY 2009/2010

Data represents average days to complete process for records closed during timeframe.



All Case Types – FY 2010/2011

Data represents average days to complete process for records closed during timeframe.

Medical Board of California

Investigation & Prosecution Timeframes*

	2005	2006		2007		2008		2009		2010		Q1 2011	Q2 2011
	Prior to VE	All	VE	All	VE	All	VE	All	VE	All	VE	All	All
Calendar Day Age from Case Assigned to Case Closed Not Resulting in Prosecution													
Average	271	299	138	330	268	374	358	383	381	333	333	332	305
Median	252	285	134	304	269	335	324	346	346	298	297	312	289
Record Count	827	703	192	648	539	609	588	673	672	664	663	192	231
Calendar Day Age from Request to Suspension Order Granted													
Average	51	44	4	34	38	19	19	52	39	40	40	13	20
Median	17	3	2	22	23	10	10	23	23	1	1	5	10
Record Count	24	21	11	17	13	21	17	17	16	27	27	4	7
Calendar Day Age from Request to Receipt of Medical Records													
Average	58	53	37	59	57	63	58	73	73	64	64	90	46
Median	32	31	26	31	31	28	28	32	32	29	29	27	21
Record Count	475	376	228	264	259	256	252	243	243	257	257	38	34
Calendar Day Age from Request to Physician Interview Completed													
Average	48	51	43	52	50	63	63	52	52	46	46	55	58
Median	36	42	38	37	36	41	42	37	37	34	34	41	38
Record Count	597	453	172	406	371	473	466	696	696	582	582	145	145
Calendar Day Age from Request to Receipt of Expert Opinion													
Average	51	47	35	51	43	50	50	48	48	47	47	63	49
Median	41	35	31	36	35	39	38	36	35	37	37	43	39
Record Count	519	424	82	344	270	374	359	426	424	415	415	152	150
Calendar Day Age from Case Assigned to Completed Investigation and Accusation Filed													
Average	556	554	140	543	340	565	493	584	578	589	588	535	614
Median	525	504	120	523	339	541	486	575	569	616	616	530	628
Record Count	187	149	17	198	95	157	131	189	186	200	199	59	60
Calendar Day Age from Accusation Filed to Disciplinary Outcome**													
Average	608	602	85	576	188	561	243	473	339	426	340	456	450
Median	526	466	99	426	182	384	238	351	309	326	304	361	432
Record Count	212	195	3	226	29	203	80	198	145	171	156	35	43

*Excludes Out of State and Headquarters Cases
**Excludes Outcomes where no Accusation Filed

Medical Board of California

Citations Issued & Civil Actions Filed by Calendar Year

	2005	2006	2007	2008	2009	2010	Q1 2011	Q2 2011
***Citations Issued**	80	81	76	109	124	100	13	5
Citations Issued for Failure to Produce Records	0	6	3	3	2	5	0	0
Civil Actions Filed	3	3	1	1	2	1	0	3
Civil Actions Filed for Failure to Produce Records	2	2	1	1	0	0	0	3

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

AG Data
Unfiled Cases
7/14/11

AG Office	30 Days	31-60	61-90	90+
Sacramento	0	1	0	0
San Francisco	1	3	2	2
Los Angeles	2	2	1	1
San Diego	0	1	0	1
Total	**3**	**7**	**3**	**4**

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(Rev. 06/2011)

LEGISLATIVE PACKET

MEDICAL BOARD MEETING

JULY 29, 2011
SACRAMENTO, CA

Medical Board of California
Tracker - Legislative Bill File
7/18/2011

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 415	Logue	Healing Arts: Telehealth	Senate Approps	Support	7/7/2011
AB 507	Hayashi	Pain Management	Senate Approps	Support	7/1/2011
AB 536	Ma	Physicians and Surgeons: Expungement	Senate	Reco: Support	6/14/2011
AB 584	Fong	Worker's Comp: Utilitzation Review	Senate Approps - Susp.	Reco: Support	4/6/2011
AB 589	Perea	Medical School Scholarships	Senate Approps	Support	7/12/2011
AB 1127	Brownley	Physicians & Surgeons: Physician Interview	Enrolled	Sponsor/Support	4/4/2011
AB 1267	Halderman	Physicians & Surgeons: Misdemeanor Incarceration	Enrollment	Sponsor/Support	6/30/2011
AJR 13	Lara	Graduate Medical Education Residency Positions	Senate	Reco: Support	6/2/2011
SB 100	Price	Healing Arts : Outpatient Settings	Assembly Approps	Support	7/12/2011
SB 233	Pavley	Emergency Services and Care: Physician Assistants	Assembly Approps	Support	7/14/2011
SB 380	Wright	Chronic Disease Prevention - Nutrition/Lifestyle Behavior	Assembly	Reco: Neutral	6/20/2011
SB 541	Price	Regulatory Boards: Expert Consultants	Assembly Approps.	Sponsor/Support	6/21/2011
SB 824	Negrete McLeod	Opticians: Change of Ownership	Assembly	Reco: Neutral	6/23/2011
SB 943	Sen. B&P	Healing Arts - Polysom Grandfathering	Assembly Approps	Reco: Support	7/12/2011
		2-Year Status			
AB 352	Eng	Radiologist Assistants	Asm. B&P - 2 yr.	Support	4/15/2011
AB 374	Hayashi	Athletic Trainers	Senate B&P - 2 yr	Oppose Unless Amended	5/27/2011
AB 783	Hayashi	Professional Corporations: Licensed PTs	Senate B&P - 2 yr.	Support	4/7/2011
AB 824	Chesbro	Rural Hospitals: Physician Services	Asm. Health- 2 yr.		3/31/2011
AB 895	Halderman	Personal Income Tax: Physicians: Qual. Med. Svcs.	Asm. Rev. & Tax	Support	5/9/2011
AB 926	Hayashi	Physicians & Surgeons: Direct Employment	Asm. B&P		4/27/2011
AB 958	Berryhill, B.	Regulatory Boards: Statutes of Limitation	Asm. B&P - 2 yr.		
AB 1360	Swanson	Physicians & Surgeons: Employment	Asm. Health - 2 yr.		
SB 544	Price	Consumer Health Protection Enforcement Act	Senate B&P - 2 yr.		4/14/2011

Pink - Sponsored Bill, Green - 2 year bill, Blue - For Discussion

SPONSORED BILLS

AB 1127

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1127
Author: Brownley
Bill Date: April 4, 2011, amended
Subject: Physicians and Surgeons: Unprofessional Conduct
Sponsor: Medical Board of California
Position: Sponsor/Support

STATUS OF BILL:

This bill has been enrolled and is now with the Governor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would make it a violation of unprofessional conduct for a physician and surgeon who is the subject of an investigation by the Medical Board of California (the Board) to repeatedly fail, absent good cause, to attend and participate in an interview scheduled by mutual agreement of the physician and surgeon and the Board.

ANALYSIS:

This bill is sponsored by the Board. Currently, when the Board receives a complaint from a consumer, the Board must interview the physician to either close the case, or move forward with disciplinary action. The Board is having documented delays in investigations due to physicians intentionally not showing up for their physician interviews. Out of the total 3,568 cases opened over the last three year, 338 cases, or 9.5%, have required subpoenas to be issued for the purpose of requiring a subject physician to appear at a physician interview with the Board. This has resulted in case delays anywhere from 60 days to over a year.

In 2005, the board's enforcement program monitor released the final report that found, among other things, that the Board's case processing times were high and cited delays in physician interviews as a contributing factor. This bill will address this issue and is supported by the Center for Public Interest Law for this reason. Further, many other healing arts boards are in the process of putting this requirement in regulations as part of the Consumer Protection Enforcement Initiative.

The Board decided to sponsor this bill because it believes that it will help to expedite the closure of disciplinary cases and significantly reduce case delays by providing an incentive for physicians to attend and participate in physician interviews.

This bill was recently amended to address concerns raised by the California Medical Association, and they are now Neutral on the bill.

SUPPORT: Medical Board of California (Sponsor)
Center for Public Interest Law

OPPOSITION: None on file

FISCAL: None

POSITION: Sponsor/Support

July 1, 2011

AMENDED IN ASSEMBLY APRIL 4, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1127

Introduced by Assembly Member Brownley

February 18, 2011

An act to amend Section 2234 of the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 1127, as amended, Brownley. Physicians and surgeons: unprofessional conduct.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law requires the board to take action against any licensee who is charged with unprofessional conduct and describes acts constituting unprofessional conduct. Existing law makes a violation of that provision a crime.

This bill would provide that unprofessional conduct also includes~~, among other things, the willful noncompliance by a certificate holder with the duty to cooperate with an investigation being conducted by the board~~ *the repeated failure, except for good cause, by a certificate holder who is the subject of a board investigation, to attend and participate in an interview scheduled by the mutual agreement of the certificate holder and the board.*

By changing the definition of a crime, the bill would impose a state-mandated local program.

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

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

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 2234 of the Business and Professions
2 Code is amended to read:
3 2234. The board shall take action against any licensee who is
4 charged with unprofessional conduct. In addition to other
5 provisions of this article, unprofessional conduct includes, but is
6 not limited to, the following:
7 (a) Violating or attempting to violate, directly or indirectly,
8 assisting in or abetting the violation of, or conspiring to violate
9 any provision of this chapter.
10 (b) Gross negligence.
11 (c) Repeated negligent acts. To be repeated, there must be two
12 or more negligent acts or omissions. An initial negligent act or
13 omission followed by a separate and distinct departure from the
14 applicable standard of care shall constitute repeated negligent acts.
15 (1) An initial negligent diagnosis followed by an act or omission
16 medically appropriate for that negligent diagnosis of the patient
17 shall constitute a single negligent act.
18 (2) When the standard of care requires a change in the diagnosis,
19 act, or omission that constitutes the negligent act described in
20 paragraph (1), including, but not limited to, a reevaluation of the
21 diagnosis or a change in treatment, and the licensee's conduct
22 departs from the applicable standard of care, each departure
23 constitutes a separate and distinct breach of the standard of care.
24 (d) Incompetence.
25 (e) The commission of any act involving dishonesty or
26 corruption which is substantially related to the qualifications,
27 functions, or duties of a physician and surgeon.
28 (f) Any action or conduct which would have warranted the
29 denial of a certificate.
30 (g) The practice of medicine from this state into another state
31 or country without meeting the legal requirements of that state or
32 country for the practice of medicine. Section 2314 shall not apply
33 to this subdivision. This subdivision shall become operative upon

the implementation of the proposed registration program described in Section 2052.5.

~~(h) The willful noncompliance by a certificate holder with the duty to cooperate with an investigation being conducted by the board. For the purposes of this subdivision, "willful noncompliance" includes, but is not limited to, repeated failure,~~

(h) The repeated failure by a certificate holder, in the absence of good cause, to attend *and participate in* an interview scheduled by *the* mutual agreement of the certificate holder and the board. *This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.*

SEC. 2. 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 1267

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1267
Author: Halderman
Bill Date: June 30, 2011, amended
Subject: Physicians and Surgeons: Certificate
Sponsor: Medical Board of California
Position: Sponsor/Support

STATUS OF BILL:

This bill has been sent to enrollment.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize the Medical Board of California (the Board) to automatically place a physician's license on inactive status when a physician is incarcerated after the conviction of a misdemeanor for the period of incarceration. This bill would allow the Board to disclose the reason for the inactive status on the Board's Internet Web site.

This bill was amended in Senate Business, Professions and Economic Development Committee to require the Board to move the physician's license status back to its prior or appropriate status within five business days of receiving notification from the Attorney General's Office that the physician is no longer incarcerated.

This bill was recently amended to remove the Attorney General's name from the bill and instead put the five day time line starting when the Board receives notice that the physician is no longer incarcerated. This bill now requires the Board to adopt regulations to specify the type of notice required to be submitted to the Board.

ANALYSIS:

This bill is sponsored by the Board. Existing law, Business and Profession Code Section 2236.1, authorizes the Board to automatically suspend the license of a physician incarcerated for a felony. An automatic suspension is a disciplinary action that goes on the physician's license and is reported to the National Practitioner's Data Bank. Currently, the Board finds out when a physician is incarcerated because information is obtained from DOJ on arrests, and staff tracks the trial and the sentencing. The physician is also required to let us know when they are convicted.

After meeting with CMA on this bill and working with them on amendments, it was suggested that instead of an automatic suspension, that the license be put on inactive

status. This achieves the same goal; the physician is not allowed to practice medicine while incarcerated. The difference from the original concept is that this is not a disciplinary action and does not negatively affect the physician's licensing record. This would be an internal action that changes the license status to inactive while the physician is incarcerated. The bill would still require disclosure on the Board's Internet Web site for the public, the fact that the physician is incarcerated would be disclosed.

When the physician is released from incarceration, even if the Board's investigation is not complete, the license would no longer be on inactive status and the notice of incarceration would be removed from the Board's Web site. The process for the Board to find out when a physician is released from incarceration for felonies now is that the physician's attorney lets the Attorney General's (AG) office know, and the AG's office lets Board staff know. The same process would take place for misdemeanor incarcerations and the Medical Board would be able to change the status back internally in a short amount of time after notification (five or less working days).

The June 9th amendments were taken in Senate Business, Professions and Economic Development Committee at the request of a committee member to require the Board to move the physician's license status back to its prior or appropriate status within five business days of receiving notification from the Attorney General's Office that the physician is no longer incarcerated. Board staff believes that this time frame is reasonable.

The June 30th amendments were taken to address concerns raised by the Attorney General's (AG's) Office. It had concerns that naming the AG's Office in the bill, although this process mirrors existing practice, was putting a new, implied obligation on the Attorney General that may result in costs. To address the concerns, the Board took the AG's name out of the bill. The amendments now start the five day time line when the Board receives notice that the physician is no longer incarcerated. The Board will be required to adopt regulations to specify the type of notice that needs to be submitted to the Board.

The Medical Board of California fundamentally believes that physicians should not be practicing medicine while incarcerated. Currently, there is nothing prohibiting physicians incarcerated for misdemeanors from practicing medicine while incarcerated. This bill will protect consumers in California by not allowing incarcerated physicians to practice medicine and allowing for greater transparency by providing this information on Board's Internet Web site. Consumers have a right to know if their physician is incarcerated and physicians should cease practicing medicine until they are released from incarceration. This is an interim measure and would only be effective for the period of incarceration; the Board would still go through its normal enforcement process related to the investigation of the misdemeanor conviction.

SUPPORT: Medical Board of California (Sponsor)

OPPOSITION: None on File

FISCAL: None

POSITION: Sponsor/Support

June 29, 2011

AMENDED IN SENATE JUNE 30, 2011

AMENDED IN SENATE JUNE 9, 2011

AMENDED IN ASSEMBLY APRIL 12, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1267

Introduced by Assembly Member Halderman

February 18, 2011

An act to add Section 2236.2 to the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 1267, as amended, Halderman. Physicians and surgeons: certificate.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law requires that a physician and surgeon's certificate be suspended automatically when the holder of the certificate is incarcerated after a felony conviction.

This bill would require that a physician and surgeon's certificate be automatically placed on inactive status during any period of incarceration after a misdemeanor conviction. The bill would require the reason for this type of inactive status to be disclosed, as specified. *The bill would require a certificate placed on inactive status to be returned by the board to its prior or appropriate status, as specified, and would require the board to adopt regulations in this regard.*

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 2236.2 is added to the Business and
2 Professions Code, to read:
3 2236.2. (a) Notwithstanding Article 9 (commencing with
4 Section 700) of Chapter 1 of Division 2 or any other provision of
5 law, a physician and surgeon's certificate shall be automatically
6 placed on inactive status during any period of time that the holder
7 of the certificate is incarcerated after conviction of a misdemeanor.
8 (b) A physician and surgeon's certificate placed on inactive
9 status pursuant to subdivision (a) shall be returned by the board
10 to its prior or appropriate status within five business days of
11 receiving notice ~~from the Attorney General~~ that the physician and
12 surgeon is no longer incarcerated. *The board shall adopt*
13 *regulations that specify the type of notice required to be submitted*
14 *to the board.*
15 (c) The reason for the inactive status described in subdivision
16 (a) shall be disclosed on the board's Internet Web site.

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SB 541

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 541
Author:	Price
Bill Date:	June 21, 2011, amended
Subject:	Regulatory Boards: Expert Consultants
Sponsor:	Medical Board of California (co-sponsor) Contractors State License Board (co-sponsor)
Position:	Co-Sponsor/Support

STATUS OF BILL:

This bill is currently in Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would enable all boards and bureaus in the Department of Consumer Affairs (DCA) to continue to utilize expert consultants, using a simplified contract and an expedited contracting process, without having to go through the formal contracting process.

This bill was recently amended to specify that nothing in this bill shall be construed to expand the scope of practice of an expert consultant providing services.

ANALYSIS:

The Board has been hiring and paying experts for over 25 years using a signed agreement and statement of services, without going through a formal contracting process. DCA issued a memo on November 10, 2010 that stated all boards and bureaus must enter into a formal consulting services contract with each expert consultant they use to provide an opinion in an enforcement matter (from the initial review through testifying at a hearing). The memo further stated that each board would need to go through the required contracting process for each consultant utilized.

During the past calendar year, the Board referred approximately 2,900 cases to expert consultants performing the initial or triage review to determine the need to move the case forward for investigation. It utilized 281 expert consultants in one quarter to review completed investigations, which translates to 457 cases. Under the new DCA policy, the Board would be required to go through the contracting process for each expert consultant, even if the expert only reviews one case. The contract would need to be approved before the Board can utilize the expert's services and the Board would have to encumber the funding for the expert consultant once the contract is approved (again, before the expert's services are utilized).

This bill would enable the Board to continue to utilize expert consultants, via a simplified contracting process, without having to go through the formal contracting process.

The June 21st amendment specifies that nothing in this bill shall be construed to expand the scope of practice of an expert consultant providing services. This amendment was added to ensure that the expert services listed in the bill, if not within an expert's scope of practice, are not interpreted to expand that expert's scope of practice (since the expert is also a licensee).

Going through the formal contracting process in order to utilize the services of an expert consultant would create an enormous backlog for both DCA and the Board and would significantly impact the time required to complete the initial review and investigate complaints filed with the Board. In addition, this would severely limit the Board's ability to take disciplinary actions against physicians and result in tremendous case delays. This could mean cases would be lost due to the statute of limitations expiring.

SUPPORT: Medical Board of California (co-sponsor); Contractors State License Board (co-sponsor); Board of Barbering and Cosmetology; Board of Behavioral Sciences; Board of Optometry; Board of Pharmacy; Board of Podiatric Medicine; Board of Psychology; Board of Registered Nursing; Board of Vocational Nursing and Psychiatric Technicians; California Board of Accountancy; California State Pipe Trades Council; Court Reporters Board of California; Dental Board of California; International Brotherhood of Electrical Workers; Physician Assistant Committee; Respiratory Care Board of California; State Board of Guide Dogs for the Blind; and Western States Council of Sheet Metal Workers

OPPOSITION: None on file

FISCAL: None – without this bill, workload will increase by requiring the Board to go through the formal contracting process for each expert consultant and pro rata would increase as DCA would have to increase staffing in order to process these in a timely manner.

AMENDED IN ASSEMBLY JUNE 21, 2011

AMENDED IN SENATE APRIL 13, 2011

SENATE BILL No. 541

Introduced by Senator Price

February 17, 2011

An act to add Section 40 to the Business and Professions Code, relating to ~~profession~~ *professions* and vocations, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 541, as amended, Price. ~~Contractors' State License~~ Regulatory boards: expert consultants.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department 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. Existing law, the Osteopathic Act, requires the Osteopathic Medical Board of California to regulate osteopathic physicians and surgeons. Existing law generally requires applicants for a license to pass an examination and authorizes boards to take disciplinary action against licensees for violations of law. Existing law establishes standards relating to personal service contracts in state employment.

This bill would authorize these boards to enter into an agreement with an expert consultant, subject to the standards regarding personal service contracts described above, to provide enforcement and examination assistance. The bill would require each board to establish policies and procedures for the selection and use of these consultants.

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. Section 40 is added to the Business and
2 Professions Code, to read:
3 40. (a) Subject to the standards described in Section 19130 of
4 the Government Code, any board, as defined in Section 22, the
5 State Board of Chiropractic Examiners, or the Osteopathic Medical
6 Board of California may enter into an agreement with an expert
7 consultant to do any of the following:
8 (1) Provide an expert opinion on enforcement-related matters,
9 including providing testimony at an administrative hearing.
10 (2) Assist the board as a subject matter expert in examination
11 development, examination validation, or occupational analyses.
12 (3) Evaluate the mental or physical health of a licensee or an
13 applicant for a license as may be necessary to protect the public
14 health and safety.
15 (b) An executed contract between a board and an expert
16 consultant shall be exempt from the provisions of Part 2
17 (commencing with Section 10100) of Division 2 of the Public
18 Contract Code.
19 (c) Each board shall establish policies and procedures for the
20 selection and use of expert consultants.
21 *(d) Nothing in this section shall be construed to expand the*
22 *scope of practice of an expert consultant providing services*
23 *pursuant to this section.*
24 SEC. 2. This act is an urgency statute necessary for the
25 immediate preservation of the public peace, health, or safety within
26 the meaning of Article IV of the Constitution and shall go into
27 immediate effect. The facts constituting the necessity are:
28 To ensure that licensees engaging in certain professions and
29 vocations are adequately regulated at the earliest possible time in
30 order to protect and safeguard consumers and the public in this
31 state, it is necessary that this act take effect immediately.

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2011 TRACKER 1

AB 415

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 415
Author: Logue
Bill Date: July 7, 2011, Amended
Subject: Healing Arts: Telehealth
Sponsor: California State Rural Health Association
Position: Support

STATUS OF BILL:

This bill is currently in Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would repeal existing law related to telemedicine and replaces this law with the Telehealth Advancement Act of 2011.

This bill was amended to include language from existing law, which provides that a violation of the telemedicine law constitutes unprofessional conduct. This bill was amended to include the remainder of the language in existing law related to not altering the scope of practice of any health care provider; the portion related to the delivery of services was added. This bill was also amended to add language that clarifies that the physician is responsible for determining if treatment is appropriate for telehealth. These amendments were suggested by the Board and have changed the Board's position from "Support if Amended" to "Support".

Recent amendments make technical changes and address concerns raised by health care service plans. These amendments do not change the Board's support position.

ANALYSIS:

Existing law related to telemedicine defines telemedicine, requires informed consent for patients and provides that a violation of the telemedicine law constitutes unprofessional conduct.

This bill would repeal existing law and replace it with a new section. This bill makes findings and declarations under the Telehealth Advancement Act of 2011. The bill finds that lack of primary care providers, specialty providers and transportation are all barriers to care. The bill also states that parts of California have difficulty attracting and retaining health professionals and many providers in underserved areas are isolated from necessary information resources. This bill states the intent of the Legislature to create a parity of telehealth with other care delivery modes and to actively promote telehealth to improve health status and system improvement. It also states intent related to telehealth,

as being part of a multifaceted approach to address inadequate provider distribution and to assist in improving the physical and economic health of medically underserved communities. Lastly, it states the intent that the provider–patient relationship be preserved and states that payment needs to be assured and legal and policy barriers need to be resolved to realize the full potential of telehealth.

This bill repeals and replaces section 2290.5 of the Business and Professions Code to do the following:

- Defines "Asynchronous store and forward" as the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.

- Defines "Distant Site" as a site where a health care provider is located while providing services via a telecommunications system.

- Defines "Originating Site" as a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward transfer occurs.

- Defines "telehealth" as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at the distant site. States that telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

- States that this section shall not be construed to alter the scope of practice of any health care provider.

  This was taken from language in existing law; however, the rest of the language should be added "....or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law."

- Provides that all laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telehealth interactions.

- This bill also applies the Business and Professions Code Section to the laws relating to Health Care Service Plans and to the Insurance code and requires health care service plans and health insurance companies to adopt payment policies to compensate health care providers who provide covered health care services through telehealth. This bill also applies these requirements to the Medi-Cal managed care program.

According to the author's office, the purpose of this bill is to remove barriers in existing law and update the law to current practice regarding the use of telehealth in the delivery of health care. The author's office believes that telehealth has the potential to reduce costs, increase access, and improve quality of care, especially in underserved areas of the state where it is difficult for patient to get specialized care.

Board staff suggested that amendments are needed in order for the Board to support this bill, as follows:

- Existing law provides that a violation of the telemedicine law constitutes unprofessional conduct. This language should be added to this bill.
- This bill should include the remainder of the language in existing law related to not altering the scope of practice of any health care provider; the portion related to the delivery of services should be added.
- This bill should add language that would clarify that the physician is responsible for determining if treatment is appropriate for telehealth; this should not be decided by the payment policies that are required to be adopted by health care service plans and health insurance companies.

The May 10th amendments make the changes suggested by the Board listed in the bullets above. The language that clarifies that the provider is responsible for determining if treatment is appropriate for telehealth states that a health insurer is not authorized to require the use of telehealth when the health care provider has determined it is not appropriate. With these changes, the Board now has a Support position on this bill.

The May 27th amendments are technical and clarifying changes related to Medi-Cal reimbursement, they do not affect the Board or the Board's support position.

The July 7th amendments make technical and clarifying changes and also address concerns raised by health care service plans. These amendments do not affect the Board or the Board's support position.

SUPPORT: California State Rural Health Association (sponsor); AgeTech California; Association of California Healthcare Districts; California Association of Physician Groups; California Center for Rural Health Policy; California Healthcare Institute; California Hospital Association; California Medical Association; Children's Partnership Del Norte Clinics, Inc; Kaiser Permanente; Kings View Corporation; Latino Coalition for a Healthy California; Medical Board of California; National Multiple Sclerosis Society - CA Action Network; Occupational Therapy Association of California; Peach Tree Healthcare; Regional Council of Rural Counties; Rural Health Sciences Institute, College of the Siskiyous; and University of California

OPPOSITION: None on file

FISCAL: None

AMENDED IN SENATE JULY 7, 2011

AMENDED IN ASSEMBLY MAY 27, 2011

AMENDED IN ASSEMBLY MAY 10, 2011

AMENDED IN ASSEMBLY APRIL 25, 2011

AMENDED IN ASSEMBLY MARCH 31, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 415

Introduced by Assembly Member Logue
(Principal coauthors: Assembly Members Chesbro, Pan, and V. Manuel Pérez)

February 14, 2011

An act to repeal and add Section 2290.5 of the Business and Professions Code, to repeal and add Section 1374.13 of the Health and Safety Code, to repeal and add Section 10123.85 of the Insurance Code, and to amend Sections 14132.72 and 14132.725 of the Welfare and Institutions Code, relating to telehealth.

LEGISLATIVE COUNSEL'S DIGEST

AB 415, as amended, Logue. Healing arts: telehealth.

(1) Existing law provides for the licensure and regulation of various healing arts professions by various boards within the Department of Consumer Affairs. A violation of specified provisions is a crime. Existing law defines telemedicine, for the purpose of its regulation, to mean the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Existing law requires a health

care practitioner, as defined, to ~~obtained~~ *obtain* verbal and written informed consent from the patient or the patient's legal representative before telemedicine is delivered. Existing law also imposes various requirements with regard to the provision of telemedicine by health care service plans, health insurers, or under the Medi-Cal program, including a prohibition on requiring face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine, subject to certain contracts or policies. Existing law provides that health care service plans and health insurers shall not be required to pay for consultations provided by telephone or facsimile machines. Existing law provides that a willful violation of the provisions governing health care service plans is a crime.

This bill would delete the provisions regarding telemedicine as described above, and would instead set forth provisions relating to telehealth, as defined. This bill would require a health care provider, as defined, to, prior to the delivery health care via telehealth, verbally inform the patient that telehealth may be used and obtain verbal consent from the patient. This bill would provide that failure to comply with this provision constitutes unprofessional conduct. This bill would also set forth provisions for the payment of telehealth services by health care service plans and health insurers. By changing the definition of a crime applicable to health care service plans, the bill would impose a state-mandated local program.

(2) Existing law prohibits a requirement of face-to-face contact between a health care provider and a patient under the Medi-Cal program for services appropriately provided through telemedicine, subject to reimbursement policies developed by the Medi-Cal program to compensate licensed health care providers who provide health care services, that are otherwise covered by the Medi-Cal program, through telemedicine.

This bill would, instead, prohibit a requirement of in-person contact between a health care provider and patient under the Medi-Cal program for any service otherwise covered by the Medi-Cal program when the service is appropriately provided by telehealth, as defined, and would make related changes.

(3) Existing law, until January 1, 2013, and to the extent that federal financial participation is available, authorizes, under the Medi-Cal program, teleophthalmology and teledermatology by store and forward, as defined.

This bill would delete the repeal of the above-described authorization.

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

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

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

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

1 SECTION 1. This act shall be known, and may be cited, as the
2 Telehealth Advancement Act of 2011.
3 SEC. 2. The Legislature finds and declares all of the following:
4 (a) Lack of primary care providers, specialty providers, and
5 transportation continue to be significant barriers to access to health
6 services in medically underserved rural and urban areas.
7 (b) Parts of California have difficulty attracting and retaining
8 health professionals, as well as supporting local health facilities
9 to provide a continuum of health care.
10 (c) Many health care providers in medically underserved areas
11 are isolated from mentors, colleagues, and the information
12 resources necessary to support them personally and professionally.
13 (d) It is the intent of the Legislature to create a parity of
14 telehealth with other health care delivery modes, to actively
15 promote telehealth as a tool to advance stakeholders' goals
16 regarding health status and health system improvement, and to
17 create opportunities and flexibility for telehealth to be used in new
18 models of care and system improvements.
19 (e) Telehealth is a mode of delivering health care services and
20 public health utilizing information and communication technologies
21 to enable the diagnosis, consultation, treatment, education, care
22 management, and self-management of patients at a distance from
23 health care providers.
24 (f) Telehealth is part of a multifaceted approach to address the
25 problem of inadequate provider distribution and the development
26 of health systems in medically underserved areas by improving
27 communication capabilities and providing convenient access to
28 up-to-date information, consultations, and other forms of support.
29 (g) The use of information and telecommunication technologies
30 to deliver health services has the potential to reduce costs, improve

quality, change the conditions of practice, and improve access to health care, particularly in rural and other medically underserved areas.

(h) Telehealth will assist in maintaining or improving the physical and economic health of medically underserved communities by keeping the source of medical care in the local area, strengthening the health infrastructure, and preserving health care-related jobs.

(i) Consumers of health care will benefit from telehealth in many ways, including expanded access to providers, faster and more convenient treatment, better continuity of care, reduction of lost work time and travel costs, and the ability to remain with support networks.

(j) It is the intent of the Legislature that the fundamental health care provider-patient relationship cannot only be preserved, but can also be augmented and enhanced, through the use of telehealth as a tool to be integrated into practices.

(k) Without the assurance of payment and the resolution of legal and policy barriers, the full potential of telehealth will not be realized.

SEC. 3. Section 2290.5 of the Business and Professions Code is repealed.

SEC. 4. Section 2290.5 is added to the Business and Professions Code, to read:

2290.5. (a) For purposes of this division, the following definitions shall apply:

(1) "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.

(2) "Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) "Health care provider" means a person who is licensed under this division.

(4) "Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications ~~system or where the asynchronous store and forward transfer occurs.~~ *system or where the asynchronous store and forward service originates.*

(5) "Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

~~(5)~~

(6) "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Prior to the delivery of health care via telehealth, the health care provider *at the originating site* shall verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. The verbal consent shall be documented in the patient's medical record.

(c) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(d) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(e) All laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telehealth interactions.

SEC. 5. Section 1374.13 of the Health and Safety Code is repealed.

SEC. 6. Section 1374.13 is added to the Health and Safety Code, to read:

1374.13. (a) For the purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code shall apply.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the health care provider.

(c) No health care service plan shall require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through ~~telehealth, and every health care service plan shall adopt payment policies consistent with this section to compensate health care providers who provide covered health care services through~~ telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, *and between the health care service plan and its participating providers or provider groups*.

(d) For the purposes of payment for covered treatment or services provided through telehealth, the health care service plan shall not limit the type of setting where services are provided for the patient or by the health care provider.

(e) The requirements of this subdivision shall also be operative for health care service plan contracts with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing ~~with Section 14089), or Chapter 8 (commencing with Section 14200).~~ *with Section 14087.96), or Article 2.91 (commencing with Section 14089) of Chapter 7, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code.*

(f) Nothing in this section shall be interpreted to authorize a health care service plan to require the use of telehealth when the health care provider has determined that it is not appropriate.

SEC. 7. Section 10123.85 of the Insurance Code is repealed.

SEC. 8. Section 10123.85 is added to the Insurance Code, to read:

10123.85. (a) For purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code shall apply.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the health care provider.

(c) No health insurer shall require that in-person contact occur between a health care provider and a patient before payment is made for the services appropriately provided through telehealth, ~~and every health insurer shall adopt payment policies consistent~~

~~with this section to compensate health care providers who provide covered health care services through telehealth,~~ subject to the terms and conditions of the contract entered into between the policyholder or contractholder and the insurer, *and between the insurer and its participating providers or provider groups*.

(d) For the purposes of payment for covered treatment or services provided through telehealth, the health insurer shall not limit the type of setting where services are provided for the patient or by the health care provider.

(e) Nothing in this section shall be interpreted to authorize a health insurer to require the use of telehealth when the health care provider has determined that it is not appropriate.

SEC. 9. Section 14132.72 of the Welfare and Institutions Code is amended to read:

14132.72. (a) For purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code shall apply.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the provider.

(c) In-person contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telehealth, subject to reimbursement policies adopted by the department to compensate a licensed health care provider who provides health care services through telehealth that are otherwise reimbursed pursuant to the Medi-Cal program. *Nothing in this section or the Telehealth Advancement Act of 2011 shall be construed to conflict with or supersede the provisions of Section 14091.3 of this code or any other existing state laws or regulations related to reimbursement for services provided by a noncontracted provider.*

(d) The department shall not require a health care provider to document a barrier to an in-person visit for Medi-Cal coverage of services provided via telehealth.

(e) For the purposes of payment for covered treatment or services provided through telehealth, the department shall not limit the type of setting where services are provided for the patient or by the health care provider.

(f) Nothing in this section shall be interpreted to authorize the department to require the use of telehealth when the health care provider has determined that it is not appropriate.

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

SEC. 10. Section 14132.725 of the Welfare and Institutions Code is amended to read:

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

(b) For purposes of this section, "teleophthalmology and teledermatology by store and forward" means an asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology or, for teleophthalmology, by an optometrist who is licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code, where the physician or optometrist at the distant site reviews the medical information without the patient being present in real time. A patient receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician or optometrist, and shall receive an interactive communication with the distant specialist physician or optometrist, upon request. If requested, communication with the distant specialist physician or optometrist may occur either at the time of the consultation, or within 30 days of the patient's notification of the results of the consultation. If the reviewing optometrist identifies a disease or condition requiring consultation or referral pursuant to Section 3041 of the Business and Professions Code, that consultation or referral shall be with an ophthalmologist or other appropriate physician and surgeon, as required.

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

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

SEC. 11. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

AB 507

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 507
Author: Hayashi
Bill Date: July 1, 2011, Amended
Subject: Pain Management
Sponsor: American Cancer Society
Position: Support

STATUS OF BILL:

This bill is currently in Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would repeal existing law that allows the Department of Justice (DOJ) employ physicians for interviewing and examining patients related to prescription possession and use of controlled substances. This bill would also make changes to existing law related to severe chronic intractable pain.

This bill was amended to make changes to existing law affecting the Pharmacy Board; these changes do not impact the Board's analysis or recommended position.

This bill was recently amended to take out the provisions impacting the Pharmacy Board and to no longer require a physician who refuses to prescribe opiate medication for patients who request the treatment for "pain or a condition causing pain" to refer patients to physicians who treat pain or a condition causing pain, with methods that include the use of opiates. This bill now goes back to existing law that requires a physician to inform the patient that there are physicians who treat pain and whose methods include the use of opiates.

ANALYSIS:

Existing law allows DOJ to employ physicians in order to examine patients related to prescription possession and use of controlled substances. This bill would repeal this law.

> DOJ may have issues with this law being repealed; however, these issues have not been relayed to the Medical Board of California (the Board).

Existing law also allows physicians to refuse to prescribe opiate medication for patients who request the treatment for severe chronic intractable pain, but requires physicians to inform patients that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opiates.

This bill would continue to allow physicians to refuse to prescribe opiate medication for patients who request the treatment for "pain or a condition causing pain". This bill would have required physicians to refer patients to physicians who treat pain or a condition causing pain, with methods that include the use of opiates.

> This would have been problematic because it requires a physician to refer the patient to another physician. If the physician does not know of another physician to refer the patient to, the physician would be in violation of law. This bill should be amended to be permissive, to provide an exclusion for physicians who do not know of another physician to refer their patient to, or to provide a referral to a Web site that would contain a list of physicians such as one or more of the American Board of Medical Specialties certified physician sites (see attached). The other changes in this bill are technical in nature.

The April 27th amendments make changes to existing law affecting the Pharmacy Board; these changes do not impact the Board's analysis or recommended position.

The June 20th amendments take out the take out the provisions impacting the Pharmacy Board. The June 20th and the July 1st amendments also address the Board's concerns and this bill no longer requires a physician who refuses to prescribe opiate medication for patients who request the treatment for "pain or a condition causing pain" to refer patients to physicians who treat pain or a condition causing pain, with methods that include the use of opiates. This bill now goes back to existing law and only requires a physician to inform the patient that there are physicians who treat pain and whose methods include the use of opiates. As such, the Board now has a support position on this bill.

According to the author, this bill seeks to fix ambiguities and inconsistencies in existing law surrounding pain practice that unduly restrict health care practice and interfere with patient access to effective pain treatment. The author states that this bill will remove remaining legal barriers to optimal pain management for patients with cancer, HIV/AIDS, and other diseases or conditions causing pain.

SUPPORT: American Cancer Society (Sponsor); American Chronic Pain Association; American Society for Pain Management Nursing; California Academy of Physician Assistants; Feinberg Medical Group; For Grace; Hollywood Presbyterian Medical Center; Medical Board of California; Southern California Cancer Pain Initiative; and USC/Keck School of Medicine CARE Team/ Palliative Medicine Department

OPPOSITION: None on file

FISCAL: None

July 6, 2011

AMENDED IN SENATE JULY 1, 2011

AMENDED IN SENATE JUNE 20, 2011

AMENDED IN ASSEMBLY APRIL 27, 2011

AMENDED IN ASSEMBLY APRIL 13, 2011

AMENDED IN ASSEMBLY MARCH 21, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 507

Introduced by Assembly Member Hayashi

February 15, 2011

An act to amend Sections 124960 and 124961 of, and to repeal Section 11453 of, the Health and Safety Code, relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

AB 507, as amended, Hayashi. Pain management.

(1) Existing law authorizes the Department of Justice to employ a physician to interview and examine any patient in connection with the prescription, possession, or use of a controlled substance, requires the patient to submit to the interview and examination, and authorizes the physician to testify in prescribed administrative proceedings.

This bill would repeal that provision.

(2) Existing law, the Medical Practice Act, provides for the licensing and regulation of physicians and surgeons by the Medical Board of California~~, and the~~. *The* violation of specified provisions of the act is a crime. Existing law authorizes a physician and surgeon to prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition, drugs or prescription controlled substances for the

treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

This bill would conform findings and declarations and other references to severe chronic intractable pain and to the California Intractable Pain Treatment Act.

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 11453 of the Health and Safety Code is
2 repealed.
3 SEC. 2. Section 124960 of the Health and Safety Code is
4 amended to read:
5 124960. The Legislature finds and declares all of the following:
6 (a) The state has a right and duty to control the illegal use of
7 opiate drugs.
8 (b) Inadequate treatment of acute and chronic pain originating
9 from cancer or noncancerous conditions is a significant health
10 problem.
11 (c) For some patients, pain management is the single most
12 important treatment a physician can provide.
13 (d) A patient suffering from pain or a condition causing pain,
14 including, but not limited to, intractable pain should have access
15 to proper treatment of his or her pain.
16 (e) Due to the complexity of their problems, many patients
17 suffering from pain or a condition causing pain, including, but not
18 limited to, intractable pain may require referral to a physician with
19 expertise in the treatment of pain or a condition causing pain,
20 including, but not limited to, intractable pain. In some cases, pain
21 or a condition causing pain, including, but not limited to, intractable
22 pain is best treated by a team of clinicians in order to address the
23 associated physical, psychological, social, and vocational issues.
24 (f) In the hands of knowledgeable, ethical, and experienced pain
25 management practitioners, opiates administered for pain or a
26 condition causing pain, including, but not limited to, intractable
27 pain can be safe.
28 (g) Opiates can be an accepted treatment for patients in pain or
29 a condition causing pain, including, but not limited to, intractable

pain who have not obtained relief from any other means of treatment.

(h) A patient suffering from pain or a condition causing pain, including, but not limited to, intractable pain has the option to request or reject the use of any or all modalities to relieve his or her pain.

(i) A physician treating a patient who suffers from pain or a condition causing pain, including, but not limited to, intractable pain may prescribe a dosage deemed medically necessary to relieve pain as long as the prescribing is in conformance with Section 2241.5 of the Business and Professions Code.

(j) A patient who suffers from pain or a condition causing pain, including, but not limited to, intractable pain, has the option to choose opiate medication for the treatment of the severe chronic intractable pain as long as the prescribing is in conformance with the provisions of Section 2241.5 of the Business and Professions Code.

(k) The patient's physician may refuse to prescribe opiate medication for a patient who requests the treatment for pain or a condition causing pain, including, but not limited to, intractable pain. However, that physician shall ~~refer the patient to~~ *inform the patient that there are* physicians who treat pain or a condition causing pain, including, but not limited to, intractable pain with methods that include the use of opiates.

SEC. 3. Section 124961 of the Health and Safety Code is amended to read:

124961. Nothing in this section shall be construed to alter any of the provisions set forth in Section 2241.5 of the Business and Professions Code. This section shall be known as the Pain Patient's Bill of Rights.

(a) A patient suffering from pain or a condition causing pain, including, but not limited to, intractable pain has the option to request or reject the use of any or all modalities in order to relieve his or her pain.

(b) A patient who suffers from pain or a condition causing pain, including, but not limited to, intractable pain has the option to choose opiate medications to relieve that pain without first having to submit to an invasive medical procedure, which is defined as surgery, destruction of a nerve or other body tissue by manipulation, or the implantation of a drug delivery system or

1 device, as long as the prescribing physician acts in conformance
2 with the provisions of the California Intractable Pain Treatment
3 Act, Section 2241.5 of the Business and Professions Code.
4 (c) The patient's physician may refuse to prescribe opiate
5 medication for the patient who requests a treatment for pain or a
6 condition causing pain, including, but not limited to, intractable
7 pain. However, that physician shall inform the patient that there
8 are physicians who treat pain and whose methods include the use
9 of opiates.
10 (d) A physician who uses opiate therapy to relieve pain or a
11 condition causing pain, including, but not limited to, intractable
12 pain may prescribe a dosage deemed medically necessary to relieve
13 the patient's pain, as long as that prescribing is in conformance
14 with Section 2241.5 of the Business and Professions Code.
15 (e) A patient may voluntarily request that his or her physician
16 provide an identifying notice of the prescription for purposes of
17 emergency treatment or law enforcement identification.
18 (f) Nothing in this section shall do either of the following:
19 (1) Limit any reporting or disciplinary provisions applicable to
20 licensed physicians and surgeons who violate prescribing practices
21 or other provisions set forth in the Medical Practice Act, Chapter
22 5 (commencing with Section 2000) of Division 2 of the Business
23 and Professions Code, or the regulations adopted thereunder.
24 (2) Limit the applicability of any federal statute or federal
25 regulation or any of the other statutes or regulations of this state
26 that regulate dangerous drugs or controlled substances.

O

AB 536

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 536
Author: Ma
Bill Date: June 14, 2011, amended
Subject: Physicians and Surgeons
Sponsor: Union of American Physician and Dentists
Position: Opposition Removed

STATUS OF BILL:

This bill is currently in the Senate.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would have required the Medical Board of California (the Board) to remove misdemeanor or felony convictions posted by the Board on the Internet within 90 days of receiving a certified copy of an expungement order from the licensee.

This bill was amended, as suggested by the Board, to instead require the Board to post notification of the expungement order and date of expungement on its Internet Web site within six months of the receipt of the certified expungement order.

ANALYSIS:

Current law requires the Board to post information regarding licensed physicians and surgeons on its Internet Web site, including all felony convictions reported to the Board after January 3, 1991 and any misdemeanor conviction that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed.

According to the author's office, the Board has kept criminal misdemeanor or felony convictions that have been legally expunged on its Web site. The author's office believes this leads the public to assume the physician is guilty of the described behavior, which can be economically disastrous for the physician and disrupt the delivery of health care services to consumers.

This bill would require the Board to remove the misdemeanor or felony convictions within 90 days of receiving a certified copy of the expungement order.

The Board took an Oppose Unless Amended position on this bill at its May Board Meeting. The Board does not believe expunged convictions should be removed from the Board's Internet Web site, as they are still required to be reported to the Board and maintained in the licensee's file. The Board suggested amendments to instead require the Board to include information on its Internet Web site for expunged convictions, the fact

that the conviction has been expunged and the date of expungement. These amendments will ensure that the public has information on the conviction, but will also inform the public of the fact that the conviction has been expunged. This will give the public access to accurate information and ensure that public protection is maintained.

The June 14th version of the bill incorporated the Board's suggested amendments; as such, the Board's opposition was removed. Since the Board's amendments were taken, staff is suggesting a Support position on this bill.

SUPPORT: Union of American Physicians and Dentists (Sponsor)
American Federation of State, County and Municipal Employees
California Medical Association

OPPOSITION: None on file

FISCAL: None

POSITION: Recommendation: Support

June 15, 2011

AMENDED IN SENATE JUNE 14, 2011

AMENDED IN ASSEMBLY APRIL 11, 2011

AMENDED IN ASSEMBLY MARCH 7, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 536

Introduced by Assembly Member Ma

February 16, 2011

An act to ~~add Section 2027.1 to~~ *amend Section 2027 of* the Business and Professions Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 536, as amended, Ma. Physicians and surgeons.

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

This bill would require the board to ~~remove expunged misdemeanor or felony convictions posted pursuant to those provisions~~ *post notification of an expungement order and the date of the order* within ~~90 days~~ *6 months* of receiving a certified copy of the expungement order from the licensee.

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 2027 of the Business and Professions*
2 *Code is amended to read:*
3 2027. (a) The board shall post on the Internet the following
4 information in its possession, custody, or control regarding licensed
5 physicians and surgeons:
6 (1) With regard to the status of the license, whether or not the
7 licensee is in good standing, subject to a temporary restraining
8 order (TRO), subject to an interim suspension order (ISO), or
9 subject to any of the enforcement actions set forth in Section 803.1.
10 (2) With regard to prior discipline, whether or not the licensee
11 has been subject to discipline by the board or by the board of
12 another state or jurisdiction, as described in Section 803.1.
13 (3) Any felony convictions reported to the board after January
14 3, 1991.
15 (4) All current accusations filed by the Attorney General,
16 including those accusations that are on appeal. For purposes of
17 this paragraph, "current accusation" shall mean an accusation that
18 has not been dismissed, withdrawn, or settled, and has not been
19 finally decided upon by an administrative law judge and the
20 Medical Board of California unless an appeal of that decision is
21 pending.
22 (5) Any malpractice judgment or arbitration award reported to
23 the board after January 1, 1993.
24 (6) Any hospital disciplinary actions that resulted in the
25 termination or revocation of a licensee's hospital staff privileges
26 for a medical disciplinary cause or reason. The posting shall also
27 provide a link to any additional explanatory or exculpatory
28 information submitted electronically by the licensee pursuant to
29 subdivision (f) of Section 805.
30 (7) Any misdemeanor conviction that results in a disciplinary
31 action or an accusation that is not subsequently withdrawn or
32 dismissed.
33 (8) Appropriate disclaimers and explanatory statements to
34 accompany the above information, including an explanation of
35 what types of information are not disclosed. These disclaimers and
36 statements shall be developed by the board and shall be adopted
37 by regulation.

(9) Any information required to be disclosed pursuant to Section 803.1.

(b) Upon receipt of a certified copy of an expungement order granted pursuant to Section 1203.4 of the Penal Code from a licensee, the board shall, within six months of receipt of the expungement order, post notification of the expungement order and the date thereof on its Internet Web site.

~~(b)~~

(c) (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)~~

(d) The board shall also post on the Internet a factsheet that explains and provides information on the reporting requirements under Section 805.

~~(d)~~

(e) 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.

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

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

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AB 584

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 584
Author: Fong
Bill Date: April 6, 2011, Amended
Subject: Workers' Compensation: Utilization Review
Sponsor (s): American Federation of State, County, and Municipal Employees
California Society of Industrial Medicine and Surgery
California Society of Physical Medicine and Rehabilitation
Union of American Physicians and Dentists

STATUS OF BILL:

This bill is in Senate Appropriations Committee, on the suspense file.

DESCRIPTION OF CURRENT LEGISLATION:

This bill clarifies current law to provide that physicians performing utilization review for injured workers must be licensed in California. Other provisions included in this bill do not affect the Medical Board of California (the Board).

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 Board by requiring all physicians performing these reviews to be licensed in California.

This bill is similar to AB 933 (Fong, 2009) and AB 2969 (Lieber, 2008) which were both vetoed. The Board has supported this legislation in the past.

SUPPORT: American Federation of State, County, and Municipal Employees (Co-sponsor); California Society of Industrial Medicine and Surgery (Co-sponsor); California Society of Physical Medicine and Rehabilitation (Co-

sponsor); Union of American Physicians and Dentists (Co-sponsor); Association for Los Angeles Deputy Sheriffs; California Applicants' Attorneys Association; California Chiropractic Association; California Medical Association; California Nurses Association; California Physical Therapy Association; International Chiropractors Association of California; Peace Officers Research Association of California; Pfizer; and one individual.

OPPOSITION: Acclamation Insurance Management Services; Allied Managed Care; Alpha Fund; American Insurance Association; Association of California Insurance Companies; Association of California Water Agencies; California Association of Joint Powers Authority; California Coalition on Workers Compensation; California Special Districts Association; California State Association of Counties; CSAC Excess Insurance Authority; League of California Cities; Liberty Mutual Group; and Regional Council of Rural Counties.

FISCAL: None to the Board

POSITION: Recommendation: Support

June 9, 2011

AMENDED IN ASSEMBLY APRIL 6, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 584

Introduced by Assembly Member Fong

February 16, 2011

An act to amend Sections 3209.3 and 4610 of the Labor Code, *and to amend Section 2708 of the Unemployment Insurance Code,* relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 584, as amended, 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.

Existing law authorizes the Employment Development Department to administer the disability compensation program. Existing law requires a claim for disability benefits to be supported by a certification of a treating physician or practitioner. Existing law defines physician by reference to the above provision and defines a practitioner as a person duly licensed or certified in California acting within the scope of his or her license or certification who is a dentist, podiatrist, or nurse practitioner, as specified, or, as to normal pregnancy or childbirth, a midwife, nurse midwife, or a nurse practitioner.

This bill would provide that claim for disability benefits may also be supported by a health professional as defined, and as specified.

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" means physicians and surgeons holding
4 an M.D. or D.O. degree, psychologists, acupuncturists,
5 optometrists, dentists, podiatrists, and chiropractic practitioners
6 licensed by California state law and within the scope of their
7 practice as defined by California state law.
8 (b) "Psychologist" means a psychologist licensed by California
9 state law with a doctoral degree in psychology, or a doctoral degree
10 deemed equivalent for licensure by the Board of Psychology
11 pursuant to Section 2914 of the Business and Professions Code,
12 and who either has at least two years of clinical experience in a
13 recognized health setting or has met the standards of the National
14 Register of the Health Service Providers in Psychology.

(c) When treatment or evaluation for an injury is provided by a psychologist, provision shall be made for appropriate medical collaboration when requested by the employer or the insurer.

(d) "Acupuncturist" means a person who holds an acupuncturist's certificate issued pursuant to Chapter 12 (commencing with Section 4925) of Division 2 of the Business and Professions Code.

(e) Nothing in this section shall be construed to authorize acupuncturists to determine disability for the purposes of Article 3 (commencing with Section 4650) of Chapter 2 of Part 2~~, or under Section 2708 of the Unemployment Insurance Code.~~.

SEC. 2. Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, "utilization review" 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 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.

SEC. 3. 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, *health professional,* 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, *health professional,* 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, *health professional's,* or practitioner's knowledge, based on a physical examination and a documented medical history of the claimant by the physician, *health professional,* or practitioner, indicating the physician's or practitioner's conclusion as to the claimant's disability, and a statement of the physician's, *health professional'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, *health professional'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, *health professional,* 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, *health professional,* 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, *health professional,* 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, *health professional,* or practitioner fully cooperates, and continues to cooperate with the investigation. A physician, *health professional's,* 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) "Health professional" means a psychologist, optometrist, dentist, podiatrist, or chiropractor, provided that he or she is duly licensed on any state or foreign country, or in a territory or possession of a country, in which care and treatment was provided to the employee or the employee's family member with a serious health condition. The care and treatment shall be within the scope of his or her practice, as defined by the laws of the licensing jurisdiction. For purposes of this part, all references to a physician shall be also deemed to apply to a health professional.

~~(1)~~

(2) "Physician" ~~has the same meaning as defined in Section 3209.3 of the Labor Code~~ *means a physician and surgeon holding an M.D. or D.O. degree, provided that he or she is duly licensed in any state or foreign country, or in a territory or possession of any country, in which care and treatment was provided to the*

employee or the employee's family member with a serious health condition. The care and treatment shall be within the scope of his or her practice, as defined by the laws of the licensing jurisdiction.

~~(2)~~

(3) (A) "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, or a nurse practitioner, and in the case of a nurse practitioner, after performance of a physical examination by a nurse practitioner and collaboration with a physician and surgeon, or as to normal pregnancy or childbirth, a midwife or nurse midwife, or nurse practitioner~~ *nurse practitioner who is duly licensed or certified in any state or foreign country, or in a territory or possession of any country, in which he or she has provided care and treatment to the employee or the employee's family member with a serious health condition. The care and treatment shall be within the scope of his or her practice, as defined by the laws of the licensing or certifying jurisdiction and the nurse practitioner shall have performed a physical examination and collaborated with a physician and surgeon holding an M.D. or D.O. degree.*

(B) For purposes of normal pregnancy or childbirth, "practitioner" means a midwife, nurse midwife, or a nurse practitioner operating within the scope of his or her practice, as determined by the laws of the licensing or certifying jurisdiction, who is duly licensed or certified in any state or foreign country, or a territory or possession of a country, in which he or she has provided care to the employee or the employee's family member with a serious health condition.

(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~~ *This* section shall *not* 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, *health professional,* or practitioner treating the claimant.

(B) The registrar, authorized medical officer, or other duly authorized official of the hospital or health facility treating the claimant.

(C) An examining physician or other representative of the department.

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AB 589

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 589
Author: Perea
Bill Date: July 12, 2011, amended
Subject: Medical School Scholarships
Sponsor: California Medical Association
Position: Support

STATUS OF BILL:

This bill is currently in Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would create the Steven M. Thompson Medical School Scholarship Program (STMSSP) within the Health Professions Education Foundation (HPEF).

This bill was amended and no longer funds the STMSSP from funds transferred from the Managed Care Administrative Fines and Penalties Fund. As amended, STMSSP is funded by private or federal funds and will only be implemented if HPEF determines that sufficient funds are available.

Recent amendments specify that Steven M. Thompson Loan Repayment Program funds shall not be used to fund the STMSSP.

ANALYSIS:

The Steven M. Thompson Loan Repayment Program (STLRP) was created in 2002 via legislation which was co-sponsored by the Medical Board of California (the Board). The STLRP encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans (up to $105,000) in exchange for a minimum three years of service. In 2006, the administration of STLRP was transitioned from the Board to HPEF. Since 1990, HPEF has administered statewide scholarship and loan repayment programs for a wide range of health professions students and recent graduates and is funded through grants and contributions from public and private agencies, hospitals, health plans, foundations, corporations, as well as through a surcharge on the renewal fees of various health professionals, including a $25 fee paid by physicians and surgeons.

AB 589 would create the STMSSP in HPEF. STMSSP participants must commit in writing to three years of full-time professional practice in direct patient care in an eligible setting. The maximum amount per total scholarship is $105,000 to be distributed over the course of medical school.

The committee charged with selecting scholarship recipients must use guidelines that provide priority consideration to applicants who are best suited to meet the cultural and linguistic needs and demands of patients from medically underserved populations and who meet one or more of the following criteria:

- Speak a Medi-Cal threshold language.
- Come from an economically disadvantaged background.
- Have experience working in medically underserved areas or with medically underserved populations.

The selection committee must give preference to applicants who have committed to practicing in a primary specialty and who will serve in a practice setting in a super-medically underserved area. The selection committee must also include a factor ensuring geographic distribution of placements.

The STMSSP would have originally been funded by funds transferred from the Managed Care Administrative Fines and Penalties Fund that are in excess of the first $1,000,000, including accrued interest, as the first $1,000,000 funds the STLRP (this bill would not reduce the funding to the current STLRP).

The May 27th amendments remove all references to the STMSSP being funded by the Managed Care Administrative Fines and Penalties Fund. As amended, the STMSSP would be funded by federal or private funds and the bill shall only be implemented if HPEF determines that there are sufficient funds available in order to implement STMSSP.

The July 12th amendments specify that STLRP funds shall not be used to fund the STMSSP.

According to the author's office, this bill will address shortages of physician services that exist in over 200 regions in California identified as medically underserved areas. The purpose of this bill is to make medical school more financially accessible for students who are willing to pursue careers in primary care. According to the author's office, this bill will help to address the geographical disparity of physician supply in California, as well as the increasing cost of medical education, which is a barrier to entry for students from economically disadvantaged backgrounds. The author's office believes this bill will provide underserved communities with greater access to medical care. This bill is consistent with the mission of the Medical Board of promoting access to care.

SUPPORT: California Medical Association (Sponsor); Association of California Healthcare Districts; California Primary Care Association; Children's Hospital Central California; City of Kernan; Community Clinic Association of Los Angeles County; and Medical Board of California

OPPOSITION: None on file

FISCAL: None

July 18, 2011

AMENDED IN SENATE JULY 12, 2011

AMENDED IN ASSEMBLY MAY 27, 2011

AMENDED IN ASSEMBLY APRIL 11, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 589

Introduced by Assembly Member Perea
(Principal coauthors: Senators Alquist and Rubio)

February 16, 2011

An act to add Article 6 (commencing with Section 128560) to Chapter 5 of Part 3 of Division 107 of the Health and Safety Code, relating to health professions.

LEGISLATIVE COUNSEL'S DIGEST

AB 589, as amended, Perea. Medical school scholarships.

Existing law establishes the Medically Underserved Account for Physicians within the Health Professions Education Fund that is managed by the Health Professions Education Foundation and the Office of Statewide Health Planning and Development. Under existing law, the primary purpose of the account is to fund the Steven M. Thompson Physician Corps Loan Repayment Program, which provides for the repayment of prescribed educational loans, not to exceed $105,000, obtained by a physician and surgeon who practices in a medically underserved area of the state.

This bill would establish within the Health Professions Education Foundation the Steven M. Thompson Medical School Scholarship Program (STMSSP), managed by the foundation and the Office of Statewide Health Planning and Development to promote the education of medical doctors and doctors of osteopathy, as specified. This bill

would provide up to $105,000 in scholarships to selected participants who agree in writing prior to entering an accredited medical or osteopathic school to serve in an eligible setting.

This bill would establish the Steven M. Thompson Medical School Scholarship Account within the Health Professions Education Fund to receive federal or private funds for the STMSSP. This bill would provide that the STMSSP will be implemented only to the extent that the account contains sufficient funds as determined by the foundation.

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. Article 6 (commencing with Section 128560) is
2 added to Chapter 5 of Part 3 of Division 107 of the Health and
3 Safety Code, to read:
4
5 Article 6. Steven M. Thompson Medical School Scholarship
6 Program
7
8 128560. (a) There is hereby established within the Health
9 Professions Education Foundation, the Steven M. Thompson
10 Medical School Scholarship Program.
11 (b) It is the intent of this article that the foundation and the office
12 provide the ongoing program management for the program.
13 128565. For purposes of this article, the following definitions
14 shall apply:
15 (a) "Account" means the Steven M. Thompson Medical School
16 Scholarship Account established within the Health Professions
17 Education Fund pursuant to this article.
18 (b) "Foundation" means the Health Professions Education
19 Foundation.
20 (c) "Medi-Cal threshold languages" means primary languages
21 spoken by limited-English-proficient (LEP) population groups
22 meeting a numeric threshold of 3,000 LEP individuals eligible for
23 Medi-Cal residing in a county, 1,000 LEP individuals eligible for
24 Medi-Cal residing in a single ZIP Code, or 1,500 LEP individuals
25 eligible for Medi-Cal residing in two contiguous ZIP Codes.
26 (d) "Medically underserved area" means an area defined as a
27 health professional shortage area in Part 5 (commencing with Sec.

5.1) of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist as determined by the California Healthcare Workforce Policy Commission pursuant to Section 128225.

(e) "Medically underserved population" means the persons served by the Medi-Cal program, the Healthy Families Program, and uninsured populations.

(f) "Office" means the Office of Statewide Health Planning and Development (OSHPD).

(g) "Practice setting" means either of the following:

(1) A community clinic as defined in subdivision (a) of Section 1204 and subdivision (c) of Section 1206, a clinic owned or operated by a public hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role pursuant to Section 17000 of the Welfare and Institutions Code, each of which is located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved population.

(2) A medical practice located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved population.

(h) "Primary specialty" means family practice, internal medicine, pediatrics, or obstetrics/gynecology.

(i) "Program" means the Steven M. Thompson Medical School Scholarship Program.

(j) "Selection committee" means the advisory committee of not more than seven members established pursuant to subdivision (b) of Section 128551.

(k) "Super-medically underserved area" means an area defined as medically underserved pursuant to subdivision (d) that also meets a heightened criteria of physician shortage as determined by the foundation.

128570. (a) Persons participating in the program shall be persons who agree in writing prior to entering an accredited medical or osteopathic school to serve in an eligible practice setting, pursuant to subdivision (g) of Section 128565, for at least three years. The program shall be used only for the purpose of promoting the education of medical doctors and doctors of osteopathy and related administrative costs.

(b) A program participant shall commit to three years of full-time professional practice once the participant has achieved full licensure pursuant to Article 4 (commencing with Section 2080) of Chapter 5 or Section 2099.5 of the Business and Professions Code and after completing an accredited residency program. The obligated professional service shall be in direct patient care in an eligible practice setting pursuant to subdivision (g) of Section 128565.

(1) Leaves of absence shall be permitted for serious illness, pregnancy, or other natural causes. The selection committee shall develop the process for determining the maximum permissible length of an absence and the process for reinstatement. Awarding of scholarship funds shall be deferred until the participant is back to full-time status.

(2) Full-time status shall be defined by the selection committee. The selection committee may establish exemptions from this requirement on a case-by-case basis.

(c) The maximum allowable amount per total scholarship shall be one hundred five thousand dollars ($105,000). These moneys shall be distributed over the course of a standard medical school curriculum. The distribution of funds shall increase over the course of medical school, increasing to ensure that at least 45 percent of the total scholarship award is distributed upon matriculation in the final year of school.

(d) In the event the program participant does not complete the minimum three years of professional service pursuant to the contractual agreement between the foundation and the participant, the office shall recover the funds awarded plus the maximum allowable interest for failure to begin or complete the service obligation.

128575. (a) The selection committee shall use guidelines that meet all of the following criteria to select scholarship recipients:

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

(A) Speak a Medi-Cal threshold language.

(B) Come from an economically disadvantaged background.

(C) Have experience working in medically underserved areas or with medically underserved populations.

(2) Give preference to applicants who have committed to practicing in a primary specialty.

(3) Give preference to applicants who will serve in a practice setting in a super-medically underserved area.

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

(b) The selection committee may award up to 20 percent of the available scholarships to program applicants who will practice specialties outside of a primary specialty.

(c) The foundation, in consultation with the selection committee, shall develop a process for outreach to potentially eligible applicants.

128580. (a) The Steven M. Thompson Medical School Scholarship Account is hereby established within the Health Professions Education Fund for the purposes of receiving federal or private funds.

(b) Funds in the account shall be used to fund scholarships pursuant to agreements made with recipients and as follows:

(1) Scholarships shall not exceed one hundred five thousand dollars ($105,000) per recipient.

(2) Scholarships shall not exceed the amount of the educational expenses incurred by the recipient.

(c) Funds placed in the account for purposes of this article shall, upon appropriation by the Legislature, be used for the purposes of this article. *Funds supporting the Steven M. Thompson Physician Corps Loan Repayment Program established pursuant to Article 5 (commencing with Section 128550) shall not be used for the purposes of this article.*

(d) The account shall be used to pay for the cost of administering the program, not to exceed 5 percent of the total appropriation for the program.

(e) The office and the foundation shall manage the account established by this section prudently in accordance with other provisions of law.

(f) This article shall be implemented only to the extent that the account contains sufficient funds as determined by the foundation.

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AJR 13

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AJR 13
Author: Lara
Bill Date: June 2, 2011, introduced
Subject: Graduate Medical Education
Sponsor: California Medical Association

STATUS OF BILL:

This bill is currently in the Senate.

DESCRIPTION OF CURRENT LEGISLATION:

This resolution urges the President and U.S. Congress to continue to provide funding to increase the physician supply in California and encourages consideration of solutions in order to increase the number of graduate medical education (GME) slots in California.

ANALYSIS:

In 2010 President Obama signed the Patient Protection and Affordable Care Act (PPACA), otherwise known as Health Care Reform, into law. The PPACA contains provisions that are intended to address the growing shortage of physicians. The author believes that the supply of physicians in California is inadequate, especially in underserved areas serving ethnic populations. This resolution was introduced to bring these important physician workforce supply issues to the attention of the President and U.S. Congress.

This resolution would urge the President and the U.S. Congress to continue to provide resources to increase the supply of physicians in California, in order to improve access to care, particularly for Californians in rural areas and members of underrepresented ethnic groups. This resolution would also encourage the President and U.S. Congress to consider solutions that would increase the number of graduate medical education (GME) residency positions to keep pace with the growing number of medical school graduates and the growing need for physicians in California.

The Board is supportive of any measure that will help to address workforce issues, especially since the shortage of physicians may be exacerbated by the implementation of PPACA or Health Care Reform. Increasing the supply of physicians and the number of GME residency slots will help to address this shortage and help to increase access to care, which is consistent with the mission of the Board of promoting access to care.

SUPPORT: California Medical Association (Sponsor)
Latino Coalition for a Healthy California

OPPOSITION: None on file

FISCAL: None

POSITION: Recommendation: Support

June 21, 2011

Assembly Joint Resolution No. 13

Introduced by Assembly Member Lara
(Coauthors: Assembly Members Alejo, Allen, Bradford, Butler, Campos, Carter, Cedillo, Davis, Eng, Fong, Furutani, Hueso, Mendoza, Mitchell, Pan, Perea, V. Manuel Pérez, Solorio, Swanson, Torres, Williams, and Yamada)

June 2, 2011

Assembly Joint Resolution No. 13—Relative to health care.

LEGISLATIVE COUNSEL'S DIGEST

AJR 13, as introduced, Lara. Graduate medical education.

This measure would urge the President and the Congress of the United States to continue to provide resources to increase the supply of physicians in California and to consider solutions that would increase the number of graduate medical education residency positions.

Fiscal committee: no.

WHEREAS, Congress approved, and President Barack Obama signed, the federal Patient Protection and Affordable Care Act (PPACA) of 2010 (Public Law 111-148), to expand health insurance coverage, reduce health care costs, and address the growing shortage of physicians; and

WHEREAS, The PPACA aims to specifically address shortages in primary care through adjustments to the Medicare and Medicaid fee schedules, reallotment of unused graduate medical education slots, and a suite of grants, scholarships, loans, and loan forgiveness programs; and

WHEREAS, Forty-two of California's 58 counties fall below the Council on Graduate Medical Education's recommendations for minimum primary care physician supply, and of these 42 counties, 16 have a Latino population that exceeds 30 percent; and

WHEREAS, The PPACA encourages more physicians to practice in rural settings, where Latinos can constitute 50 percent of the population, through Rural Physician Training Grants for medical schools; and

WHEREAS, California's rural counties suffer from particularly low physician practice rates, of the rural counties with the lowest number of primary care physicians, three have a Latino population over 50 percent; and

WHEREAS, The PPACA endeavors to create a more diverse and culturally competent physician workforce by funding scholarships, educational assistance, and loan repayment programs for minority medical students, as well as by building diversity training curricula for medical schools and continuing medical education programs; and

WHEREAS, California is a diverse state that demands a culturally competent and multiethnic physician workforce. According to the 2010 Census, of the state's residents 40 percent are non-Hispanic White, 38 percent are Hispanic, 13 percent are Asian, 6 percent are African American, 3 percent are multiracial, and approximately 1 percent are American Indian; and

WHEREAS, Currently Latinos, African Americans, Samoans, Cambodians, Hmong, and Laotians are underrepresented in California's physician workforce. The underrepresentation of Latino physicians is particularly dire: Latinos represent over one-third of the state's population, but account for only 5 percent of the state's physicians; and

WHEREAS, The majority of the state's ethnic communities enjoys a ratio of 361 physicians per 100,000 residents, but African American communities have only 178 physicians per 100,000 residents and Latino communities have only 56 physicians per 100,000 residents; and

WHEREAS, The number of physicians retiring currently outpaces the number of physicians entering the workforce in California, where, in the last 15 years, the number of medical school graduates in California has been at a plateau even though there has been a population growth in the state of 20 percent; and

WHEREAS, The magnitude of this physician shortage will only increase the cost of public health care in the health care institutions of the state given that Latinos will constitute the majority of Californians by the year 2040. Currently, to reach parity with the non-Latino patient population, there would need to be approximately 27,309 more Latino physicians in California; and

WHEREAS, The PPACA reforms graduate medical education by expanding the scope of Medicare-recognized patient care settings, creating funding for community-based graduate medical education training, and establishing Teaching Health Centers development grants; and

WHEREAS, The increase of medical school debt is one of the primary factors for a student not to pursue medical school because the average medical student now graduates with about $150,000 in debt. If that trend continues at the average rate, medical school debt will amount to $750,000 by 2033; and

WHEREAS, It was reported that in 2009 there were over 45,500 applications to California's eight medical schools but that these schools only offered a total of 1,084 spots; and

WHEREAS, The primary bottleneck in the United States' physician training pipeline is at residency. California is host to 12 percent of the United States' population, but only has 8.3 percent of the country's medical residents. This means that in 2008, California had 9,200 medical residents, which was significantly below the national average; and

WHEREAS, California is able to meet only 25 percent of its current physician workforce needs with physicians who undergo graduate medical education in-state; and

WHEREAS, The PPACA demonstrates an ongoing commitment to evaluation and assessment of the physician workforce by establishing the National Health Care Workforce Commission, Centers for Health Care Workforce Analysis at the national, state, and regional levels, and funding state health care workforce development grants; and

WHEREAS, The expansion of health insurance coverage under the PPACA will further increase the need for physicians. Nearly 4.7 million nonelderly adults and children who were uninsured in all or part of 2009 will qualify for coverage under the PPACA; now, therefore, be it

1 *Resolved by the Assembly and the Senate of the State of*
2 *California, jointly,* That the Legislature urges the President and
3 the Congress of the United States to continue to provide resources
4 to increase the supply of physicians in California, in order to
5 improve access to care, particularly for Californians in rural areas
6 and members of underrepresented ethnic groups; and be it further
7 *Resolved,* That the Legislature encourages the President and the
8 Congress of the United States to consider solutions that would
9 increase the number of graduate medical education residency
10 positions to keep pace with the growing numbers of medical school
11 graduates and the growing need for physicians in California and
12 the United States; and be it further
13 *Resolved,* That the Chief Clerk of the Assembly transmit copies
14 of this resolution to the President and Vice President of the United
15 States, to the Speaker of the House of Representatives, to the
16 Majority Leader of the Senate, to each Senator and Representative
17 from California in the Congress of the United States, and to the
18 author for appropriate distribution.

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SB 100

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 100
Author: Price
Bill Date: July 12, 2011, amended
Subject: Healing Arts
Sponsor: Author
Board Position: Support

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill covers a variety of subjects. This bill will allow outpatient settings to be licensed by the California Department of Public Health (CDPH) or accredited by an accreditation agency approved by the Medical Board of California (the Board). This bill also contains new requirements for outpatient setting accreditation and licensing and for information sharing between CDPH and the Board. In addition, this bill includes requirements on the supervision of laser and intense pulse laser device procedures, advertising, and disclosing outpatient setting information to the public.

The April 25th amendments make significant changes to this bill. First, they take out all provisions regarding licensing of outpatient settings by the California Department of Public Health (CDPH). They also take out all provisions related to advertising. Lastly, they add to requirements for accreditation agencies, outpatient settings and the Board.

Recent amendments delete the provision in existing law that allows outpatient settings with multiple service sites to have only a sample of the sites inspected and now requires all of the sites to be inspected. The amendments also specify that only final inspection reports are public records and require the final inspection reports to include specified information. The amendments require accreditation agencies to ensure that outpatient settings, whose accreditation has been denied or revoked, correct those deficiencies and that an onsite inspection be completed before accrediting that outpatient setting. The amendments also specify that inspections shall be onsite. The amendments require the Board to bring action to enjoin an outpatient setting when appropriate, through, or in conjunction with, the local district attorney. The amendments make other technical changes.

ANALYSIS:

The June 23rd and July 12th amendments address the concerns raised by the Board. The below sections in bold outline the recent changes to the bill:

Amends H&S Code Section 1248.15

This section was amended to do the following:

- Require outpatient settings to submit for approval by an accreditation agency at the time accreditation, 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 or to govern emergency and urgent care situations. The plan must include, at a minimum, that when a patient is being transferred to a local accredited or licensed acute care hospital, the outpatient setting must: (1) notify the individual designated by the patient to be notified in case of an emergency; (2) ensure that the mode of transfer is consistent with the patient's medical condition; (3) ensure that all relevant clinical information is documented and accompanies the patient at the time of transfer, and (4) continue to provide appropriate care to the patient until the transfer can be effectuated.

  This language has been added to address concerns that detailed procedures are not in place at these settings.

- Allow the Board to adopt regulations to specify procedures that should be performed in an accredited setting for facilities or clinics that are outside the definition of an outpatient setting.

  This is to address the concern that some procedures are being performed in facilities that do not have to be accredited.

- Require the accrediting agency as part of the accreditation process to conduct a reasonable investigation of the prior history of the outpatient setting, including all licensed physicians and surgeons who have an ownership interest therein, to determine whether there have been any adverse accreditation decisions rendered against them. "Conducting a reasonable investigation" for the purposes of this section means querying the Medical Board of California and the Osteopathic Medical Board of California to ascertain if either the outpatient setting has, or if its owners are licensed physicians and surgeons, if those physicians and surgeons have, been subject to an adverse accreditation decision.

  This will proactively help to ensure that outpatient settings have not had adverse actions and are not owned by physicians that have adverse actions, which will promote consumer protection.

- An outpatient setting shall be subject to the reporting requirements in Section 1279.1 and the penalties for failure to report specified in Section 1280.4

  This subjects the outpatient setting to the never events reporting requirements and fines associated.

- **Delete the provision in existing law that allows outpatient settings with multiple service sites to have only a sample of the sites inspected and now requires all of the sites to be inspected.**

  This will require all outpatient setting service sites to be inspected, this will help to ensure consumer protection.

Amends H&S Code Section 1248.2

This section was amended to require that the listing of information that the Board must obtain and maintain to be posted on the Board's Internet Web site. In addition, the list now must include any owner's medical license number and also requires accrediting agencies to provide and update the Board on all outpatient settings that are accredited.

This will ensure that the Board is provided this information and that consumers have access to this information.

Amends H&S Code Section 1248.25

This section now requires the accrediting agency to report to the Board within three business days (instead of immediately) when an outpatient settings' accreditation has been revoked.

Amends H&S Code Section 1248.35

This section was amended to do the following:

- Require outpatient settings to correct identified deficiencies within a set time and specify that failure to comply results in the accrediting agency issuing a reprimand or suspending or revoking the accreditation.

- Require an outpatient setting to comply with a corrective action within a timeframe specified by the accrediting agency, if the outpatient setting does not comply, the accrediting agency shall issue a reprimand, and may either place the outpatient setting on probation, suspend or revoke the accreditation of an outpatient setting, and shall notify the board of its action.

- Require the accreditation agency, upon receipt of a complaint from the Board that an outpatient setting poses an immediate risk to public safety, to inspect an outpatient setting and report its findings within five business days. Accreditation agencies shall investigate any other complaints received by the Board and report its findings to the Board within 30 days.

  This will help to ensure than inspections are done timely and will promote consumer protection.

- Require the inspection results to be kept on file with the Board and the accreditation agency along with the plan of correction and comments. It also specifies that

inspection reports, lists of deficiencies, and plans of corrections are public records open to public inspection.

The inspection reports should be confidential until the final report is done. If there is an issue that the accrediting agency is working with the outpatient setting on to correct, it should not be made public until the final report and results are complete.

Recent amendments amend this section to address the Board's concern. The bill now only makes the final report a public document. The bill also requires the final report to include the lists of deficiencies, plans of correction or requirements for improvement, and notes when corrective action is completed.

This amendment will ensure that the final reports include valuable information and make this information available to the public.

- Require that if one accrediting agency denies, revokes, or suspends accreditation, the action shall apply to all other accreditation agencies. Recent amendments allow an outpatient setting to re-apply for accreditation with the same agency, or with another agency if the outpatient setting discloses the full accreditation report. It is the responsibility of the outpatient setting to disclose the accreditation report.

  This is to prohibit "accreditation shopping"; however, the recent amendments allow the outpatient setting to possibly be accredited if the full accreditation report is disclosed.

  Recent amendments require the new accrediting agency to ensure that all deficiencies in the accreditation report have been corrected and require the new accreditation agency to conduct a new onsite inspection before accrediting the outpatient setting.

  These amendments will help to prevent accreditation shopping and will help to ensure consumer protection by requiring deficiencies to be corrected and the completion of a new onsite inspection.

- Require an accreditation agency that has suspended, revoked or denied accreditation for an outpatient setting to do the following:
  - Notify the Board.
  - Send a notification letter to the outpatient setting stating that the setting is no longer allowed to perform procedures that require accreditation.
  - Require the outpatient setting to remove its accreditation certification and post the notification letter in a conspicuous location, accessible to public view.

  This will help to ensure that both the Board and consumers are notified and made aware when an outpatient setting is no longer accredited.

- Allow the Board to take any appropriate action it deems necessary if an outpatient settings accreditation has been suspended, revoked, or denied.

Amend H&S Code Section 1248.7

This section will require the Board to investigate all complaints concerning a violation of this chapter. Requires the Board, upon discovery that an outpatient setting in operation but not accredited, the Board or the local district attorney (DA) must bring an action to enjoin the outpatient setting's operation. This bill would specify that if an outpatient setting is operating without accreditation, it shall be prima facie evidence that a violation of law has occurred and additional proof shall not be necessary to enjoin the outpatient setting's operation.

This bill was amended on July 12th to only require the Board to bring an action to enjoin the outpatient setting's operation when appropriate, and specifies that the action to enjoin be done through, or in conjunction with, the local DA.

Currently, if the Board receives this type of complaint, it would be forwarded to the local DA. This bill now requires the Board to investigate these complaints, which will add to the Board's workload. This workload would be given to the Board's Operation Safe Medicine Unit, which will be dissolved beginning July of 2011 if it is not included in the budget.

The Board had a concern related to the requirement that the local DA or the Board must bring an action to enjoin the outpatient setting because it was in place regardless of the outcome of the investigation or if the action is appropriate. The July 12th amendments address this concern by only requiring an action when it is appropriate, and they also more accurately reflect the board's role in working with the local DA.

Amends H&S Code Section 1248.85

Lastly, this bill specifies that a survey shall not constitute an inspection.

This should be amended to say that a physical inspection is required. According to the accrediting agencies, they call their inspections surveys, and they are always done in person, never by paper only, which is the situation this provision is trying to address.

This bill was amended to address the Board's concern. Instead saying a survey shall not constitute an inspection, the bill now specifies that the inspection shall be an onsite inspection, which has been the intent of this language.

FISCAL: The newly required evaluations that must be performed by the Board every three years will result in additional workload for the Board, as will the requirement for the Board to investigate all complaints related to outpatient settings in operation that are not accredited, but should be. This workload is absorbable.

SUPPORT: California Medical Association
California Society of Anesthesiologists
California Society of Dermatology and Dermatologic Surgery
The Board

OPPOSITION: None on File

AMENDED IN ASSEMBLY JULY 12, 2011

AMENDED IN ASSEMBLY JUNE 23, 2011

AMENDED IN SENATE MAY 3, 2011

AMENDED IN SENATE APRIL 25, 2011

SENATE BILL No. 100

Introduced by Senator Price

January 11, 2011

An act to amend Section 2023.5 of the Business and Professions Code, and to amend Sections 1248, 1248.15, 1248.2, 1248.25, 1248.35, 1248.5, 1248.7, and 1248.85 of the Health and Safety Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 100, as amended, Price. Healing arts.

(1) Existing law provides for the licensure and regulation of various healing arts practitioners by boards under the Department of Consumer Affairs. 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, 2013, 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.

(2) 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. This bill would, as part of the accreditation process, authorize the accrediting agency to conduct a reasonable investigation, as defined, of the prior history of the outpatient setting. 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, instead, require the board to obtain and maintain the list for all accredited outpatient settings, and to notify the public, by placing the information on its Internet Web site, whether the setting is accredited or the setting's accreditation 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 report within 3 business days 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. The bill would also apply the denial of accreditation, or the revocation or suspension of accreditation by one accrediting agency, to all other accrediting agencies.

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 and the department, 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 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.

Existing law authorizes the board or the local district attorney to bring an action to enjoin a violation or threatened violation of the licensing provisions for outpatient settings in the superior court in and for the county in which the violation occurred or is about to occur.

This bill would require the board to investigate all complaints concerning a violation of these provisions and, with respect to any complaints relating to a violation of a specified provision, or upon discovery that an outpatient setting is not in compliance with that specified provision, would require the board ~~or~~ *to investigate and, where appropriate, the board, through or in conjunction with* the local district attorney, to bring an action to enjoin the outpatient setting's operation, as specified.

(3) 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 2023.5 of the Business and Professions
2 Code is amended to read:
3 2023.5. (a) The board, in conjunction with the Board of
4 Registered Nursing, and in consultation with the Physician
5 Assistant Committee and professionals in the field, shall review
6 issues and problems surrounding the use of laser or intense light
7 pulse devices for elective cosmetic procedures by physicians and
8 surgeons, nurses, and physician assistants. The review shall include,
9 but need not be limited to, all of the following:
10 (1) The appropriate level of physician supervision needed.
11 (2) The appropriate level of training to ensure competency.
12 (3) Guidelines for standardized procedures and protocols that
13 address, at a minimum, all of the following:
14 (A) Patient selection.
15 (B) Patient education, instruction, and informed consent.
16 (C) Use of topical agents.
17 (D) Procedures to be followed in the event of complications or
18 side effects from the treatment.
19 (E) Procedures governing emergency and urgent care situations.
20 (b) On or before January 1, 2009, the board and the Board of
21 Registered Nursing shall promulgate regulations to implement
22 changes determined to be necessary with regard to the use of laser
23 or intense pulse light devices for elective cosmetic procedures by
24 physicians and surgeons, nurses, and physician assistants.
25 (c) On or before January 1, 2013, the board shall adopt
26 regulations regarding the appropriate level of physician availability
27 needed within clinics or other settings using laser or intense pulse
28 light devices for elective cosmetic procedures. However, these
29 regulations shall not apply to laser or intense pulse light devices
30 approved by the federal Food and Drug Administration for
31 over-the-counter use by a health care practitioner or by an
32 unlicensed person on himself or herself.
33 (d) Nothing in this section shall be construed to modify the
34 prohibition against the unlicensed practice of medicine.
35 SEC. 2. Section 1248 of the Health and Safety Code is amended
36 to read:
37 1248. For purposes of this chapter, the following definitions
38 shall apply:

(a) "Division" means the Medical Board of California. All references in this chapter to the division, the Division of Licensing of the Medical Board of California, or the Division of Medical Quality shall be deemed to refer to the Medical Board of California pursuant to Section 2002 of the Business and Professions Code.

(b) (1) "Outpatient setting" means any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Section 1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.

(2) "Outpatient setting" also means facilities that offer in vitro fertilization, as defined in subdivision (b) of Section 1374.55.

(3) "Outpatient setting" does not include, among other settings, any setting where anxiolytics and analgesics are administered, when done so in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

(c) "Accreditation agency" means a public or private organization that is approved to issue certificates of accreditation to outpatient settings by the board pursuant to Sections 1248.15 and 1248.4.

SEC. 3. Section 1248.15 of the Health and Safety Code is amended to read:

1248.15. (a) The board shall adopt standards for accreditation and, in approving accreditation agencies to perform accreditation of outpatient settings, shall ensure that the certification program shall, at a minimum, include standards for the following aspects of the settings' operations:

(1) Outpatient setting allied health staff shall be licensed or certified to the extent required by state or federal law.

(2) (A) Outpatient settings shall have a system for facility safety and emergency training requirements.

(B) There shall be onsite equipment, medication, and trained personnel to facilitate handling of services sought or provided and to facilitate handling of any medical emergency that may arise in connection with services sought or provided.

(C) In order for procedures to be performed in an outpatient setting as defined in Section 1248, the outpatient setting shall do one of the following:

(i) Have a written transfer agreement with a local accredited or licensed acute care hospital, approved by the facility's medical staff.

(ii) Permit surgery only by a licensee who has admitting privileges at a local accredited or licensed acute care hospital, with the exception that licensees who may be precluded from having admitting privileges by their professional classification or other administrative limitations, shall have a written transfer agreement with licensees who have admitting privileges at local accredited or licensed acute care hospitals.

(iii) 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.

(D) In addition to the requirements imposed in subparagraph (C), the outpatient setting shall submit 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 that would place a patient at high risk for injury or harm or to govern emergency and urgent care situations. The plan shall include, at a minimum, that if a patient is being transferred to a local accredited or licensed acute care hospital, the outpatient setting shall do all of the following:

(i) Notify the individual designated by the patient to be notified in case of an emergency.

(ii) Ensure that the mode of transfer is consistent with the patient's medical condition.

(iii) Ensure that all relevant clinical information is documented and accompanies the patient at the time of transfer.

(iv) Continue to provide appropriate care to the patient until the transfer is effectuated.

(E) 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 or in accordance with existing law.

(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 shall have all of the sites inspected.

(8) Outpatient settings shall post the certificate of accreditation in a location readily visible to patients and staff.

(9) Outpatient settings shall post the name and telephone number of the accrediting agency with instructions on the submission of complaints in a location readily visible to patients and staff.

(10) Outpatient settings shall have a written discharge criteria.

(b) Outpatient settings shall have a minimum of two staff persons on the premises, one of whom shall either be a licensed physician and surgeon or a licensed health care professional with current certification in advanced cardiac life support (ACLS), as long as a patient is present who has not been discharged from supervised care. Transfer to an unlicensed setting of a patient who does not meet the discharge criteria adopted pursuant to paragraph (10) of subdivision (a) shall constitute unprofessional conduct.

(c) An accreditation agency may include additional standards in its determination to accredit outpatient settings if these are approved by the board to protect the public health and safety.

(d) No accreditation standard adopted or approved by the board, and no standard included in any certification program of any accreditation agency approved by the board, shall serve to limit the ability of any allied health care practitioner to provide services within his or her full scope of practice. Notwithstanding this or any other provision of law, each outpatient setting may limit the privileges, or determine the privileges, within the appropriate scope of practice, that will be afforded to physicians and allied health care practitioners who practice at the facility, in accordance with credentialing standards established by the outpatient setting in compliance with this chapter. Privileges may not be arbitrarily restricted based on category of licensure.

(e) The board shall adopt standards that it deems necessary for outpatient settings that offer in vitro fertilization.

(f) The board may adopt regulations it deems necessary to specify procedures that should be performed in an accredited outpatient setting for facilities or clinics that are outside the definition of outpatient setting as specified in Section 1248.

(g) As part of the accreditation process, the accrediting agency shall conduct a reasonable investigation of the prior history of the outpatient setting, including all licensed physicians and surgeons who have an ownership interest therein, to determine whether there have been any adverse accreditation decisions rendered against them. For the purposes of this section, "conducting a reasonable investigation" means querying the Medical Board of California and the Osteopathic Medical Board of California to ascertain if either the outpatient setting has, or, if its owners are licensed physicians and surgeons, if those physicians and surgeons have, been subject to an adverse accreditation decision.

(h) An outpatient setting shall be subject to the reporting requirements in Section 1279.1 and the penalties for failure to report specified in Section 1280.4.

SEC. 4. Section 1248.2 of the Health and Safety Code is amended to read:

1248.2. (a) Any outpatient setting may apply to an accreditation agency for a certificate of accreditation. Accreditation shall be issued by the accreditation agency solely on the basis of compliance with its standards as approved by the board under this chapter.

(b) The board shall obtain and maintain a list of accredited outpatient settings from the information provided by the accreditation agencies approved by the board, and shall notify the public, by placing the information on its Internet Web site, whether an outpatient setting is accredited or the setting's accreditation has been revoked, suspended, or placed on probation, or the setting has received a reprimand by the accreditation agency.

(c) The list of outpatient settings shall include all of the following:

(1) Name, address, and telephone number of any owners, and their medical license numbers.

(2) Name and address of the facility.

(3) The name and telephone number of the accreditation agency.

(4) The effective and expiration dates of the accreditation.

(d) Accrediting agencies approved by the board shall notify the board and update the board on all outpatient settings that are accredited.

SEC. 5. Section 1248.25 of the Health and Safety Code is amended to read:

1248.25. If an outpatient setting does not meet the standards approved by the board, accreditation shall be denied by the accreditation agency, which shall provide the outpatient setting notification of the reasons for the denial. An outpatient setting may reapply for accreditation at any time after receiving notification of the denial. The accreditation agency shall report within three business days to the board if the outpatient setting's certificate for accreditation has been denied.

SEC. 6. Section 1248.35 of the Health and Safety Code is amended to read:

1248.35. (a) Every outpatient setting which is accredited shall be inspected by the accreditation agency and may also be inspected by the Medical Board of California. The Medical Board of California shall ensure that accreditation agencies inspect outpatient settings.

(b) Unless otherwise specified, the following requirements apply to inspections described in subdivision (a).

(1) The frequency of inspection shall depend upon the type and complexity of the outpatient setting to be inspected.

(2) Inspections shall be conducted no less often than once every three years by the accreditation agency and as often as necessary by the Medical Board of California to ensure the quality of care provided.

(3) The Medical Board of California or the accreditation agency may enter and inspect any outpatient setting that is accredited by an accreditation agency at any reasonable time to ensure compliance with, or investigate an alleged violation of, any standard of the accreditation agency or any provision of this chapter.

(c) If an accreditation agency determines, as a result of its inspection, that an outpatient setting is not in compliance with the standards under which it was approved, the accreditation agency may do any of the following:

(1) Require correction of any identified deficiencies within a set timeframe. Failure to comply shall result in the accrediting agency issuing a reprimand or suspending or revoking the outpatient setting's accreditation.

(2) Issue a reprimand.

(3) Place the outpatient setting on probation, during which time the setting shall successfully institute and complete a plan of correction, approved by the board or the accreditation agency, to correct the deficiencies.

(4) Suspend or revoke the outpatient setting's certification of accreditation.

(d) (1) 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 setting. During the allotted time to correct the deficiencies, the plan of correction, which includes the deficiencies, shall be conspicuously posted by the outpatient setting in a location accessible to public view. Within 10 days after the adoption of the plan of correction, the accrediting agency shall send a list of deficiencies and the corrective action to be taken to the board. 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.

(2) If an outpatient setting does not comply with a corrective action within a timeframe specified by the accrediting agency, the accrediting agency shall issue a reprimand, and may either place the outpatient setting on probation or suspend or revoke the accreditation of the outpatient setting, and shall notify the board of its action. This section shall not be deemed to prohibit an outpatient setting that is unable to correct the deficiencies, as specified in the plan of correction, for reasons beyond its control, from voluntarily surrendering its accreditation prior to initiation of any suspension or revocation proceeding.

(e) The accreditation agency shall, within 24 hours, 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.

(f) The accreditation agency, upon receipt of a complaint from the board that an outpatient setting poses an immediate risk to public safety, shall inspect the outpatient setting and report its findings of inspection to the board within five business days. If an accreditation agency receives any other complaint from the board, it shall investigate the outpatient setting and report its findings of investigation to the board within 30 days.

(g) Reports on the results of any inspection shall be kept on file with the board and the accreditation agency along with the plan of correction and the comments of the outpatient setting. The

inspection report may include a recommendation for reinspection. All final inspection reports, which include the lists of deficiencies, plans of correction or requirements for improvements and correction, and corrective action completed, shall be public records open to public inspection.

(h) If one accrediting agency denies accreditation, or revokes or suspends the accreditation of an outpatient setting, this action shall apply to all other accrediting agencies. An outpatient setting that is denied accreditation is permitted to reapply for accreditation with the same accrediting agency. The outpatient setting also may apply for accreditation from another accrediting agency, but only if it discloses the full accreditation report of the accrediting agency that denied accreditation. Any outpatient setting that has been denied accreditation shall disclose the accreditation report to any other accrediting agency to which it submits an application. The new accrediting agency shall ensure that all deficiencies have been corrected and conduct a new onsite inspection consistent with the standards specified in this chapter.

(i) If an outpatient setting's certification of accreditation has been suspended or revoked, or if the accreditation has been denied, the accreditation agency shall do all of the following:

(1) Notify the board of the action.

(2) Send a notification letter to the outpatient setting of the action. The notification letter shall state that the setting is no longer allowed to perform procedures that require outpatient setting accreditation.

(3) Require the outpatient setting to remove its accreditation certification and to post the notification letter in a conspicuous location, accessible to public view.

(j) The board may take any appropriate action it deems necessary pursuant to Section 1248.7 if an outpatient setting's certification of accreditation has been suspended or revoked, or if accreditation has been denied.

SEC. 7. Section 1248.5 of the Health and Safety Code is amended to read:

1248.5. The board shall evaluate the performance of an approved accreditation agency no less than every three years, or in response to complaints against an agency, or complaints against one or more outpatient settings accreditation by an agency that

indicates noncompliance by the agency with the standards approved by the board.

SEC. 8. Section 1248.7 of the Health and Safety Code is amended to read:

1248.7. (a) The board shall investigate all complaints concerning a violation of this chapter. With respect to any complaints relating to a violation of Section 1248.1, or upon discovery that an outpatient setting is not in compliance with Section 1248.1, the board ~~or~~ *shall investigate and, where appropriate, the board, through or in conjunction with* the local district attorney, shall bring an action to enjoin the outpatient setting's operation. The board or the local district attorney may bring an action to enjoin a violation or threatened violation of any other provision of this chapter in the superior court in and for the county in which the violation occurred or is about to occur. Any proceeding under this section shall conform to the requirements of Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, except that the Division of Medical Quality shall not be required to allege facts necessary to show or tending to show lack of adequate remedy at law or irreparable damage or loss.

(b) With respect to any and all actions brought pursuant to this section alleging an actual or threatened violation of any requirement of this chapter, the court shall, if it finds the allegations to be true, issue an order enjoining the person or facility from continuing the violation. For purposes of Section 1248.1, if an outpatient setting is operating without a certificate of accreditation, this shall be prima facie evidence that a violation of Section 1248.1 has occurred and additional proof shall not be necessary to enjoin the outpatient setting's operation.

SEC. 9. Section 1248.85 of the Health and Safety Code is amended to read:

1248.85. This chapter shall not preclude an approved accreditation agency from adopting additional standards consistent with Section 1248.15, establishing procedures for the conduct of onsite inspections, selecting onsite inspectors to perform accreditation onsite inspections, or establishing and collecting reasonable fees for the conduct of accreditation onsite inspections.

SEC. 10. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because

1 the only costs that may be incurred by a local agency or school
2 district will be incurred because this act creates a new crime or
3 infraction, eliminates a crime or infraction, or changes the penalty
4 for a crime or infraction, within the meaning of Section 17556 of
5 the Government Code, or changes the definition of a crime within
6 the meaning of Section 6 of Article XIII B of the California
7 Constitution.

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SB 233

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 233
Author: Pavley
Bill Date: July 14, 2011, amended
Subject: Emergency Services and Care
Sponsor: California Academy of Physician Assistants
Position: Support

STATUS OF BILL:

This bill is currently in Assembly Appropriations Committee

DESCRIPTION OF CURRENT LEGISLATION:

This bill would explicitly clarify that a physician assistant (PA) can provide treatment and consultation in an emergency care setting.

This bill was amended to specifically clarify that appropriate licensed persons (including PAs) acting within their scope of licensure can provide treatment and consultation in an emergency care setting. This bill further specifies that it does not expand the scope of licensure for licensed persons providing services under this bill.

Recent amendments make changes to the definition of "consultation". These changes are consistent with the Federal Emergency Medical Treatment and Labor Act (EMTALA) and the interpretive guidelines.

ANALYSIS:

Existing law allows PAs to provide evaluation, consultation, and treatment, as long as these services are performed pursuant to a PA's scope of practice and delegation of services agreement and under the supervision of a physician and surgeon.

The existing definition of "emergency services and care" in the health and safety code does not specifically list a PA as being allowed to give this treatment. Existing law says, "other appropriate personnel under the supervision of a physician". According to the author's office, an issue recently arose at Mission Hospital in Orange County, in which a PA was prohibited by the hospital from providing a "consult" in the emergency room. The hospital pointed to the existing law that this bill is proposing to amend as the reasoning because it does not explicitly authorize a PA to perform consulting and treatment in an emergency room setting.

This bill would have clarified existing law to explicitly authorize PAs to perform consulting and treatment, which is also in line with the Federal Emergency Medical Treatment and Labor Act (EMTALA), which permits PAs to provide consults in the emergency department.

As amended on May 4th and May 18th, instead of only applying to PAs, the bill now applies to all appropriate licensed persons. The bill now specifically clarifies that appropriate licensed persons (including PAs) acting within their scope of licensure can provide treatment and consultation in an emergency care setting. This bill further specifies that it does not expand the scope of licensure for licensed persons providing services under this bill. The purpose of these amendments is to not limit other mid-range practitioners in emergency departments from providing appropriate services. This bill would still make state law consistent with federal law.

The June 28th amendments make changes to the definition of "consultation". They add "other appropriate personnel acting pursuant to their scope of practice" to the definition, in addition to the "licensed persons acting within their scope of licensure" that was already in the bill.

Board staff and legal counsel have concerns with this language because all individuals that are consulting in an emergency room should be licensed individuals

The June 28th amendments also add to the definition of "consultation" and allow the treating physician to request to communicate directly with the consulting physician, when determined to be medically necessary jointly by both the treating and consulting physicians. The amendments also require the consulting physician to examine and treat the patient in person and state that the consulting physician is ultimately responsible for providing the necessary consultation to the patient, regardless of who makes the in-person appearance.

These changes are consistent with federal law and do not affect existing law in the Medical Practice Act as the bill specifies that they only apply to this article of the Health and Safety Code.

The July 11th amendments are clarifying and technical in nature and do not affect the Board or its support position.

The July 14th amendments strike "other appropriate personnel acting pursuant to their scope of practice" in the definition of consultation, which addresses the concern raised by Board staff and legal counsel.

SUPPORT: California Academy of Physician Assistants (Sponsor); Medical Board of California; and United Nurses Associations of California/Union of Healthcare Professionals

OPPOSITION: California Nurses Association

FISCAL: None

July 18, 2011

AMENDED IN ASSEMBLY JULY 14, 2011

AMENDED IN ASSEMBLY JULY 11, 2011

AMENDED IN ASSEMBLY JUNE 28, 2011

AMENDED IN SENATE MAY 18, 2011

AMENDED IN SENATE MAY 4, 2011

AMENDED IN SENATE MARCH 31, 2011

SENATE BILL No. 233

Introduced by Senator Pavley

February 9, 2011

An act to *repeal and* amend Section 1317.1 of the Health and Safety Code, relating to emergency services.

LEGISLATIVE COUNSEL'S DIGEST

SB 233, as amended, Pavley. Emergency services and care.

Existing law provides for the licensure and regulation of health facilities. A violation of these provisions is a crime. Existing law requires emergency services and care to be provided to any person requesting the services or care for any condition in which the person is in danger of loss of life, or serious injury or illness, at any licensed health facility. For the purposes of these provisions, emergency services and care is defined to include medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition or active labor, within the capability of the facility. Existing law defines consultation

as the rendering of an opinion, advice, or prescribing treatment by telephone and, when determined to be medically necessary jointly by the emergency and specialty physicians, includes review of the patient's record, examination, and treatment of the patient in person by a specialty physician who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient. Existing law also defines when stabilization of a patient has occurred.

This bill would recast the definition of emergency services and care to include other appropriate licensed persons acting within their scope of licensure under the supervision of a physician and surgeon. This bill would expand the definition of consultation to also mean the rendering of a decision regarding hospitalization or transfer and would provide that consultation includes review of the patient's medical record, examination, and treatment of the patient in person by a consulting physician and surgeon when determined to be medically necessary jointly by the treating physician and surgeon and the consulting physician and surgeon, or by other appropriate personnel acting within their scope of ~~practice or~~ licensure under the supervision of a treating physician and surgeon. The bill would authorize the treating physician and surgeon to request to communicate directly with the consulting physician and surgeon, and would require the consulting physician and surgeon to examine and treat the patient in person when it is determined to be medically necessary, as specified. This bill would expand the definition of when stabilization of a patient has occurred to include the opinion of other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon.

By expanding the definition of a crime, this bill would impose a state-mandated local program.

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

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

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

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

SECTION 1. Section 1317.1 of the Health and Safety Code, as amended by Section 91 of Chapter 886 of the Statutes of 1989, is repealed.

~~1317.1. Unless the context otherwise requires, the following definitions shall control the construction of this article:~~

~~(a) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.~~

~~(b) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:~~

~~(1) Placing the patient's health in serious jeopardy.~~

~~(2) Serious impairment to bodily functions.~~

~~(3) Serious dysfunction of any bodily organ or part.~~

~~(c) "Active labor" means a labor at a time at which either of the following would occur:~~

~~(1) There is inadequate time to effect safe transfer to another hospital prior to delivery.~~

~~(2) A transfer may pose a threat to the health and safety of the patient or the unborn child.~~

~~(d) "Hospital" means all hospitals with an emergency department licensed by the state department.~~

~~(e) "State department" means the State Department of Health Services.~~

~~(f) "Medical hazard" means a material deterioration in, or jeopardy to, a patient's medical condition or expected chances for recovery.~~

~~(g) "Board" means the Medical Board of California.~~

~~(h) "Within the capability of the facility" means those capabilities which the hospital is required to have as a condition of its emergency medical services permit and services specified~~

~~on Services Inventory Form 7041 filed by the hospital with the Office of Statewide Health Planning and Development.~~

~~(i) "Consultation" means the rendering of an opinion, advice, or prescribing treatment by telephone and, when determined to be medically necessary jointly by the emergency and the specialty physicians, includes review of the patient's medical record, examination and treatment of the patient in person by a specialty physician who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient.~~

~~SECTION 1.~~

SEC. 2. Section 1317.1 of the Health and Safety Code, as amended by Section 1 of Chapter 423 of the Statutes of 2009, is amended to read:

1317.1. Unless the context otherwise requires, the following definitions shall control the construction of this article and Section 1371.4:

(a) (1) "Emergency services and care" means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons acting within their scope of licensure under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

(2) (A) "Emergency services and care" also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

(B) The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or to an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, pursuant to subdivision (k). Nothing in this subparagraph shall be construed to permit a transfer that is in conflict with the

1 Lanterman-Petris-Short Act (Part 1 (commencing with Section
2 5000) of Division 5 of the Welfare and Institutions Code).
3 (C) For the purposes of Section 1371.4, emergency services and
4 care as defined in subparagraph (A) shall not apply to Medi-Cal
5 managed care plan contracts entered into with the State Department
6 of Health Care Services pursuant to Chapter 7 (commencing with
7 Section 14000), Chapter 8 (commencing with Section 14200), and
8 Chapter 8.75 (commencing with Section 14590) of Part 3 of
9 Division 9 of the Welfare and Institutions Code, to the extent that
10 those services are excluded from coverage under those contracts.
11 (D) This paragraph does not expand, restrict, or otherwise affect
12 the scope of licensure or clinical privileges for clinical
13 psychologists or other medical personnel.
14 (b) "Emergency medical condition" means a medical condition
15 manifesting itself by acute symptoms of sufficient severity
16 (including severe pain) such that the absence of immediate medical
17 attention could reasonably be expected to result in any of the
18 following:
19 (1) Placing the patient's health in serious jeopardy.
20 (2) Serious impairment to bodily functions.
21 (3) Serious dysfunction of any bodily organ or part.
22 (c) "Active labor" means a labor at a time at which either of the
23 following would occur:
24 (1) There is inadequate time to effect safe transfer to another
25 hospital prior to delivery.
26 (2) A transfer may pose a threat to the health and safety of the
27 patient or the unborn child.
28 (d) "Hospital" means all hospitals with an emergency department
29 licensed by the state department.
30 (e) "State department" means the State Department of Public
31 Health.
32 (f) "Medical hazard" means a material deterioration in medical
33 condition in, or jeopardy to, a patient's medical condition or
34 expected chances for recovery.
35 (g) "Board" means the Medical Board of California.
36 (h) "Within the capability of the facility" means those
37 capabilities that the hospital is required to have as a condition of
38 its emergency medical services permit and services specified on
39 Services Inventory Form 7041 filed by the hospital with the Office
40 of Statewide Health Planning and Development.

(i) "Consultation" means the rendering of an opinion, advice, prescribing treatment, or decision regarding hospitalization or transfer by telephone or other means of communication. When determined to be medically necessary, jointly by the treating physician and surgeon, or by other appropriate ~~personnel acting pursuant to their scope of practice and~~ licensed persons acting within their scope of licensure, under the supervision of a physician and surgeon, and the consulting physician and surgeon, "consultation" includes review of the patient's medical record, examination, and treatment of the patient in person by a consulting physician and surgeon, or by other appropriate licensed persons acting within their scope of licensure under the supervision of a consulting physician and surgeon, who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient. A request for consultation shall be made by the treating physician and surgeon, or by other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon, provided the request is made with the contemporaneous approval of the treating physician and surgeon. The treating physician and surgeon may request to communicate directly with the consulting physician and surgeon, and when determined to be medically necessary, jointly by the treating physician and surgeon and the consulting physician and surgeon, the consulting physician and surgeon shall examine and treat the patient in person. The consulting physician and surgeon is ultimately responsible for providing the necessary consultation to the patient, regardless of who makes the in-person appearance.

(j) A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating physician and surgeon, or other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient as provided for in Section 1317.2, Section 1317.2a, or other pertinent statute.

(k) (1) "Psychiatric emergency medical condition" means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

(A) An immediate danger to himself or herself or to others.

(B) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

(2) This subdivision does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or medical personnel.

(*l*) This section shall not be construed to expand the scope of licensure for licensed persons providing services pursuant to this section.

~~SEC. 2.~~

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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SB 380

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 380
Author: Wright
Bill Date: June 20, 2011, amended
Subject: Continuing Medical Education
Sponsor: California Academy of Preventive Medicine

STATUS OF BILL:

This bill is in the Assembly.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require specified physicians and surgeons to complete a one-time continuing medical education (CME) course within a four year period in the subject of nutrition and lifestyle behavior for the prevention and treatment of chronic diseases.

This bill was amended and no longer requires mandated CME. The current version of this bill would authorize the Medical Board of California (the Board) to set content standards for any educational activity concerning a chronic disease that includes appropriate information on the impact, prevention, and cure of the chronic disease by the application of changes in nutrition and lifestyle behavior.

Recent amendments require the Board to periodically disseminate information and educational material regarding the prevention and treatment of chronic disease by the application of changes in nutrition and lifestyle behavior to each licensed physician and surgeon and to each general acute care hospital in California. Recent amendments also require the Board to convene a working group of interested parties to discuss nutrition and lifestyle behavior for the prevention and treatment of chronic disease at a quarterly board meeting within three years of the effective date of this bill.

ANALYSIS:

Existing law requires physicians and surgeons to complete at least 50 hours of approved CME during each two year license renewal cycle. Currently, physicians and surgeons only have a mandatory one-time CME requirement of 12 credit hours in the subject of pain management and the treatment of the terminally ill. There is also a mandate in existing law that requires general internists and family physicians who have a patient population of which over 25 percent are 65 years of age or older to complete at least 20 percent of all mandatory CME in a course in the field of geriatric medicine or the care of older patients.

This bill would have required practicing primary care physicians and all other physicians and surgeons who provide care or consultation for chronic disease to complete a mandatory continuing education course in the subject of nutrition and lifestyle behavior for the prevention and treatment of chronic diseases. This would have been a one-time requirement of seven credit hours that must be completed by December 31, 2016. Physicians licensed on and after January 1, 2012 must have completed the requirement within four years or by their second renewal date. This bill would have allowed the Board to verify completion of the requirement on the annual renewal form. This bill does not apply to physicians and surgeons practicing in pathology or radiology specialty areas or who do not reside in California.

This bill makes findings and declarations related to health care costs for chronic disease treatment and the last World Health Organization Report that concluded diet was a major factor in the cause of chronic diseases. The findings also state that practicing physicians rate their nutrition knowledge and skills as inadequate. Every physician has the opportunity to treat patients at risk for chronic disease or that suffer from poor nutrition or lifestyle choices. According to the author's office, chronic conditions are avoidable, but responsible for 7 out of 10 deaths among Americans each year. The author's office believes that education is the key in prevention and reducing health care costs, but states that medical students receive fewer than 20 contact hours of nutrition instruction during their entire medical school careers. One of the Board's medical consultants confirmed this to be true. The Board's medical consultant also stated the little emphasis is put on nutrition and lifestyle behavior as it relates to preventing and treating chronic diseases in medical schools and residencies.

The April 27th amendments were made to address opposition's concerns related to mandating CME; this bill no longer mandates CME. This bill would now authorize the Board to set content standards for any educational activity concerning a chronic disease that includes appropriate information on the impact, prevention, and cure of the chronic disease by the application of changes in nutrition and lifestyle behavior. It is important to note that this bill only allows the board to set content standards; it does not require the Board to do so.

The June 20th amendments would require the Board to periodically disseminate information and educational material regarding the prevention and treatment of chronic disease by the application of changes in nutrition and lifestyle behavior to each licensed physician and surgeon and to each general acute care hospital in California. This could be done through articles in the newsletter and this information could be provided to GACHs through a joint effort with the California Department of Public Health.

The June 20th amendments also would require the Board to convene a working group of interested parties to discuss nutrition and lifestyle behavior for the prevention and treatment of chronic disease at a quarterly board meeting within three years of the effective date of this bill.

There is a noted prevalence of preventable chronic diseases in California and it is true that medical students do not receive much training in nutrition instruction. The language recently added to the bill will help to ensure that physicians receive educational material on the prevention and treatment of chronic disease by the application of changes in nutrition and lifestyle behavior and also open up this topic for discussion at one of the Board's quarterly meetings. As such, the Board is suggesting a neutral position on this bill.

SUPPORT: California Academy of Preventive Medicine (Sponsor); American College for Lifestyle Medicine; Center for Science in the Public Interest; Physicians Committee for Responsible Medicine; and several individuals.

OPPOSITION: None on file

FISCAL: Minimal and absorbable

POSITION: Recommendation: Neutral

June 21, 2011

AMENDED IN ASSEMBLY JUNE 20, 2011

AMENDED IN SENATE APRIL 27, 2011

AMENDED IN SENATE APRIL 7, 2011

AMENDED IN SENATE MARCH 23, 2011

SENATE BILL No. 380

Introduced by Senator Wright

February 15, 2011

An act to amend Section 2190 of, *and to add Sections 2196.6 and 2196.7 to,* the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

SB 380, as amended, Wright. Continuing medical education.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under that act, the board is required to adopt and administer standards for the continuing education of physicians and surgeons. Existing law requires physicians and surgeons to complete a mandatory continuing education course in the subjects of pain management and the treatment of terminally ill and dying patients, except that it does not apply to physicians and surgeons practicing in pathology or radiology specialty areas. *Existing law also requires the board to periodically disseminate information and educational material regarding detection of spousal or partner abuse to physicians and surgeons and acute care hospitals.*

This bill would authorize the board to also set content standards for an educational activity concerning chronic disease, as specified. *The bill would require the board to periodically disseminate information and educational material regarding nutritional and lifestyle behavior*

for prevention and treatment of chronic disease to physicians and surgeons and acute care hospitals. The bill would require the board to convene a working group regarding nutrition and lifestyle behavior, 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. The Legislature finds and declares all of the
2 following:
3 (a) In 2008, U.S. health care spending was about $7,681 per
4 resident and accounted for 16.2 percent of the nation's gross
5 domestic product; this is among the highest of all industrialized
6 countries. Expenditures in the United States on health care
7 surpassed $2.3 trillion in 2008, more than three times the $714
8 billion spent in 1990, and over eight times the $253 billion spent
9 in 1980.
10 (b) It is estimated that health care costs for chronic disease
11 treatment account for over 75 percent of national health
12 expenditures.
13 (c) Seven out of 10 deaths among Americans each year are from
14 chronic diseases. Heart disease, cancer, and stroke account for
15 more than 50 percent of all deaths each year.
16 (d) The last major report from the World Health Organization
17 in March 2003 concluded diet was a major factor in the cause of
18 chronic diseases.
19 (e) Dramatic increases in chronic diseases have been seen in
20 Asian countries since the end of WWII with the increase in the
21 gross national product and change to the western diet.
22 (f) Only 19 percent of students believed that they had been
23 extensively trained in nutrition counseling. Fewer than 50 percent
24 of primary care physicians include nutrition or dietary counseling
25 in their patient visits.
26 (g) Practicing physicians continually rate their nutrition
27 knowledge and skills as inadequate. More than one-half of
28 graduating medical students report that the time dedicated to
29 nutrition instruction is inadequate.
30 SEC. 2. Section 2190 of the Business and Professions Code is
31 amended to read:

2190. In order to ensure the continuing competence of licensed physicians and surgeons, the board shall adopt and administer standards for the continuing education of those licensees. The board may also set content standards for any educational activity concerning a chronic disease that ~~includes appropriate information on the impact, prevention, and cure of the chronic disease by the application of changes in~~ *includes appropriate information on prevention of the chronic disease, and on treatment of patients with the chronic disease, by the application of changes in* nutrition and lifestyle behavior. The board shall require each licensed physician and surgeon to demonstrate satisfaction of the continuing education requirements at intervals of not less than four nor more than six years.

SEC. 3. Section 2196.6 is added to the Business and Professions Code, to read:

2196.6. The board shall periodically disseminate information and educational material regarding the prevention and treatment of chronic disease by the application of changes in nutrition and lifestyle behavior to each licensed physician and surgeon and to each general acute care hospital in the state.

SEC. 4. Section 2196.7 is added to the Business and Professions Code, to read:

2196.7. The board shall convene a working group of interested parties to discuss nutrition and lifestyle behavior for the prevention and treatment of chronic disease at one of its quarterly meetings within three years after the operative date of this section.

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SB 824

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 824
Author: Negrete McLeod
Bill Date: June 23, 2011, amended
Subject: Opticians: Regulation
Sponsor: LensCrafters (co-sponsor), Target Optical (co-sponsor), and Sears Optical (co-sponsor)
Position: Support

STATUS OF BILL:

This bill is currently in the Assembly.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require a registered dispensing optician (RDO) acquiring ownership of a business to file the notice with the Medical Board of California (the Board) within 10 days of the completion of the transfer of ownership. This bill would also make the RDO selling or transferring the ownership interest responsible for complying with all laws relating to the place of business until the cancellation notice is received by the Board.

This bill was amended and now only puts the 10 day time line on the RDO assuming ownership of the business. The amendments also make a technical change.

ANALYSIS:

Existing law requires individuals, corporations, and firms to apply to the Board for registration as a dispensing optician. When the Board approves an application, it issues a certificate of dispensing optician to the applicant. Each certificate shall be displayed at all times in a conspicuous place at the certified place of business.

According to the sponsors, the requirement that the certificate be posted is hard to comply with during a change of ownership, as the registration documents must be furnished to the Board. This can leave an RDO without a certificate for a period of time while the registration is being processed. Recently Sears and Target Optical went through an internal change of ownership. Their interpretation of the law required each store to file new registrations the same day the switch in ownership occurred, which was time consuming. They believe this bill will provide a process that allows the RDO to remain open while the documents are being processed.

Currently, the Board sometimes has issues receiving both the new RDO application and the notice of cancellation for the RDO selling or transferring the

ownership in the same time period. The Board first has to process the notice of cancellation before the new certificate of dispensing optician can be issued to the applicant. The Board believes that putting a 10 day timeline on both parties to get their required paper work in to the Board will make this process run more smoothly and effectively for the Board. This bill also makes it clear that the RDO selling or transferring ownership is the responsible party until the notice of cancellation is received by the Board.

The June 23rd amendments now only put the 10 day time line on the RDO assuming ownership of the business. This does affect the Board's Support position because the bill no longer puts the 10 time line on both parties and will no longer help make the Board's process run more smoothly and effectively. As such, staff is recommending that the Board take a Neutral position on this bill.

SUPPORT: LensCrafters (co-sponsor); Target Optical (co-sponsor); and Sears Optical (co-sponsor).

OPPOSITION: None on file

FISCAL: None

POSITION: Recommendation: Neutral

July 8, 2011

AMENDED IN ASSEMBLY JUNE 23, 2011

SENATE BILL No. 824

Introduced by Senator Negrete McLeod

February 18, 2011

An act to add Section 2553.1 to the Business and Professions Code, relating to opticians.

LEGISLATIVE COUNSEL'S DIGEST

SB 824, as amended, Negrete McLeod. Opticians: regulation.

Existing law requires that dispensing opticians register with the ~~Division of Licensing of the~~ Medical Board of California *prior to engaging in the practice of a dispensing optician*. Under existing law, a registered dispensing optician is required to obtain and display a separate certificate of registration at each location where his or her business is conducted. Existing law makes a violation of laws regulating a registered dispensing optician a misdemeanor.

This bill would require a registered dispensing optician acquiring ownership of a business to file a notice with the board within 10 days of the completion of the transfer of ownership to him or her. The bill would specify that until receipt of the notice by the board, the registered dispensing optician selling or transferring the interest remains responsible for complying with all laws regulating the business.

Because a violation of laws regulating registered dispensing opticians is a crime, this bill would impose a state-mandated local program by creating a new crime.

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 2553.1 is added to the Business and
2 Professions Code, to read:
3 2553.1. If a registered dispensing optician sells or transfers in
4 any ~~matter on~~ *manner an* ownership interest in his or her place of
5 business, the registered dispensing optician assuming the ownership
6 of the business shall record with the board a written notice of the
7 change of ownership, providing all information required by the
8 board. The registered dispensing optician *assuming the ownership*
9 *of the business* shall file the notice with the board no later than 10
10 calendar days after the change of ownership is completed. The
11 registered dispensing optician selling or transferring the ownership
12 interest in his or her business shall be responsible for complying
13 with all laws relating to the place of business until the notice is
14 received by the board. This section does not apply to a change of
15 location of business by a registered dispensing optician.
16 SEC. 2. No reimbursement is required by this act pursuant to
17 Section 6 of Article XIII B of the California Constitution because
18 the only costs that may be incurred by a local agency or school
19 district will be incurred because this act creates a new crime or
20 infraction, eliminates a crime or infraction, or changes the penalty
21 for a crime or infraction, within the meaning of Section 17556 of
22 the Government Code, or changes the definition of a crime within
23 the meaning of Section 6 of Article XIII B of the California
24 Constitution.

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SB 943

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 943
Author: Senate Business, Professions and Economic Development Committee
Bill Date: July 12, 2011, amended
Subject: Omnibus/Polysomnography
Sponsor: Committee

STATUS OF BILL:

This bill is in Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the vehicle by which omnibus legislation has been carried by the Senate Business and Professions Committee. This analysis will only cover the portion of the bill that impacts the Medical Board of California (the Board).

This omnibus bill clarifies the grandfathering provisions in existing law related to polysomnographic technologists. This bill would authorize current practitioners to be grandfathered in by allowing them to apply for registration as a certified polysomnographic technologist if they submit proof to the Board of five years of experience in practicing polysomnography in a manner that is acceptable to the Board. The grandfathering provision language would allow current practitioners three years to meet the new requirements for certification as a polysomnographic technologist.

Recent amendments do not affect the portion of the bill that impacts the Board.

ANALYSIS

SB 132 (Denham), Chapter 635, Statutes of 2009 established a certification program for sleep professionals assisting physicians in the practice of sleep medicine. The Board is responsible for administering this Polysomnography program. In order to prevent a flood of applications for initial certification, a grandfathering provision was added to grandfather in current practitioners with practice experience.

However, the grandfathering provision was drafted in a manner that is ambiguous and can be interpreted as meaning that there in effect is no grandfathering provision because the granfathering language was added to existing paragraph (3), as opposed to being drafted to add a new paragraph. This created the ambiguity that the grandfathering provision potentially only applies to the requirements of paragraph (3). Under this interpretation, there would in effect be no grandfathering provision.

When SB 132 was being drafted and discussed, it was the intent of the Legislature and interested parties that the grandfathering language be included in order to allow time for current practitioners to meet the new requirements and to make the workload for the Board more manageable by ensuring that the Board does not receive a flood of new applicants for certification.

This bill would clarify existing law and allow practitioners applying for certification as polysomnographic technologists to satisfy the qualifications for certification by submitting proof to the board that he or she has been practicing polysomnography for at least five years in a manner that is acceptable to the Board.

This clarifying language will reflect the original intent of SB 132 and allow the Board to correctly implement the grandfathering provision. Further, this provision will help to ensure that there is not a disruption in patient access to sleep medicine services from the lack of a grandfathering provision and will prevent hospitals and clinics from experiencing a shortage of health professionals assisting physicians in the practice of sleep medicine. Staff recommends that he Board support the provision in this bill related to the Polysomnography program.

FISCAL: None to the Board

SUPPORT: California Sleep Society

OPPOSITION: None on file

POSITION: Recommendation: Support provisions related to the Polysomnography Program.

July 18, 2011

AMENDED IN SENATE MAY 11, 2011

SENATE BILL No. 943

Introduced by Committee on Business, Professions and Economic Development (Senators Price (Chair), Corbett, Correa, Emmerson, Hernandez, Negrete McLeod, Vargas, Walters, and Wyland)

March 31, 2011

An act to amend Sections 1916, 1918, 1922, 1927, 1950, 1952, 1955, 1957, 1959, 1961, 1962, 1963, 1966.1, 2736.5, 2836.2, 2936, *3519, 3575,* 4200, *4836.1,* 4980.36, 4980.37, 4980.40.5, 4980.42, ~~4980.43,~~ 4980.45, 4982.25, 4989.54, 4990.38, 4992.3, 4992.36, 4996.13, 4996.24, 4999.12, and 4999.90 of, to add Sections 1902.1, 4999.91, and 4999.455 to, and to repeal Section 1945 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 943, as amended, Committee on Business, Professions and Economic Development. Healing arts.

Existing law provides for the licensure and regulation of various healing arts licensees by boards within the Department of Consumer Affairs.

(1) Existing law, the Dental Practice Act, provides for the licensure and regulation of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions by the Dental Hygiene Committee of California within the Dental Board of California.

Existing law requires applicants for licensure to provide fingerprint images for submission to governmental agencies, in order to, among other things, establish the identity of the applicant. Existing law requires

questions or complaints, you may contact the board on the Internet at www.psychboard.ca.gov, by calling 1-866-503-3221, or by writing to the following address:

Board of Psychology

2005 Evergreen Street, Suite 1400
Sacramento, California 95815-3894"

SEC. 19. Section 3519 of the Business and Professions Code is amended to read:

3519. The committee shall issue under the name of the Medical Board of California a license to all physician assistant applicants who meet all of the following requirements:

(a) Provide evidence of ~~one of the following:~~

~~(1) Successful~~ *successful* completion of an approved program.

~~(2) Successful completion in a medical school approved by the Division of Licensing of a resident course of professional instruction which meets the requirements of Sections 2088 and 2089.~~

(b) Pass any examination required under Section 3517.

(c) Not be subject to denial of licensure under Division 1.5 (commencing with Section 475) or Section 3527.

(d) Pay all fees required under Section 3521.1.

SEC. 20. Section 3575 of the Business and Professions Code is amended to read:

3575. (a) For the purposes of this chapter, the following definitions shall apply:

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

(2) "Polysomnography" means the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders. Polysomnography shall include, but not be limited to, the process of analysis, monitoring, and recording of physiologic data during sleep and wakefulness to assist in the treatment of disorders, syndromes, and dysfunctions that are sleep-related, manifest during sleep, or disrupt normal sleep activities. Polysomnography shall also include, but not be limited to, the therapeutic and diagnostic use of oxygen, the use of positive airway pressure including continuous positive airway pressure (CPAP) and bilevel modalities, adaptive servo-ventilation, and

maintenance of nasal and oral airways that do not extend into the trachea.

(3) "Supervision" means that the supervising physician and surgeon shall remain available, either in person or through telephonic or electronic means, at the time that the polysomnographic services are provided.

(b) *(1)* Within one year after the effective date of this chapter, the board shall promulgate regulations relative to the qualifications for the registration of individuals as certified polysomnographic technologists, polysomnographic technicians, and polysomnographic trainees. The qualifications for a certified polysomnographic technologist shall include all of the following:

~~(1)~~

(A) He or she shall have valid, current credentials as a polysomnographic technologist issued by a national accrediting agency approved by the board.

~~(2)~~

(B) He or she shall have graduated from a polysomnographic educational program that has been approved by the board.

~~(3)~~

(C) He or she shall have passed a national certifying examination that has been approved by the board~~, or in the alternative, may submit~~.

(2) An applicant for registration as a certified polysomnographic technologist may satisfy the qualifications described in paragraph (1) by submitting proof to the board that he or she has been practicing polysomnography for at least five years in a manner that is acceptable to the board. However, beginning three years after the effective date of this chapter, all individuals seeking to obtain certification as a polysomnographic technologist shall have passed a national certifying examination that has been approved by the board.

(c) In accordance with Section 144, any person seeking registration from the board as a certified polysomnographic technologist, a polysomnographic technician, or a polysomnographic trainee shall be subject to a state and federal level criminal offender record information search conducted through the Department of Justice as specified in paragraphs (1) to (5), inclusive, of this subdivision.

(1) The board shall submit to the Department of Justice fingerprint images and related information required by the Department of Justice of all polysomnographic technologist, technician, or trainee certification candidates for the purposes of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and also information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her recognizance pending trial or appeal.

(2) When received, the Department of Justice shall forward to the Federal Bureau of Investigation requests for federal summary criminal history information received pursuant to this subdivision. The Department of Justice shall review the information returned from the Federal Bureau of Investigation and compile and disseminate a response to the board.

(3) The Department of Justice shall provide state and federal responses to the board pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(4) The board shall request from the Department of Justice subsequent arrest notification service, pursuant to Section 11105.2 of the Penal Code, for persons described in this subdivision.

(5) The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this subdivision. The individual seeking registration shall be responsible for this cost.

(d) An individual may use the title "certified polysomnographic technologist" and may engage in the practice of polysomnography only under the following circumstances:

(1) He or she is registered with the board and has successfully undergone a state and federal level criminal offender record information search pursuant to subdivision (c).

(2) He or she works under the supervision and direction of a licensed physician and surgeon.

(3) He or she meets the requirements of this chapter.

(e) Within one year after the effective date of this chapter, the board shall adopt regulations that establish the means and circumstances in which a licensed physician and surgeon may employ polysomnographic technicians and polysomnographic trainees. The board may also adopt regulations specifying the scope

of services that may be provided by a polysomnographic technician or polysomnographic trainee. Any regulation adopted pursuant to this section may specify the level of supervision that polysomnographic technicians and trainees are required to have when working under the supervision of a certified polysomnographic technologist or licensed health care professional.

(f) This section shall not apply to California licensed allied health professionals, including, but not limited to, respiratory care practitioners, working within the scope of practice of their license.

(g) Nothing in this chapter shall be interpreted to authorize a polysomnographic technologist, technician, or trainee to treat, manage, control, educate, or care for patients other than those with sleep disorders or to provide diagnostic testing for patients other than those with suspected sleep disorders.

~~SEC. 19.~~

SEC. 21. Section 4200 of the Business and Professions Code is amended to read:

4200. (a) The board may license as a pharmacist an applicant who meets all the following requirements:

(1) Is at least 18 years of age.

(2) (A) Has graduated from a college of pharmacy or department of pharmacy of a university recognized by the board; or

(B) If the applicant graduated from a foreign pharmacy school, the foreign-educated applicant has been certified by the Foreign Pharmacy Graduate Examination Committee.

(3) Has completed at least 150 semester units of collegiate study in the United States, or the equivalent thereof in a foreign country. No less than 90 of those semester units shall have been completed while in resident attendance at a school or college of pharmacy.

(4) Has earned at least a baccalaureate degree in a course of study devoted to the practice of pharmacy.

(5) Has completed 1,500 hours of pharmacy practice experience or the equivalent in accordance with Section 4209.

(6) Has passed the North American Pharmacist Licensure Examination and the California Practice Standards and Jurisprudence Examination for Pharmacists on or after January 1, 2004.

(b) Proof of the qualifications of an applicant for licensure as a pharmacist shall be made to the satisfaction of the board and shall

TRACKER II

Medical Board of California
Tracker II - Legislative Bills
7/18/2011

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 70	Monning	CHHS: Public Health: Federal Grant Opportunities	2-year	
AB 127	Logue	Regulations: Effective Date	2-year	
AB 137	Portantino	Health Care Coverage: Mammographies	2-year	
AB 172	Eng	Public Contracts: Information: Web site	Senate	07/13/11
AB 174	Monning	Health Information Exchange	2-year	03/21/11
AB 186	Williams	Reportable Diseases and Conditions	Sen. Approps - Susp.	03/30/11
AB 242	Rev. & Tax	Income Taxes: Federal Health Care	Sen. Approps	06/29/11
AB 273	Valadao	Regulations: Economic Impacts Review	2-year	
AB 300	Ma	Safe Body Art Act	Senate	06/30/11
AB 377	Solorio	Pharmacy	Sen. Approps	04/14/11
AB 386	Galgiani	Prisons: Telehealth Systems	2-year	05/11/11
AB 389	Mitchell	Bleeding Disorders	Sen. Approps	03/30/11
AB 393	Wagner	APA: Legislative Intent	2-year	
AB 425	Nestande	State Regulations: Review	2-year	
AB 428	Portantino	Health Care Coverage: Fertility Preservation	2-year	04/27/11
AB 439	Skinner	Health Care Information	2-year	06/28/11
AB 499	Atkins	Minors: Medical Care: Consent	Sen. Approps	
AB 530	Smyth	Regulations: Economic and Technical Information	2-year	03/31/11
AB 655	Hayashi	Healing Arts: Peer Review	Senate	07/06/11
AB 673	Perez, J.	Office of Multicultural Health: LGBT Communities	Sen. Approps - Susp.	06/01/11

Medical Board of California
Tracker II - Legislative Bills
7/18/2011

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 675	Hagman	Continuing Education	2-year	04/05/11
AB 678	Pan	Medi-Cal: Supplemental Provider Reimbursement	Sen. Approps - Susp.	05/27/11
AB 714	Atkins	Health Care Coverage: California Health Benefit Exchange	Sen. Approps	06/30/11
AB 740	Blumenfield	Personal Services Contracts	Sen. Approps	
AB 778	Atkins	Health Care Service Plans: Vision Care	2-year	06/21/11
AB 847	Lowenthal, B.	Pharmacy: Clinics	2-year	
AB 916	Perez, M.	Promotores: Medically Underserved Communities: Federal Grants	Senate	05/27/11
AB 917	Olsen	State Agencies: Sunset Review	2-year	
AB 922	Monning	Office of Health Consumer Assistance	Sen. Approps	06/20/11
AB 951	Perea	State Employees: Memorandum of Understanding	Assembly	06/13/11
AB 991	Olsen	State Gov't: Licenses: California Licensing & Permit Center	2-year	04/13/11
AB 1003	Smyth	Professional and Vocational Licenses	2-year	
AB 1078	Grove	Legislature: Former Members: State Boards and Commissions	2-year	
AB 1088	Eng	State Agencies: Collection of Demographic Data	Sen. Approps	06/21/11
AB 1192	Garrick	Immunization Information: Pertussis	2-year	04/25/11
AB 1213	Nielsen	Regulations	2-year	04/12/11
AB 1217	Fuentes	Assisted Reproductive Technology: Parentage	2-year	06/20/11
AB 1280	Hill	Ephedrine: Retail Sale	Sen. Approps	05/26/11
AB 1296	Bonilla	Health Care Eligibilty, Enrollment, and Retention Act	Sen. Approps	07/13/11
AB 1322	Bradford	Regulations: Principles of Regulation	2-year	04/15/11
AB 1328	Pan	Clinical Laboratories	2-year	03/31/11
AB 1424	Perea	Franchise Tax Board: Delinquent Tax Debt	Sen. Approps	07/12/11
ABX1 3	Logue	Regulations: 5-Year Review and Report	Assembly	

Medical Board of California
Tracker II - Legislative Bills
7/18/2011

BILL	AUTHOR	TITLE	STATUS	AMENDED
ABX1 4	Logue	Regulations: Effective Date	Assembly	
ABX1 5	Logue	Regulations: Legislative Notice	Assembly	
ABX1 6	Logue	Regulations: Economic Impacts Review	Assembly	
AJR 10	Brownley	School-Based Health Centers	Enrollment	05/02/11
SB 38	Padilla	Radiation Control: Health Facilities and Clinics: Records	Enrollment	03/29/11
SB 41	Yee	Hypodermic Needles and Syringes	Assembly	06/28/11
SB 103	Liu	State Government: Meetings	Asm. Approps	07/12/11
SB 173	Simitian	Healing Arts: Mammograms	Asm. Approps	05/31/11
SB 227	Wyland	Business and Professions: Licensure	2-year	
SB 231	Emmerson	Regulatory Boards: Healing Arts	2-year	
SB 236	Anderson	California Public Records Act	2-year	
SB 252	Vargas	Public Contracts: Personal Services	2-year	05/31/11
SB 347	Rubio	Graduate Medical Education Payments: Medi-Cal	2-year	03/21/11
SB 360	DeSaulnier	Controlled Substance Utilization Review and Eval. System	Asm. Approps	07/07/11
SB 393	Hernandez	Medical Homes	2-year	05/31/11
SB 396	Huff	Regulations: Review Process	2-year	04/07/11
SB 399	Huff	Healing Arts: Advertising	2-year	
SB 411	Price	Home Care Services Act of 2011	Asm. Approps	07/12/11
SB 442	Calderon	Hospitals: Interpreters	Asm. Approps	04/26/11
SB 538	Price	Nursing	Asm. Approps	06/27/11
SB 553	Fuller	Regulations: Effective Date	2-year	04/05/11
SB 616	DeSaulnier	Medi-Cal: Grants	2-year	04/26/11
SB 628	Yee	Acupuncture: Regulation	2-year	06/29/11

Medical Board of California
Tracker II - Legislative Bills
7/18/2011

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 667	Runner	Naturopathic Doctor	2-year	03/31/11
SB 728	Hernandez	Health Care Coverage	2-year	05/31/11
SB 742	Yee	Medicine	2-year	
SB 746	Lieu	Tanning Facilities	Asm. Approps	03/22/11
SB 747	Kehoe	Continuing Education: LGBT Patients	Asm. Approps - Susp.	06/13/11
SB 850	Leno	Medical Records: Confidential Information	Asm. Approps	06/22/11
SB 924	Walters	Physical Therapists: Direct Access	2-year	05/24/11
SB 946	Heath Comm.	Public Health	Asm. Approps	05/10/11
SJR 6	Kehoe	Survivors of Torture	Chapter, #45	6/22/2011

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***
Polysomno-graphy Program	Staff finalizing file	7/30/10	9/10/10	11/5/10	2/22/11			
Limited Practice License	Pending review at OAL	7/30/10	9/10/10	11/5/10	11/5/10	To DCA 5/12/11, approved by SCSA 6/8/11; approved by DOF 7/5/11	7/8/11	
Disciplinary Guidelines – 2010	Pending review at DCA	7/30/10	9/17/10	11/5/10	1/24/11	To DCA 6/28/11		
Sponsored Free Health Care Events	Modified text: 15-day public comment period ended 7/5/11; staff finalizing file	1/28/11	3/11/11	5/6/11	7/5/11			
Clinical Training Programs–Intern'l Medical Students	Pending review at DCA	1/28/11	3/11/11	5/6/11	5/6/11	To DCA 6/8/11; to SCSA 6/28/11		
Non-substantive changes from all units (Section 100 changes)	Next review of MBC regulations pending Fall 2011							

* - 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

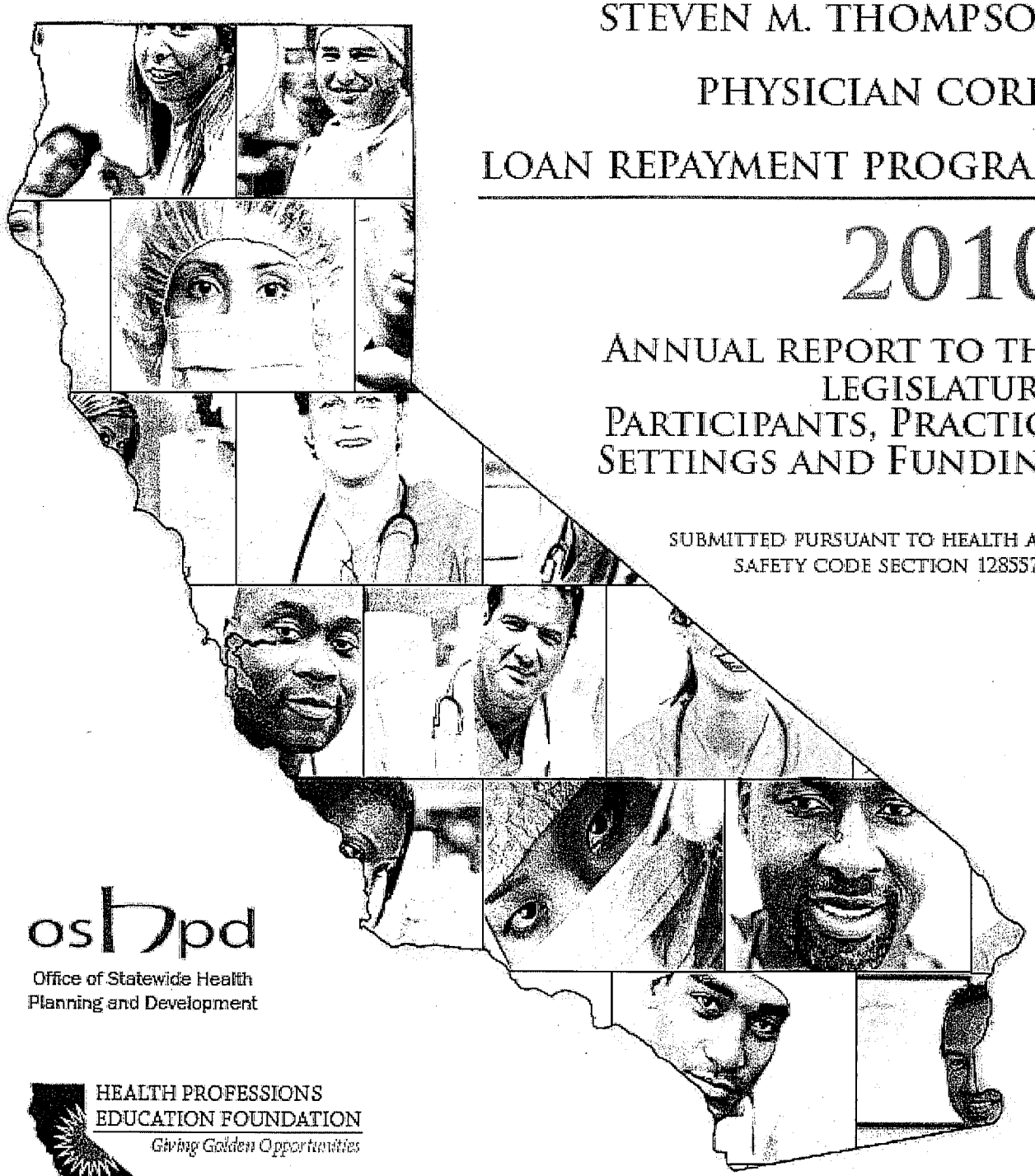
Prepared by Kevin A. Schunke
Updated July 8, 2011
For questions, call (916) 263-2368

STEVEN M. THOMPSON PHYSICIAN CORPS LOAN REPAYMENT PROGRAM

2010

ANNUAL REPORT TO THE LEGISLATURE: PARTICIPANTS, PRACTICE SETTINGS AND FUNDING

SUBMITTED PURSUANT TO HEALTH AND SAFETY CODE SECTION 128557(a).



oshpd

Office of Statewide Health Planning and Development

HEALTH PROFESSIONS EDUCATION FOUNDATION

Giving Golden Opportunities

PREPARED BY THE HEALTH PROFESSIONS EDUCATION FOUNDATION

Executive Summary

The Health Professions Education Foundation (Foundation) is required to submit an annual report to the California State Legislature documenting the performance of the Steven M. Thompson Physician Corps Loan Repayment Program (STLRP). In 2010, 63 applicants requested approximately $5,036,259.21 in loan repayments. Twenty nine applicants were awarded $2,809,820.66 in loan repayments. **Twelve applications were incomplete or ineligible.** The Foundation continues to expect a high demand for this program and will continue to seek additional revenue sources to meet its program objectives.

Issue Statement

Health and Safety Code Section 128557 (a) requires the Foundation to submit an annual report to the Legislature for the Steven M. Thompson Physician Corps Loan Repayment Program (STLRP), documenting the following five requirements: number of program participants, name and location of practice settings, amount of funds expended, information from annual performance reviews, and an update on the status and statistics for the Physician Volunteer Program. To date, the Physician Volunteer Program has not been implemented therefore there are no statistics available for this program. This report is being submitted as required by statute.

Background

The STLRP was created in 2003 to increase the accessibility of healthcare and promote the longevity of primary care physicians in medically underserved areas of California. Physicians and surgeons can receive up to $105,000 in exchange for providing direct patient care in a medically underserved area for a minimum of three years.

The application deadline for the STLRP is scheduled annually in the spring. Pursuant to Health and Safety Code 128553 section (c)(5)(d)(2), "the selection committee may fill up to 20 percent of the available positions with program applicants from specialties outside of the primary care specialties." Thus, 80 percent of available funds will be allocated for applicants who have completed a three-year postgraduate residency in the areas of primary care including family practice, internal medicine, pediatrics or obstetrics and gynecology. Further, pursuant to the California Code of Regulations, Title 16, Division 13, Chapter 1, Article 3.1, Section1313.02 (b), "priority consideration is given to the applicants best suited to meet the cultural and linguistic needs of patients." The applicant is evaluated according to the following criteria:

- speaks a Medi-Cal threshold language;
- comes from an economically disadvantaged background;
- has received significant training in culturally and linguistically appropriate service delivery;
- has three years of experience working in a medically underserved area or with a medically underserved population; and
- has recently obtained a license to practice medicine in any state of the United States or Canada.

Objectives

This report will provide in detail the performance of STLRP in 2010. This will include documenting the number of program participants, name and location of practice settings, and amount of funds expended. As stated earlier, this report will not present information on the Physician Volunteer Program as this program has not been implemented to date.

Study Methodology

This report used various sources of information to document its findings. This included information from the Foundation's Health Professions Student Monitoring System (HPSAMS), the Office of Statewide Health Planning and Development (OSHPD) Budget Office and legislation that may impact the program's objectives. HPSAMS is the Foundation's internal monitoring system used to track demand for the program. This includes collecting information such as applications received and awarded, funds requested and awarded, and other demographic information on applicants and awardees including debt owed, specialties, and regions served. OSHPD's Budget Office was responsible for the financial monitoring and reporting of the funds collected and disbursed. Finally, the Foundation also tracked legislative initiatives with a potential impact to the program.

Two legislative measures in 2008 and one legislative measure in 2009 significantly impacted STLRP and were signed into law. Collectively, the three legislative measures resulted in an increase in program funding for the 2010 cycle. During the 2010 award cycle, the impact of the legislation was realized. The following information summarizes the intent of the bills (Appendix B provides a complete timeline of the legislation pertaining to the program):

AB 2439 (De la Torre, Chapter 640, Statutes of 2008) requires the Medical Board of California (Medical Board) to collect a mandatory $25 fee from physicians and surgeons at the time of initial licensure or biennial renewal to support the STLRP. It also allowed that up to 15 percent of the funds collected from the additional $25 fee be dedicated to loan assistance for physicians who agree to practice in geriatric care settings or settings that primarily serve adults over the age of 65 years or adults with disabilities.

SB 1379 (Ducheny, Chapter 607, Statutes of 2008) requires that beginning September 1, 2009, and annually thereafter, the first $1,000,000 deposited into the Department of Managed Health Care's Managed Care Administrative Fines and Penalties Fund be transferred to the Medically Underserved Account for Physicians (MUAP) to be used for loan repayment awards under the STLRP. The bill also requires an immediate one-time transfer of $1,000,000 from the Managed Care Administrative Fine and Penalties Fund to the Account.

SB 606 (Ducheny, Chapter 600, Statutes of 2009) makes osteopathic physicians and surgeons eligible for the STLRP and requires that the Osteopathic Medical Board of California collect a mandatory $25 fee from physicians and surgeons at the time of initial licensure or biennial renewal to support the STLRP.

Findings

Based on the number of applicants and the amount of funds available each year, the process of selecting recipients continues to be competitive. To date, the STLRP has awarded more than

$12.9 million dollars to 147 individuals. Table One shows a summary of the applicants to the program since its inception.

Table One: Summary of Applicants, 2003-2010

Award Cycle	Applicants	Awarded	Declines	Amount Requested	Amount Awarded
2010	**63**	**29**	**1**	**$5,036,259**	**$2,809,821**
2009	66	16	1	$4,767,727	$1,510,027
2008	40	5	2	$3,484,255	$250,000
2007	52	12	0	$4,303,516	$989,000
2006	63	21	4	$5,640,000	$1,686,810
2005	57	19	3	$4,069,000	$1,700,493
2004	77	16	0	$6,154,000	$1,310,178
2003	96	29	1	$8,157,000	$2,691,764
Total	**514**	**147**	**12**	**$41,611,757**	**$12,948,093**

Program Funding

As mentioned above, the impact of AB 2439, SB 1379 and SB 606 have provided a secure and stable source of funding for the program. However, the Foundation has maintained efforts to find additional substantial contributions to support this program. The details of revenues and expenditures for Fiscal Year 2009-2010 are noted in Table Two.

Table Two: STLRP FY 2009-2010 Revenue and Expenditures

SOURCES OF REVENUE	
Beginning Balance	**$1,579,107**
Mandatory License Fees	$1,700,990
Dept. of Managed Health Care's Managed Care Administrative Fines and Penalties Fund	$1,000,000
Grant: PacifiCare/UnitedHealthcare	$557,725
Grant: The California Wellness Foundation	$60,000
Income from Surplus Money Investments	$32,058
Private Donations and Physician Contributions	$150
TOTAL REVENUE	**$4,930,030**
EXPENDITURES AND EXPENDITURE ADJUSTMENTS	$1,578,171
FUND BALANCE	**$3,351,859**

Expenditures may not match total revenue, as award amounts are determined by the amount of funding available in the Medically Underserved Account for Physicians (MUAP) prior to the STLRP Advisory Committee meeting, rather than the total amount of revenues at the end of the fiscal year. As such, revenues that are deposited into the MUAP after the date that the Advisory Committee meets are not available until the following award cycle.

Monitoring
The Foundation currently monitors the 29 contracts for award recipients selected in 2010, as well as 33 contracts for award recipients selected in 2007, 2008 and 2009. In addition, there are 77 contracts that have been finalized and closed, as those recipients have completed their service obligation. All recipients are required to work three years in a medically underserved area providing full-time direct patient care. Program Officers are responsible for monitoring award recipients every six months to verify their employment with a designated shortage area, and payments are issued annually. At the completion of the participant's three-year service obligation, Foundation staff sends a post-program survey to evaluate the effectiveness of the STLRP.

Breach of Contract
A breach is defined as the failure by one party to carry out any condition of the contract. The 2003, 2004 and 2005 award recipients have completed their contract obligations and received the funds due to them. One individual from the 2004 cycle received a first installment check in the amount of $22,800 following the first year of her service obligation and then ended her employment at the eligible practice site. The Medical Board of California determined that this was a breach of contract because she did not maintain employment in a qualified facility and is required to reimburse the Foundation $22,800 plus interest. The Medical Board has agreed to collect the money owed because her contractual agreement is with them. To date, the individual has not repaid her award. This remains the only breach in the STLRP as of this report.

2010 Award Cycle
For the March 2010 cycle, the Foundation received a total of 63 applications for the STLRP, representing a cumulative request of $5,036,259.21 to repay educational debt. The Advisory Committee was charged with identifying awardees and awarding them a total of $2,833,255.97 for loan repayments. Of the 63 applications received, the Advisory Committee selected 29 qualifying physicians and awarded them a loan repayment up to $105,000 or the total amount owed, whichever was lower. The chosen awardees came from various medical specialties and facilities located throughout California. One individual declined the award citing the applicant's inability to commit to the required three-year service obligation. The first alternate recipient selected by the Advisory Committee was contacted and accepted the award. Funds dispersed for the STLRP totaled $2,809,820.66.

Practice Settings
The STLRP Advisory Committee chooses the most qualified applicants who are working in the practice settings that meet the requirements of the STLRP. Of the 29 practice settings throughout California, 12 were in community clinics and three were located in rural areas of the state.

Practice Settings and Program Participants Program Reviews
Performance reviews of STLRP participants are conducted by the Foundation through mandatory semiannual reports which are completed and submitted by supervisors, clinic directors or other appropriate managers of the practice settings where the participants are serving their service obligation. Thus the status of the program participants and their practice settings are verified on a continuous basis by the Foundation. Appendix C, page 9 of this report details the physician practice settings for the STLRP 2010 awards.

Specialties

Pursuant to Health and Safety Code 128553 section (c)(5)(d)(2), "the selection committee may fill up to 20 percent of the available positions with program applicants from specialties outside of the primary care specialties." Therefore, 80 percent of STLRP participants are primary care providers, and include the following specialties: family practice, internal medicine, pediatrics, and/or obstetrics and gynecology. A listing of postgraduate training for the 2010 award recipients is as follows[1]:

Table Three: Specialties, 2010 Award Recipients

Specialty	Awardees
Family Practice	36%
Pediatrics	29%
Psychiatry & Neurology	18%
Internal Medicine	7%
Obstetrics/Gynecology	3%
No Specialty	7%

Geriatricians

The 2010 STLRP application was modified so that the Foundation could accurately determine and award physicians working in geriatric care settings pursuant to AB 2439. Ten applications were received from physicians who stated that they worked in a facility that met the geriatric practice requirements of the program. Of these applicants, three were selected to receive awards.

Osteopathic Physicians and Surgeons

The 2010 STLRP award cycle was the first cycle that legislation provided for the participation of Osteopathic physicians and surgeons. The Foundation received applications from 12 individuals who stated they were Osteopathic physicians and surgeons. Of these applicants, seven were awarded in 2010.

Foreign Languages

The STLRP requires the Advisory Committee to consider an applicant's ability to meet the cultural and linguistic needs of a diverse patient population. Linguistic competency can help physicians break down language and cultural barriers commonly present when providing care to patients of diverse backgrounds. Eighty percent of the awardees spoke a language other than English. Languages used in the workplace by awardees are detailed below.

Table Four: Languages Spoken by 2010 Award Recipients

Languages Spoken	Awardees
Spanish	**16**
English only	**6**
Hmong	**2**
Farsi and Spanish	**2**
Vietnamese	**1**
Korean	**1**
Korean and Spanish	**1**

[1] Some physicians hold more than one specialty.

History of Program Legislation

Legislation	Description
AB 982 (Firebaugh) Chapter 1131, Statutes of 2002	The bill established the California Physician Corps Loan Repayment Program within the Medical Board of California. The program encourages recently licensed physicians to practice in underserved locations in California by awarding loan repayments of up to $105,000. AB 982 also authorized the Medical Board to allocate $3 million from its Contingent Fund to implement the program and to support physician loan repayments.
AB 1403 (Nunez) Chapter 367, Statutes of 2004	The bill renamed the program the Steven M. Thompson Physician Corps Loan Repayment Program effective January 1, 2005.
AB 327 (De la Torre) Chapter 293, Statutes of 2005	The bill established a $50 voluntary donation from physicians and surgeons at the time of initial licensure or biennial renewal to support the Steven M. Thompson Physician Corps Loan Repayment Program.
AB 920 (Aghazarian) Chapter 317, Statutes of 2005	The bill transferred the administration of the Steven M. Thompson Physician Corps Loan Repayment Program from the Medical Board of California to the Health Professions Education Foundation.
AB 2439 (De la Torre) Chapter 640, Statutes of 2008	The bill established a mandatory $25 fee from physicians and surgeons at the time of initial licensure or biennial renewal to support the Steven M. Thompson Physician Corps Loan Repayment Program. The bill also required that up to 15 percent of the funds collected from the $25 fee to be used for loan repayment for physicians who agree to practice in geriatric care settings or settings that primarily serve adults over the age of 65 years or adults with disabilities.
SB 1379 (Ducheny) Chapter 607, Statutes of 2008	The bill required that, beginning September 1, 2009, and annually thereafter, the first $1,000,000 deposited into the Managed Care Administrative Fines and Penalties Fund be transferred to the Medically Underserved Account for Physicians to be used for loan repayment awards under the Steven M. Thompson Physician Corps Loan Repayment Program. The bill also required an immediate one-time transfer of $1,000,000 from the Managed Care Administrative Fine and Penalties Fund to the Account.
SB 606 (Ducheny) Chapter 600, Statutes of 2009	The bill makes osteopathic physicians and surgeons eligible for the STLRP and requires that the Osteopathic Medical Board of California collect a mandatory $25 fee from physicians and surgeons at the time of initial licensure or biennial renewal to support the STLRP.

Practice Settings
2010 Award Recipients

Practice Specialty/Description/Practice Setting	Award
Family Practice: *Family Medicine is a form of primary care that provides continuing, comprehensive healthcare for the individual and family across all ages, sexes, diseases, and parts of the body.*	
Community Medical Center-Fresno Family Health Center	$105,000
Natividad Medical Center	$105,000
Vantage Comprehensive Care	$105,000
Vista Community Clinic	$105,000
St. Anthony's Free Medical Clinic	$62,370
Stanislaus County Health Services Agency-Hughson Medical Office	$105,000
Santa Paula West Medical Clinic	$105,000
Sutter Gould Pattersen	$105,000
Imperial Beach Health Center	$105,000
Redding Rancheria Indian Health Center	$96,873
Internal Medicine: *Internal medicine physicians diagnose and treat the general medical problems of adult patients, as well as disorders of the internal organs.*	
Contra Costa Regional Medical Center & Health Centers	$79,047
Altamed Health Services	$105,000
Obstetrics/Gynecology: *OB-GYN physicians specialize in obstetrics and gynecology. Obstetrics is the medical discipline focusing on pregnancy and childbirth. Gynecology is the general care and management of the female reproductive system.*	
Harbor-UCLA Medical Center	$95,653
Pediatrics: *Pediatric physicians assess and treat the physical, emotional and social health of children from birth to young adulthood.*	
Clinica Monsignor Oscar A. Romero	$105,000
Long Beach Hospital Based	$105,000
Clinica Monsignor Oscar A. Romero	$105,000
General Practitioner of Pediatrics Community Clinic, Los Angeles	$85,018
Children's Hospital Central California	$105,000
San Francisco General Hospital, Children's Health Center	$89,758
Ravenswood Family Health Center	$105,000
Santa Clara Valley Medical Center, East Valley Clinic	$18,064
Long Beach Gastroenterology (Pediatrics) Clinic	$105,000
Psychiatry/Neurology: *Physicians concerned with the nervous system function and disorders.*	
Santa Clara County Mental Health Center	$78,037
Los Angeles Child/Adolescent Psychiatry	$105,000
San Fernando Mental Health Clinic	$105,000
Long Beach Community Clinic	$105,000
D'Veal Family & Youth Services, Foothill Family Service & Bienvenidos	$105,000
No Specialty: *These physicians have not yet selected a specialty that they will pursue.*	
Harbor-UCLA Medical Center	$105,000
Seneca Healthcare District	$105,000

HEALTH PROFESSIONS
EDUCATION FOUNDATION
Giving Golden Opportunities

Steven M. Thompson
Summary Statistics
March 2011 Application Cycle

Applications Received	Rev	Awd
84	**79**	**34**

Gender	Rev	Awd
Male	35	12
Female	44	22
	79	**34**

Geriatric	Rev	Awd
Geriatric	9	3
Non-Geriatric	70	31
	79	**34**

Osteopathic	Rev	Awd
Osteopathic	15	7
Non-Osteopathic	64	27
	79	**34**

Medical Specialties	Rev	Awd
Emergency Medicine	4	0
Family Practice	18	11
Infectious Diseases	2	0
Internal Medicine	9	4
Obstetrics and Gynecology	2	2
Pathology	1	0
Pediatrics	8	4
Physical Medicine and Rehabilitation	1	1
Psychiatry and Neurology	6	3
Rheumatology	1	0
None	27	9
	79	**34**

Practice Setting

County	Rev	Awd	County (cont.)	Rev	Awd	County (cont.)	Rev	Awd
Alameda	3	2	Marin			San Mateo	1	1
Alpine			Mariposa			Santa Barbara	1	0
Amador			Mendocino			Santa Clara	3	1
Butte			Merced	1	1	Santa Cruz		
Calaveras			Modoc			Shasta		
Colusa			Mono			Sierra		
Contra Costa	3	0	Monterey	4	1	Siskiyou		
Del Norte			Napa			Solano	1	0
El Dorado	1	0	Nevada			Sonoma	2	2
Fresno	4	2	Orange	6	2	Stanislaus	4	3
Glenn			Placer			Sutter		
Humboldt	2	2	Plumas			Tehama		
Imperial			Riverside	3	1	Trinity		
Inyo			Sacramento			Tulare		
Kern			San Benito			Tuolumne		
Kings			San Bernardino	3	0	Ventura	5	2
Lake			San Diego	4	2	Yolo		
Lassen			San Francisco	4	3	Yuba		
Los Angeles	22	8	San Joaquin					
Madera	2	1	San Luis Obispo					
						Total	**79**	**34**

oshpd Office of Statewide Health Planning and Development

Healthcare Workforce Development Division
Health Professions Education Foundation
400 R Street
Sacramento, California 95811-6213
(916) 326-3700
Fax (916) 322-2588
www.oshpd.ca.gov

California State Loan Repayment Program
and
Steven M. Thompson Physician Corps Loan Repayment Program

DEADLINE TO APPLY: AUGUST 1, 2011

Program Description

The State of California, Office of Statewide Health Planning and Development (OSHPD) administers the State Loan Repayment Program (SLRP) and the Steven M. Thompson Physician Corps Loan Repayment Program (STLRP) to assist with the repayment of educational loans for primary healthcare professionals who provide healthcare services in federally designated Health Professional Shortage Areas (HPSAs) in California. SLRP is funded through a grant from the Bureau of Health Professions, National Health Service Corps and STLRP provides matching funds from the Managed Care Administrative Fines and Penalties Fund, licensure fees, private donations, and grants.

Health Professionals

Eligible health disciplines include: Physicians (MD/DO) specializing in family practice, general internal medicine, general pediatrics, obstetrics/gynecology, gerontology, and general psychiatry.

Applicants must meet the following requirements:

- Be U.S. citizen with a valid, unrestricted healthcare license or certificate for the State of California;
- Have no other existing service commitment;
- Be free of judgments arising from Federal debt; Be current on all child support payments;
- Be currently employed or have accepted employment at a SLRP Certified Eligible Site;
- Commit to providing full-time (40 hours per week) primary care service in a California HPSA for a minimum of 2 years.

Full-time is defined as follows:

Obstetricians/Gynecologists: Full time is defined as a minimum of 21 hours at a site providing direct patient care, with the remaining hours providing inpatient care to patients of the approved site, and/or in practice-related activities. Other practice- related activities (e.g., precepting, meetings, CME, etc.) cannot exceed 8 hours per week. The time spent "on-call" cannot be counted toward the 40 hour week;

All others: Full-time is defined as a minimum of 40 hours per week; 32 hours at site providing direct patient care and up to 8 hours in practice-related activities (e.g., chart review, meetings, precepting, CME, etc.). The time spent "on-call" cannot be counted toward the 40-hour week.

Health professionals participating in SLRP must practice in public or private not-for-profit settings approved by the OSHPD, therefore, cannot establish private practices.

The application postmark deadline is August 1, 2011. Interested health providers can download the Primary Care Health Professional Application from the following website: http://www.oshpd.ca.gov/HWDD/SLRP.html.

Certified Eligible Sites

SLRP has Certified Eligible Sites in approximately 40 counties. They include county facilities, rural health clinics, community health clinics, and federally qualified health centers in the urban, rural, and frontier areas of California.

Practice sites must meet the following requirements:

- Be a public or private non-profit;
- Be located in a California HPSA;
- Be on the SLRP Certified Eligible Site List;
- Commit to three-year employment; and
- Pay prevailing wages.

To view the SLRP Certified Eligible Site list, please visit:
http://www.oshpd.ca.gov/HWDD/pdfs/PCCertifiedEligibleSites2010.xls

Loan Repayment Award Amounts

Health professionals may be granted up to $105,000 for a three-year award. The SLRP award is disbursed quarterly to the educational lender(s) and the matching STLRP award is disbursed annually directly to the health professional in the following amounts:

	SLRP Award	STLRP Match	Total
First Year	$ 17,500	$ 12,600	$ 30,100
Second Year	$ 17,500	$ 17,325	$ 34,825
Third Year	$ 17,500	$ 22,575	$ 40,075
		Maximum Award	$105,000

The American Job Creation Act exempts any loan repayment funds disbursed on or after January 1, 2004 from gross income and employment taxes.

Program Contact

OSHPD/HWDD
State Loan Repayment Program
400 R Street, Suite 330
Sacramento, CA 95811

Phone (916) 326-3785
E-mail SLRP@oshpd.ca.gov
Website www.oshpd.ca.gov/HWDD

OSHPD/Health Professions Education Foundation
Steven M. Thompson Physician Corps Loan Repayment
400 R Street, Suite 460
Sacramento, CA 95811

(916) 326-3640
HPEF-email@oshpd.ca.gov
www.healthprofessions.ca.gov

Standing Committees, Task Forces & Councils of the Medical Board of California July 2011

Committee	*Members*
Executive Committee	**Barbara Yaroslavsky, Chair** Hedy Chang, Secretary Shelton Duruisseau, Ph.D. Sharon Levine, M.D. Janet Salomonson, M.D. Vice President - vacant
Access to Care Committee ********** **Subcommittee: Malpractice Task Force**	**Gerrie Schipske, R.N.P., J.D., Chair** Hedy Chang Jorge Carreon, M.D. Shelton Duruisseau, Ph.D. Barbara Yaroslavsky ********** Jorge Carreon, M.D. Yvonne Choong, CMA Wendy Keegan, CHA William N. Guertin, MIEC
Cultural & Linguistic Competency Work Group	**Jorge Carreon, M.D., Chair** Shelton Duruisseau, Ph.D. Barbara Yaroslavsky David Hayes-Bautista, Ph.D. Sergio Aguilar-Gaxiola, M.D., Ph.D.
Physician Recognition Committee	**Mary Lynn Moran, M.D., Chair**
Education Committee	**Barbara Yaroslavsky, Chair** Jorge Carreon, M.D. Hedy Chang Sharon Levine, M.D. Mary Lynn Moran, M.D. Janet Salomonson, M.D. Gerrie Schipske, R.N.P., J.D.
Special Faculty Permit Review Committee	**Reginald Low, M.D., Chair** Hedy Chang Neal Cohen, M.D. (UCSF) Daniel Giang, M.D. (LLU) F. Allan Hubbell, M.D. (UCI) James Nuovo, M.D. (UCD) Frank Sinatra, M.D. (USC) Neil Parker, M.D. (UCLA) Andrew Ries, M.D. (UCSD) Lawrence Shuer, M.D. (Stanford)
Wellness Committee	**Shelton Duruisseau, Ph.D., Chair** Jorge Carreon, M.D. Silvia Diego, M.D. Daniel Giang, M.D. Laurie C. Gregg, M.D. William Norcross, M.D. Gary Nye, M.D.
Midwifery Advisory Council	**Karen Ehrlich, L.M., Chair** Faith Gibson, L.M. William Frumovitz, M.D. Ruth Haskins, M.D. Carrie Sparrevohn, L.M. Barbara Yaroslavsky

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

Revised: 7/7/11

Special Programs Committee	Hedy Chang Shelton Duruisseau, Ph.D.
Enforcement Committee	**Reginald Low, M.D., Chair** Sharon Levine, M.D. Mary Lynn Moran, M.D. Gerrie Schipske, R.N.P., J.D.
Licensing Committee ********** **Subcommittee: Application Review Committee**	**Janet Salomonson, M.D., Chair** Jorge Carreon, M.D. Hedy Chang Silvia Diego, M.D. Shelton Duruisseau, Ph.D. Gerrie Schipske, R.N.P., J.D. ********** **Gerrie Schipske, R.N.P., J.D., Chair** Silvia Diego, M.D. Reginald Low, M.D.
Advisory Committee on Physician Responsibility in the Supervision of Affiliated Health Care Professionals	**Mary Lynn Moran, M.D., Chair** Gerrie Schipske, R.N.P., J.D. Janet Salomonson, M.D. Christopher Barnard, M.D. Jack Bruner, M.D. Beth Grivett, P.A. Suzanne Kilmer, M.D. James Newman, M.D. Paul Phinney, M.D. Harrison Robbins, M.D.
Panel A	**Shelton Duruisseau, Ph.D., Chair** Janet Salomonson, M.D., Vice Chair Jorge Carreon, M.D. Silvia Diego, M.D. Barbara Yaroslavsky
Panel B	**Hedy Chang, Chair** Mary Lynn Moran, M.D , Vice Chair Sharon Levine, M.D. Reginald Low, M.D. Gerrie Schipske, R.N.P., J.D.

Revised: 7/7/11

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

FY 2011-12 Governor's Proposed Budget	Actual 2009-10	Budget Act CY 2010-11	Governor's Budget BY 2011-12	BY+1 2012-13	BY+2 2013-14
BEGINNING BALANCE	$ 24,380	$ 27,903	$ 29,123	$ 16,809	$ 12,397
Prior Year Adjustment	$ 32	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 24,412	$ 27,903	$ 29,123	$ 16,809	$ 12,397
REVENUES AND TRANSFERS					
Revenues:					
125600 Other regulatory fees	$ 271	$ 314	$ 313	$ 313	$ 313
125700 Other regulatory licenses and permits	$ 5,321	$ 5,533	$ 5,533	$ 5,533	$ 5,533
125800 Renewal fees	$ 44,670	$ 43,357	$ 44,838	$ 45,226	$ 45,621
125900 Delinquent fees	$ 94	$ 96	$ 96	$ 96	$ 96
142500 Miscellaneous services to the public	$ 37	$ 25	$ 25	$ 25	$ 25
150300 Income from surplus money investments	$ 178	$ 172	$ 167	$ 76	$ 41
160400 Sale of fixed assets	$ 20	$ -	$ -	$ -	$ -
161000 Escheat of unclaimed checks and warrants	$ 23	$ -	$ -	$ -	$ -
161400 Miscellaneous revenues	$ 1	$ 20	$ 20	$ 20	$ 20
164300 Penalty assessments - Probation Monitoring		$ 1,100	$ 1,100	$ 1,100	$ 1,100
Totals, Revenues	$ 50,615	$ 50,617	$ 52,092	$ 52,389	$ 52,749
Transfers:					
GENERAL FUND LOAN			$ (9,000)		
TOTALS, REVENUES AND TRANSFERS	$ 50,615	$ 50,617	$ 43,092	$ 52,389	$ 52,749
TOTAL RESOURCES	$ 75,027	$ 78,520	$ 72,215	$ 69,199	$ 65,147
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	$ 33	$ 80	$ 58	$ -	$ -
8880 FSCU (State Operations)		$ 31	$ 232		
1110 Program Expenditures (State Operations)	$ 47,091	$ 51,827	$ 55,116	$ 56,218	$ 57,343
2010-11 Approved BCPs:					
License Application Processing		$ -	$ -	$ -	$ -
Cal-Licensing System-BCP 1111-04: BreEZe		$ (41)			
Proposed 2012-13 Augmentations (Board):					
Operation Safe Medicine				$ 583	$ 583
Totals, Disbursements	$ 47,124	$ 51,897	$ 55,406	$ 56,801	$ 57,926
Unexpended Appropriation		$ 2,500			
FUND BALANCE					
Reserve for economic uncertainties	$ 27,903	$ 29,123	$ 16,809	$ 12,397	$ 7,221
Months in Reserve	6.5	6.3	3.6	2.6	1.5

NOTES:
A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2010-11 AND BEYOND.
B. INTEREST ON FUND ESTIMATED AT .68% in FY 09/10 and beyond.
C. FY 10-11 RENEWAL FEE REVENUE INCLUDES A ONE-TIME CREDIT OF $22 FOR EACH PHYSICIAN RENEWING (ELIMINATION OF THE DIVERSION PROGRAM)

6/14/2011

Medical Board of California
FY 10/11
Budget Expenditure Report
(As of May 31, 2011)
(91.7% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	15,038,145	12,218,231	81.2	2,819,914
Board Members	31,500	51,800	164.4	(20,300)
Phy Fitness Incentive Pay	29,623	26,065	88.0	3,558
Temp Help	1,144,410	1,466,697	128.2	(322,287)
Overtime	12,143	32,342	266.3	(20,199)
Staff Benefits	7,101,561	5,613,943	79.1	1,487,618
Salary Savings	(1,588,105)			(1,588,105)
TOTALS, PERS SERVICES	21,769,277	19,409,078	89.2	2,360,199
OPERATING EXP & EQUIP				
General Expense	795,533	288,440	36.3	507,093
Fingerprint Reports	333,448	269,431	80.8	64,017
Minor Equipment	253,500	240,853	95.0	12,647
Printing	483,755	410,676	84.9	73,079
Communications	287,780	255,705	88.9	32,075
Postage	280,511	151,642	54.1	128,869
Insurance	41,053	13,073	31.8	27,980
Travel In-State	494,298	280,378	56.7	213,920
Travel Out-of-State	1,000	0	0.0	1,000
Training	76,895	66,568	86.6	10,327
Facilities Operation (Rent)	2,758,140	2,358,890	85.5	399,250
Consult/Prof Services	982,594	1,295,899	131.9	(313,305)
Departmental Prorata	4,049,322	3,670,183	90.6	379,139
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	646,809	322,434	49.8	324,375
Data Processing	128,492	113,099	88.0	15,393
Central Admin Svcs (Statewide Prorata)	1,718,857	1,718,857	100.0	0
Attorney General Services	13,347,280	11,333,134	84.9	2,014,146
Office of Administrative Hearings	1,862,591	832,200	44.7	1,030,391
Evidence/Witness	1,893,439	1,462,977	77.3	430,462
Court Reporter Services	175,000	97,622	55.8	77,378
Major Equipment	563,000	51,998	9.2	511,002
Other Items of Expense	81	39,073	48,238.3	(38,992)
Vehicle Operations	261,925	281,352	107.4	(19,427)
Court-ordered Payments	0	21,570		(21,570)
Board of Control Claim	0	3,872		(3,872)
TOTALS, OE&E	31,440,445	25,579,926	81.4	5,860,519
TOTALS, EXPENDITURES	53,209,722	44,989,004	84.6	8,220,718
Scheduled Reimbursements	(384,000)	(294,267)	76.6	(89,733)
Distributed Costs	(999,000)	(694,240)	69.5	(304,760)
NET TOTAL, EXPENDITURES	51,826,722	44,000,497	84.9	7,826,225
Unscheduled Reimbursements		(1,201,883)		
		42,798,614		

Budget Expenditure Report.xls
Date: June 13, 2011

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2010 - MAY 31, 2011

	FY 10/11 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,213,961	2,071,888	current
Staff Benefits	1,134,900	916,098	current
TOTAL PERSONAL SERVICES	3,348,861	2,987,986	
OPERATING EXPENSES & EQUIPMENT			
General Expense	85,000	16,417	1-2
Fingerprint Reports*	329,248	264,017	1-2
Printing	30,000	22,703	1-2
Communications	50,000	37,133	1-2
Postage	73,511	106,448	1-2
Travel In-State	25,000	12,221	1-2
Training	3,500	4,390	1-2
Facilities Operation	225,000	225,069	current
Consult/Professional Services	506,873	638,686	1-2
Departmental Services	393,594	356,770	current
Interagency Services	500	0	current
Data Processing	3,000	3,800	1-2
Statewide Pro Rata	167,073	167,073	current
Attorney General	150,000	137,909	current
Evidence/Witness Fees	7,500	0	1-2
Court Reporter Services	250	0	1-2
Major Equipment	12,000	11,745	1-2
Minor Equipment	67,500	212	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	2,129,549	2,004,593	
SCHEDULED REIMBURSEMENTS	(384,000)	(294,267)	
DISTRIBUTED COSTS	(49,282)	(36,962)	
TOTAL BUDGET/EXPENDITURES	**5,045,128**	**4,661,350**	

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

g/admin/licensn2.xls
7/8/2011

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2010 - MAY 31, 2011

	FY 10/11 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	8,980,637	8,297,646	current
Staff Benefits	4,183,459	3,308,101	current
TOTAL PERSONAL SERVICES	13,164,096	11,605,747	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	389,731	136,129	1-2
Printing	214,944	275,026	1-2
Communications	140,780	159,089	1-2
Postage	50,000	40,990	1-2
Insurance	38,235	11,057	current
Travel In-State	282,139	170,578	1-2
Training	35,209	44,063	1-2
Facililties Operations	2,056,940	1,690,858	current
Consultant/Professional Services	300,000	250,359	1-2
Departmental Services	2,948,429	2,672,295	current
Interagency Services	3,744	0	1-2
Data Processing	18,000	26,441	1-2
Statewide Pro Rata	1,251,500	1,251,500	current
Attorney General 1/	13,197,280	11,195,225	current
OAH	1,862,591	832,200	1
Evidence/Witness Fees	1,820,939	1,430,692	1-2
Court Reporter Services	174,750	97,622	1-2
Major Equipment	503,000	0	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	81	38,186	1-2
Vehicle Operations	210,925	239,457	1-2
Minor Equipment	1,600	26,119	1-2
Court-Ordered Payments	0	25,442	current
TOTAL OPERATING EXPENSES & EQUIPMENT	25,500,817	20,613,328	
DISTRIBUTED COSTS	(945,405)	(654,043)	
TOTAL BUDGET/EXPENDITURES	**37,719,508**	**31,565,032**	
Unscheduled Reimbursements		(97,532)	
		31,467,500	

1/See next page for monthly billing detail

7/8/2011
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MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 10/11
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

		Number of Hours	Rate	Amount
July	Attorney Services	5,879.25	170.00	999,472.50
	Paralegal Services	442.75	120.00	53,130.00
	Auditor/Analyst Services	92.25	99.00	9,132.75
	Cost of Suit			
				1,061,735.25
August	Attorney Services	5,896.00	170.00	1,002,320.00
	Paralegal Services	376.00	120.00	45,120.00
	Auditor/Analyst Services	87.50	99.00	8,662.50
	Cost of Suit			
				1,056,102.50
September	Attorney Services	5,613.00	170.00	954,210.00
	Paralegal Services	318.75	120.00	38,250.00
	Auditor/Analyst Services	92.50	99.00	9,157.50
	Cost of Suit			
				1,001,617.50
October	Attorney Services	5,597.00	170.00	951,490.00
	Paralegal Services	245.50	120.00	29,460.00
	Auditor/Analyst Services	83.25	99.00	8,241.75
	Cost of Suit			8,879.53
				998,071.28
November	Attorney Services	4,956.75	170.00	842,647.50
	Paralegal Services	237.75	120.00	28,530.00
	Auditor/Analyst	83.00	99.00	8,217.00
	Cost of Suit			658.72
				880,053.22
December	Attorney Services	5,412.00	170.00	920,040.00
	Paralegal Services	254.25	120.00	30,510.00
	Auditor/Analyst	88.00	99.00	8,712.00
	Cost of Suit			273.10
				959,535.10
			Total July-Dec =	**5,957,114.85**
			FY 10/11 Budget =	**13,197,280.00**

Revised 07/8/2011

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 10/11
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

January	Attorney Services	5,631.75	170.00	957,397.50
	Paralegal Services	300.75	120.00	36,090.00
	Auditor/Analyst	79.00	99.00	7,821.00
	Cost of Suit			2,734.00
				1,004,042.50
February	Attorney Services	5,187.25	170.00	881,832.50
	Paralegal Services	274.00	120.00	32,880.00
	Auditor/Analyst	87.50	99.00	8,662.50
	Cost of Suit			2,261.13
				925,636.13
March	Attorney Services	6,460.50	170.00	1,098,285.00
	Paralegal Services	302.50	120.00	36,300.00
	Auditor/Analyst Services	100.00	99.00	9,900.00
	Cost of Suit			702.81
				1,145,187.81
April	Attorney Services	5,861.25	170.00	996,412.50
	Paralegal Services	287.25	120.00	34,470.00
	Auditor/Analyst Services	86.25	99.00	8,538.75
	Cost of Suit			2,418.86
				1,041,840.11
May	Attorney Services	6,317.00	170.00	1,073,890.00
	Paralegal Services	287.75	120.00	34,530.00
	Auditor/Analyst Services	115.25	99.00	11,409.75
	Cost of Suit			1,574.11
				1,121,403.86
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
			FYTD Total =	**11,195,225.26**
			FY 10/11 Budget =	**13,197,280.00**

Revised 07/8/2011
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ENFORCEMENT/PROBATION RECEIPTS
MONTHLY PROFILE: JULY 2008 - JUNE 2011

	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	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	0	2,186	11,388	1,500	42,850
Criminal Cost Recovery	0	0	0	0	0	0	0	0	0	0	0	0	0
Probation Monitoring	46,225	21,354	22,836	34,983	22,419	186,279	345,366	200,249	60,048	59,731	29,879	42,043	1,071,412
Exam	150	250	105	330	3,480	1,658	292	200	1,500	300	325	500	9,090
Cite/Fine	3,500	3,025	2,425	3,225	3,055	5,320	475	4,723	4,600	5,200	3,261	5,340	44,149
MONTHLY TOTAL	54,361	25,679	26,616	39,278	29,021	194,418	353,542	216,785	66,148	67,417	44,853	49,383	1,167,501
FYTD TOTAL	54,361	80,040	106,656	145,934	174,955	369,373	722,915	939,700	1,005,848	1,073,265	1,118,118	1,167,501	

	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	FYTD Total
Invest Cost Recovery	3,981	971	871	846	996	2,177	896	3,550	896	896	1,100	1,146	18,326
Criminal Cost Recovery	0	0	0	0	0	0	0	0	0	0	0	0	0
Probation Monitoring	43,697	74,202	31,474	35,029	120,104	157,971	332,595	170,590	72,520	94,712	71,738	47,283	1,251,913
Exam	2,475	3,730	1,750	9,456	4,031	1,158	1,237	2,621	1,400	4,235	2,500	627	35,219
Cite/Fine	5,500	9,000	10,075	4,000	2,600	5,700	5,000	2,896	1,950	5,650	950	200	53,521
MONTHLY TOTAL	55,653	87,903	44,170	49,331	127,731	167,006	339,728	179,656	76,766	105,493	76,288	49,255	1,358,980
FYTD TOTAL	55,653	143,557	187,727	237,058	364,788	531,794	871,522	1,051,178	1,127,944	1,233,436	1,309,725	1,358,980	

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Medical Board of California
Board Members' Expense Report
JULY 1, 2010 - MAY 31, 2011
Amended

	*Per Diem**			*Per Diem*	*Travel Expenses**	*Total Mar-May*	***Total FYTD***
	MAR	APR	MAY	*TOTAL*			
Dr. Carreon	900	1,000	0	1,900	0.00	1,900.00	10,644.64
Ms. Chang	0	0	0	0	0.00	0.00	0.00
Dr. Chin	0	0	0	0	0.00	0.00	0.00
Dr. Diego	600	500	0	1,100	0.00	1,100.00	3,423.96
Dr. Duruisseau	700	700	1,500	2,900	804.82	3,704.82	10,325.99
Dr. Esrailian	100	0	400	500	471.02	971.02	4,867.02
Ms. Kent	0	0	0	0	0.00	0.00	339.42
Dr. Levine	0	0	0	0	0.00	0.00	0.00
Dr. Low	0	0	0	0	0.00	0.00	0.00
Dr. Moran	1,400	1,300	0	2,700	0.00	2,700.00	9,900.00
Dr. Salomonson	0	0	300	300	0.00	300.00	3,745.61
Ms. Schipske	900	0	700	1,600	475.83	2,075.83	7,164.60
Ms. Yaroslavsky	2,000	2,400	2,000	6,400	0.00	6,400.00	20,109.19
Mr. Zerunyan	1,400	1,600	1,800	4,800	668.70	5,468.70	18,585.08
BOARD TOTAL	8,000	7,500	6,700	22,200	2,420.37	24,620.37	**89,105.51**

*includes claims paid/submitted through June 15, 2011

Board Members Expense Report July 1-May 31 2011.xls
Date: July 11, 2011

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 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	2,030,000	36,539,000	567,000	4,262,000	1,558,000		2,953,000	1,589,000	49,498,000
$ Spent *	2,920,000	34,130,000	494,000	4,772,000	1,547,000		2,728,000	500,000	47,091,000 *
Positions Authorized	8.8	146.6	6.0	45.5	15.0		16.0	25.0	262.9
FY 10/11									
$ Budgeted	1,944,000	37,720,000	577,000	5,045,000	1,688,000		3,118,000	1,735,000	51,827,000
$ Spent thru 5/31*	1,659,972	31,467,500	620,482	4,661,350	1,397,782		2,525,230	466,298	42,798,614 *
Positions Authorized	8.8	165.0	6.0	52.3	15.0		17.0	25.0	289.1
FY 11/12									
$ Budgeted									55,116,000
Positions Authorized	8.8	167.6		52.3	15.0		17.0	25.0	285.7

* net expenditures (includes unscheduled reimbursements)

7/8/2011
Budget Overview by Program.xls

STATE AND CONSUMER SERVICES AGENCY - *Department of Consumer Affairs* Arnold Schwarzenegger, *Governor*

MEDICAL BOARD OF CALIFORNIA
Executive Office

PROPOSED BOARD MEETING DATES FOR 2012

February 2 -3	San Francisco
May 3-4	Los Angeles
July 26-27	Sacramento
October 25-26	San Diego

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

MEDICAL BOARD OF CALIFORNIA
Executive Office

Agenda Item 19

Date: July 20, 2011

To: Members
Medical Board of California

Subject: Revised Protocol for Pharmacists Furnishing Emergency Contraception

The Medical Board originally adopted the protocol for pharmacists furnishing emergency contraception at its Quarterly Board Meeting on May 7, 2004. This protocol was required to be developed and approved by both the Medical Board and the Pharmacy Board per SB 490 (Alpert, Chapter 651, Statutes of 2003), which amended Business and Professions Code Section 4052 to add this requirement.

Attached is the revised protocol for pharmacists furnishing emergency contraception, which is being presented to the Board for your consideration and approval. The strikeout document is included so you may see the changes, and the final revised document without strikeouts is included for your review.

This revised protocol will be presented by Ms. Smith-Crowley, Ms. Besinque, and Ms. Herold.

Attachments

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-2389 (916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

Pharmacists Protocol for Dispensing Emergency Contraception

~~Senate Bill 490 (Chapter 651, Statutes of 2003) permits pharmacists~~ Pharmacists- may ~~to~~ furnish emergency contraception medications based on a statewide protocol adopted by the California State Board of Pharmacy and the Medical Board of California (section 4052.3(a)(2) of the California Business and Professions Code).

On the following page is the approved protocol. Pharmacists may use this protocol after they have completed one hour of continuing education credit in emergency contraception ~~(a requirement of the new law)~~.

Additionally p~~Prior legislation (Senate Bill 1169, Chapter 900, Statutes of 2001) P~~harmacists may ~~also permitspharmacists to~~ furnish emergency contraception medications to patients based on a protocol with a single licensed prescriber (section 4052.3 of the California Business and Professions Code). ~~Existing protocols developed with a prescriber remain valid.~~

~~Last p~~Pharmacists ~~also~~ may also -furnish levonorgestrel emergency contraception ~~Plan B~~ without a prescription or a physician protocol -to a man or wo~~r~~man aged 17 or older pursuant to FDA requirements.

~~The~~ This statewide protocol was prepared with the intent to keep it simple and to comply with the statutory requirements established by -California law. ~~Senate Bill 490.~~

~~The statutory provisions for pharmacists furnishing emergency contraception arefound in California Business and Professions Code section 4052.~~

Protocol for Pharmacists Furnishing Emergency Contraception (EC)

Authority: Section 4052.3(a)(2) of the California Business and Professions Code authorizes a pharmacist to furnish emergency contraception pursuant to a protocol approved by the California State Board of Pharmacy and the Medical Board of California. Use of the following protocol satisfies that requirement.

Purpose: To provide timely access to emergency contraceptive medication ~~within required limits~~ and ensure that the patient receives adequate information to successfully complete therapy.

Procedure: When a patient requests emergency contraception, the pharmacist will ask and ~~state~~ communicate the following:

- Are you allergic to any medications?
- Timing is an essential element of the product's effectiveness. EC should be taken as soon as possible after unprotected intercourse. Treatment may be initiated up to five days (120 hours) ~~of~~ after unprotected intercourse. ~~EC effectiveness declines gradually over five days and~~
- EC use will not interfere with an established ~~(~~or implanted~~)~~ pregnancy.
- If more than 72 hours have elapsed since unprotected intercourse, ~~-~~the use of ella® (ulipristal) may be more effective than levonorgestrel. Other options for EC include consultation with your~~her~~ physician regarding insertion of an IUD.

The pharmacist shall provide ~~the~~ a fact sheet and review any questions the patient may have regarding EC. In addition, the pharmacist shall collect the information required for a patient medication~~l~~ record by Section 1707.1 of Title 16 of the California Code of Regulations (reference attached).

Fact Sheet: The pharmacist will provide the patient with a copy of the current EC fact sheet approved by the Board of Pharmacy.

Referrals and Supplies: If emergency contraception services are not immediately available at the pharmacy or the pharmacist declines to furnish pursuant to conscience clause, the pharmacist will refer the patient to another emergency contraception provider. The pharmacist shall comply with all state mandatory reporting laws, including sexual abuse laws.

The pharmacist may provide up to 12 non-spermicidal condoms to each Medi-Cal and Family PACT client who obtains emergency contraception.

Advanced Provision: The pharmacist may dispense emergency contraception medication for a patient in advance of the need for emergency contraception.

EC Product Selection: The pharmacist will provide emergency contraception medication ~~compatible with product information~~ from the list of products appended to this protocol. This list must be kept current and maintained in the pharmacy. Along with emergency contraception~~p~~ products, the list will include adjunctive medications indicated for nausea and vomiting associated with taking EC ~~-~~containing estrogen. Patients will be provided information concerning dosing and potential adverse effects.

Documentation: Each prescription authorized by a pharmacist will be documented in a patient profile as required by law.

Training: Prior to furnishing emergency contraception, pharmacists who participate in this protocol must have completed a minimum of one hour of continuing education ~~or curriculum-based instruction from an ACPE accredited School of Pharmacy~~ specific to emergency contraception.

Appendix 1: ~~Brands and Doses of Oral Contraceptive Tablets~~ Medications Used for Emergency Contraception

Dedicated Approved Products for Emergency Contraception				
Brand	~~Manufacturer~~	~~Tablets per~~ Dose	Ethinyl Estradiol per dose (mcg)	~~Levonorgestrel per dose(mg)~~
One Dose Regimen				
~~PlanB~~	~~Duramed~~	~~2 tablets per dose~~	~~0~~	~~1.5~~
PlanB-OneStep		1 tablet	0	1.5mg levonorgestrel
Ella		1 tablet	0	30mg ulipristal
Two Dose Regimen				
NextChoice		1 tablet per dose	0	1.5mg levonorgestrel
~~Plan B~~	~~Duramed~~	~~1 tablet per dose~~	~~0~~	~~0.75~~
~~Preven**~~	~~Duramed~~	~~2 tablets per dose~~	~~100~~	~~0.50~~
Oral Contraceptive Pills				
Brand	~~Manufacturer~~	Tablets per Dose (two doses 12 hours apart*)	Ethinyl Estradiol per dose(mcg)	Levonorgestrel per dose(mg)
Levora	~~Watson~~	4 white tablets	120	0.6
Ovral	~~Wyeth~~	2 white tablets	100	0.5
Ogestrel	~~Watson~~	2 white tablets	100	0.5
Nordette	~~Wyeth~~	4 light-orange tablets	120	0.6
Tri-Levlen	~~Berlex~~	4 yellow tablets	100	0.5
Alesse	~~Wyeth~~	5 pink tablets	100	0.5
Aviane	~~Duramed~~	5 orange tablets	100	0.5
Triphasil	~~Wyeth~~	4 yellow tablets	120	0.5
Levlen	~~Berlex~~	4 light-orange tablets	120	0.6
Trivora	~~Watson~~	4 pink tablets	120	0.5
Levlite	~~Berlex~~	5 pink tablets	100	0.5
Lo/Ovral	~~Wyeth~~	4 white tablets	120	0.5
Low-Ogestrel	~~Watson~~	4 white tablets	120	0.6
Ovrette	~~Wyeth~~	20 yellow tablets	0	0.75

*The progestin in Ovral, Lo/Ovral, and Ovrette is norgestrel, which contains two isomers, only one of which (levonorgestrel) is bioactive; the amount of norgestrel in each dose is twice the amount of levonorgestrel

** ~~**~~ In addition to the products listed above, generic equivalent products may be furnished. Estrogen containing regimens are not preferred and should be used only when the other options are not available~~Preven was discontinued as of May 2004~~

Appendix 2 --~~Sample list~~ List of Anti-Emetics for Use with Emergency Contraception.

Anti-nausea Treatment Options for use with Emergency Contraception

Drug	Dose	Timing of Administration
Non-prescription Drugs		
Meclizine hydrochloride (Dramamine II, Bonine)	One or two 25 mg tablets	1 hour before first EC dose; repeat if needed in 24 hours
Diphenhydramine hydrochloride (Benadryl)	One or two 25 mg tablets or capsules.	1 hour before first EC dose; repeat as needed every 4-6 hours
Dimenhydrinate (Dramamine)	One or two 50 mg tablets or 4-8 teaspoons liquid	30 minutes to 1 hour before first ECP dose; repeat as needed every 4-6 hours
Cyclizine hydrochloride (Marezine)	One 50 mg tablet	30 minutes before first EC dose; repeat as needed every 4-6 hours

Appendix 3 – Title 16, Section 1707.1 of the California Code of Regulations
§1707.1. Duty to Maintain Medication Profiles (Patient Medication Records)
(a) A pharmacy shall maintain medication profiles on all patients who have prescriptions filled in that pharmacy except when the pharmacist has reasonable belief that the patient will not continue to obtain prescription medications from that pharmacy.
(1) A patient medication record shall be maintained in an automated data processing or manual record mode such that the following information is readily retrievable during the pharmacy's normal operating hours.
(A) The patient's full name and address, telephone number, date of birth (or age) and gender;
(B) For each prescription dispensed by the pharmacy:
1. The name, strength, dosage form, route of administration, if other than oral, quantity and directions for use of any drug dispensed;
2. The prescriber's name and where appropriate, license number, DEA registration number or other unique identifier;
3. The date on which a drug was dispensed or refilled;
4. The prescription number for each prescription; and
5. The information required by section 1717.
(C) Any of the following which may relate to drug therapy: patient allergies, idiosyncrasies, current medications and relevant prior medications including nonprescription medications and relevant devices, or medical conditions which are communicated by the patient or the patient's agent.
(D) Any other information which the pharmacist, in his or her professional judgment, deems appropriate.
(2) The patient medication record shall be maintained for at least one year from the date when the last prescription was filled.
Authority cited: Sections 4005, 4121 and 4122, of the Business and Professions Code.
Reference: Sections 4005, 4121 and 4122, of the Business and Professions Code.

Pharmacists Protocol for Dispensing Emergency Contraception

Pharmacists may furnish emergency contraception medications based on a statewide protocol adopted by the California State Board of Pharmacy and the Medical Board of California (section 4052.3(a)(2) of the California Business and Professions Code).

On the following page is the approved protocol. Pharmacists may use this protocol after they have completed one hour of continuing education credit in emergency contraception.

Additionally pharmacists may furnish emergency contraception medications to patients based on a protocol with a single licensed prescriber (section 4052.3 of the California Business and Professions Code).

Pharmacists may also furnish levonorgestrel emergency contraception without a prescription or a physician protocol to a man or woman aged 17 or older pursuant to FDA requirements.

This statewide protocol was prepared with the intent to keep it simple and to comply with the statutory requirements established by California law.

Protocol for Pharmacists Furnishing Emergency Contraception (EC)

Authority: Section 4052.3(a)(2) of the California Business and Professions Code authorizes a pharmacist to furnish emergency contraception pursuant to a protocol approved by the California State Board of Pharmacy and the Medical Board of California. Use of the following protocol satisfies that requirement.

Purpose: To provide timely access to emergency contraceptive medication and ensure that the patient receives adequate information to successfully complete therapy.

Procedure: When a patient requests emergency contraception, the pharmacist will ask and communicate the following:

- Are you allergic to any medications?
- Timing is an essential element of the product's effectiveness. EC should be taken as soon as possible after unprotected intercourse. Treatment may be initiated up to five days (120 hours) after unprotected intercourse.
- EC use will not interfere with an established or implanted pregnancy.
- If more than 72 hours have elapsed since unprotected intercourse, the use of ella® (ulipristal) may be more effective than levonorgestrel. Other options for EC include consultation with your physician regarding insertion of an IUD.

The pharmacist shall provide a fact sheet and review any questions the patient may have regarding EC. In addition, the pharmacist shall collect the information required for a patient medication record by Section 1707.1 of Title 16 of the California Code of Regulations (reference attached).

Fact Sheet: The pharmacist will provide the patient with a copy of the current EC fact sheet approved by the Board of Pharmacy.

Referrals and Supplies: If emergency contraception services are not immediately available at the pharmacy or the pharmacist declines to furnish pursuant to conscience clause, the pharmacist will refer the patient to another emergency contraception provider. The pharmacist shall comply with all state mandatory reporting laws, including sexual abuse laws.

The pharmacist may provide up to 12 non-spermicidal condoms to each Medi-Cal and Family PACT client who obtains emergency contraception.

Advanced Provision: The pharmacist may dispense emergency contraception medication for a patient in advance of the need for emergency contraception.

EC Product Selection: The pharmacist will provide emergency contraception medication from the list of products appended to this protocol. This list must be kept current and maintained in the pharmacy. Along with emergency contraception products, the list will include adjunctive medications indicated for nausea and vomiting associated with taking EC containing estrogen. Patients will be provided information concerning dosing and potential adverse effects.

Documentation: Each prescription authorized by a pharmacist will be documented in a patient profile as required by law.

Training: Prior to furnishing emergency contraception, pharmacists who participate in this protocol must have completed a minimum of one hour of continuing education specific to emergency contraception.

Appendix 1: Medications Used for Emergency Contraception

Dedicated Approved Products for Emergency Contraception				
Brand		Dose	Ethinyl Estradiol per dose (mcg)	
One Dose Regimen				
PlanB-OneStep		1 tablet	0	1.5mg levonorgestrel
Ella		1 tablet	0	30mg ulipristal
Two Dose Regimen				
NextChoice		1 tablet per dose	0	1.5mg levonorgestrel
Oral Contraceptive Pills				
Brand		Tablets per Dose (two doses 12 hours apart*)	Ethinyl Estradiol per dose(mcg)	Levonorgestrel per dose(mg)
Levora		4 white tablets	120	0.6
Ovral		2 white tablets	100	0.5
Ogestrel		2 white tablets	100	0.5
Nordette		4 light-orange tablets	120	0.6
Tri-Levlen		4 yellow tablets	100	0.5
Alesse		5 pink tablets	100	0.5
Aviane		5 orange tablets	100	0.5
Triphasil		4 yellow tablets	120	0.5
Levlen		4 light-orange tablets	120	0.6
Trivora		4 pink tablets	120	0.5
Levlite		5 pink tablets	100	0.5
Lo/Ovral		4 white tablets	120	0.5
Low-Ogestrel		4 white tablets	120	0.6
Ovrette		20 yellow tablets	0	0.75

*The progestin in Ovral, Lo/Ovral, and Ovrette is norgestrel, which contains two isomers, only one of which (levonorgestrel) is bioactive; the amount of norgestrel in each dose is twice the amount of levonorgestrel

** In addition to the products listed above, generic equivalent products may be furnished. Estrogen containing regimens are not preferred and should be used only when the other options are not available

Appendix 2 -- List of Anti-Emetics for Use with Emergency Contraception.

Anti-nausea Treatment Options for use with Emergency Contraception

Drug	Dose	Timing of Administration
Non-prescription Drugs		
Meclizine hydrochloride (Dramamine II, Bonine)	One or two 25 mg tablets	1 hour before first EC dose; repeat if needed in 24 hours
Diphenhydramine hydrochloride (Benadryl)	One or two 25 mg tablets or capsules.	1 hour before first EC dose; repeat as needed every 4-6 hours
Dimenhydrinate (Dramamine)	One or two 50 mg tablets or 4-8 teaspoons liquid	30 minutes to 1 hour before first ECP dose; repeat as needed every 4-6 hours
Cyclizine hydrochloride (Marezine)	One 50 mg tablet	30 minutes before first EC dose; repeat as needed every 4-6 hours

Appendix 3 – Title 16, Section 1707.1 of the California Code of Regulations
§1707.1. Duty to Maintain Medication Profiles (Patient Medication Records)
(a) A pharmacy shall maintain medication profiles on all patients who have prescriptions filled in that pharmacy except when the pharmacist has reasonable belief that the patient will not continue to obtain prescription medications from that pharmacy.
(1) A patient medication record shall be maintained in an automated data processing or manual record mode such that the following information is readily retrievable during the pharmacy's normal operating hours.
(A) The patient's full name and address, telephone number, date of birth (or age) and gender;
(B) For each prescription dispensed by the pharmacy:
1. The name, strength, dosage form, route of administration, if other than oral, quantity and directions for use of any drug dispensed;
2. The prescriber's name and where appropriate, license number, DEA registration number or other unique identifier;
3. The date on which a drug was dispensed or refilled;
4. The prescription number for each prescription; and
5. The information required by section 1717.
(C) Any of the following which may relate to drug therapy: patient allergies, idiosyncrasies, current medications and relevant prior medications including nonprescription medications and relevant devices, or medical conditions which are communicated by the patient or the patient's agent.
(D) Any other information which the pharmacist, in his or her professional judgment, deems appropriate.
(2) The patient medication record shall be maintained for at least one year from the date when the last prescription was filled.
Authority cited: Sections 4005, 4121 and 4122, of the Business and Professions Code.
Reference: Sections 4005, 4121 and 4122, of the Business and Professions Code.

Medical Education in California

An Update for the Medical Board of California

Cathryn L. Nation, MD
Associate Vice President - Health Sciences
University of California, Office of the President
July 29, 2011

California's Physician Workforce

- California faces a shortfall of up to 17,000 physicians by 2015.
- The Inland Empire and the Central Valley are expected to face serious and worsening shortages.
- The demand for doctors will increase as the population ages, as more people become insured through health reform, and as growing numbers of providers retire.

MEDICAL EDUCATION

California Medical Schools:
Student Enrollment 2010-11

There are approximately 6,460 students enrolled in California's 8 allopathic and 2 osteopathic medical schools.

Nearly half of all California medical students are enrolled at the University of California's five Schools of Medicine.

UC Medical School Enrollment 2010-2011

UC Davis	436
UC Irvine	483
UC Los Angeles	837
UC San Diego	592
UC San Francisco	791
Total UC Enrollment	3,139

Private Medical School Enrollment 2010-2011

Allopathic Schools	
Loma Linda	713
Southern California	721
Stanford	461
Total Enrollment	1,895
Osteopathic Schools	
Touro	551
Western	875
Total Enrollment	1,426

First-Year California URM Enrollment

Numbers (and %) for Schools 2010-11

	UC	Private (MD)	Private (DO)
Native Am	2 (0.3)	1 (0.2)	0
Black/Afr Am	51 (7.5)	22 (5.2)	0
Hispanic	86 (12.7)	35 (8.2)	12 (3.3)
Pacific Islander	11 (1.6)	5 (1.2)	0
Multi-Race URM	6 (0.9)	5 (1.2)	0
Total URM	156 (23)	68 (16)	12 (3.3)

First-Year URM Enrollment Comparison

	UC	CA	US
Native Am	2 (0.3)	3 (0.2)	51 (0.3)
Black/Afr Am	51 (7.5)	73 (5.0)	1,174 (6.3)
Hispanic	86 (12.7)	133 (9.1)	1,474 (7.9)
Pacific Islander	11 (1.6)	16 (1.1)	25 (0.1)
Multi-Race URM	6 (0.9)	11 (0.8)	n/a
Total URM	156 (23)	236 (16.2)	2,724 (14.6)

Recent Enrollment Growth
UC System-wide PRIME Initiative

Fall 2010 Race/Ethnicity:	UCD	UCI	UCLA	UCSD	UCSF	TOTAL
Native American/Alaskan Native	1	0	0	0	0	1
Black/African American	0	2	6	3	15	26
MexicanAmer/Chic/Other Hisp/Lat	8	39	20	12	14	93
Pacific Islander	2	0	0	0	7	9
Multiple race/ethnicity (URM)	3	0	8	0	0	11
Total URM's & Other Hispanic/Latinos	**14 (30%)**	**41 (71%)**	**34 (64%)**	**15 (39%)**	**36 (63%)**	**140 (55%)**
Asian American	4	0	8	8	7	27
White/Caucasian	27	14	9	15	14	79
Other/Non-Reporting	2	3	2	0	0	7
TOTAL ENROLLMENT	47	58	53	38	57	253

Plans and Changes at New Sites

- UC System-wide PRIME enrollment will total approximately 300 students in fall 2011.
- Planning continues for a new School of Medicine at UC Riverside, with a goal of admitting a first class in fall 2013.
- New UC Davis PRIME – UC Merced San Joaquin Valley PRIME program will admit its first class in fall 2011, with goals for growth over time.

RESIDENCY TRAINING

UC Medical Resident Enrollment 2010-2011

- The University of California trains more than 4,400 medical residents and fellows, nearly half of the state's total.

✓Primary Care	1,614
✓Hospital-Based Specialties	919
✓Surgery	782
✓Other Specialties	1,104
✓Total UC Medical Residents	4,419

CHALLENGES AHEAD

Federal/State Budget

- Unprecedented economic challenges resulting in an additional $650M reduction in state support to the UC system (for fiscal year 2011-12).
- Proposed cuts to Medicare funding for graduate medical education that could result in cuts to UC medical centers of up to $900M over ten years (if passed by Congress).
- Rapidly increasing fees and rising debt loads may discourage economically disadvantaged students from pursuing health careers and hinder recruitment of students interested in primary care careers or service to the underserved.

Average 4-Year Cost of Attendance California Medical Schools (2006-2010)

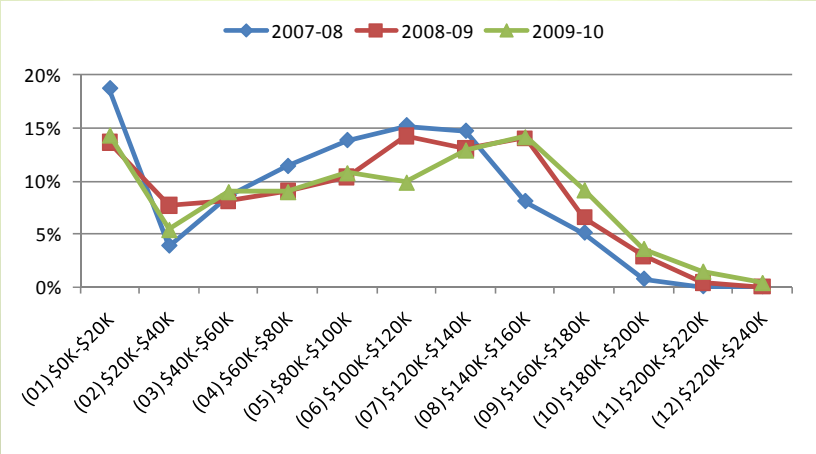
Medical School	Average Cost
UC Davis	$187,615
UC Irvine	$195,780
UC Los Angeles	$199,730
UC San Diego	$196,698
UC San Francisco	$198,805
Loma Linda	$230,126
Southern California	$273,485
Stanford	$294,259

Percent Change in 4-Year Cost of Attendance (2005 -2010)

Campus	Percent Change
UC Irvine	56%
UC Davis	50%
UC San Diego	49%
UC Los Angeles	36%
UC San Francisco	35%

Distribution of Debt at Graduation
UC Medical School Graduates

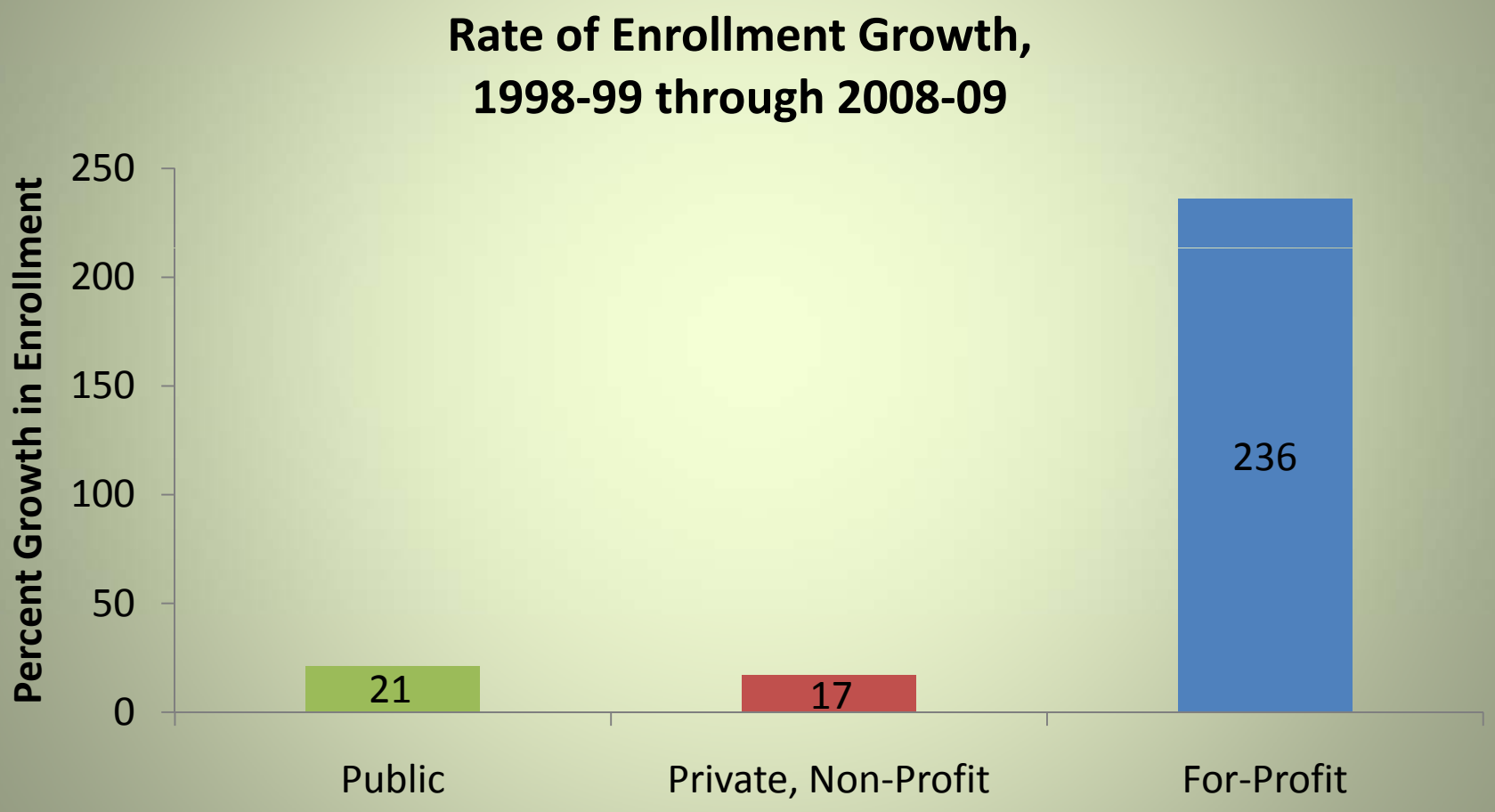
Figures do not include undergraduate debt



Health Reform

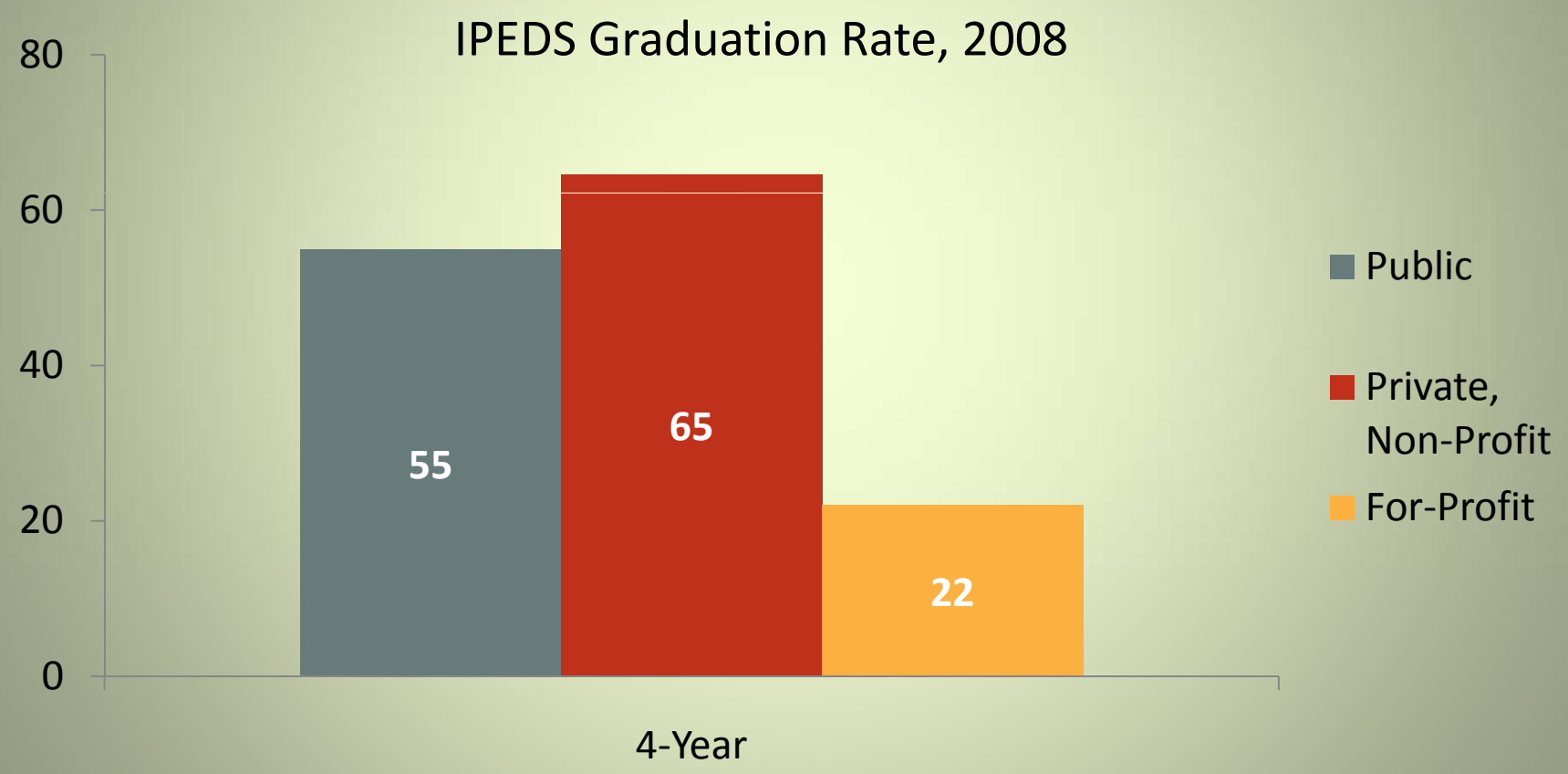
- The Patient Protection and Affordable Care Act presents great opportunities as well as substantial challenges for California.
  - Large increases in the number of Californians with health insurance.
  - Corresponding (and exacerbating) existing health workforce challenges statewide.

Enrollment at for-profits is growing rapidly



- Ed Trust analysis of IPEDS, 12-Month Enrollment Survey, 12-month unduplicated headcount enrollment at Title IV U.S. institutions, 1998-99 and 2008-09.

4-year for-profits have much lower graduation rates than non-profits



- IPEDS First Look 2008-09, Table 5. Graduation rates at Title IV institutions, by race/ethnicity, level and control of institution, gender, and degree at the institution where the students started as full-time, first-time students: United States, cohort year 2002.

For-Profit Medical Education

- Although there are LCME accredited medical schools throughout Canada and Puerto Rico, there are also at least 56 offshore non-LCME accredited medical schools in the Caribbean, 35 of which have opened since 1999
- All are for-profit institutions
- Substantial concerns exist regarding these trends and their ramifications for education and practice

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 8, 2011
ATTENTION:	Medical Board of California
SUBJECT:	Recognition of International Medical School American University of Antigua College of Medicine Site Visit Report
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

To recognize AUACOM and deem it to be in substantial compliance with the requirements of Business and Professions Code Sections 2089 and 2089.5 and California Code of Regulations, Title 16, Division 13, Section 1314.1 and to extend that recognition only to those who matriculate at AUACOM on or after January 1, 2007.

Note: Students who matriculated at AUACOM prior to January 1, 2007, in accordance with Business and Professions Code Section 2135.5(e), may apply for licensure in California and be evaluated by the Board, through its Application Review Committee.

BACKGROUND AND ANALYSIS:

AUACOM submitted the Board's "International Medical School Self-Assessment Report" (SAR) in March 2008. The SAR was reviewed by Board staff and the provided to the Board's Licensing Medical Consultant, James Nuovo, M.D., (Medical Consultant) for review.

- November 2008, the Board requested that AUACOM provide additional information.
- August 2009, the Board staff mailed a due diligence letter to AUACOM. The Board received AUACOM's response September 2009. Board staff reviewed AUACOM's material and provided the material to Dr. Nuovo in October 2009.
- February 2010, Board staff requested additional information from AUACOM and received that additional information in April 2010After review of that information by the Medical Consultant, the Board staff sent AUACOM another request for additional information. A telephone conference was held with AUACOM and the Board staff to discuss the requested additional information.
- July 20 and 28, 2010, the Board received additional information from AUACOM and at the July 2010 Board meeting, the Board authorized staff to begin the process to for a site visit after AUACOM provided the requested additional information.

- October 2010, Board staff drafted the out of country travel requested. In addition, staff requested further documentation from AUACOM.

- November 2010, the Board received additional information from AUACOM. Board staff submitted the Board's request for out of state/country travel for the AUAUCOM site visit to DCA. Board staff requested clarification regarding some of the information that AUACOM submitted to the Board in early November 2010 and received that clarification from AUACOM.

- December 2010, the Board received the requested clarification from AUACOM. The Governor's office approved the Board's request for the out of state/country travel for the AUACOM site visit. .

  January 2011, the Board received the check for the estimated cost of the site visit.
- The Board had originally scheduled the site visit for March 2011. However, in February 2011 the site visit was rescheduled to May 2011 at the request of the Board due to unforeseen circumstances.

The site visit was conducted between May 15-21, 2011.

The Board's site visit team consisted of the following team members:

Linda Whitney, Executive Director, MBC
Shelton Duruisseau, PhD, MBC Board Member
Anita Scuri, DCA, Supervising Legal Counsel
Jim Nuovo, MD, MBC Licensing Medical Consultant

The site visit consisted of two days in New York visiting two of the hospitals (Richmond University Medical Center on Staten Island and Wyckoff Heights Medical Center in Brooklyn) where AUACOM students receive their clinical rotations (one day at each hospital); a day of travel to the AUACOM campus in Antigua; and two days at the AUACOM campus that also included visiting the new 185 bed hospital where students are allowed to interact with patients to prepare them for their clinical clerkships training in the U.S. The site visit included touring the facilities, reviewing documents, and interviewing AUACOM management, faculty and students at all locations.

Staff requests that Board members review the Medical Consultant's reports (June 6, 2011 and July 6, 2011) and AUACOM's response to the June 6, 2011 report and determine whether to recognize the medical education provided to students by AUACOM who matriculated on or after January 1, 2007.

Neal Simon, President - AUACOM, has advised Board staff that he plans to attend the July Board meeting and Mr. Simon will be joined by Dr. Jagbir Nagra Executive Dean - Antigua Campus & Vice President for Academic Affairs and Dr. Peter Bell-- Vice President for Academic Development and Executive Dean Clinical Sciences.

FISCAL CONSIDERATIONS:

In accordance with Business and Professions Code Section 2089.5, the costs of conducting a site inspection are borne by the medical school applying for the Board's recognition. These costs include all team members' air and ground travel costs within the guidelines allowed by the State, the consultant's daily per diem expense, and the consultant's travel expenses to and from any Board meetings where the team presents its report, and includes the reimbursement of the Board member's per diem of $100.00 per-day for seven days. Subsection (e) of Section 1314.1 of the regulations requires the medical school to reimburse the Board for the team's estimated travel expenses in advance of the site visit. AUACOM prepaid the estimated cost of the site visit and Board staff is in the process of auditing the final costs of the Site Visit Team and preparing to submit the refund request to reimburse AUACOM for the overpayment.

If you have any questions concerning this memorandum, please telephone me at (916) 263-2382.

July 6, 2011 AGENDA ITEM 21

To: Members
Medical Board of California

From: Jim Nuovo, MD
Professor & Associate Dean of Student Affairs and Graduate Medical Education
UC Davis School of Medicine

Re: Evaluation of the American University of Antigua College of Medicine's (AUACOM) Application for Recognition in California

I have received the June 20, 2011 packet submitted by Dr. Seymour I. Schwartz, Provost and the June 24, 2011 letter from Neal S. Simon, President of AUACOM. These materials were submitted in response to questions submitted by the Medical Board's site visit team which are presented in the June 6, 2011 memo.

Based on my review of these materials, and in consultation with all of the members of the site visit team, I feel that AUACOM's response satisfactorily addresses all of the areas of concern.

In summary, I feel that AUACOM is in substantial compliance with the requirements of Business and Professions Code Sections 2089 and 2089.5 and California Code of Regulations, Title 16, Division 13, Section 1314.1. I recommend that the Board recognize AUACOM and that the recognition extend only to those who matriculate at AUACOM on or after January 1, 2007.

June 6, 2011 AGENDA ITEM 21

To: Members
Medical Board of California

From: Jim Nuovo, MD
Professor & Associate Dean of Student Affairs and Graduate Medical Education
UC Davis School of Medicine

Re: Evaluation of the American University of Antigua College of Medicine's (AUACOM) Application for Recognition in California

BACKGROUND

The Medical Board of California (Board) requested a review of materials provided by the American University of Antigua College of Medicine (AUACOM), located on the Caribbean island of Antigua. These were submitted in pursuit of a request for recognition of AUACOM by the Board to enable their students and graduates to participate in clinical clerkships, to enter graduate medical education programs, and become eligible for licensure to practice medicine in California. The goal of this review was to determine if the medical education received at AUACOM meets the requirements of current California statutes and regulations for recognition by the Board.

This report is based on my review of the documents previously provided to the Board by AUACOM, as well as additional information reviewed by the site visit team.

Site Visit Team

The Site Visit Team included:

Linda Whitney, Executive Director, MBC
Shelton Duruisseau, PhD, MBC Board Member
Anita Scuri, DCA, Supervising Legal Counsel
Jim Nuovo, MD, MBC Licensing Medical Consultant

Site Visit Process

Two clinical sites were chosen in New York City which allowed the team to tour the training facilities and to interview students and faculty in all of the core clinical clerkships including: Internal Medicine, Pediatrics, Psychiatry, Obstetrics and Gynecology, Surgery, and Family Medicine. The two training sites were Richmond University Medical Center on Staten Island and Wyckoff Heights Medical Center in Brooklyn. Both hospitals are accredited by the Joint Commission and have ACGME accredited residency training programs. An agenda for the site visit was developed by the team. The site visit at Richmond University Medical Center began at 8 AM and was completed by 6 PM on May 16, 2011. The team met with the educational leadership of

the hospital and then had a series of 45 minute meetings with the key clinical faculty for each clerkship. In these meetings we discussed the goals and objectives of the service, how the instructors determined if the students met these educational objectives, how the faculty monitor each student's performance, how the faculty communicate with AUACOM, and the clinical faculty's perception of how well the students are prepared when they start their clinical rotations.

We then met separately with student groups who were currently on each of the clerkships. In these meetings we asked students to describe how they came to be at AUACOM, how they were informed of the goals and objectives of the rotation, the expectations for the clerkship, how performance feedback is given, the process they use to maintain a log of their clinical experience, how they evaluate the rotation and the faculty, and whether they were aware of differences between the clinical training at their clerkship site versus others offered by AUACOM. There were a total of 27 students interviewed overall at this site.

We had a tour of the hospital at the end of the day which included visiting the following: the Emergency Department, patient wards, conference rooms, student work rooms, call rooms, the library, and information technology resources.

The site visit the following day, May 17, 2011, at Wyckoff Heights Medical Center was identical in structure. The only difference is that we also met with student leadership, who gave a presentation on clinical research projects including poster presentations and community outreach activities. There were a total of 57 students interviewed at this site.

At both sites we reviewed the following documents: the educational binder given to students which included a copy of the goals and objectives for the clerkship, a copy of the requirements to complete the clerkship, performance evaluation forms, and examples of the written examination.

The site visit team then traveled to the main campus on Antigua on May 18th.

On May 19th at 8 AM, we met with the leadership of the School, including Mr. Neal Simon (President of AUACOM), Dr. J.S. Nagra (Executive Dean), Dr. Reza Sanii (Associate Dean of Student Affairs), and Dr. Peter Bell (Executive Dean and Vice President for Academic Development). Dr. Nagra gave an overview of the program and led a tour of the facilities to include: classrooms, simulation training rooms, the library, study rooms, the anatomy/cadaver laboratory, administrative/staff offices, the Educational Enhancement Suite, an outdoor amphitheater, and miscellaneous conference rooms. In addition, the team observed portions of several lectures.

We subsequently met separately with the Deans of Medical Education, the faculty who participate in basic science training, the faculty who direct the clinical training of students during the basic science years, the faculty who have oversight to promotions, education enhancement, and counseling services, and the faculty with oversight into the research program. We had a presentation from Dr. Marcus Merrin, who is in charge of the

Blackboard Educational Enhancement Program, which will be described below. Briefly, Blackboard is a computer-based software learning management system that facilitates communication between students and faculty and provides a portal for access to all the elements of the School's curriculum and administrative tasks. We met with individual groups of students from the Second, Third, and Fourth Semesters; approximately 15 students in each group. The interviews were completed by 6:30 PM.

The following day started with a tour of the Mount St. John's Medical Centre. This is a 185-bed facility where the students are involved in activities to develop their clinical skills during the basic science period (First through Fourth Semesters). This is a newly built hospital and provides care for patients from the island. Dr. Madeleine Fraser and Dr. Hani Morcos, both involved in the Introduction to Clinical Medicine Course, guided the tour. We met with community physicians from the Departments of Surgery, Obstetrics and Gynecology, Internal Medicine and Oncology. We saw the Emergency Department, the Pediatric Ward, the Intensive Care Unit, Labor and Delivery, General Medicine/Surgical Wards, the Dialysis Unit, Radiology, Medical Records, and Administrative Offices.

We returned to the main campus and were provided with the documents listed below; some of which we were able to review on site.

- Minutes from the AUACOM 2010 Joint Meeting of the Basic Sciences and Clinical Sciences Faculty.

- A DVD of the 2011 Joint Meeting of the Basic Sciences and Clinical Sciences Faculty.

- Student portfolios from the clinical clerkships.

- All 140 MSPEs (medical student performance evaluations also known as the Dean's Letter) for the graduating class of 2010.

- The School also provided documentation on the students' performance on USMLE Step 1, Step 2 CK (Clinical Knowledge) and CS (Clinical Skills), outcome information on the 2010 National Residency Matching Program (NRMP) match, and clerkship evaluations required by the AUACOM.

After review of these documents we met for approximately one hour with senior leadership for summary discussion and closing comments. The content of this discussion is included in the section on "Areas Requiring a Response From the School."

On the evening of the final day, we attended a cultural awareness program put on by the students.

RECOMMENDATIONS

After review of all of the information described above it is the opinion of the site visit team that when the issues identified below have been satisfactorily addressed, AUACOM should be deemed to be in substantial compliance with the requirements of Business and Professions Code Sections 2089 and 2089.5 and California Code of Regulations, Title 16, Division 13, Section 1314.1.

However, AUACOM needs to provide additional information to the Board before further action is taken on this recommendation. The specific information needed by the School is described in the section titled "Areas Requiring a Response From the School."

General Overview of the School Curriculum

AUACOM has been in existence since January 2004. It had been previously owned by the Greater Caribbean Learning Resources Incorporated of New York Corporation. It is currently owned by Manipal Corporation which is based out of India. Its stated mission is to "provide excellent medical education to committed candidates in order to graduate skilled ethical and caring physicians who will become life long learners with the ability to conduct and critically evaluate medical research."

AUACOM further states that its "objective is to graduate physicians who have the necessary skills and knowledge to be able to face the increasing challenges healthcare presents globally and specifically in the United States, while breaking down the barriers that underrepresented minorities face in obtaining a medical education and subsequent licensure in the United States."

The 4-Year MD Degree Program at AUACOM is comprised of 10 semesters. The first 4 semesters are covered in two academic years and are primarily didactic with a clinical component integrated into the basic science course work; the Introduction to Clinical Medicine Course. The last two academic years are comprised of 6 semesters which includes taking and successfully completing USMLE Step 1 and completion of the "fifth semester program" at one of AUACOMs five locations in the United States. The fifth semester program is designed to prepare the students for the transition from the basic sciences to the clinical clerkships.

The Clinical Science Component may be completed at 29 participating hospitals in the United States. The arrangements and assignments of the core and elective clinical clerkships are through AUACOM's administrative offices in New York.

The following is a detailed assessment of AUACOM based on the aforementioned regulations and on their responses to the Self-Assessment Report, the additional concerns posed by this reviewer, and the information gathered by the site visit team.

Business and Professions Code Sections 2089

Section 2089 requires the medical curriculum to extend over four years or 32 months of actual instruction. AUACOM's 4-Year MD Program is comprised of 10 semesters. The total number of hours of all courses required to complete the MD degree program is 5,090. This complies with the 4,000 hour minimum requirement in Section 2089. AUACOM requires 80% attendance in all of its courses and monitors compliance through the Blackboard System. AUACOM's curriculum includes all of the courses listed in Section 2089 (b). The information provided in the self-assessment report indicates that the goals, objectives and course content are appropriate.

Business and Professions Code Sections 2089.5

As to the specific clinical sciences requirements in Section 2089.5, AUACOM documented that instruction in the clinical courses meets or exceeds these requirements. For example, Section 2089.5 requires a minimum of 72 weeks of clinical coursework. AUACOM requires 90 weeks of clinical coursework.

Students complete the core clinical rotations required in Section 2089.5 in multiple hospitals in the United States. There are 29 hospitals listed from 7 states and Puerto Rico. The information provided by AUACOM indicates that it is in compliance with item (d); specifically, that the sites provided for these core clinical rotations are in hospitals that meet one of the stated requirements.

California Code of Regulations, Title 16, Division 13, Section 1314.1

The medical school is owned and operated by the Manipal Corporation. AUACOM's mission is to "provide an excellent medical education to committed candidates in order to graduate skilled ethical and caring physicians who will become life long learners with the ability to conduct and critically evaluate medical research," and to "graduate physicians who have the necessary skills and knowledge to be able to face the increasing challenges healthcare presents globally and specifically in the United States, while breaking down the barriers that underrepresented minorities face in obtaining a medical education and subsequent licensure in the United States."

AUACOM provided a description of the faculty for each preclinical course; and these documents indicate that there are an adequate number for the size of the school. There is a sufficient description of the credentials of the faculty to indicate that they are appropriately qualified to teach their specific curricular content.

Based on information obtained in the site visit, AUACOM provides sufficient faculty with appropriate credentials in the clinical clerkships. AUACOM provides sufficient patient exposure to meet these educational requirements except for one area of concern in the outpatient experience in the Family Medicine clerkship at Wyckoff Heights Medical Center. The response required by the School is listed below in the section "Areas Requiring a Response From the School."

AUACOM has published standards governing admission requirements. There is a description of the admissions criteria, student selection and promotion. The School provided sufficient information during the site visit to indicate that it has a comprehensive method of review of students' performance and this is reflected in modifications of the admissions policies and procedures.

AUACOM's policy on the acceptance of transfer students appears similar to the Liaison Committee on Medical Education (LCME) specifically, transfer students must demonstrate achievements in medical school comparable to those of the students in the class that they join. This same criteria applies to transfer students accepted by the AUACOM.

From the information provided and the site visit, the School has adequate facilities to carry out the educational mission; both for the basic sciences and clinical rotations. The main campus is new and opened in January of 2010. It has state of the art information technology systems in place to facilitate the educational mission; i.e. the Blackboard Educational Enhancement Program. Blackboard is a learning management system that enhances accountability. This system permits all examinations to be web-based. The responder lockdown software keeps examinations Internet-secure. It permits a separate version of the examination to be provided to those who request special accommodation. Blackboard can identify students who are at risk—for example, those who scored too low on an examination. Blackboard also includes the turning point audience response system, which allows monitoring of attendance, student feedback, and interactive lectures. AUACOM also has state of the art Simulation Suites to enhance training in basic procedures such as intravenous access, intubation, pelvic and breast examination, insertion of a foley catheter, basic life support, advanced cardiac life support, pediatric resuscitation, and obstetrical care. Some of these efforts are linked to AUACOM's regional efforts to standardize and improve quality of the response to medical emergencies on the island. This is reflected in the AUACOM's support of Mr. Vernon Solomon, the EMT Course director and in having all AUACOM students become ACLS certified.

The classrooms/cadaver laboratory/study space and library resources are all well designed and include the resources necessary for AUACOM to meet the educational objectives of the program.

A concern from my prior evaluation of the AUACOM's Self-Assessment Report was whether it was able to meet the requirements of item (14); Evaluation of Program Effectiveness. Based on the information reviewed at the site visit it is clear that AUACOM has an effective method of collecting and using a variety of outcome data to demonstrate the extent to which it is meeting the educational program objectives. An example of this is in the minutes of the 2010 Joint Meeting of the Basic Sciences and Clinical Sciences Faculty. This document demonstrates compliance with an ongoing method of effective self-assessment and continuous improvement in the integration of the basic and clinical sciences. The summary points made in these minutes closely matched

the independent assessment of the Board's site visit team. We feel this confirms that AUACOM has a robust means of self-assessment to guide continuous improvement.

AUACOM is meeting its stated goals to support diversity of its student body and its faculty and is actively involved in its community with projects for health screening and education of the island's population.

Efforts to improve the Introduction to Clinical Medicine (ICM) Course have been substantial, are well-documented and meet the objectives. Students are better prepared for their clerkships. The site visit team was informed by virtually all of the clinical faculty in New York that there had been a substantial improvement in clinical skills and preparedness within the past two years and that the students are now on a par with students from other medical schools.

The educational resources for the expanded ICM Course include:

- The Doctor/Patient/Society (DPS) Curriculum.
- A Hospital Community Project.
- Simulation Suite Training (as described above).
- Professional Patients.
- Small Group Labs.
- Hospital Rounds.
- Lectures.
- Community Based Clinics.
- School Education Projects.
- 7 Station OSCEs (Objective Structured Clinical Examinations).
- NBME (National Board of Medical Examiners) Preparation.
- Skills Labs.
- The Pan Caribbean Center for excellence; a regional effort to improve delivery of ACLS level care.

There is a growing research presence on the campus and at the clinical clerkship sites. There were a number of poster presentations that we reviewed including a variety of scholarly efforts. Many of these involved case reports and community projects. The School currently has a $70,000 (US dollars) budget to support these research activities. AUACOM is engaged in discussions about forming a foundation or other nonprofit entity that could obtain funding for research for which AUACOM itself may not otherwise be eligible.

AUACOM presented information on its financial resources. The funds to support AUACOM come from tuition fees. AUACOM describes an operating budget of $38.5 million (US dollars). AUACOM appears to have sufficient financial resources to carry out its stated mission.

AUACOM indicates that it is compliant with the requirement to retain student transcripts. They are kept indefinitely.

Areas Requiring a Response From the School

1. The site visit team was concerned with the ability of the school to assess the content of the student portfolios to ensure that each student was given appropriate supervision and performance feedback. Further, the team was concerned whether AUACOM was using aggregate information from the portfolios to assess the quality and equivalence of the clerkship sites and the effectiveness of the basic science and clinical training in the first five semesters on the student's performance in the clerkships.

Portfolios are required for each student and based on our review of these documents, the content areas in these portfolios is appropriate. However, upon review of the completed portfolios at the main campus the team identified areas for improvement that need to be addressed by AUACOM prior to further action by the Board.

It was unclear how the clinical site faculty closed the feedback loop to follow-up with a student's performance deficiencies. For example, when students were given feedback that their history and physical exam sections needed improvement, we could not determine if there was sufficient follow-up with subsequent write ups. It was unclear how the portfolio was integrated back with the main campus; for example, in a student with performance concerns in physiology; how this information is linked back to the basic science faculty. For a student with performance improvement needed in physical diagnosis, it was unclear how this information came back to the instructors in the Introduction to Clinical Medicine course.

AUACOM needs to provide the Board with its corrective action plan to link the portfolio findings for continuous improvement for each student and for the aggregate of students. For each student, AUACOM should provide a corrective action plan with outcomes on how clinical site faculty will address performance concerns and how the outcomes will be monitored; e.g. how they will be able to determine if the student did correct the observed deficiency after receiving feedback. AUACOM will need to describe its process for monitoring this continuity over each clerkship for a student. Specifically, that if it observed that a student has a weakness in linking basic science knowledge to clinical practice in one setting; that this doesn't repeat in subsequent clerkships. AUACOM needs to demonstrate that it links the findings of the portfolio to activities in the ICM Course, SIM efforts, the Basic Science Courses, and the Educational Enhancement Department. Finally, AUACOM needs to provide the Board with its method to review the portfolio results in aggregate to ensure the various clinical sites are providing equivalent experiences. For example, in determining whether all students see the appropriate mix of patient problems and whether they have adequate exposure to procedures.

2. The site visit team also noted variability in how the clinical clerkships assessed cognitive skills obtained during the clerkships. Some clerkship directors used a written exam from another medical school and some used an examination that they personally wrote. The grading of the examinations was inconsistent and it was unclear how this information was used to determine if a student passed the clerkship.

AUACOM needs to describe steps it will take to standardize assessment of the cognitive skills in clinical clerkships outside of its efforts to use the shelf exams. AUACOM's Blackboard system has the capability to provide it sufficient tools to help it with such standardization; and must present a clear action plan with outcome goals that are measurable.

3. The Educational Enhancement Department (EED) activities in AUACOM is a real strength and demonstrates commitment to supporting the students. However, EED is not sufficiently linked to the students when they are offsite. This is a concern, as it is expected that students will have performance concerns that are within the scope of this office, and that involvement of the EED in the clerkship years will provide important information on the effectiveness of educational interventions. AUACOM should provide a written summary to the Board with its corrective action plan that provides stronger educational and mental health support link between this department and students in the clerkship years. This response should include what outcomes will be monitored.

4. Our team's reflection of clinical sciences training is that there are excellent educational opportunities for the students. AUACOM supports a head of a clinical department who is the key contact person for the rotation. The faculty we met are uniformly enthusiastic teachers and are clearly qualified to be in the teaching role. But AUACOM must demonstrate its authority and responsibility for the educational outcomes and assessment for each student and the aggregate of students over time. This must include methods to standardize the evaluation process and to train the clinical faculty utilizing the same method used to standardize test questions for the basic sciences. AUACOM must inform the board how AUACOM will intervene to ensure that clinical faculty are trained in development of summative and formative feedback, that they can identify performance areas of concern, intervene, and monitor outcomes of the intervention over time. It should be noted that AUACOM has already demonstrated its capacity to do this with the Basic Science Faculty; an example being the standardization of methods to write test questions. Applying this same process to the Clinical Faculty should result in improvement in setting performance standards that are consistently applied and reviewed across all clinical sites.

5. Our team was concerned with the lack of comprehensive written feedback given by the head of the clinical department for a clerkship, how this information is given to the students and to the School, and how this information is incorporated into the final performance summation letter [known as the MSPE (Medical Student Performance Evaluation) or Dean's Letter]. This concern overlaps with the previously stated need to ensure that clinical faculty are trained in the development of summative and formative feedback and that the school ensures that students review this information, develop an educational plan to address performance deficiencies if necessary, and that the School demonstrate oversight in monitoring a students performance over the time they are in the clinical years of training. In reviewing the 140 MSPE's from the Class of 2010, it was noted that none of the letters contained structured summative evaluations from all of the clerkships. Further, the performance information provided does not reflect an assessment in each of the core competencies; medical knowledge, patient care, interpersonal skills

and communication, professionalism, practice-based learning and improvement, and systems-based practice. This is not consistent with the 2002 Association of American Medical Colleges (AAMC) Guidelines for writing an MSPE. It is also not consistent with the expectations that the institution collect and use outcome-based performance measures of knowledge, skills, attitudes and values. The content of the MSPE functions as one means to document that the school has comprehensive oversight to the performance of its students. Omitting performance content from most of the clinical clerkships may diminish the strength of a student's application for a residency position.

As stated above, there should be a written response to how AUACOM will intervene to ensure that clinical faculty are trained in development of summative and formative feedback, that they document that students and AUACOM faculty review this feedback, that educational plans are developed and monitored to address performance deficiencies, and to ensure that the MSPE provides a comprehensive report of performance in each of the clerkships.

6. The clinical training in outpatient family medicine at Wyckoff Heights Medical Center was concerning. The students described a volume of patients that was low and described variable expectations for whether they should write a note or present a patient to the resident or attending. Specifically, students informed the site visit team that they would see on average 1-2 patients during a clinic and that the resident may or may not have them write a note and present the patient to them, and that sometimes the faculty would only have the resident present the case. The School needs to reassess the quality of the outpatient experience at this site and inform the Board the steps that have been taken to ensure that students have an appropriate clinical experience in family medicine. AUACOM needs to describe to the Board the methods it will use to monitor this experience and to ensure that the onsite faculty are aware of their teaching expectations.

SUMMARY

Again, the summary recommendation by the site visit team is that AUACOM is in substantial compliance with the applicable statutes and regulations provided there is a satisfactory response to the above stated concerns prior to action by the Board on the request for recognition. In addition, AUACOM must respond to the above stated concerns prior to action by the Board.

Should the Board vote for recognition it will need to be determined whether this recognition will be retroactive to prior graduating classes. The site visit team had the opportunity to assess this question. The faculty at the clinical training sites indicated repeatedly that "something happened in the past two years" that demonstrated effective change by AUACOM in preparing their students for the clerkships. It became clear to the site visit team that the reasons for this improvement are multi-factorial and reflect changes in the Introduction to Clinical Medicine, Curricular Integration of Basic and Clinical Sciences, and the Fifth Semester Program.

Given this information, it is the opinion of the site visit team that when the issues identified above have been satisfactorily addressed, AUACOM should be deemed to be in substantial compliance with the requirements of Business and Professions Code Sections 2089 and 2089.5 and California Code of Regulations, Title 16, Division 13, Section 1314.1 and given the information provided at the clinical sites regarding the timing of significant changes in the preparation of the students, the team recommends that the Board's recognition extend only to those who matriculate at AUACOM on or after January 1, 2007.

We note that, in accordance with Business and Professions Code Section 2135.5(e), a student who matriculated at AUACOM prior to January 1, 2007 may nonetheless apply for licensure in California and be evaluated by the Board, through its Application Review Committee.

Finally, we are aware that students from Kasturba Medical College International Center (KMCIC), located in India, complete their basic science training at that site, and then do clinical training at the same facilities as students enrolled at AUACOM. The site visit was not focused on the training at KMCIC, and it should be clear that graduates of this school are not part of the recognition process of this report.

Students who complete their Basic Sciences at KMCIC will therefore not be eligible to do clinical rotations or postgraduate training in California nor would they be eligible for licensure in California even if they graduate with an MD degree from AUACOM unless KMCIC or its parent school (if applicable) applies for and is granted recognition of the program/school.

AMERICAN UNIVERSITY OF ANTIGUA COLLEGE OF MEDICINE

RESPONSE TO

MEDICAL BOARD OF CALIFORNIA
JUNE 6, 2011 - SITE VISIT REPORT

American University of Antigua
Manipal Education

June 24, 2011

Curt Worden, Esq.
Chief of Licensing
California Medical Board
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

RE: Site Visit

Dear Mr. Worden:

Please find AUA's responses to the California Site Team's "areas requiring a response from the school."

On behalf of AUA, its administrators, faculty and students, I join Dr. Seymour Schwartz in thanking the site team for their time and effort in reviewing AUACOM. AUA is committed to improving its educational programs. AUA is not just interested in meeting standards, but rather in exceeding standards, to provide the best medical education possible.

The site team's report has been invaluable in this regard. I trust AUA's response to the "areas needing a response" is indicative of the value we place on the input of the site team as well as AUA's commitment to a continued process of improvement.

Thank you.

Sincerely yours,

Neal S. Simon
President

c/o GCLR, LLC, 2 Wall Street, • New York, NY 10005 • 212-661-8899

American University of Antigua
Manipal Education

June 20, 2011

RE: AUA Site Visit

To the California Site Team:

On behalf of the faculty and staff of the AUA, I express deep appreciation for efforts expended in conducting your thorough review of our academic program. We are in agreement with the California Site Team's suggestions. We are extremely pleased and encouraged by your generally favorable assessment and offer the accompanying responses to your specific areas of concern.

We emphasize that it has been the continuous and unalterable goal of our institution to provide our students with an educational experience that equates with the continental United States and Canadian schools. The desired end points are that our graduates perform well on licensing examinations, achieve sought-after residencies, and, ultimately, become highly regarded participants in the medical profession. Not only does the AUA hope to be recognized for its parity with the other institutions approved by the California Board, but it intends to become regarded as the premier off-shore medical school.

Respectfully submitted,

Seymour I. Schwartz, M.D., Provost

c/o GCLR, LLC, 2 Wall Street, • New York, NY 10005 • 212-661-8899

Areas Requiring a Response from the School

1. The site visit team was concerned with the ability of the school to assess the content of the student portfolios to ensure that each student was given appropriate supervision and performance feedback. Further, the team was concerned whether AUACOM was using aggregate information from the portfolios to assess the quality and equivalence of the clerkship sites and the effectiveness of the basic science and clinical training in the first five semesters on the student's performance in the clerkships.

Portfolios are required for each student and based on our review of the documents, the content areas in these portfolios is appropriate. However, upon review of the completed portfolios at the main campus the team identified areas for improvement that need to be addressed by AUACOM prior to further action by the Board.

It was unclear how the clinic site faculty closed the feedback loop to follow-up with a student's performance deficiencies. For example, when students were given feedback that their history and physical exam sections needed improvement, we could not determine if there was sufficient follow-up with subsequent write ups. It was unclear how the portfolio was integrated back with the main campus; for example, in a student with performance concerns in physiology; how this information is linked back to the basic science faculty. For a student with performance improvement needed in physical diagnosis, it was unclear how this information came back to the instructors in the Introduction to Clinical Medicine course.

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Corrective Action Plan

Based on AUACOM's own assessment of the evaluation of each student's performance in a given clinical rotation, each student's longitudinal performance throughout the clinical education

in various subjects at different departments, the comparability of rotations in the same subject area at different clinical sites and on the oral recommendations of the Site Visit Team, AUACOM has introduced improvements to its existing procedures. Portfolio review is conducted as follows:

1. Students maintain a portfolio on a daily basis.

2. Students submit the portfolio on a weekly basis to clinical faculty for sign off.

3. On a weekly basis at the time of the faculty sign off, the faculty will review the student's portfolio and will address performance concerns directly with the student. Areas where improvement is needed will be re-visited during the sign off in the following week. This is in addition to the continuous daily supervision of the student by the clinical faculty. The quality of the student's portfolio is part of the student's clerkship evaluation.

4. Faculty can comment in writing during the sign offs or at the final review of the portfolio (a weekly faculty sign off box and a faculty comment box have been added to the formal portfolio). [see attached]

5. The completed portfolio, including faculty comments and sign offs, list of academic activities, patient logs and case write ups, is submitted by the student to the office of the Executive Dean Clinical Sciences (EDCS).

6. If a student receives a failing grade in the clerkship, he/she must repeat the clerkship. If the failing grade is due to failing the portfolio or other academically-related competency, then the EDCS shall contact the student to determine what remediation the student might need in order to improve his/her portfolio or other academically-related competency and arrange for necessary remediation with EED faculty, mentor, etc. The EDCS shall in addition notify the clinical chair responsible for the next scheduled rotation to monitor the student's overall performance as well as his specific performance on the portfolio during that rotation.

7. The office of the EDCS files the portfolios in the school's database.

8. The grade for the clerkship will not be released to the student unless the portfolio was submitted.

9. AUACOM's database provides web-based access to authorized individuals such as the EDCS, the clinical chairs and the clinical faculty.

10. EDCS, the clinical chairs and the clinical faculty review individual student portfolios, or all portfolios of a given student, all portfolios at a given clinical site, and all portfolios of a given subject on a real time basis.

11. The Office of the Executive Dean shall compile and maintain aggregate information of student performance for each individual clinical site.

AUACOM has had, and continues to have, a policy that requires review of student portfolios, the student's evaluation of the individual rotation, the EDCS and clinical chair's ongoing communication with clinical faculty at the various clinical sites, either via phone or email and at a minimum annual site visits by each program chair and discussions at bi-monthly scheduled conference calls between EDCS and the clinical chairs and during the annual Basic & Clinical Sciences Faculty Meeting. In addition, the EDCS and the clinical chairs provide formal and informal feedback to the basic sciences faculty including Education Enhancement Department (EED) faculty. Clinical chairs also meet with basic sciences faculty in Antigua on as needed basis but at least twice a year.

Based on the described review processes the Provost, EDCS and Clinical Chairs evaluate the continuity of clinical education across all clinical sites; thereby ensuring that the various clinical sites provide equivalent clinical experience to all students.

A summary of this feedback is provided during weekly scheduled conference calls between the Provost, EDCS, the dean responsible for 5th semester and the Executive Dean Basic Sciences, in direct communication among the clinical chairs and the basic sciences faculty via phone and email, in direct communication and discussions during the annual Basic & Clinical Sciences Joint Faculty Meeting, during the annual Clinical Chair meeting on the basic sciences campus in Antigua (one out of 4 scheduled clinical chair meetings per year) and during the visits of individual clinical chairs to the campus in order to fulfill their teaching commitment in the basic sciences courses, especially ICM.

The revised ICM syllabus, the establishment of the clinical skills laboratory, the simulation laboratory on the Antigua campus, the revised format of the 5th semester and the overall curriculum revision leading to a 24 month clinically integrated basic sciences education serve as evidence that an effective ongoing feedback mechanism is in place. Suggestions by clinical faculty and students are communicated to basic sciences committees which induce necessary changes to improve learning.

As a consequence of the clinical students' feedback, communicated to the Provost, the Physiology course at AUA is currently undergoing external review by a member of the faculty from Washington University, St Louis. Similarly, Pathology has been reviewed by the course instructor at the University of Rochester, School of Medicine. The process of external review by medical education experts from U.S. Medical Schools has been and will continue to play an important part in AUA's course evaluation process. In addition to the above external reviews, faculty from the University of Rochester School of Medicine have conducted external reviews of the Anatomy course, the Microbiology course, and the Histology course. The recommendations of the eternal reviewers have played an important role in the course evaluations and have led to changes in course curriculum as appropriate.

AMERICAN UNIVERSITY OF ANTIGUA

College of Medicine

Student Portfolio

Student Name:

Student ID Number:

Name of Hospital:

Type of Clerkship:

(Choose from Internal Medicine, Surgery, Pediatrics, Obstetrics & Gynecology, Psychiatry, Family Practice or enter an Elective)

Name of Specialty:

Start Date (mm/dd/yyyy): **End Date (mm/dd/yyyy):**

PART 1

Patient Log:

See Attached Spreadsheet

PART 2

List 3 cases and discuss in depth:

- Pathophysiology
- Differential Diagnosis
- Findings to Support Final Diagnosis
- Treatment Options

Case 1: (500 word maximum)

Case 2: (500 word maximum)

Case 3: (500 word maximum)

PART 3

Procedure Log:

See attached Spreadsheet

PART 4

Academic Activities:

See attached Spreadsheet

Formal Case Presentations (If Applicable):

See attached Spreadsheet

Lectures/Grand Rounds/ Conference Attended:

See attached Spreadsheet

Faculty Comments

Weekly Faculty Sign-off

Week	1	2	3	4	5	6	7	8	9	10	11	12
Faculty Initial												

2. The site visit team also noted variability in how the clinical clerkships assessed cognitive skills obtained during the clerkships. Some clerkship directors used a written exam from another medical school and some used an examination that they personally wrote. The grading of the examinations was inconsistent and it was unclear how this information was used to determine if a student passed the clerkship. AUACOM needs to describe steps it will take to standardize assessment of the cognitive skills in clinical clerkships outside of its efforts to use the shelf exams. AUACOM's Blackboard system has the capability to provide it sufficient tools to help it with such standardization; and must present a clear action plan with outcome goals that are measurable.

AUACOM recognizes the need to improve the standardized assessment of cognitive skills obtained during the clerkships at various clinical sites and has found that it agrees with the LCME that this is one of the most difficult challenges in modern medical education. At present, AUACOM utilizes site specific examinations at the end of each clerkship in addition to USMLE Step 2 CK for final determination of the student's cognitive skills; passing of USMLE Step 2 CK (and CS) is a pre-requisite for graduation. The National Board of Medical Examiners (NBME) describes their exams as follows:

> Step 2 assesses whether you can apply medical knowledge, skills, and understanding of clinical science essential for the provision of patient care under supervision and includes emphasis on health promotion and disease prevention. Step 2 ensures that due attention is devoted to principles of clinical sciences and basic patient-centered skills that provide the foundation for the safe and competent practice of medicine.
>
> Step 2 CK assesses whether you can demonstrate the fundamental clinical skills essential for safe and effective patient care under supervision. There are three subcomponents of Step 2 CS: Integrated Clinical Encounter (ICE). Communication and Interpersonal Skills (CIS) and Spoken English Proficiency (SEP).

Corrective Action Plan

By July 2012, NBME has agreed to administer clinical shelf exams for AUA at PROMETRIC centers. Discussions with the National Board of Medical Examiners (NBME) over the past 15 months revealed that paper-based NBME clinical subject shelf examinations are not a feasible solution for AUACOM's students because it would require that all clinical sites be accredited as NBME testing sites and that each site administer different NBME shelf examinations at different times. NBME was not supportive of this solution. Web-based NBME clinical subject shelf examinations were not available at that time. In recent discussions between AUACOM and NMBE, a solution was found. By July 2012, NBME will be in the position to administer clinical subject shelf examinations web-based via PROMETRIC testing centers nationwide. AUACOM has already agreed to subscribe to that service as soon as it becomes available. Utilizing web-

based NBME clinical subject shelf examinations administered at PROMETRIC testing sites will provide standardized assessment of cognitive skills at the end of each clerkship.

Until July 2012 when NBME is in the position to administer web-based clinical subject shelf examinations at PROMETRIC testing centers, AUACOM will administer standardized web-based examinations in all clinical core subjects. The NBME has agreed to provide seminars to faculty.

In Family Medicine, OB/GYN, and Psychiatry, the AUA faculty is developing standardized examinations. The examinations will contain no less than 30 questions, written by AUACOM faculty and chairs. Those examinations will be administered as open book web-based examinations at the end of each clerkship via AUACOM's e-learning platform BlackBoard. Clinical chairs will review and grade the examinations, allowing them to further assess the cognitive skills of each student. The first exam in the subject of Psychiatry has already been placed on BlackBoard, and serves as a pilot study for internal exam evaluation.

In the core subject areas of Surgery, Internal Medicine, and Pediatrics, AUACOM uses MedU, a web-based peer reviewed e-learning platform widely used by U.S. LCME accredited medical schools. The programs, SIMPLE for Internal Medicine, CLIPP for Pediatrics and WISEMD for Surgery provide case-based clinical content in those subject areas already utilized by AUACOM in order to standardize clinical subject content across clinical sites, and content testing features. AUACOM clinical faculty is in the process of familiarizing with the subject testing features. The first tests administered via MedU in Internal Medicine using the case-based SIMPLE testing feature is scheduled to be administered in late June of this year.

3. The Educational Enhancement Department (EED) activities in AUACOM is a real strength and demonstrates commitment to supporting the students. However, EED is not sufficiently linked to the students when they are offsite. This is a concern, as it is expected that students will have performance concerns that are within the scope of this office, and that involvement of the EED in the clerkship years will provide important information on the effectiveness of educational interventions. AUACOM should provide a written summary to the Board with its corrective action plan that provides stronger educational and mental health support link between this department and students in the clerkship years. This response should include what outcomes will be monitored.

Corrective Action Plan

AUACOM has recognized the positive impact of the Department for Educational Enhancement (EED) on the performance of the students during their education in basic sciences. The benefits of extending the services of the EDD to students during their clinical education are evident. In order to fulfill this goal AUACOM has retained a long serving faculty member of EED, to extend the reach of the department to clinical sciences students. This individual, Dr. Carla Cummings, is now based in the U.S. and will interact with the clinical students through site visits, personal counseling and via the established BlackBoard e-learning platform.

In this position, she works directly with the EDCS, the clinical chairs and faculty to create avenues for students to work towards a seamless transition from basic sciences to clinical sciences through residency and maximizing opportunities from the moment they commence their clinical rotations.

A Community area in Blackboard for Students has been created and includes:

USMLE Exam study strategies/resources will include

- Video Demos, Internet Links, Self-Assessment, E-Textbooks, Simulated Patient Scenarios
- Time management/Exam taking skills/Test Anxiety resources
- Resource Area for each level, Step 1, Step 2 CK, Step CS, Step 3

Perspectives from Current Students

- Advice on Passing Step
- Balancing professional and personal lives

Transitional Information for Clinical Site Areas/Student Discussion Boards

- Housing
- Transportation
- Basic Needs

Professional Organizations

- Conferences
- Networking

Workplace

- Conflict resolution
- Professionalism/Ethics
- Networking/Communication

Funding/Grant Writing/Scholarship Opportunities

Value of Professional Development Opportunities (in collaboration with AUACOM's section for professional guidance)

- Research
- Community Service/International Service Opportunities
- Journal Article Submission

Resume/Personal Statement Writing

- Sample Resumes and Personal Statements for Health Professionals
- Practice Interview Questions

Self-Enrolled Groups are being created for each Clinical Site/Discussion Boards for each Hospital

The U.S. based EED faculty member will connect with clinical students as they transition to the States to alert them to the support AUACOM provides:

- Blackboard Community, Social Networking, Email, Phone
- Site visits as necessary
- Assessment of students' perception of needs

The clinical faculty member, in co-operation with campus-based EED faculty and the Associate Dean for Clinical Students, Christine Olazagasti, will provide individual mentoring and assistance to students. Students who are deemed to be at risk due to academic (poor exam results, clerkship evaluations, portfolio comments) or non-academic activities will be identified and contacted to set up necessary remedial assistance. The EED will be available for clinical students through a number of modalities including in-person interaction, as well as via Skype, BlackBoard, on-line chat, email and phone.

In addition, EED will help students establish teaching assistant (TA) style study groups at each clinical site based on the positive experience with those groups on campus. Those groups will facilitate student's self-study utilizing mock examinations as well as patient simulators (SIM-Man, Harvey, models) where available.

The AUACOM's Student Ambassadors Program is being extended to the clinical sites. Two or more student representatives at each clinical site will guide new students through their first weeks of new clerkship experience and will assist in academic and non-academic issues.

The envisioned success of that program, similar to the success of the EED's program on campus, cannot be monitored or defined by a single outcome indicator. Outcome indicators include but are not limited to student performance in clinical clerkships as documented on the clerkship evaluation form, performance on standardized tests including USMLE Step 2 CS and CK, and clinical student exams, student satisfaction surveys and residency placement.

To supplement our present Mental Health support for clinical students, AUA has added additional U.S. based staff to its counseling center. Dr. Joyce Kleinberg, Ph.D., who is based in the New York Metropolitan area and who has previous experience counseling students as part of a University Counseling Center and who has been in private practice for over 25 years, shall provide mental health counseling or referrals to mental health professionals as circumstances dictate. In addition, AUA will continue to use the Department of Psychiatry of Richmond University Medical Center for consults and referrals in mental health issues.

4. ***Our team's reflection of clinical sciences training is that there are excellent educational opportunities for the students. AUACOM supports a head of a clinical department who is the key contact person for the rotation. The faculty we met are uniformly enthusiastic teachers and are clearly qualified to be in the teaching role. But AUACOM must demonstrate its authority and responsibility for the educational outcomes and assessment for each student and the aggregate of students over time. This must include methods to standardize the evaluation process and to train the clinical faculty utilizing the same method used to standardize test questions for the basic sciences. AUACOM must inform the board how AUACOM will intervene to ensure that clinical faculty are trained in development of summative and formative feedback, that they can identify performance areas of concern, intervene, and monitor outcomes of the intervention over time. It should be noted that AUACOM has already demonstrated its capacity to do this with the Basic Science Faculty; an example being the standardization of methods to write test questions. Applying this same process to the Clinical Faculty should result in improvement in setting performance standards that are consistently applied and reviewed across all clinical sites.***

LCME ED-8 states: There must be comparable educational experiences and equivalent methods of evaluation across all alternative instructional sites within a given discipline.

> Compliance with this standard requires that educational experiences given at alternative sites be designed to achieve the same educational objectives. Course duration or clerkship length should be identical, unless a compelling reason exists for varying the length of the experience. The instrument and criteria used for student evaluation, as well as policies for the determination of grades, should be the same at all alternative sites. The faculty who teach at various sites should be sufficiently knowledgeable in the subject matter to provide effective instruction, with a clear understanding of the objectives of the educational experience and the evaluation methods used to determine achievement of those objectives. Opportunities to enhance teaching and evaluation skills should be available for faculty at all instructional sites.
>
> While the types and frequency of problems or clinical conditions seen at alternative sites may vary, each course or clerkship must identify any core experiences needed to achieve its objectives, and assure that students received sufficient exposure to such experiences. Likewise, the proportion of time spent in inpatient and ambulatory settings may vary according to local circumstance, but in such cases the course or clerkship director must assure that limitations in learning environments do not impede the accomplishment of objectives.
>
> To facilitate comparability of educational experiences and equivalency of evaluation methods, the course or clerkship director should orient all participants, both teachers and learners, about the educational objectives and grading system used. This is accomplished through regularly scheduled meetings between the director of the course or clerkship and the directors of the various sites that are used.

The course/clerkship leadership should review student evaluations of their experiences at alternative sites to identify any persistent variations in educational experiences or evaluation methods.

While AUACOM believes that in general it complies with ED-8, it agrees with the site team, that AUA must do more so that the instruments and criteria used for student evaluations as well as determination of grades are comparable at all alternative sites, and we thank the site team for confirming our concerns.

AUA realizes that this is a difficult task as does the LCME (See Whitcomb, The AAMC Project on Clinical Evaluation of Medical Students).

Corrective Action Plan

AUACOM has recognized the need to improve standardized assessment of an individual student's performance across various disciplines and clinical sites. As detailed in AUACOM's response number two (2), AUACOM is in the process of introducing standardized tests in the core subject areas utilizing either AUACOM's web-based BlackBoard e-learning platform (Family Medicine, OB/GYN and Psychiatry) or the web-based peer reviewed e-learning platform MedU (Internal Medicine, Surgery, Pediatrics) and will introduce clinical subject shelf exams in 2012. Clinical chairs and faculty are currently trained by AUACOM's EED faculty and members of AUACOM's information technology team, which includes one academician. Pilot tests are conducted via BlackBoard for Psychiatry and via MedU for Internal Medicine (SIMPLE).

AUA recognizes its responsibility to ensure that its faculty has adequate training in the development of summative and formative feedback. In order to improve faculty skills in this regard, AUACOM will use the resources of EED, which are being made available to clinical faculty utilizing AUACOM's web-based e-learning platform BlackBoard, as well as promoting live or virtual attendance of faculty in educational workshops provided by professional associations, including the AAMC, even if they have already taken part in these workshops in the past. AUACOM faculty and programs are also subject to systematic program review. The program review process includes analyses of the faculty members' achievement of the program's outcomes and supports appropriate linkages among scholarship, teaching, and student learning. AUA has already acted on the suggestion of the site team that the clinical faculty receive continued training in such areas as the "standardization of methods to write test questions." In this regard, we have contacted **Aggie Butler Ph.D., Associate Vice President of Medical School Services of the National Board of Medical Examiners to have the National Board of Medical Examiners conduct training sessions on standardization of methods and writing test questions for AUA clinical faculty.** The first seminar is tentatively scheduled for New York in July. We are awaiting the contract from the NBME, which will be forwarded to you upon receipt.

EED supports AUACOM faculty in providing orientation, training, teaching assistantships, and small learning communities. Evaluation practices are aligned with the mission of the institution and educational objectives. Evaluation processes are systematic and include peer review. Evidence of teaching effectiveness including student evaluations of instruction is included. Resources are provided from a review of the literature. Qualitative and quantitative research studies are provided to faculty to promote the development of formative and summative

assessments that are tracked in Blackboard. Additionally, EED provides faculty with updates on best practices in the field. These practices are now being extended to all clinical faculty.

EED also provides additional opportunities for faculty professional development for the purpose of improving teaching and student learning that meet the institution's objectives. AUA is adding to its agenda for its annual clinical faculty meeting, sessions on improving teaching and student evaluation techniques. These sessions will be conducted by specialists in clinical teaching and assessment; we expect the NBME will agree to conduct some of these sessions.

5. Our team was concerned with the lack of comprehensive written feedback given by the head of the clinical department for a clerkship, how this information is given to the students and to the School, an how this information is incorporated into the final performance summation letter [known as the MSPE (Medical Student Performance Evaluation) or Dean's Letter]. This concern overlaps with the previously stated need to ensure that clinical faculty are trained in the development of summative and formative feedback and that the school ensures that students review this information, develop an educational plan to address performance deficiencies if necessary, and that the School demonstrate oversight in monitoring a students performance over the time they are in the clinical years of training. In reviewing the 140 MSPE's from the Class of 2010, it was noted that none of the letters contained structured summative evaluations from all of the clerkships. Further, the performance information provided does not reflect an assessment in each of the core competencies; medical knowledge, patient care, interpersonal skills and communication, professionalism, practice-based learning and improvement, and systems-based practice. This is not consistent with the 2002 Association of American Medical Colleges (AAMC) Guidelines for writing an MSPE. It is also not consistent with the expectations that the institution collect and use outcome-based performance measures of knowledge, skills, attitudes and values. The content of the MSPE functions as one means to document that the school has comprehensive oversight to the performance of its students. Omitting performance content from most of the clinical clerkships may diminish the strength of a student's application for a residency position.

As stated above, there should be a written response to how AUACOM will intervene to ensure that clinical faculty are trained in development of summative and formative feedback, that they document that students and AUACOM faculty review this feedback, that educational plans are developed and monitored to address performance deficiencies, and to ensure that the MSPE provides a comprehensive report of performance in each of the clerkships.

AUA has arranged for faculty from the University of Rochester School of Medicine and is in discussion with the Mayo Medical School to have faculty with expertise in development of summative and formative feedback provide additional training to AUA's clinical faculty in development of summative and formative feedback These seminars will also be available to AUA faculty through BlackBoard.

In order to insure that student feedback from faculty is documented, AUACOM is requiring the clinical faculty to formally review student portfolios on a weekly basis; a comment box and a sign off box have been added to the formal portfolio [see attachment to response #1]. During those formal reviews, faculty will address areas of concern in direct conversation with the student. This is in addition to the daily educational interaction between faculty and students, during which deficiencies are immediately addressed and corrected. It is the policy of AUA that student portfolios and the clerkship evaluation forms are submitted to the office of the EDCS at

the end of each rotation and are made web-based available via the AUACOM's database to all stakeholders.

Even though AUACOM's MSPEs played a significant role in securing outstanding residencies for our students in the 2011 match AUACOM recognizes the need to enhance the formative and summative evaluation of its students' clinical performance, and the need to communicate and remediate perceived shortcomings. While the AAMC Guidelines for writing MSPEs are not always followed (by U.S. medical schools), we agree with and appreciate the site team's suggestions that AUA's MSPEs should follow the AAMC Guidelines. In this regard, AUA has already provided the various involved parties the AAMC Guide to the preparation of the MSPE [see attached].

In order to follow the recommendations of the AAMC Guidelines, AUA will also need to change its clinical evaluation forms. AUA has reviewed clinical evaluation forms used by a number of U.S. Schools. AUA decided that the clinical evaluation form attached hereto is best suited for evaluating clinical students and providing information needed for the MSPEs.

In addition, to formalize performance feedback between student and faculty, faculty and students will be given a format for student evaluations.

1. Prior to entering the clerkship, students will be given copies of the evaluation format, so that they know what behaviors are praiseworthy and which are deemed unacceptable. Our standards of excellence should be clearly advertised to the students at the outset [see attached- Domains of Performance].
2. Near the mid-point of the clerkship, faculty will be required to conduct an on-line mid-clerkship formative evaluation, focusing on how students have fulfilled those expected standards. Faculty will be encouraged to be critical in these formative mid-clerkship evaluations, citing specific deficiencies and areas to improve upon. Faculty will be encouraged to specify at least two domains in which each student (even the best) should strive to improve upon. It should be noted by all that these mid-clerkship evaluations will not be counted in the final grading, except to make note of improvement or lack thereof.
3. To educate faculty on proper evaluation, each of the six domains of evaluation will list examples of performance deemed unacceptable and examples of outstanding performance. Faculty will be expected to check the box denoting the level met by each student and to write a narrative evaluation of each evaluated domain.
4. Each student will meet with the Faculty mid-way through the clerkship to review the student's performance. Specific deficiencies and excellences will be discussed, and the Faculty member will counsel students on ways to improve areas of perceived deficiency.
5. At the end of the clerkship, teaching faculty will complete the evaluation form and submit it on-line to the Site Director. The Site Director will then form a composite evaluation, weighting grades and comments made by faculty according to their duration of exposure to the student. Special note will be made of improvement (or lack of it) in domains previously identified as having been problematic. A copy of that composite evaluation will be made available to the student, and a copy will be submitted to the Clinical Chair and to the Graduate Affairs Office. Abstracts of these evaluations will be incorporated into the body of the student's MSPE.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

A Guide to the Preparation of the Medical Student Performance Evaluation

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Foreword

Establishment of Initial Guidelines for the Dean's Letter

In 1989, the Association of American Medical Colleges (AAMC) charged a Committee on Deans' Letters, composed of experienced representatives from medical schools and graduate medical education (GME) programs, to "develop guidelines on the evaluative information desired by program directors" and to "explore the feasibility of providing a model format for deans' letters." In 1989, the AAMC distributed the resulting "Guide to the Preparation of the Medical School Dean's Letter," in which the committee noted that:

- "Graduation from medical school...is the student's transition from a general phase to a specialized phase" of medical education.
- "Residency program directors and their selection committees require information about the levels of accomplishment candidates for their programs have achieved during medical school. The transmission of this information is through an instrument termed THE DEAN'S LETTER of EVALUATION."
- The dean's letter "is not a letter of recommendation; it is a letter of evaluation."
- A "common, recurrent complaint of those who interpret deans' letters of evaluation is that too often it is impossible to estimate how a candidate performed in comparison to his or her peers. The dean's letter can provide information about comparative performance. The comparative report should be compiled and formatted so that a recipient can perceive a candidate's performance profile consistent with the medical school's grading system."
- The "gradations [within medical school grading systems] are sufficient to place a candidate's performance in relationship to his or her classmates. These descriptions of performance can be included in the body of the letter, but a more easily interpreted display is recommended."
- "Rarely do those who prepare dean's letters of evaluation have sufficient information to be students' advocates for selection in a particular specialty. Students should be counseled to identify faculty members who will advocate their suitability for a career in a specialty and to write a separate *letter of recommendation* for their training in that specialty."

A Need for Revision, Enhancement, and Continuous Quality Improvement

In late 2000, four factors resulted in the AAMC's appointment of a second Dean's Letter Advisory Committee (DLAC):

- A lack of implementation by all schools of the 1989 guidelines.
- The involvement, by a variety of professional organizations, in significant ongoing efforts to define and assess professionalism in medicine.
- The decline in the importance of the dean's letter to the GME community.
- The significant changes in the delivery of residency application information resulting from the introduction of the Electronic Residency Application Service (ERAS).

During 2001-02, the DLAC:

- Consulted with the medical school and GME communities through a comprehensive Web-based questionnaire.
- Developed a comprehensive set of preliminary recommendations and presented them at the 2001 AAMC Annual Meeting.
- Received and incorporated feedback regarding these preliminary recommendations from the medical school and GME communities.
- Submitted a comprehensive set of final recommendations to the AAMC Executive Council.

The final recommendations of the DLAC, approved by the AAMC Executive Council in March 2002, represent attempts to:

- Ensure consistency in the re-designed and renamed Medical Student Performance Evaluation across medical schools.
- Strongly reaffirm the purpose of the Medical Student Performance Evaluation.

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- Improve collaboration and communication between senders and recipients of the Medical Student Performance Evaluation.
- Establish an ongoing quality improvement process, across medical schools, for the Medical Student Performance Evaluation.

The Medical Student Performance Evaluation

Name and Purpose. The name of the dean's letter has been changed, effective immediately, to Medical Student Performance Evaluation (MSPE) in order to reflect its purpose as an evaluation of a medical student's performance (rather than a recommendation or prediction of future performance). The MSPE describes, in a sequential manner, a student's performance, as compared to that of his/her peers, through three full years of medical school and, as much as possible, the fourth year. The MSPE includes an assessment of both the student's academic performance and professional attributes.

Timeline. The MSPE is completed upon the successful completion of all core clinical clerkships (Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Psychiatry, and Surgery) in the third year (or their institutional equivalents).

Composition. Final authority for composing the MSPE, as an institutional assessment composed on behalf of the medical school faculty, should rest with a professional person, at the faculty level in the institution, who has access to all relevant evaluation data for all students. Ideally, the process by which the MSPE is composed should include a personal meeting with each student.

Student review. The MSPE, as an institutional assessment, should be considered a component of the student's academic record and, thus, be available for a student's review. The student should be permitted to correct factual errors in the MSPE, but not to revise evaluative statements in the MSPE.

Release date. The MSPE release date will continue to be November 1.

ERAS Post Office opening date. With the approval of the Electronic Residency Application Service (ERAS) Advisory Committee, the opening date of the ERAS Post Office has been moved, by two weeks, from August 15 to September 1.

NRMP Rank Order List deadline date. With the approval of the National Resident Matching Program (NRMP) Board of Directors, the deadline date for submission of Rank Order Lists (ROL) for the Main Match has been moved later by six days.

Mode of delivery. The MSPE will be delivered via ERAS in a computer file compatible with an Internet-based delivery system.

MSPE Advisory Committee. An MSPE Advisory Committee has been established to:

- Establish a mechanism for ongoing information exchange between schools and GME programs about the MSPE.
- Implement recommendations for standardization of MSPE content and format among medical schools.
- Define a standard set of measurable professional attributes expected of medical students.
- Develop by 2006, in concert with a representative group of medical schools, policy and procedure guidelines for the systematic, performance-based assessment, across third-year clerkships, of these professional attributes. This assessment will be a component of the academic evaluation of students and complementary to the grade that will appear on the academic transcript.
- Ensure a continuous quality improvement process for the MSPE.

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A Guide to the Preparation of the Medical Student Performance Evaluation

Length and Format: The MSPE should be a two-to-three page, single-spaced, appropriately formatted document, with five appendices. The MSPE should be typed, single-spaced, in New Times Roman, 12-point font with a one-inch margin on each side.

Content: The MSPE contains six sections:

The Identifying Information section includes the:

- Student's legal name.
- Name and location of the medical school.

The Unique Characteristics section includes a brief statement about the unique characteristics of the student, as follows:

- Information about special considerations, including any distinguishing characteristics exhibited by the student in medical school (e.g., demonstrated leadership and research abilities, participation in community service activities).
- Information about any significant challenges or hardships encountered by the student during medical school.

The Academic History section includes:

- The month and year of the student's initial matriculation in, and expected graduation from, medical school.
- An explanation, based on school-specific policies, of any extensions, leave(s) of absence, gap(s), or break(s) in the student's educational program.
- Information about the student's prior, current, or expected enrollment in, and the month and year of the student's expected graduation from, dual, joint, or combined degree programs.
- Information, based upon school-specific policies, of coursework that the student was required to repeat or otherwise remediate during the student's medical education.
- Information, based on school-specific policies, of any adverse action(s) imposed on the student by the medical school or its parent institution.

The Academic Progress section includes information about the student's academic performance and professional attributes in preclinical/basic science coursework and core clinical and elective rotations, as follows:

- Narrative information regarding the student's overall (rather than course-specific) performance in the preclinical/basic science curriculum.
- Narrative information regarding the student's overall performance on each core clinical clerkship and elective rotation completed to date, with a focus on summative, rather than formative, comments by clerkship/elective directors. This information should be provided in the chronological order in which the student completed each core clinical clerkship and elective rotation. Information should be provided about the location of any "away" elective rotations.
- Narrative information about the student's level of initiative, enthusiasm, and ability to self-start in all curricular components.
- An assessment of the student's compatibility with faculty members, peers, other members of the health care team, and patients during all curricular components.

The Summary section includes a summative assessment, based upon the school's evaluation system, of the student's comparative performance in medical school, relative to his/her peers, including information about any school-specific categories used in differentiating among levels of student performance.

The Appendices section includes:

- **Appendix A:** a graphic representation of the student's performance, relative to his/her peers, in each preclinical/basic science course.
- **Appendix B:** a graphic representation of the student's performance, relative to his/her peers, in each core third-year clinical clerkship.
- **Appendix C:** information supplementary to that contained in the body of the MSPE regarding the assessment of the student's performance, relative to his/her peers, in the area of professional attributes. This assessment should be linked to those professional attributes of students that are specifically and systematically observed,

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evaluated and reported upon by medical school faculty members. Where the medical school has defined a set of professional attributes for which systematic evaluations are available, a graphic representation of the student's comparative performance in this area is recommended. Where the medical school has not yet defined and/or does not systematically evaluate a set of essential professional attributes, a narrative assessment, in the body of the MSPE, of the degree to which the student has demonstrated the following professional attributes, relative to his/her peers, should be considered: ability to treat patients with compassion; honesty and integrity; respect for others; ability to act as an advocate for patients; communication skills; and commitment to putting the needs of others before one's own needs. A final set of recommendations for this appendix is expected by 2006.

- **Appendix D:** a graphic representation of the student's overall performance in medical school, relative to his/her peers, including a list of the school-specific categories used in distinguishing among levels of student performance, a definition of each category, and a report of the distribution of students among categories.
- **Appendix E:** the Medical School Information Page, includes:
- Information about any specific programmatic emphases, strengths, mission(s), or goal(s) of the medical school.
- Information about any unusual characteristics of the medical school's educational program, including the timing of preclinical/ basic science coursework, core clinical clerkships, and elective rotations.
- Information about the average length of enrollment of students in this graduating class, from initial matriculation until graduation.
- Information about the medical school's compliance with the AAMC "Guidelines for Medical Schools Regarding Academic Transcripts" (www.aamc.org/members/gsa/transcripts.htm and see page 9).
- A description of the evaluation system used at the medical school, including a "translation" of the "meaning" of the grades received by the student.
- A statement about medical school requirements regarding a student's successful completion of USMLE Step 1 and Step 2 for promotion and/or graduation.
- Information about the use at the medical school of Objective Structured Clinical Evaluations (OSCEs) in the assessment of medical students.
- Information about the utilization of narrative comments from medical school course, clerkship, or elective directors in the composition of the MSPE.
- Information about the process by which the MSPE is composed at the medical school
- Information about whether the student is permitted to review his/her MSPE prior to transmission.

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Template

Medical Student Performance Evaluation for

_____
Student's Legal Name

_____
Month, Date, Year

Identifying Information

_____ is a fourth-year student at _____ in _____.
Student's Legal Name — Medical School — City, State

Unique Characteristics

(Provide narrative information about distinguishing characteristics exhibited and any significant challenges or hardships encountered by the student during medical school)

Academic History

Date of Expected Graduation from Medical School: _____ Month, Date, Year

Date of Initial Matriculation in Medical School: _____ Month, Date, Year

Please explain any extensions, leave(s) of absence, gap(s), or break(s)in the student's educational program. or ❑ Not applicable

For transfer students: ❑ Not applicable

Date of Initial Matriculation in Prior Medical School: _____ Month, Date, Year

Date of Transfer from Prior Medical School: _____ Month, Date, Year

For dual/joint/combined degree students: ❑ Not applicable

Date of Initial Matriculation in Other Degree Program: _____ Month, Date, Year

Date of Expected Graduation from Other Degree Program: _____ Month, Date, Year

Type of Other Degree Program: _____ Degree, Major

Was this student required to repeat or otherwise remediate any coursework during his/her medical education?
❑ No
❑ Yes - Please explain:

Was this student the recipient of any adverse actions(s) by the medical school or its parent institution?
❑ No
❑ Yes - Please explain:

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AAMC

Academic Progress

Preclinical/Basic Science Curriculum:
(Provide narrative information about overall, not course-specific, performance)

Core Clinical Clerkships and Elective Rotations:
(Provide a narrative evaluation about each core clinical clerkship and elective rotation taken in chronological order)

Example I
(when school policy requires that students complete all core clerkships prior to enrollment in electives)

Clerkship 1:

Clerkship 2:

Clerkship 3:

Clerkship 4:

Clerkship 5:

Clerkship 6:

Elective 1:
(Provide location if an "away" elective rotation)

Elective 2:
(Provide location if an "away" elective rotation)

Example II:
(when school policy permits interspersal of core clerkships and electives)

Clerkship 1:

Clerkship 2:

Elective 1:
(Provide location if an "away" elective rotation)

Clerkship 3:

Clerkship 4:

Elective 2:
(Provide location if an "away" elective rotation)

Clerkship 5:

Clerkship 6:

Summary

(Provide a summative assessment, in narrative format, of the student's comparative performance, relative to his/her peers, in medical school, including information about any school-specific categories used in differentiating among levels of student performance)

Signature of School Official

Name of School Official

Title

E-mail address

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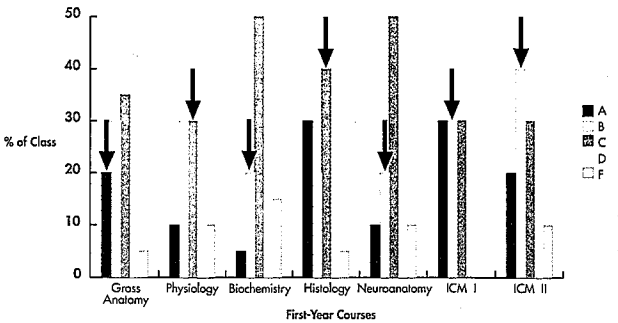
For purposes of illustration only; school-specific course and clerkship names, grading systems, and categories of overall performance will vary by school.

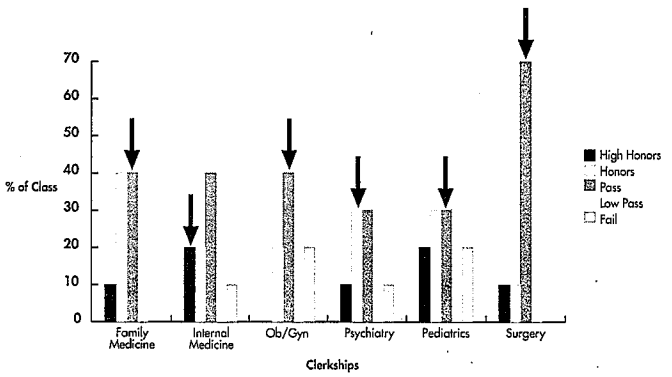
Appendix A

Graphic Representations of Comparative Performance in Preclinical/Basic Science Coursework



Appendix B

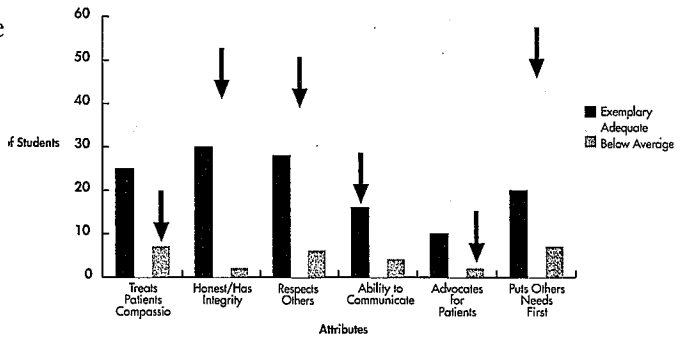
Graphic Representations of Comparative Performance in Core Clinical Clerkships



Appendix C

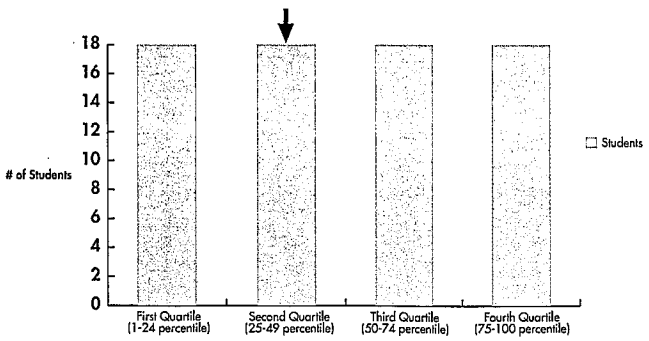
Graphic Representations of Comparative Performance in Professional Attributes

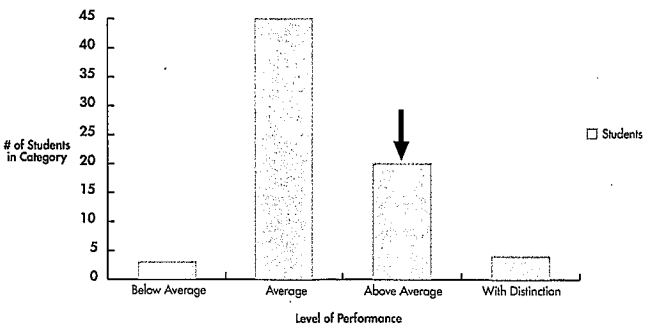
(Final recommendations expected by 2006)



Appendix D

Graphic Representations of Overall Comparative Performance in Medical School





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AAMC

Appendix E

Medical School Information Page

_____
Medical School Name

_____
City, State

Special programmatic emphases, strengths, mission/goal(s) of the medical school:

Special characteristics of the medical school's educational program:

Average length of enrollment (initial matriculation to graduation) at the medical school:

_____
Years Months

Description of the evaluation system used at the medical school:

Medical school requirements for successful completion of USMLE Step 1, 2 (check all that apply):

USMLE Step 1:

- ❑ Required for promotion
- ❑ Required for graduation
- ❑ Required, but not for promotion/graduation
- ❑ Not required

USMLE Step 2:

- ❑ Required for promotion
- ❑ Required for graduation
- ❑ Required, but not for promotion/graduation
- ❑ Not required

Medical school requirements for successful completion of Objective/Observed Structured Clinical Evaluation (OSCE) at medical school. OSCEs are used for (check all that apply):

- ❑ Completion of course
- ❑ Completion of clerkship
- ❑ Completion of third year
- ❑ Graduation
- ❑ Other:_____

Utilization of the course, clerkship, or elective director's narrative comments in composition of the MSPE. The narrative comments contained in the attached MSPE can best be described as (check one):

- ❑ Reported exactly as written
- ❑ Edited for length or grammar, but not for content
- ❑ Edited for content or included selectively

Utilization by the medical school of the AAMC "Guidelines for Medical Schools Regarding Academic Transcripts." This medical school is:

- ❑ Completely in compliance with Guidelines' recommendations
- ❑ Partially in compliance with Guidelines' recommendations
  Exceptions:
- ❑ Not in compliance with Guidelines' recommendations

Description of the process by which the MSPE is composed at the medical school (including number of school personnel involved in composition of the MSPE).

Students are permitted to review the MSPE prior to its transmission:

- ❑ Yes
- ❑ No

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Group on Student Affairs Guidelines for Medical Schools Regarding Academic Transcripts

An academic transcript is a certified document intended for use by parties outside the educational institution and is an unabridged summary of the student's academic history at that institution. It is distinguished from the larger body of information which may be contained in the student's educational or academic record. The educational or academic record is an internal document that also reflects the student's unabridged academic history at the institution, but which may contain additional data that are useful internally, yet not needed externally.

1. Medical schools are encouraged to follow the recommendations of the American Association of Collegiate Registrars and Admissions Officers (AACRAO) as published in the Academic Record and Transcript Guide. Where the medical school is part of a university, the school is encouraged to consult with the university registrar to ensure that the medical school transcript is in compliance with university requirements.

2. The academic transcript should reflect the total, unabridged academic history of the student at the institution. All courses should be recorded in the academic period in which the course was taken and graded.

3. Essential elements of an academic transcript include: name of institution, location of institution, name of student, terms of attendance, withdrawal date, course identification number and title, credit hours for each course, units of credit, grade in each course, summary of transfer credit accepted and the name of the institution from which the credit is accepted, any instances of academic suspension or dismissal and the date, title of degree awarded, date degree is conferred, program studied (i.e., medicine), date of issuance of the transcript, and date of last entry to the transcript. Name changes should be recorded on transcripts only while the individual is enrolled and the name can be changed concurrently in the AAMC database.

4. Each student should have a unique identification number that is recorded on the transcript.

5. The following items are NOT recommended for inclusion on the academic transcript (although the institution may wish to retain some of these items in the educational or academic record): student's address, place of birth, gender, ethnicity, marital status, religious preference, disability, and INS status; secondary school data; prior post-secondary school data; academic probation; class rank.

6. Medical schools should record on a transcript only that academic information which is under the purview of the school's faculty of medicine. Consequently, United States Medical Licensing Examination (USMLE) results and election to Alpha Omega Alpha (AOA) should NOT be included on the transcript. However, honors awarded by the school's faculty, either in course or at graduation, should be included on the transcript.

7. It is essential that the transcript include notation of any academic suspension or dismissal since this is an academic action that interrupts the student's continued enrollment. Similarly, a suspension for academic misconduct (e.g., plagiarism) should be included on the transcript. While an institution may want to include academic probation in the educational database, it is not desirable to include this status on an academic transcript since the definition of academic probation varies from school to school. Thus, the item serves no useful purpose on an academic transcript which, by definition, is intended for use outside the school. In any event, if academic probation is included on the transcript, it is vital that this term be clearly defined in the transcript legend or key.

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8. Where a student is dismissed, the transcript should record the initial date of dismissal. If there is a subsequent appeal, the result of this appeal and the date of this decision should be recorded, as well. If the student is permitted to continue in the curriculum pending the outcome of an appeal, this should be noted on the transcript with a footnote.

9. In the case of a student who is a candidate for two degrees (e.g., MD/PhD), courses which are given combined or dual credit toward both degrees should be so noted.

10. The transcript should include the title and number for each course taken by the student and should show the academic period in which the course is taken. Both required and elective courses should be courses that have been developed and approved by faculty following the school's procedures for approval of courses. All courses, including elective courses, should have an identification number, title, and course description and appear in the school's Bulletin or Elective Handbook, or both. In the case when a student is currently enrolled, courses which the student is taking are listed with an indication that these courses are in progress.

11. The transcript should include a legend that explains the grading system, symbols, inclusive dates for grading systems where changes have occurred, honors, units of credit, and notation of courses in progress. If the school requires a passing score on USMLE for promotion and/or graduation, this policy should be included in the transcript legend. Additionally, the legend should include the accreditation status of the school, Family Educational Rights and Privacy Act (FERPA) disclaimer, and an explanation of how the authenticity of the transcript can be determined.

12. Issuing official academic transcripts is a central and unique function of the Registrar's Office. Transcripts should be issued only upon written request of the student/alumnus who has properly identified himself/herself with an ID card, driver's license, or signature on a request form or letter. Telephone and e-mail requests for transcripts should NOT be accepted because security and authenticity cannot be ensured.

    a. A transcript is issued only at the written request of the student/alumnus or a specified third party whom the student/alumnus has authorized, in writing, to obtain a transcript for a specific stated purpose. The request must be signed and dated; the third party must be specified and the release must state that the school may release the student's/alumnus' transcript for that purpose.

    b. A transcript ceases to be an "official" transcript if it is photocopied or faxed. An original transcript must not be transferred to a third party since doing so violates FERPA.

    c. The Registrar's Office must maintain a Transcript Transmittal Record for each student/alumnus. This record must show the date and party to whom a transcript is sent and the purpose for which the transcript is issued. Transcripts issued to the student/alumnus should say "Issued to the Student" rather than "Unofficial Transcript" since the latter can be altered easily.

    d. If the school has a policy that requires withholding transcripts for default on student loans or other reasons, that policy should be stated clearly in both the Bulletin and the Student Handbook. Transcript holds for financial reasons should be limited to charges that relate directly to the education that is reported on the student's/alumnus' academic transcript.

    e. If there is an institutional charge for issuing a transcript, this fee should be modest.

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f. Faxing a transcript should be avoided unless there is an urgency that requires immediate transfer. If a transcript is faxed, it is important that proper procedures for the transcript request be used (#12.a.); a properly signed fax request may be accepted. Additionally, a transcript that is faxed should be considered "unofficial" and used only until an original can be sent. A cover memorandum should describe the document as confidential information intended for the exclusive use of the addressee.

13. Where a transcript is to be transmitted electronically (e.g., ERAS, SPEEDE), it is recommended that the system used require that the sending and receiving stations be authenticated.

14. Schools are encouraged to take a number of steps to protect the institution from fraudulent transcripts. The use of special paper, multicolored pens for the Registrar's signature, metered postage rather than postage stamps and inclusion of a physical description of the transcript in the transcript key are helpful ways to improve security. Additionally, it is recommended that the transcript include an institutional statement regarding the school's plans to pursue vigorously all allegations of security breaches with respect to transcripts.

15. The educational record database and academic transcripts should be stored in a secure location which is fireproof. Access to the database and to the area where documents and equipment (records, stationery, and the school seal and signature equipment) are stored should be limited to authorized personnel only.

16. A medical school should have a disaster plan for the secure storage and recovery of educational records and academic transcripts which may be damaged or destroyed in the event of a catastrophic disaster. Usually, this entails the identification of a remote location where duplicate records are maintained. It is important for the school to develop an appropriate protocol for the regular duplication and transfer of records to the remote location.

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Dean's Letter Advisory Committee

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Clinical Clerkship Evaluation Form

Please mail the complete form to the following address:
Registrar
American University of Antigua
2 Wall Street 5th Floor
New York, New York
10005

Student First & Last Name (Full Name, no nicknames)

Student ID

Rotation Name

Rotation Dates (Must start on a Monday and end on a Friday)

Start Date End Date

Hospital Name

Hospital Address

Hospital City

Hospital State

(Must be full name of accredited hospital - not clinical or physician's office)

Name and Phone Number of Director of Medical Education

(Name) (Phone)

Patient Interaction:

Provides compassionate interaction that is effective for health promotion, wellness and disease treatment.

Assessed Skills:

Physical examinations, patient reviews, judgement, consideration of patient privacy.

○ A Outstanding ○ B Competent ○ C Adequate ○ F Substandard

Comments:

Medical Knowledge:

Demonstrates appropriate knowledge of basic sciences & clinical sciences and applies that knowledge effectively

Assessed Skills:

Degree of knowledge; commitment to life-long learning; complex problem-solving skills.

○ A Outstanding ○ B Competent ○ C Adequate ○ F Substandard

Comments:

Practice-Based Learning and Improvement:

Understanding evidence-based medicine and applies sound principles of practice within the context of patient care.

Assessed Skills:

Relationship with patient/families; educates and counsels patient/families.

○ A Outstanding ○ B Competent ○ C Adequate ○ F Substandard

Comments:

Interpersonal and Communication Skills:

Demonstrates skills (i.e. listening, responding) that results in effective information exchange between patients and the healthcare team.

Assessed Skills:

Establishes relationships with patients/families; educates and counsels patients/families; maintains comprehensive, timely, legible medical records.

○ A Outstanding ○ B Competent ○ C Adequate ○ F Substandard

Comments:

Professionalism:

Demonstrates commitment to professional development and ethical principles and sensitivity to patient/family and peer diversity

Assessed Skills:

Shows compassion, respect and honesty, accepts responsibility for actions; dresses in a professional manner.

○ A Outstanding ○ B Competent ○ C Adequate ○ F Substandard

Comments:

Student Portfolio:

Provides information about student's exposure to patients and academic curricular and non-curricular activities

Assessed Skills:

Adequate patient encounters, adequate curricular and non-curricular academic activities, comprehensive case presentations

○ A Outstanding ○ B Competent ○ C Adequate ○ F Substandard

Comments:

Name of Supervising Physician

Supervising Physician's Phone

Date of Evaluation (mm/dd/yy)

Signature of Supervising Physician

DME SIGNATURE

Place Seal Here

Print Form

Domains of Performance:

1. Patient Care

Examples of Unacceptable Performance:

Frequently fails to gather important historical information

Has difficulty performing basic aspects of the physical examination

Cannot synthesize bedside and laboratory data to form an inclusive differential

Write-ups are often late, illegible, or incomplete

Oral presentations are disorganized, omit important data, or are inaccurate

Examples of Outstanding Performance:

Routinely compiles an accurate, organized, and thorough history and physical exam

Is able to synthesize clinical data into an organized differential diagnosis

Submits timely, legible, and thorough patient write-ups

Presents patients orally in a systematic, organized, and lucid fashion

Makes sound diagnostic and therapeutic judgments about patients

2. Medical Knowledge

Examples of Unacceptable Performance:

Rarely demonstrates even basic knowledge of patients' conditions

Gives no evidence of having read about aspects of patients' presenting problems

Does not know anatomy, physiology, or pathophysiology of conditions being considered

Cannot reason through clinical data to formulate differential diagnosis.

Examples of Outstanding Performance:

Reliably has read about patients' conditions and is able to answer questions related to it

Cites and brings relevant journal articles pertaining to their patients

Demonstrates knowledge of basic science pertinent to patients' problems

Applies basic science knowledge to reason through patients' clinical presentation

Routinely accesses on-line information to address questions relevant to their patients
Demonstrates advanced clinical reasoning skills

3. Professionalism

Examples of Unacceptable Performance:

Lacks respect, compassion, integrity, honesty

Disregards need for self-assessment

Fails to acknowledge errors

Does not consider needs of patients, families, colleagues

Does not take responsibility for role in patient care

Is insensitive to cultural, racial, gender issues

Often arrives late to appointments, meetings

Examples of Outstanding Performance:

Always demonstrates respect, compassion, integrity, honesty

Teaches and models responsible behavior

Demonstrates total commitment to patients' care

Willingly acknowledges errors

Always considers needs of patients, families, colleagues ahead of personal needs

Is sensitive to and respects cultural diversity

Is reliably punctual

4. Practice-Based Learning Improvement

Examples of Unacceptable Performance:

Fails to perform self-evaluation

Lacks insight, initiative

Resists or ignores feedback

Fails to use information technology to enhance patient care or pursue self-improvement

Examples of Outstanding Performance:

Constantly evaluates own performance

Incorporates feedback into improvement activities

Effectively uses technology to manage information for patient care and self-improvement

5. Interpersonal and Communication Skills

Examples of Unacceptable Performance:

Does not establish even minimally effective therapeutic relationships with patients and families

Does not demonstrate ability to build relationships through listening

Is argumentative with or abrasive to patients, colleagues, staff, attendings

Examples of Outstanding Performance:

Listens intently to patients

Establishes a highly effective therapeutic relationship with patients and families

Demonstrates excellent relationship-building through listening, narrative, and non-verbal skills

Relates constructively with colleagues, staff, and attendings

6. System-Based Learning

Examples of Unacceptable Performance:

Unable to access/mobilize outside resources

Actively resists efforts to improve systems of care

Does not use systematic approaches to reduce error and improve patient care

Examples of Outstanding Performance:

Effectively accesses/utilizes outside resources

Effectively uses systematic approaches to reduce errors and improve patient care

Enthusiastically assists in developing system' improvement

6. The clinical training in outpatient family medicine at Wyckoff Heights Medical Center was concerning. The students described a volume of patients that was low and described variable expectations for whether they should write a note or present a patient to the resident or attending. Specifically, students informed the site visit team that they would see on average 1-2 patients during a clinic and that the resident may or may not have them write a note and present the patient to them, and that sometimes the faculty would only have the resident present the case. The School needs to reassess the quality of the outpatient experience at this site and inform the Board the steps that have been taken to ensure that students have an appropriate clinical experience in family medicine. AUACOM needs to describe to the Board the methods it will use to monitor this experience and to ensure that the onsite faculty are aware of their teaching expectations.

AUACOM was surprised and concerned by the findings of the site team that students at Wyckoff Heights Medical Center "would see an average of 1-2 patients during a clinic." AUACOM is in complete agreement that such a small number of patient interactions would not be acceptable. In addition, it would mean that the clerkship was not being properly monitored. Therefore, upon receipt of the site team report, AUACOM began an immediate investigation into the team's finding. We found the following:

1. Data supplied by Wyckoff Heights Medical Center show that the outpatient clinic used for the Family Practice residency at Wyckoff Heights Medical Center saw over 10,000 patients per annum [see attached Wyckoff Heights Medical Center outpatient admissions by date].

2. AUACOM's Executive Dean of Clinical Sciences (EDCS) did a review of the chair's site visit reports. This review confirmed that students see an adequate number of students at the site (4-5 patients on a 4-hour session). (Note: AUA's chair of Family Practice, Dr. Nischal, is actually on site at Wyckoff Heights Medical Center.

3. AUA's Dean of Academic Affairs, Dr Rafael Olazagasti, who had visited the site on numerous occasions and met with Family Practice students, also reported that the students saw an adequate number of patients (4-5 patients per session).

4. AUA's Clinical Chair for Family Medicine conducted an additional review of clinical sites' outpatient caseload and student portfolios, the patient logs that students at Wyckoff Heights Medical center have to maintain and patient charts. Based on that data, students see a minimum number of 4 to 5 patients in the outpatient family medicine setting per 4-hour session, a minimum of 12 patients per day in the in-patient setting and about 15 to 20 patients on emergency calls and rounds during night calls. In addition, formal write-ups are submitted by students and discussed as a group with a senior faculty member on a weekly

basis. There is also noted documentation from the students on patient charts in the form of H&P and progress note.

Based on AUA's review, including documentary evidence, we believe the site team was misinformed. However, based on the site team's stated concern regarding Wyckoff Heights Medical Center's Family Practice clinics, AUA will increase its monitoring of patient case logs, particularly in the clinical areas of concern, from rotating students at the outpatient family medicine facility at Wyckoff Heights Medical Center. Faculty and administration of Wyckoff Heights Medical Center have been made aware, that regardless of whether or not students have been seeing an adequate number of patients as their investigation shows, there is a vital need to ensure that students are exposed to an adequate number of patients in both ambulatory and out-patient settings.

Corrective Action Plan

The EDCS and the Clinical Chair for Family Medicine will increase their monitoring to ensure that students at that facility will be exposed to an adequate number of patients in order to fulfill the educational requirements. AUA's Chair of Family Practice has, since the site team report, increased his number of regular visits to the Wyckoff Heights Medical Center Family Practice clinic, and he will continue to visit the clinic on a more frequent basis. He will provide the EDCS with reports specifically addressing the number of patients seen by students at the clinic.

The EDCS and Clinical Chair, in their continued monitoring of all sites, will pay additional attention of the number of patients seen by students in outpatient clinics and the EDCS has sent a memo to all clinical sites advising that per our agreement, students must see a sufficient number of patients in each clinical rotation to meet our curricula goals.

Wyckoff Heights Medical Center
Outpatient Visits by Location from 2010 to Date

Service Year	Service Month	Location Name	Location ID	CLI	ER	RCR	REF	SDC	Month Total
2010	1	12 SOUTH ED TRIAGE	NS12ST		239		2		241
2010	1	4 NORTH SURG DAY CARE(ASU) HD	NS4NH					361	361
2010	1	BUENA VITA LAB WORK	POPBUENAVI				308		308
2010	1	CAMBA BROADWAY HOUSE	POPCAMBA				3		3
2010	1	CARE COACH	POPCARECOA				73		73
2010	1	CATHERIZATION LAB - ASU	NSCATHLAB					6	6
2010	1	CYTOGENETICS	CYTOGEN				105		105
2010	1	EMERGENCY DEPT FASTTRACK	NSEDF		1,066				1,066
2010	1	EMERGENCY ROOM - ADULT	NSEDA		2,086				2,086
2010	1	EMERGENCY ROOM - PEDIATRICS	NSEDP		1,835		1		1,836
2010	1	ENDOSCOPY SUITE - ASU ONLY	NS10E					173	173
2010	1	FAMILY MEDICINE CLINIC	OPFAMMED	170					170
2010	1	FAMILY MEDICINE GYN	OPFAMGYN	7					7
2010	1	FAMILY MEDICINE PEDS	OPFAMPED	61					61
2010	1	FETAL ASSESSMENT RADIOLOGY	FETALASSES	2			420		422
2010	1	HYPERBARIC CHAMBER (RCR)	OPHYPER			1			1
2010	1	JACKSON HEIGHTS ID CLINIC	OPJACKID	26					26
2010	1	LA MARCA LAB WORK	POPLAMA				47		47
2010	1	LABOR & DELIVERY-SDC (ASU)	NS12SDC		9			16	25
2010	1	LAMARCA FAMILY HEALTH GYN	LAMAGYN	5					5
2010	1	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	651					651
2010	1	LAMARCA FAMILY HEALTH OB	LAMAOB	11					11
2010	1	LAMARCA FAMILY HEALTH PEDS	LAMAPED	76					76
2010	1	LAMARCA NUTRITIONAL COUNSEL	LAMADIET				1		1
2010	1	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				168		168
2010	1	OB SONOGRAM	OBSONO				39		39
2010	1	OP PEDS HIGH RISK	OPPEDHIRSK	26					26
2010	1	OUT PATIENT ALLERGY ADULT	OPALLERGY	9					9
2010	1	OUT PATIENT ASTHMA ADULT	OPASTHMA	19					19
2010	1	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	11					11
2010	1	OUT PATIENT CARDIOLOGY	OPCARD	100					100
2010	1	OUT PATIENT CHEMOTHERAPY	OPCHEMO				2		2
2010	1	OUT PATIENT DENTAL	OPDENT			139			139
2010	1	OUT PATIENT DERMATOLOGY	OPDERM	30					30
2010	1	OUT PATIENT DIABETIC	OPDIAB	113					113
2010	1	OUT PATIENT EAR NOSE & THROAT	OPENT	125					125
2010	1	OUT PATIENT ENDOCRINOLOGY	OPENDO	97					97
2010	1	OUT PATIENT GASTROENTEROLOGY	OPGI	94					94
2010	1	OUT PATIENT GENETIC COUNSELING	OPGENE				5		5
2010	1	OUT PATIENT GERIATRICS	OPGERIATRI	3					3
2010	1	OUT PATIENT GYN	OPGYN	583			24		607
2010	1	OUT PATIENT HEMATOLOGY	OPHEMA	47					47
2010	1	OUT PATIENT HEPATITIS C	OPHIC	26					26
2010	1	OUT PATIENT ID	OPID	195					195
2010	1	OUT PATIENT MEDICAL	OPMED	936					936
2010	1	OUT PATIENT NEPHROLOGY	OPNEPH	56					56
2010	1	OUT PATIENT NEUROLOGY	OPNEURO	45					45
2010	1	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	2					2
2010	1	OUT PATIENT OB	OPOB	797					797
2010	1	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	42					42
2010	1	OUT PATIENT OCCUP THX (RCR)	OPOT			2			2
2010	1	OUT PATIENT OPHTHALMOLOGY	OPEYE	93					93
2010	1	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	228					228
2010	1	OUT PATIENT OSTEO	OPOSTEO	24			1		25

Wyckoff Heights Medical Center
Outpatient Visits by Location from 2010 to Date

Service Year	Service Month	Location Name	Location ID	CLI	ER	RCR	REF	SDC	Month Total
2010	1	OUT PATIENT PAIN MANAGMENT	OPPAIN	80					80
2010	1	OUT PATIENT PEDIATRICS	OPPED	513					513
2010	1	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	15					15
2010	1	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	8					8
2010	1	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	27					27
2010	1	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	146					146
2010	1	OUT PATIENT PHYSICAL THX (RCR)	OPPT	6		6			12
2010	1	OUT PATIENT PODIATRY	OPPOD	243					243
2010	1	OUT PATIENT PULMONARY	OPPULMO	30					30
2010	1	OUT PATIENT RHEUMATOLOGY	OPRHEUM	20					20
2010	1	OUT PATIENT SURGICAL	OPSURG	229					229
2010	1	OUT PATIENT UROLOGY	OPGU	175					175
2010	1	OUT PATIENT VASCULAR	OPVASC	83			2		85
2010	1	OUT PATIENT WOUND CARE	OPWOUND	189					189
2010	1	OUT PT PLASTIC SURGERY/HAND	OPPLAST	108					108
2010	1	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	25					25
2010	1	PRESURGICAL TESTING	PRETEST				154		154
2010	1	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD	1			125		126
2010	1	PRIVATE OUT PATIENT CHEMO	POPCHEMO				98		98
2010	1	PRIVATE OUT PATIENT LAB	POPLAB	2			986		988
2010	1	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				1,691		1,691
2010	1	QUEENSBRIDGE CARDIOLOGY	QBRIGCARD	10					10
2010	1	QUEENSBRIDGE CLINIC	POPQBRIDGE				41		41
2010	1	QUEENSBRIDGE GYN	QBRIGGYN	12					12
2010	1	QUEENSBRIDGE MEDICAL	QBRIGMED	226			1		227
2010	1	QUEENSBRIDGE PEDIATRICS	QBRIGPED	78					78
2010	1	QUEENSBRIDGE PODIATRY	QBRIGPOD	27					27
2010	1	VASCULAR LAB	VASLAB				73		73
2010	1	WYCKOFF CLINIC LAB WORK	POPCLINIC	2			716		718
2010	2	12 SOUTH ED TRIAGE	NS12ST		207			1	208
2010	2	4 NORTH SURG DAY CARE(ASU) HD	NS4NH					325	325
2010	2	BUENA VITA LAB WORK	POPBUENAVI				353		353
2010	2	CAMBA BROADWAY HOUSE	POPCAMBA				8		8
2010	2	CARE COACH	POPCARECOA				81		81
2010	2	CATHERIZATION LAB - ASU	NSCATHLAB					7	7
2010	2	CYTOGENETICS	CYTOGEN				106		106
2010	2	EMERGENCY DEPT FASTTRACK	NSEDF		949				949
2010	2	EMERGENCY ROOM - ADULT	NSEDA		1,924				1,924
2010	2	EMERGENCY ROOM - PEDIATRICS	NSEDP		1,562				1,562
2010	2	ENDOSCOPY SUITE - ASU ONLY	NS10E				1	163	164
2010	2	FAMILY MEDICINE CLINIC	OPFAMMED	171					171
2010	2	FAMILY MEDICINE GYN	OPFAMGYN	7					7
2010	2	FAMILY MEDICINE PEDS	OPFAMPED	38					38
2010	2	FETAL ASSESSMENT RADIOLOGY	FETALASSES	5			368		373
2010	2	HYPERBARIC CHAMBER (RCR)	OPHYPER			1			1
2010	2	JACKSON HEIGHTS ID CLINIC	OPJACKID	29					29
2010	2	LA MARCA LAB WORK	POPLAMA				43		43
2010	2	LABOR & DELIVERY-SDC (ASU)	NS12SDC		20			17	37
2010	2	LAMARCA FAMILY HEALTH GYN	LAMAGYN	1					1
2010	2	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	567					567
2010	2	LAMARCA FAMILY HEALTH OB	LAMAOB	5					5
2010	2	LAMARCA FAMILY HEALTH PEDS	LAMAPED	58					58
2010	2	LAMARCA NUTRITIONAL COUNSEL	LAMADIET				1		1
2010	2	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				176		176

Wyckoff Heights Medical Center
Outpatient Visits by Location from 2010 to Date

Service Year	Service Month	Location Name	Location ID	CLI	ER	RCR	REF	SDC	Month Total
2010	2	OB GENETIC COUNSELING	OPOBGENETI				1		1
2010	2	OB SONOGRAM	OBSONO				15		15
2010	2	OP PEDS HIGH RISK	OPPEDHIRSK	20					20
2010	2	OUT PATIENT ALLERGY ADULT	OPALLERGY	15					15
2010	2	OUT PATIENT ASTHMA ADULT	OPASTHMA	15					15
2010	2	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	9					9
2010	2	OUT PATIENT CARDIOLOGY	OPCARD	116					116
2010	2	OUT PATIENT CHEMOTHERAPY	OPCHEMO				1		1
2010	2	OUT PATIENT DENTAL	OPDENT	1		140			141
2010	2	OUT PATIENT DERMATOLOGY	OPDERM	26					26
2010	2	OUT PATIENT DIABETIC	OPDIAB	95					95
2010	2	OUT PATIENT EAR NOSE & THROAT	OPENT	98					98
2010	2	OUT PATIENT ENDOCRINOLOGY	OPENDO	91					91
2010	2	OUT PATIENT GASTROENTEROLOGY	OPGI	84					84
2010	2	OUT PATIENT GENETIC COUNSELING	OPGENE				2		2
2010	2	OUT PATIENT GERIATRICS	OPGERIATRI	2					2
2010	2	OUT PATIENT GYN	OPGYN	542			1		543
2010	2	OUT PATIENT HEMATOLOGY	OPHEMA	54					54
2010	2	OUT PATIENT HEPATITIS C	OPHIC	10					10
2010	2	OUT PATIENT ID	OPID	197			1		198
2010	2	OUT PATIENT MEDICAL	OPMED	797			1		798
2010	2	OUT PATIENT NEPHROLOGY	OPNEPH	51					51
2010	2	OUT PATIENT NEUROLOGY	OPNEURO	50					50
2010	2	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	7					7
2010	2	OUT PATIENT NEWBORN SCREENING	OPPEDNEW	1					1
2010	2	OUT PATIENT OB	OPOB	677					677
2010	2	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	33					33
2010	2	OUT PATIENT OCCUP THX (RCR)	OPOT			1			1
2010	2	OUT PATIENT OPHTHALMOLOGY	OPEYE	88					88
2010	2	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	158					158
2010	2	OUT PATIENT OSTEO	OPOSTEO	14					14
2010	2	OUT PATIENT PAIN MANAGMENT	OPPAIN	76					76
2010	2	OUT PATIENT PEDIATRICS	OPPED	487					487
2010	2	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	10					10
2010	2	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	2					2
2010	2	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	22					22
2010	2	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	138		2			140
2010	2	OUT PATIENT PHYSICAL THX (RCR)	OPPT	5		89			94
2010	2	OUT PATIENT PODIATRY	OPPOD	175					175
2010	2	OUT PATIENT PULMONARY	OPPULMO	18					18
2010	2	OUT PATIENT RHEUMATOLOGY	OPRHEUM	11					11
2010	2	OUT PATIENT SURGICAL	OPSURG	187					187
2010	2	OUT PATIENT THORACIC SURGERY	OPTHORAC	3					3
2010	2	OUT PATIENT UROLOGY	OPGU	145					145
2010	2	OUT PATIENT VASCULAR	OPVASC	65			2		67
2010	2	OUT PATIENT VASCULAR LAB	OPVASCLAB				1		1
2010	2	OUT PATIENT WOUND CARE	OPWOUND	151					151
2010	2	OUT PT PLASTIC SURGERY/HAND	OPPLAST	118					118
2010	2	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	22			1		23
2010	2	PRESURGICAL TESTING	PRETEST				131		131
2010	2	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD				118		118
2010	2	PRIVATE OUT PATIENT CHEMO	POPCHEMO	2			94		96
2010	2	PRIVATE OUT PATIENT LAB	POPLAB	2			869		871
2010	2	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				1,520		1,520

Wyckoff Heights Medical Center
Outpatient Visits by Location from 2010 to Date

Service Year	Service Month	Location Name	Location ID	CLI	ER	RCR	REF	SDC	Month Total
2010	2	QUEENSBRIDGE CLINIC	POPQBRIDGE				51		51
2010	2	QUEENSBRIDGE GYN	QBRIGGYN	6					6
2010	2	QUEENSBRIDGE MEDICAL	QBRIGMED	205					205
2010	2	QUEENSBRIDGE PEDIATRICS	QBRIGPED	60					60
2010	2	QUEENSBRIDGE PODIATRY	QBRIGPOD	29					29
2010	2	VASCULAR LAB	VASLAB				71		71
2010	2	WYCKOFF CLINIC LAB WORK	POPCLINIC				586		586
2010	3	12 SOUTH ED TRIAGE	NS12ST	2	191		2	1	196
2010	3	4 NORTH SURG DAY CARE(ASU) HD	NS4NH		1			427	428
2010	3	BUENA VITA LAB WORK	POPBUENAVI				398		398
2010	3	CAMBA BROADWAY HOUSE	POPCAMBA				19		19
2010	3	CARE COACH	POPCARECOA				91		91
2010	3	CATHERIZATION LAB - ASU	NSCATHLAB					13	13
2010	3	COMMUNITY CARE COACH GYN	COACHGYN				1		1
2010	3	CYTOGENETICS	CYTOGEN				110		110
2010	3	EMERGENCY DEPT FASTTRACK	NSEDF		1,129				1,129
2010	3	EMERGENCY ROOM - ADULT	NSEDA		2,127				2,127
2010	3	EMERGENCY ROOM - PEDIATRICS	NSEDP		1,814				1,814
2010	3	ENDOSCOPY SUITE - ASU ONLY	NS10E				1	210	211
2010	3	FAMILY MEDICINE CLINIC	OPFAMMED	260					260
2010	3	FAMILY MEDICINE GYN	OPFAMGYN	5					5
2010	3	FAMILY MEDICINE PEDS	OPFAMPED	69					69
2010	3	FETAL ASSESSMENT RADIOLOGY	FETALASSES				468		468
2010	3	HYPERBARIC CHAMBER (RCR)	OPHYPER			4			4
2010	3	JACKSON HEIGHTS ID CLINIC	OPJACKID	34					34
2010	3	LA MARCA LAB WORK	POPLAMA				69		69
2010	3	LABOR & DELIVERY-SDC (ASU)	NS12SDC		19			23	42
2010	3	LAMARCA FAMILY HEALTH GYN	LAMAGYN	8					8
2010	3	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	786					786
2010	3	LAMARCA FAMILY HEALTH OB	LAMAOB	24					24
2010	3	LAMARCA FAMILY HEALTH PEDS	LAMAPED	122					122
2010	3	LAMARCA NUTRITIONAL COUNSEL	LAMADIET	1			4		5
2010	3	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				204		204
2010	3	OB GENETIC COUNSELING	OPOBGENETI				1		1
2010	3	OB SONOGRAM	OBSONO				31		31
2010	3	OP PEDS HIGH RISK	OPPEDHIRSK	27					27
2010	3	OP PULMONARY FUNCTION TEST	OPPFT				6		6
2010	3	OUT PATIENT ALLERGY ADULT	OPALLERGY	21					21
2010	3	OUT PATIENT ASTHMA ADULT	OPASTHMA	28					28
2010	3	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	21					21
2010	3	OUT PATIENT CARDIOLOGY	OPCARD	159					159
2010	3	OUT PATIENT CHEMOTHERAPY	OPCHEMO	1					1
2010	3	OUT PATIENT DENTAL	OPDENT			169			169
2010	3	OUT PATIENT DERMATOLOGY	OPDERM	26					26
2010	3	OUT PATIENT DIABETIC	OPDIAB	130					130
2010	3	OUT PATIENT EAR NOSE & THROAT	OPENT	193					193
2010	3	OUT PATIENT ENDOCRINOLOGY	OPENDO	98					98
2010	3	OUT PATIENT GASTROENTEROLOGY	OPGI	105					105
2010	3	OUT PATIENT GENETIC COUNSELING	OPGENE				5		5
2010	3	OUT PATIENT GERIATRICS	OPGERIATRI	4					4
2010	3	OUT PATIENT GYN	OPGYN	818					818
2010	3	OUT PATIENT HEMATOLOGY	OPHEMA	57					57
2010	3	OUT PATIENT HEPATITIS C	OPHIC	42					42
2010	3	OUT PATIENT ID	OPID	220					220

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Service Year	Service Month	Location Name	Location ID	CLI	ER	RCR	REF	SDC	Month Total
2010	3	OUT PATIENT MEDICAL	OPMED	1,135					1,135
2010	3	OUT PATIENT NEPHROLOGY	OPNEPH	71					71
2010	3	OUT PATIENT NEUROLOGY	OPNEURO	70					70
2010	3	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	14					14
2010	3	OUT PATIENT OB	OPOB	924					924
2010	3	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	49					49
2010	3	OUT PATIENT OPHTHALMOLOGY	OPEYE	153					153
2010	3	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	280					280
2010	3	OUT PATIENT OSTEO	OPOSTEO	34					34
2010	3	OUT PATIENT PAIN MANAGMENT	OPPAIN	74					74
2010	3	OUT PATIENT PEDIATRICS	OPPED	608					608
2010	3	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	16					16
2010	3	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	7					7
2010	3	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	39					39
2010	3	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	256		3			259
2010	3	OUT PATIENT PHYSICAL THX (RCR)	OPPT	4		64			68
2010	3	OUT PATIENT PODIATRY	OPPOD	318					318
2010	3	OUT PATIENT PULMONARY	OPPULMO	30					30
2010	3	OUT PATIENT RHEUMATOLOGY	OPRHEUM	18					18
2010	3	OUT PATIENT SURGICAL	OPSURG	222					222
2010	3	OUT PATIENT UROLOGY	OPGU	180					180
2010	3	OUT PATIENT VASCULAR	OPVASC	85			5		90
2010	3	OUT PATIENT VASCULAR LAB	OPVASCLAB				38		38
2010	3	OUT PATIENT WOUND CARE	OPWOUND	247					247
2010	3	OUT PT PLASTIC SURGERY/HAND	OPPLAST	145					145
2010	3	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	42					42
2010	3	PRESURGICAL TESTING	PRETEST				198		198
2010	3	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD	2			161		163
2010	3	PRIVATE OUT PATIENT CHEMO	POPCHEMO				88		88
2010	3	PRIVATE OUT PATIENT LAB	POPLAB				1,194		1,194
2010	3	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				2,158		2,158
2010	3	QUEENSBRIDGE CARDIOLOGY	QBRIGCARD	11					11
2010	3	QUEENSBRIDGE CLINIC	POPQBRIDGE				44		44
2010	3	QUEENSBRIDGE GYN	QBRIGGYN	11					11
2010	3	QUEENSBRIDGE MEDICAL	QBRIGMED	241					241
2010	3	QUEENSBRIDGE PEDIATRICS	QBRIGPED	89					89
2010	3	QUEENSBRIDGE PODIATRY	QBRIGPOD	42					42
2010	3	VASCULAR LAB	VASLAB				72	1	73
2010	3	WYCKOFF CLINIC LAB WORK	POPCLINIC				805		805
2010	4	12 SOUTH ED TRIAGE	NS12ST	1	175				176
2010	4	4 NORTH SURG DAY CARE(ASU) HD	NS4NH					473	473
2010	4	BUENA VITA LAB WORK	POPBUENAVI				398		398
2010	4	CAMBA BROADWAY HOUSE	POPCAMBA				3		3
2010	4	CARE COACH	POPCARECOA				113		113
2010	4	CATHERIZATION LAB - ASU	NSCATHLAB					14	14
2010	4	COMMUNITY CARE COACH PEDIATRIC	COACHPED		1				1
2010	4	CYTOGENETICS	CYTOGEN				124		124
2010	4	EMERGENCY DEPT FASTTRACK	NSEDF		971				971
2010	4	EMERGENCY ROOM - ADULT	NSEDA		2,247				2,247
2010	4	EMERGENCY ROOM - PEDIATRICS	NSEDP		1,696				1,696
2010	4	ENDOSCOPY SUITE - ASU ONLY	NS10E				4	224	228
2010	4	FAMILY MEDICINE CLINIC	OPFAMMED	239					239
2010	4	FAMILY MEDICINE GYN	OPFAMGYN	3					3
2010	4	FAMILY MEDICINE PEDS	OPFAMPED	63					63

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Service Year	Service Month	Location Name	Location ID	CLI	ER	RCR	REF	SDC	Month Total
2010	4	FETAL ASSESSMENT RADIOLOGY	FETALASSES	3			437		440
2010	4	HYPERBARIC CHAMBER (RCR)	OPHYPER			2			2
2010	4	JACKSON HEIGHTS ID CLINIC	OPJACKID	42					42
2010	4	LA MARCA LAB WORK	POPLAMA				51		51
2010	4	LABOR & DELIVERY-SDC (ASU)	NS12SDC		16			18	34
2010	4	LAMARCA FAMILY HEALTH GYN	LAMAGYN	8					8
2010	4	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	690			1		691
2010	4	LAMARCA FAMILY HEALTH OB	LAMAOB	12					12
2010	4	LAMARCA FAMILY HEALTH PEDS	LAMAPED	164					164
2010	4	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				181		181
2010	4	OB GENETIC COUNSELING	OPOBGENETI	1					1
2010	4	OB SONOGRAM	OBSONO				22		22
2010	4	OP PEDS HIGH RISK	OPPEDHIRSK	22					22
2010	4	OP PULMONARY FUNCTION TEST	OPPFT				7		7
2010	4	OUT PATIENT ALLERGY ADULT	OPALLERGY	9					9
2010	4	OUT PATIENT ASTHMA ADULT	OPASTHMA	20					20
2010	4	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	30					30
2010	4	OUT PATIENT CARDIOLOGY	OPCARD	169					169
2010	4	OUT PATIENT CHEMOTHERAPY	OPCHEMO	28					28
2010	4	OUT PATIENT DENTAL	OPDENT			194			194
2010	4	OUT PATIENT DERMATOLOGY	OPDERM	36					36
2010	4	OUT PATIENT DIABETIC	OPDIAB	133					133
2010	4	OUT PATIENT EAR NOSE & THROAT	OPENT	175					175
2010	4	OUT PATIENT ENDOCRINOLOGY	OPENDO	82					82
2010	4	OUT PATIENT GASTROENTEROLOGY	OPGI	131					131
2010	4	OUT PATIENT GERIATRICS	OPGERIATRI	2					2
2010	4	OUT PATIENT GYN	OPGYN	796					796
2010	4	OUT PATIENT HEMATOLOGY	OPHEMA	69					69
2010	4	OUT PATIENT HEPATITIS C	OPHIC	34					34
2010	4	OUT PATIENT ID	OPID	250					250
2010	4	OUT PATIENT MEDICAL	OPMED	952					952
2010	4	OUT PATIENT NEPHROLOGY	OPNEPH	92					92
2010	4	OUT PATIENT NEUROLOGY	OPNEURO	79					79
2010	4	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	11					11
2010	4	OUT PATIENT OB	OPOB	860					860
2010	4	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	38					38
2010	4	OUT PATIENT OPHTHALMOLOGY	OPEYE	172					172
2010	4	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	288					288
2010	4	OUT PATIENT OSTEO	OPOSTEO	26					26
2010	4	OUT PATIENT PAIN MANAGMENT	OPPAIN	86					86
2010	4	OUT PATIENT PEDIATRICS	OPPED	608					608
2010	4	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	17					17
2010	4	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	6					6
2010	4	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	34					34
2010	4	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	219		2			221
2010	4	OUT PATIENT PHYSICAL THX (RCR)	OPPT	1		34			35
2010	4	OUT PATIENT PODIATRY	OPPOD	301					301
2010	4	OUT PATIENT PULMONARY	OPPULMO	59					59
2010	4	OUT PATIENT RHEUMATOLOGY	OPRHEUM	16					16
2010	4	OUT PATIENT SURGICAL	OPSURG	268					268
2010	4	OUT PATIENT UROLOGY	OPGU	208					208
2010	4	OUT PATIENT VASCULAR	OPVASC	125			10		135
2010	4	OUT PATIENT VASCULAR LAB	OPVASCLAB				48		48
2010	4	OUT PATIENT WELL BABY	OPPEDWELL					1	1

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2010	4	OUT PATIENT WOUND CARE	OPWOUND	208					208
2010	4	OUT PT PLASTIC SURGERY/HAND	OPPLAST	120					120
2010	4	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	40					40
2010	4	PRESURGICAL TESTING	PRETEST				189		189
2010	4	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD				177		177
2010	4	PRIVATE OUT PATIENT CHEMO	POPCHEMO				72		72
2010	4	PRIVATE OUT PATIENT LAB	POPLAB				1,108		1,108
2010	4	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				2,097		2,097
2010	4	QUEENSBRIDGE CARDIOLOGY	QBRIGCARD	8					8
2010	4	QUEENSBRIDGE CLINIC	POPQBRIDGE				44		44
2010	4	QUEENSBRIDGE GYN	QBRIGGYN	8					8
2010	4	QUEENSBRIDGE MEDICAL	QBRIGMED	233					233
2010	4	QUEENSBRIDGE PEDIATRICS	QBRIGPED	66					66
2010	4	QUEENSBRIDGE PODIATRY	QBRIGPOD	40					40
2010	4	VASCULAR LAB	VASLAB				75		75
2010	4	WYCKOFF CLINIC LAB WORK	POPCLINIC	3			766		769
2010	5	12 SOUTH ED TRIAGE	NS12ST		199		1	1	201
2010	5	4 NORTH SURG DAY CARE(ASU) HD	NS4NH					400	400
2010	5	BUENA VITA LAB WORK	POPBUENAVI				344		344
2010	5	CAMBA BROADWAY HOUSE	POPCAMBA				6		6
2010	5	CARE COACH	POPCARECOA				96		96
2010	5	CATHERIZATION LAB - ASU	NSCATHLAB					9	9
2010	5	COMMUNITY CARE COACH MEDICAL	COACHMED				1		1
2010	5	CYTOGENETICS	CYTOGEN				114		114
2010	5	EMERGENCY DEPT FASTTRACK	NSEDF		1,237				1,237
2010	5	EMERGENCY ROOM - ADULT	NSEDA		2,240				2,240
2010	5	EMERGENCY ROOM - PEDIATRICS	NSEDP		1,884				1,884
2010	5	ENDOSCOPY SUITE - ASU ONLY	NS10E				2	174	176
2010	5	FAMILY MEDICINE CLINIC	OPFAMMED	223					223
2010	5	FAMILY MEDICINE GYN	OPFAMGYN	3					3
2010	5	FAMILY MEDICINE PEDS	OPFAMPED	53					53
2010	5	FETAL ASSESSMENT RADIOLOGY	FETALASSES	5			302		307
2010	5	HYPERBARIC CHAMBER (RCR)	OPHYPER			3			3
2010	5	JACKSON HEIGHTS ID CLINIC	OPJACKID	31					31
2010	5	LA MARCA LAB WORK	POPLAMA				51		51
2010	5	LABOR & DELIVERY-SDC (ASU)	NS12SDC		14			17	31
2010	5	LAMARCA FAMILY HEALTH GYN	LAMAGYN	11					11
2010	5	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	561					561
2010	5	LAMARCA FAMILY HEALTH OB	LAMAOB	23					23
2010	5	LAMARCA FAMILY HEALTH PEDS	LAMAPED	155					155
2010	5	LAMARCA NUTRITIONAL COUNSEL	LAMADIET				3		3
2010	5	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				174		174
2010	5	OB GENETIC COUNSELING	OPOBGENETI	5					5
2010	5	OB SONOGRAM	OBSONO	1			118		119
2010	5	OP PEDS HIGH RISK	OPPEDHIRSK	25					25
2010	5	OP PULMONARY FUNCTION TEST	OPPFT				5		5
2010	5	OUT PATIENT ALLERGY ADULT	OPALLERGY	18					18
2010	5	OUT PATIENT ASTHMA ADULT	OPASTHMA	26					26
2010	5	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	17					17
2010	5	OUT PATIENT CARDIOLOGY	OPCARD	171			1		172
2010	5	OUT PATIENT CHEMOTHERAPY	OPCHEMO	6			3		9
2010	5	OUT PATIENT DENTAL	OPDENT	762		39			801
2010	5	OUT PATIENT DERMATOLOGY	OPDERM	25					25
2010	5	OUT PATIENT DIABETIC	OPDIAB	112					112

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2010	5	OUT PATIENT EAR NOSE & THROAT	OPENT	175					175
2010	5	OUT PATIENT ENDOCRINOLOGY	OPENDO	71					71
2010	5	OUT PATIENT GASTROENTEROLOGY	OPGI	168					168
2010	5	OUT PATIENT GERIATRICS	OPGERIATRI	4					4
2010	5	OUT PATIENT GYN	OPGYN	723					723
2010	5	OUT PATIENT HEMATOLOGY	OPHEMA	70					70
2010	5	OUT PATIENT HEPATITIS C	OPHIC	31					31
2010	5	OUT PATIENT ID	OPID	301					301
2010	5	OUT PATIENT MEDICAL	OPMED	926					926
2010	5	OUT PATIENT NEPHROLOGY	OPNEPH	49					49
2010	5	OUT PATIENT NEUROLOGY	OPNEURO	79					79
2010	5	OUT PATIENT NEWBORN SCREENING	OPPEDNEW	1					1
2010	5	OUT PATIENT OB	OPOB	783			1		784
2010	5	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	49					49
2010	5	OUT PATIENT OCCUP THX (RCR)	OPOT			1			1
2010	5	OUT PATIENT OPHTHALMOLOGY	OPEYE	165					165
2010	5	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	241					241
2010	5	OUT PATIENT OSTEO	OPOSTEO	24					24
2010	5	OUT PATIENT PAIN MANAGMENT	OPPAIN	83					83
2010	5	OUT PATIENT PEDIATRICS	OPPED	520					520
2010	5	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	9					9
2010	5	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	9					9
2010	5	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	40					40
2010	5	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	168		2			170
2010	5	OUT PATIENT PHYSICAL THX (RCR)	OPPT	8		47			55
2010	5	OUT PATIENT PODIATRY	OPPOD	291			1		292
2010	5	OUT PATIENT PULMONARY	OPPULMO	33					33
2010	5	OUT PATIENT RHEUMATOLOGY	OPRHEUM	21					21
2010	5	OUT PATIENT SURGICAL	OPSURG	189					189
2010	5	OUT PATIENT THORACIC SURGERY	OPTHORAC	1					1
2010	5	OUT PATIENT UROLOGY	OPGU	173					173
2010	5	OUT PATIENT VASCULAR	OPVASC	98			4		102
2010	5	OUT PATIENT VASCULAR LAB	OPVASCLAB				12		12
2010	5	OUT PATIENT WOUND CARE	OPWOUND	225					225
2010	5	OUT PATIENT WOUND CARE ID	OPWOUNDID	1					1
2010	5	OUT PT PLASTIC SURGERY/HAND	OPPLAST	94					94
2010	5	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	33					33
2010	5	PRESURGICAL TESTING	PRETEST				152		152
2010	5	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD				136		136
2010	5	PRIVATE OUT PATIENT CHEMO	POPCHEMO				104		104
2010	5	PRIVATE OUT PATIENT LAB	POPLAB	1			982		983
2010	5	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				2,039		2,039
2010	5	QUEENSBRIDGE CARDIOLOGY	QBRIGCARD	5					5
2010	5	QUEENSBRIDGE CLINIC	POPQBRIDGE				33		33
2010	5	QUEENSBRIDGE MEDICAL	QBRIGMED	204					204
2010	5	QUEENSBRIDGE PEDIATRICS	QBRIGPED	53					53
2010	5	QUEENSBRIDGE PODIATRY	QBRIGPOD	29					29
2010	5	VASCULAR LAB	VASLAB				94		94
2010	5	WYCKOFF CLINIC LAB WORK	POPCLINIC				701		701
2010	6	12 SOUTH ED TRIAGE	NS12ST	4	190			2	196
2010	6	4 NORTH SURG DAY CARE(ASU) HD	NS4NH				1	451	452
2010	6	BUENA VITA LAB WORK	POPBUENAVI				378		378
2010	6	CAMBA BROADWAY HOUSE	POPCAMBA				10		10
2010	6	CARE COACH	POPCARECOA				106		106

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2010	6	CATHERIZATION LAB - ASU	NSCATHLAB					11	11
2010	6	CYTOGENETICS	CYTOGEN				135		135
2010	6	EMERGENCY DEPT FASTTRACK	NSEDF		1,384				1,384
2010	6	EMERGENCY ROOM - ADULT	NSEDA		2,179		2		2,181
2010	6	EMERGENCY ROOM - PEDIATRICS	NSEDP		1,658				1,658
2010	6	ENDOSCOPY SUITE - ASU ONLY	NS10E					207	207
2010	6	FAMILY MEDICINE CLINIC	OPFAMMED	222					222
2010	6	FAMILY MEDICINE GYN	OPFAMGYN	3					3
2010	6	FAMILY MEDICINE PEDS	OPFAMPED	64	1				65
2010	6	FETAL ASSESSMENT RADIOLOGY	FETALASSES	10			445		455
2010	6	HYPERBARIC CHAMBER (RCR)	OPHYPER			1			1
2010	6	JACKSON HEIGHTS ID CLINIC	OPJACKID	44					44
2010	6	LA MARCA LAB WORK	POPLAMA				39		39
2010	6	LABOR & DELIVERY-SDC (ASU)	NS12SDC		12			23	35
2010	6	LAMARCA FAMILY HEALTH GYN	LAMAGYN	10					10
2010	6	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	621					621
2010	6	LAMARCA FAMILY HEALTH OB	LAMAOB	17					17
2010	6	LAMARCA FAMILY HEALTH PEDS	LAMAPED	139					139
2010	6	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				171		171
2010	6	OB GENETIC COUNSELING	OPOBGENETI	2					2
2010	6	OB SONOGRAM	OBSONO				12		12
2010	6	OP PEDS HIGH RISK	OPPEDHIRSK	25					25
2010	6	OP PULMONARY FUNCTION TEST	OPPFT				5		5
2010	6	OUT PATIENT ALLERGY ADULT	OPALLERGY	14					14
2010	6	OUT PATIENT ASTHMA ADULT	OPASTHMA	22					22
2010	6	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	10					10
2010	6	OUT PATIENT CARDIOLOGY	OPCARD	152			1		153
2010	6	OUT PATIENT CHEMOTHERAPY	OPCHEMO	92					92
2010	6	OUT PATIENT DENTAL	OPDENT	806		20			826
2010	6	OUT PATIENT DERMATOLOGY	OPDERM	26					26
2010	6	OUT PATIENT DIABETIC	OPDIAB	119					119
2010	6	OUT PATIENT EAR NOSE & THROAT	OPENT	84					84
2010	6	OUT PATIENT ENDOCRINOLOGY	OPENDO	105					105
2010	6	OUT PATIENT GASTROENTEROLOGY	OPGI	166					166
2010	6	OUT PATIENT GERIATRICS	OPGERIATRI	4					4
2010	6	OUT PATIENT GYN	OPGYN	798			1		799
2010	6	OUT PATIENT GYN BREAST	OPGYNBRST	3					3
2010	6	OUT PATIENT HEMATOLOGY	OPHEMA	47					47
2010	6	OUT PATIENT HEPATITIS C	OPHIC	33					33
2010	6	OUT PATIENT ID	OPID	296					296
2010	6	OUT PATIENT MEDICAL	OPMED	1,021					1,021
2010	6	OUT PATIENT NEPHROLOGY	OPNEPH	67					67
2010	6	OUT PATIENT NEUROLOGY	OPNEURO	105					105
2010	6	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	8					8
2010	6	OUT PATIENT OB	OPOB	875			1		876
2010	6	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	60					60
2010	6	OUT PATIENT OPHTHALMOLOGY	OPEYE	183					183
2010	6	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	315					315
2010	6	OUT PATIENT OSTEO	OPOSTEO	19					19
2010	6	OUT PATIENT PAIN MANAGMENT	OPPAIN	93					93
2010	6	OUT PATIENT PEDIATRICS	OPPED	509					509
2010	6	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	13					13
2010	6	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	6					6
2010	6	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	33					33

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2010	6	OUT PATIENT PEDS PODIATRY	OPPEDPOD	2					2
2010	6	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	228					228
2010	6	OUT PATIENT PHYSICAL THX (RCR)	OPPT	5		23			28
2010	6	OUT PATIENT PODIATRY	OPPOD	332					332
2010	6	OUT PATIENT PULMONARY	OPPULMO	25					25
2010	6	OUT PATIENT RHEUMATOLOGY	OPRHEUM	12					12
2010	6	OUT PATIENT SURGICAL	OPSURG	162					162
2010	6	OUT PATIENT THORACIC SURGERY	OPTHORAC	4					4
2010	6	OUT PATIENT UROLOGY	OPGU	195					195
2010	6	OUT PATIENT VASCULAR	OPVASC	96					96
2010	6	OUT PATIENT VASCULAR LAB	OPVASCLAB				8		8
2010	6	OUT PATIENT WOUND CARE	OPWOUND	255					255
2010	6	OUT PT PLASTIC SURGERY/HAND	OPPLAST	133					133
2010	6	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	27					27
2010	6	PRESURGICAL TESTING	PRETEST				170		170
2010	6	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD	2			173		175
2010	6	PRIVATE OUT PATIENT CHEMO	POPCHEMO	3			39		42
2010	6	PRIVATE OUT PATIENT LAB	POPLAB				1,104		1,104
2010	6	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				2,133		2,133
2010	6	QUEENSBRIDGE CARDIOLOGY	QBRIGCARD	10					10
2010	6	QUEENSBRIDGE CLINIC	POPQBRIDGE				32		32
2010	6	QUEENSBRIDGE MEDICAL	QBRIGMED	244					244
2010	6	QUEENSBRIDGE PEDIATRICS	QBRIGPED	31					31
2010	6	QUEENSBRIDGE PODIATRY	QBRIGPOD	22					22
2010	6	VASCULAR LAB	VASLAB				110		110
2010	6	WYCKOFF CLINIC LAB WORK	POPCLINIC				803		803
2010	7	12 SOUTH ED TRIAGE	NS12ST		222			1	223
2010	7	4 NORTH SURG DAY CARE(ASU) HD	NS4NH				6	404	410
2010	7	BUENA VITA LAB WORK	POPBUENAVI				393		393
2010	7	CAMBA BROADWAY HOUSE	POPCAMBA				6		6
2010	7	CARE COACH	POPCARECOA				99		99
2010	7	CATHERIZATION LAB - ASU	NSCATHLAB					9	9
2010	7	CYTOGENETICS	CYTOGEN				119		119
2010	7	EMERGENCY DEPT FASTTRACK	NSEDF		1,719				1,719
2010	7	EMERGENCY ROOM - ADULT	NSEDA		1,950				1,950
2010	7	EMERGENCY ROOM - PEDIATRICS	NSEDP		1,712				1,712
2010	7	ENDOSCOPY SUITE - ASU ONLY	NS10E				1	187	188
2010	7	FAMILY MEDICINE CLINIC	OPFAMMED	175					175
2010	7	FAMILY MEDICINE GYN	OPFAMGYN	7					7
2010	7	FAMILY MEDICINE PEDS	OPFAMPED	36					36
2010	7	FETAL ASSESSMENT RADIOLOGY	FETALASSES	11			402		413
2010	7	HYPERBARIC CHAMBER (RCR)	OPHYPER			3			3
2010	7	LA MARCA LAB WORK	POPLAMA				54		54
2010	7	LABOR & DELIVERY-SDC (ASU)	NS12SDC		3			10	13
2010	7	LAMARCA FAMILY HEALTH GYN	LAMAGYN	16					16
2010	7	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	526					526
2010	7	LAMARCA FAMILY HEALTH OB	LAMAOB	20					20
2010	7	LAMARCA FAMILY HEALTH PEDS	LAMAPED	123					123
2010	7	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				165		165
2010	7	OB GENETIC COUNSELING	OPOBGENETI	2					2
2010	7	OB SONOGRAM	OBSONO				11		11
2010	7	OP PEDS HIGH RISK	OPPEDHIRSK	30					30
2010	7	OP PULMONARY FUNCTION TEST	OPPFT				16		16
2010	7	OUT PATIENT ALLERGY ADULT	OPALLERGY	20					20

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Service Year	Service Month	Location Name	Location ID	CLI	ER	RCR	REF	SDC	Month Total
2010	7	OUT PATIENT ASTHMA ADULT	OPASTHMA	16					16
2010	7	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	24					24
2010	7	OUT PATIENT CARDIOLOGY	OPCARD	130					130
2010	7	OUT PATIENT CHEMOTHERAPY	OPCHEMO	63			1		64
2010	7	OUT PATIENT DENTAL	OPDENT	895		3			898
2010	7	OUT PATIENT DERMATOLOGY	OPDERM	25					25
2010	7	OUT PATIENT DIABETIC	OPDIAB	151					151
2010	7	OUT PATIENT EAR NOSE & THROAT	OPENT	147					147
2010	7	OUT PATIENT ENDOCRINOLOGY	OPENDO	93					93
2010	7	OUT PATIENT GASTROENTEROLOGY	OPGI	188					188
2010	7	OUT PATIENT GENETIC COUNSELING	OPGENE	1					1
2010	7	OUT PATIENT GERIATRICS	OPGERIATRI	2					2
2010	7	OUT PATIENT GYN	OPGYN	702			1		703
2010	7	OUT PATIENT GYN BREAST	OPGYNBRST	23					23
2010	7	OUT PATIENT HEMATOLOGY	OPHEMA	48					48
2010	7	OUT PATIENT HEPATITIS C	OPHIC	43					43
2010	7	OUT PATIENT ID	OPID	245					245
2010	7	OUT PATIENT MEDICAL	OPMED	915					915
2010	7	OUT PATIENT NEPHROLOGY	OPNEPH	69					69
2010	7	OUT PATIENT NEUROLOGY	OPNEURO	77					77
2010	7	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	6					6
2010	7	OUT PATIENT OB	OPOB	784					784
2010	7	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	37					37
2010	7	OUT PATIENT OCCUP THX (RCR)	OPOT			1			1
2010	7	OUT PATIENT OPHTHALMOLOGY	OPEYE	164					164
2010	7	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	266					266
2010	7	OUT PATIENT OSTEO	OPOSTEO	21					21
2010	7	OUT PATIENT PAIN MANAGMENT	OPPAIN	62					62
2010	7	OUT PATIENT PEDIATRICS	OPPED	481					481
2010	7	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	13					13
2010	7	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	8					8
2010	7	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	25					25
2010	7	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	143					143
2010	7	OUT PATIENT PHYSICAL THX (RCR)	OPPT	5		15			20
2010	7	OUT PATIENT PODIATRY	OPPOD	346					346
2010	7	OUT PATIENT PULMONARY	OPPULMO	37					37
2010	7	OUT PATIENT RHEUMATOLOGY	OPRHEUM	15					15
2010	7	OUT PATIENT SURGICAL	OPSURG	188				4	192
2010	7	OUT PATIENT UROLOGY	OPGU	178					178
2010	7	OUT PATIENT VASCULAR	OPVASC	122			7		129
2010	7	OUT PATIENT VASCULAR LAB	OPVASCLAB				28		28
2010	7	OUT PATIENT WOUND CARE	OPWOUND	224					224
2010	7	OUT PT PLASTIC SURGERY/HAND	OPPLAST	106					106
2010	7	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	27					27
2010	7	PRESURGICAL TESTING	PRETEST				152		152
2010	7	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD				144		144
2010	7	PRIVATE OUT PATIENT CHEMO	POPCHEMO				21		21
2010	7	PRIVATE OUT PATIENT LAB	POPLAB				921		921
2010	7	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				1,862		1,862
2010	7	VASCULAR LAB	VASLAB				100		100
2010	7	WYCKOFF CLINIC LAB WORK	POPCLINIC	5			773		778
2010	8	12 SOUTH ED TRIAGE	NS12ST		221		1	1	223
2010	8	4 NORTH SURG DAY CARE(ASU) HD	NS4NH				2	431	433
2010	8	BUENA VITA LAB WORK	POPBUENAVI				388		388

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2010	8	CAMBA BROADWAY HOUSE	POPCAMBA				9		9
2010	8	CARE COACH	POPCARECOA				95		95
2010	8	CATHERIZATION LAB - ASU	NSCATHLAB					10	10
2010	8	CYTOGENETICS	CYTOGEN				101		101
2010	8	EMERGENCY DEPT FASTTRACK	NSEDF		1,697				1,697
2010	8	EMERGENCY ROOM - ADULT	NSEDA		1,907				1,907
2010	8	EMERGENCY ROOM - PEDIATRICS	NSEDP		1,409				1,409
2010	8	ENDOSCOPY SUITE - ASU ONLY	NS10E				1	211	212
2010	8	FAMILY MEDICINE CLINIC	OPFAMMED	210					210
2010	8	FAMILY MEDICINE GYN	OPFAMGYN	3					3
2010	8	FAMILY MEDICINE PEDS	OPFAMPED	46					46
2010	8	FETAL ASSESSMENT RADIOLOGY	FETALASSES	4			399		403
2010	8	HYPERBARIC CHAMBER (RCR)	OPHYPER			2			2
2010	8	LA MARCA LAB WORK	POPLAMA				71		71
2010	8	LABOR & DELIVERY-SDC (ASU)	NS12SDC		4			17	21
2010	8	LAMARCA FAMILY HEALTH GYN	LAMAGYN	14					14
2010	8	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	593					593
2010	8	LAMARCA FAMILY HEALTH OB	LAMAOB	13					13
2010	8	LAMARCA FAMILY HEALTH PEDS	LAMAPED	172					172
2010	8	LAMARCA NUTRITIONAL COUNSEL	LAMADIET				2		2
2010	8	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				152		152
2010	8	OB GENETIC COUNSELING	OPOBGENETI	5					5
2010	8	OB SONOGRAM	OBSONO				25		25
2010	8	OP PEDS HIGH RISK	OPPEDHIRSK	27					27
2010	8	OP PULMONARY FUNCTION TEST	OPPFT	1			28	1	30
2010	8	OPERATING ROOM	OR					1	1
2010	8	OUT PATIENT ALLERGY ADULT	OPALLERGY	18					18
2010	8	OUT PATIENT ASTHMA ADULT	OPASTHMA	39					39
2010	8	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	16					16
2010	8	OUT PATIENT CARDIOLOGY	OPCARD	177			2		179
2010	8	OUT PATIENT CHEMOTHERAPY	OPCHEMO	98					98
2010	8	OUT PATIENT DENTAL	OPDENT	912		1		1	914
2010	8	OUT PATIENT DERMATOLOGY	OPDERM	19					19
2010	8	OUT PATIENT DIABETIC	OPDIAB	136					136
2010	8	OUT PATIENT EAR NOSE & THROAT	OPENT	178					178
2010	8	OUT PATIENT ENDOCRINOLOGY	OPENDO	110					110
2010	8	OUT PATIENT GASTROENTEROLOGY	OPGI	212					212
2010	8	OUT PATIENT GENETIC COUNSELING	OPGENE	4					4
2010	8	OUT PATIENT GERIATRICS	OPGERIATRI	5					5
2010	8	OUT PATIENT GYN	OPGYN	805			1		806
2010	8	OUT PATIENT GYN BREAST	OPGYNBRST	21					21
2010	8	OUT PATIENT GYN COUNSELING	OPGYNCOUNS	1					1
2010	8	OUT PATIENT HEMATOLOGY	OPHEMA	49					49
2010	8	OUT PATIENT HEPATITIS C	OPHIC	9					9
2010	8	OUT PATIENT ID	OPID	327					327
2010	8	OUT PATIENT MEDICAL	OPMED	945					945
2010	8	OUT PATIENT NEPHROLOGY	OPNEPH	60					60
2010	8	OUT PATIENT NEUROLOGY	OPNEURO	21					21
2010	8	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	12					12
2010	8	OUT PATIENT OB	OPOB	848					848
2010	8	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	38					38
2010	8	OUT PATIENT OPHTHALMOLOGY	OPEYE	169					169
2010	8	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	167					167
2010	8	OUT PATIENT OSTEO	OPOSTEO	25					25

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2010	8	OUT PATIENT PAIN MANAGMENT	OPPAIN	79					79
2010	8	OUT PATIENT PEDIATRICS	OPPED	526					526
2010	8	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	12					12
2010	8	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	6					6
2010	8	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	18					18
2010	8	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	212					212
2010	8	OUT PATIENT PHYSICAL THX (RCR)	OPPT	3					3
2010	8	OUT PATIENT PODIATRY	OPPOD	331					331
2010	8	OUT PATIENT PULMONARY	OPPULMO	29			1		30
2010	8	OUT PATIENT RHEUMATOLOGY	OPRHEUM	13					13
2010	8	OUT PATIENT SURGICAL	OPSURG	176				2	178
2010	8	OUT PATIENT THORACIC SURGERY	OPTHORAC	2					2
2010	8	OUT PATIENT UROLOGY	OPGU	184					184
2010	8	OUT PATIENT VASCULAR	OPVASC	119			6		125
2010	8	OUT PATIENT VASCULAR LAB	OPVASCLAB				42		42
2010	8	OUT PATIENT WOUND CARE	OPWOUND	286					286
2010	8	OUT PT PLASTIC SURGERY/HAND	OPPLAST	98					98
2010	8	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	38					38
2010	8	PRESURGICAL TESTING	PRETEST				174		174
2010	8	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD				173		173
2010	8	PRIVATE OUT PATIENT CHEMO	POPCHEMO	2					2
2010	8	PRIVATE OUT PATIENT LAB	POPLAB	1			944		945
2010	8	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				2,041		2,041
2010	8	VASCULAR LAB	VASLAB				82	1	83
2010	8	WYCKOFF CLINIC LAB WORK	POPCLINIC				785		785
2010	9	12 SOUTH ED TRIAGE	NS12ST		192		2		194
2010	9	4 NORTH SURG DAY CARE(ASU) HD	NS4NH					408	408
2010	9	BUENA VITA LAB WORK	POPBUENAVI				382		382
2010	9	CAMBA BROADWAY HOUSE	POPCAMBA				13		13
2010	9	CARE COACH	POPCARECOA				90		90
2010	9	CATHERIZATION LAB - ASU	NSCATHLAB					17	17
2010	9	CYTOGENETICS	CYTOGEN				119		119
2010	9	EMERGENCY DEPT FASTTRACK	NSEDF		1,532				1,532
2010	9	EMERGENCY ROOM - ADULT	NSEDA		1,922				1,922
2010	9	EMERGENCY ROOM - PEDIATRICS	NSEDP		1,594				1,594
2010	9	ENDOSCOPY SUITE - ASU ONLY	NS10E					225	225
2010	9	FAMILY MEDICINE CLINIC	OPFAMMED	194					194
2010	9	FAMILY MEDICINE GYN	OPFAMGYN	4					4
2010	9	FAMILY MEDICINE PEDS	OPFAMPED	77					77
2010	9	FETAL ASSESSMENT RADIOLOGY	FETALASSES	11			432		443
2010	9	HYPERBARIC CHAMBER (RCR)	OPHYPER			4			4
2010	9	LA MARCA LAB WORK	POPLAMA				44		44
2010	9	LABOR & DELIVERY-SDC (ASU)	NS12SDC		4			14	18
2010	9	LAMARCA FAMILY HEALTH GYN	LAMAGYN	8					8
2010	9	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	524					524
2010	9	LAMARCA FAMILY HEALTH OB	LAMAOB	12					12
2010	9	LAMARCA FAMILY HEALTH PEDS	LAMAPED	161					161
2010	9	LAMARCA NUTRITIONAL COUNSEL	LAMADIET				2		2
2010	9	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				128		128
2010	9	OB GENETIC COUNSELING	OPOBGENETI	11					11
2010	9	OB SONOGRAM	OBSONO				34		34
2010	9	OP PEDS HIGH RISK	OPPEDHIRSK	30					30
2010	9	OP PULMONARY FUNCTION TEST	OPPFT				21		21
2010	9	OUT PATIENT ALLERGY ADULT	OPALLERGY	26					26

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2010	9	OUT PATIENT ASTHMA ADULT	OPASTHMA	26					26
2010	9	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	16					16
2010	9	OUT PATIENT CARDIOLOGY	OPCARD	170			1		171
2010	9	OUT PATIENT CHEMOTHERAPY	OPCHEMO	112					112
2010	9	OUT PATIENT DENTAL	OPDENT	877					877
2010	9	OUT PATIENT DERMATOLOGY	OPDERM	33					33
2010	9	OUT PATIENT DIABETIC	OPDIAB	138					138
2010	9	OUT PATIENT EAR NOSE & THROAT	OPENT	172					172
2010	9	OUT PATIENT ENDOCRINOLOGY	OPENDO	85					85
2010	9	OUT PATIENT GASTROENTEROLOGY	OPGI	218					218
2010	9	OUT PATIENT GENETIC COUNSELING	OPGENE	2					2
2010	9	OUT PATIENT GERIATRICS	OPGERIATRI	3					3
2010	9	OUT PATIENT GYN	OPGYN	785			1		786
2010	9	OUT PATIENT GYN BREAST	OPGYNBRST	21					21
2010	9	OUT PATIENT HEMATOLOGY	OPHEMA	58					58
2010	9	OUT PATIENT HEPATITIS C	OPHEPC	23					23
2010	9	OUT PATIENT ID	OPID	296					296
2010	9	OUT PATIENT MEDICAL	OPMED	1,038					1,038
2010	9	OUT PATIENT NEPHROLOGY	OPNEPH	70					70
2010	9	OUT PATIENT NEUROLOGY	OPNEURO	116					116
2010	9	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	8					8
2010	9	OUT PATIENT OB	OPOB	805					805
2010	9	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	37					37
2010	9	OUT PATIENT OPHTHALMOLOGY	OPEYE	165					165
2010	9	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	200					200
2010	9	OUT PATIENT OSTEO	OPOSTEO	36					36
2010	9	OUT PATIENT PAIN MANAGMENT	OPPAIN	84					84
2010	9	OUT PATIENT PEDIATRICS	OPPED	576					576
2010	9	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	15					15
2010	9	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	10					10
2010	9	OUT PATIENT PEDS GI	OPPEDGI	5					5
2010	9	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	22					22
2010	9	OUT PATIENT PEDS PODIATRY	OPPEDPOD	19					19
2010	9	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	196					196
2010	9	OUT PATIENT PHYSICAL THX (RCR)	OPPT	2		1			3
2010	9	OUT PATIENT PODIATRY	OPPOD	301					301
2010	9	OUT PATIENT PULMONARY	OPPULMO	41					41
2010	9	OUT PATIENT RHEUMATOLOGY	OPRHEUM	12					12
2010	9	OUT PATIENT SURGICAL	OPSURG	201				1	202
2010	9	OUT PATIENT THORACIC SURGERY	OPTHORAC	2					2
2010	9	OUT PATIENT UROLOGY	OPGU	190					190
2010	9	OUT PATIENT VASCULAR	OPVASC	116			2		118
2010	9	OUT PATIENT VASCULAR LAB	OPVASCLAB				38		38
2010	9	OUT PATIENT WOUND CARE	OPWOUND	276					276
2010	9	OUT PT PLASTIC SURGERY/HAND	OPPLAST	101					101
2010	9	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	28					28
2010	9	PRESURGICAL TESTING	PRETEST				158		158
2010	9	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD				165		165
2010	9	PRIVATE OUT PATIENT CHEMO	POPCHEMO	1					1
2010	9	PRIVATE OUT PATIENT LAB	POPLAB	1			994		995
2010	9	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				2,093		2,093
2010	9	PRVT OP RAD THX (RCR)	POPRADIAT				1		1
2010	9	VASCULAR LAB	VASLAB				75		75
2010	9	WYCKOFF CLINIC LAB WORK	POPCLINIC	1			719		720

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2010	10	12 SOUTH ED TRIAGE	NS12ST		181				181
2010	10	4 NORTH SURG DAY CARE(ASU) HD	NS4NH				2	415	417
2010	10	BUENA VITA LAB WORK	POPBUENAVI				400		400
2010	10	CAMBA BROADWAY HOUSE	POPCAMBA				14		14
2010	10	CARE COACH	POPCARECOA				76		76
2010	10	CATHERIZATION LAB - ASU	NSCATHLAB					13	13
2010	10	CYTOGENETICS	CYTOGEN				122		122
2010	10	EMERGENCY DEPT FASTTRACK	NSEDF		1,597				1,597
2010	10	EMERGENCY ROOM - ADULT	NSEDA		1,958				1,958
2010	10	EMERGENCY ROOM - PEDIATRICS	NSEDP		1,802				1,802
2010	10	ENDOSCOPY SUITE - ASU ONLY	NS10E				2	196	198
2010	10	FAMILY MEDICINE CLINIC	OPFAMMED	192					192
2010	10	FAMILY MEDICINE GYN	OPFAMGYN	4					4
2010	10	FAMILY MEDICINE PEDS	OPFAMPED	59					59
2010	10	FETAL ASSESSMENT RADIOLOGY	FETALASSES	3			395		398
2010	10	HYPERBARIC CHAMBER (RCR)	OPHYPER			2			2
2010	10	LA MARCA LAB WORK	POPLAMA				39		39
2010	10	LABOR & DELIVERY-SDC (ASU)	NS12SDC		4			8	12
2010	10	LAMARCA FAMILY HEALTH GYN	LAMAGYN	14					14
2010	10	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	578					578
2010	10	LAMARCA FAMILY HEALTH OB	LAMAOB	10					10
2010	10	LAMARCA FAMILY HEALTH PEDS	LAMAPED	184					184
2010	10	LAMARCA NUTRITIONAL COUNSEL	LAMADIET				2		2
2010	10	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				166		166
2010	10	OB GENETIC COUNSELING	OPOBGENETI	3			2		5
2010	10	OB SONOGRAM	OBSONO				42		42
2010	10	OP PEDS HIGH RISK	OPPEDHIRSK	26					26
2010	10	OP PULMONARY FUNCTION TEST	OPPFT				24		24
2010	10	OPERATING ROOM	OR				1	1	2
2010	10	OUT PATIENT ALLERGY ADULT	OPALLERGY	21					21
2010	10	OUT PATIENT ASTHMA ADULT	OPASTHMA	31					31
2010	10	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	17					17
2010	10	OUT PATIENT CARDIOLOGY	OPCARD	154					154
2010	10	OUT PATIENT CHEMOTHERAPY	OPCHEMO	69	1				70
2010	10	OUT PATIENT DENTAL	OPDENT	751				1	752
2010	10	OUT PATIENT DERMATOLOGY	OPDERM	24					24
2010	10	OUT PATIENT DIABETIC	OPDIAB	142					142
2010	10	OUT PATIENT EAR NOSE & THROAT	OPENT	162					162
2010	10	OUT PATIENT ENDOCRINOLOGY	OPENDO	89					89
2010	10	OUT PATIENT GASTROENTEROLOGY	OPGI	198					198
2010	10	OUT PATIENT GERIATRICS	OPGERIATRI	4					4
2010	10	OUT PATIENT GYN	OPGYN	825			3		828
2010	10	OUT PATIENT GYN BREAST	OPGYNBRST	20					20
2010	10	OUT PATIENT HEMATOLOGY	OPHEMA	65					65
2010	10	OUT PATIENT HEPATITIS C	OPHEPC	28					28
2010	10	OUT PATIENT ID	OPID	280					280
2010	10	OUT PATIENT MEDICAL	OPMED	1,084					1,084
2010	10	OUT PATIENT NEPHROLOGY	OPNEPH	60					60
2010	10	OUT PATIENT NEUROLOGY	OPNEURO	89					89
2010	10	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	9					9
2010	10	OUT PATIENT OB	OPOB	764					764
2010	10	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	50					50
2010	10	OUT PATIENT OPHTHALMOLOGY	OPEYE	167					167
2010	10	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	252					252

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Service Year	Service Month	Location Name	Location ID	CLI	ER	RCR	REF	SDC	Month Total
2010	10	OUT PATIENT OSTEO	OPOSTEO	27					27
2010	10	OUT PATIENT PAIN MANAGMENT	OPPAIN	72					72
2010	10	OUT PATIENT PEDIATRICS	OPPED	594					594
2010	10	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	11					11
2010	10	OUT PATIENT PEDS GI	OPPEDGI	8					8
2010	10	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	31					31
2010	10	OUT PATIENT PEDS PODIATRY	OPPEDPOD	18					18
2010	10	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	147					147
2010	10	OUT PATIENT PHYSICAL THX (RCR)	OPPT	1					1
2010	10	OUT PATIENT PODIATRY	OPPOD	322					322
2010	10	OUT PATIENT PULMONARY	OPPULMO	41					41
2010	10	OUT PATIENT SURGICAL	OPSURG	158					158
2010	10	OUT PATIENT THORACIC SURGERY	OPTHORAC	2					2
2010	10	OUT PATIENT UROLOGY	OPGU	187					187
2010	10	OUT PATIENT VASCULAR	OPVASC	86			11		97
2010	10	OUT PATIENT VASCULAR LAB	OPVASCLAB				45		45
2010	10	OUT PATIENT WOUND CARE	OPWOUND	284					284
2010	10	OUT PT PLASTIC SURGERY/HAND	OPPLAST	98					98
2010	10	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	32					32
2010	10	PRESURGICAL TESTING	PRETEST				162		162
2010	10	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD				156		156
2010	10	PRIVATE OUT PATIENT LAB	POPLAB				825		825
2010	10	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				1,999		1,999
2010	10	VASCULAR LAB	VASLAB				64		64
2010	10	WYCKOFF CLINIC LAB WORK	POPCLINIC	1			723		724
2010	11	12 SOUTH ED TRIAGE	NS12ST		170		3		173
2010	11	4 NORTH SURG DAY CARE(ASU) HD	NS4NH				1	396	397
2010	11	BUENA VITA LAB WORK	POPBUENAVI				431		431
2010	11	CAMBA BROADWAY HOUSE	POPCAMBA				11		11
2010	11	CARE COACH	POPCARECOA				85		85
2010	11	CATHERIZATION LAB - ASU	NSCATHLAB					15	15
2010	11	COMMUNITY CARE COACH PEDIATRIC	COACHPED		1				1
2010	11	CYTOGENETICS	CYTOGEN				109		109
2010	11	EMERGENCY DEPT FASTTRACK	NSEDF		1,700				1,700
2010	11	EMERGENCY ROOM - ADULT	NSEDA		1,706				1,706
2010	11	EMERGENCY ROOM - PEDIATRICS	NSEDP		1,995				1,995
2010	11	ENDOSCOPY SUITE - ASU ONLY	NS10E					200	200
2010	11	FAMILY MEDICINE CLINIC	OPFAMMED	195					195
2010	11	FAMILY MEDICINE GYN	OPFAMGYN	6					6
2010	11	FAMILY MEDICINE PEDS	OPFAMPED	67					67
2010	11	FETAL ASSESSMENT RADIOLOGY	FETALASSES				396		396
2010	11	HYPERBARIC CHAMBER (RCR)	OPHYPER			4			4
2010	11	LA MARCA LAB WORK	POPLAMA				38		38
2010	11	LABOR & DELIVERY-SDC (ASU)	NS12SDC		2			11	13
2010	11	LAMARCA FAMILY HEALTH GYN	LAMAGYN	17					17
2010	11	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	500					500
2010	11	LAMARCA FAMILY HEALTH OB	LAMAOB	9					9
2010	11	LAMARCA FAMILY HEALTH PEDS	LAMAPED	111					111
2010	11	LAMARCA NUTRITIONAL COUNSEL	LAMADIET				1		1
2010	11	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				152		152
2010	11	OB GENETIC COUNSELING	OPOBGENETI	3					3
2010	11	OB SONOGRAM	OBSONO	1			5		6
2010	11	OP PEDS HIGH RISK	OPPEDHIRSK	18					18
2010	11	OP PULMONARY FUNCTION TEST	OPPFT				32		32

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Service Year	Service Month	Location Name	Location ID	CLI	ER	RCR	REF	SDC	Month Total
2010	11	OUT PATIENT ALLERGY ADULT	OPALLERGY	28					28
2010	11	OUT PATIENT ASTHMA ADULT	OPASTHMA	30					30
2010	11	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	15					15
2010	11	OUT PATIENT CARDIOLOGY	OPCARD	151			1		152
2010	11	OUT PATIENT CHEMOTHERAPY	OPCHEMO	85					85
2010	11	OUT PATIENT DENTAL	OPDENT	781					781
2010	11	OUT PATIENT DERMATOLOGY	OPDERM	17					17
2010	11	OUT PATIENT DIABETIC	OPDIAB	104					104
2010	11	OUT PATIENT EAR NOSE & THROAT	OPENT	169					169
2010	11	OUT PATIENT ENDOCRINOLOGY	OPENDO	101					101
2010	11	OUT PATIENT GASTROENTEROLOGY	OPGI	238					238
2010	11	OUT PATIENT GERIATRICS	OPGERIATRI	2					2
2010	11	OUT PATIENT GYN	OPGYN	833			2		835
2010	11	OUT PATIENT GYN BREAST	OPGYNBRST	22					22
2010	11	OUT PATIENT HEMATOLOGY	OPHEMA	53					53
2010	11	OUT PATIENT HEPATITIS C	OPHEPC	25					25
2010	11	OUT PATIENT ID	OPID	264					264
2010	11	OUT PATIENT MEDICAL	OPMED	1,001					1,001
2010	11	OUT PATIENT NEPHROLOGY	OPNEPH	35					35
2010	11	OUT PATIENT NEUROLOGY	OPNEURO	111					111
2010	11	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	11					11
2010	11	OUT PATIENT OB	OPOB	817			1		818
2010	11	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	35					35
2010	11	OUT PATIENT OPHTHALMOLOGY	OPEYE	175					175
2010	11	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	213					213
2010	11	OUT PATIENT OSTEO	OPOSTEO	24					24
2010	11	OUT PATIENT PAIN MANAGMENT	OPPAIN	80					80
2010	11	OUT PATIENT PEDIATRICS	OPPED	568					568
2010	11	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	25					25
2010	11	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	5					5
2010	11	OUT PATIENT PEDS GI	OPPEDGI	10					10
2010	11	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	35					35
2010	11	OUT PATIENT PEDS PODIATRY	OPPEDPOD	29					29
2010	11	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	175					175
2010	11	OUT PATIENT PHYSICAL THX (RCR)	OPPT			1			1
2010	11	OUT PATIENT PODIATRY	OPPOD	232					232
2010	11	OUT PATIENT PULMONARY	OPPULMO	22					22
2010	11	OUT PATIENT SURGICAL	OPSURG	164					164
2010	11	OUT PATIENT THORACIC SURGERY	OPTHORAC	5					5
2010	11	OUT PATIENT UROLOGY	OPGU	172					172
2010	11	OUT PATIENT VASCULAR	OPVASC	88			1		89
2010	11	OUT PATIENT VASCULAR LAB	OPVASCLAB				37		37
2010	11	OUT PATIENT WOUND CARE	OPWOUND	331					331
2010	11	OUT PT PLASTIC SURGERY/HAND	OPPLAST	100					100
2010	11	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	26					26
2010	11	PRESURGICAL TESTING	PRETEST				160		160
2010	11	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD				163		163
2010	11	PRIVATE OUT PATIENT LAB	POPLAB				853		853
2010	11	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				1,919		1,919
2010	11	VASCULAR LAB	VASLAB				42		42
2010	11	WYCKOFF CLINIC LAB WORK	POPCLINIC				677		677
2010	12	*******UNKNOWN	U		521				521
2010	12	12 SOUTH ED TRIAGE	NS12ST		208				208
2010	12	4 NORTH SURG DAY CARE(ASU) HD	NS4NH					353	353

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2010	12	BUENA VITA LAB WORK	POPBUENAVI				353		353
2010	12	CAMBA BROADWAY HOUSE	POPCAMBA				5		5
2010	12	CARE COACH	POPCARECOA				80		80
2010	12	CATHERIZATION LAB - ASU	NSCATHLAB					12	12
2010	12	CYTOGENETICS	CYTOGEN				83		83
2010	12	EMERGENCY DEPT FASTTRACK	NSEDF		1,687				1,687
2010	12	EMERGENCY ROOM - ADULT	NSEDA		1,963				1,963
2010	12	EMERGENCY ROOM - PEDIATRICS	NSEDP		2,344				2,344
2010	12	ENDOSCOPY SUITE - ASU ONLY	NS10E					170	170
2010	12	FAMILY MEDICINE CLINIC	OPFAMMED	154					154
2010	12	FAMILY MEDICINE PEDS	OPFAMPED	64					64
2010	12	FETAL ASSESSMENT RADIOLOGY	FETALASSES	2			424		426
2010	12	HYPERBARIC CHAMBER (RCR)	OPHYPER			2			2
2010	12	LA MARCA LAB WORK	POPLAMA				23		23
2010	12	LABOR & DELIVERY-SDC (ASU)	NS12SDC		3		1	10	14
2010	12	LAMARCA FAMILY HEALTH GYN	LAMAGYN	4					4
2010	12	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	474					474
2010	12	LAMARCA FAMILY HEALTH OB	LAMAOB	12					12
2010	12	LAMARCA FAMILY HEALTH PEDS	LAMAPED	113					113
2010	12	LAMARCA NUTRITIONAL COUNSEL	LAMADIET				2		2
2010	12	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				199		199
2010	12	OB GENETIC COUNSELING	OPOBGENETI				1		1
2010	12	OP PEDS HIGH RISK	OPPEDHIRSK	27					27
2010	12	OP PULMONARY FUNCTION TEST	OPPFT				13		13
2010	12	OUT PATIENT ALLERGY ADULT	OPALLERGY	16					16
2010	12	OUT PATIENT ASTHMA ADULT	OPASTHMA	23					23
2010	12	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	3					3
2010	12	OUT PATIENT CARDIOLOGY	OPCARD	130			4		134
2010	12	OUT PATIENT CHEMOTHERAPY	OPCHEMO	98	2				100
2010	12	OUT PATIENT DENTAL	OPDENT	780					780
2010	12	OUT PATIENT DERMATOLOGY	OPDERM	27					27
2010	12	OUT PATIENT DIABETIC	OPDIAB	135					135
2010	12	OUT PATIENT EAR NOSE & THROAT	OPENT	132					132
2010	12	OUT PATIENT ENDOCRINOLOGY	OPENDO	64					64
2010	12	OUT PATIENT GASTROENTEROLOGY	OPGI	215					215
2010	12	OUT PATIENT GENETIC COUNSELING	OPGENE	2			1		3
2010	12	OUT PATIENT GERIATRICS	OPGERIATRI	3					3
2010	12	OUT PATIENT GYN	OPGYN	701	1				702
2010	12	OUT PATIENT GYN BREAST	OPGYNBRST	17					17
2010	12	OUT PATIENT HEMATOLOGY	OPHEMA	39					39
2010	12	OUT PATIENT HEPATITIS C	OPHEPC	20					20
2010	12	OUT PATIENT ID	OPID	213					213
2010	12	OUT PATIENT MEDICAL	OPMED	860					860
2010	12	OUT PATIENT NEPHROLOGY	OPNEPH	66					66
2010	12	OUT PATIENT NEUROLOGY	OPNEURO	56					56
2010	12	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	7					7
2010	12	OUT PATIENT OB	OPOB	804			1		805
2010	12	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	37					37
2010	12	OUT PATIENT OPHTHALMOLOGY	OPEYE	143					143
2010	12	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	217					217
2010	12	OUT PATIENT OSTEO	OPOSTEO	27					27
2010	12	OUT PATIENT PAIN MANAGMENT	OPPAIN	81					81
2010	12	OUT PATIENT PEDIATRICS	OPPED	540			1		541
2010	12	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	10					10

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2010	12	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	7					7
2010	12	OUT PATIENT PEDS GI	OPPEDGI	3					3
2010	12	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	28					28
2010	12	OUT PATIENT PEDS PODIATRY	OPPEDPOD	25					25
2010	12	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	136					136
2010	12	OUT PATIENT PODIATRY	OPPOD	258					258
2010	12	OUT PATIENT PULMONARY	OPPULMO	34					34
2010	12	OUT PATIENT RHEUMATOLOGY	OPRHEUM	10					10
2010	12	OUT PATIENT SURGICAL	OPSURG	148				1	149
2010	12	OUT PATIENT THORACIC SURGERY	OPTHORAC	3					3
2010	12	OUT PATIENT UROLOGY	OPGU	144					144
2010	12	OUT PATIENT VASCULAR	OPVASC	91			9		100
2010	12	OUT PATIENT VASCULAR LAB	OPVASCLAB				39		39
2010	12	OUT PATIENT WOUND CARE	OPWOUND	232					232
2010	12	OUT PT PLASTIC SURGERY/HAND	OPPLAST	119					119
2010	12	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	28					28
2010	12	PRESURGICAL TESTING	PRETEST				145		145
2010	12	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD				127		127
2010	12	PRIVATE OUT PATIENT LAB	POPLAB				654		654
2010	12	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				1,618		1,618
2010	12	VASCULAR LAB	VASLAB				20		20
2010	12	WYCKOFF CLINIC LAB WORK	POPCLINIC				595		595
2011	1	*******UNKNOWN	U		19				19
2011	1	12 SOUTH ED TRIAGE	NS12ST	1	201		2	2	206
2011	1	4 NORTH SURG DAY CARE(ASU) HD	NS4NH				1	377	378
2011	1	BUENA VITA LAB WORK	POPBUENAVI				363		363
2011	1	CAMBA BROADWAY HOUSE	POPCAMBA				12		12
2011	1	CARE COACH	POPCARECOA				85		85
2011	1	CATHERIZATION LAB - ASU	NSCATHLAB					6	6
2011	1	COMMUNITY CARE COACH GYN	COACHGYN				1		1
2011	1	CYTOGENETICS	CYTOGEN				104		104
2011	1	EMERGENCY DEPT FASTTRACK	NSEDF		1,791				1,791
2011	1	EMERGENCY ROOM - ADULT	NSEDA		1,861				1,861
2011	1	EMERGENCY ROOM - PEDIATRICS	NSEDP		2,188				2,188
2011	1	ENDOSCOPY SUITE - ASU ONLY	NS10E		1			143	144
2011	1	FAMILY MEDICINE CLINIC	OPFAMMED	164					164
2011	1	FAMILY MEDICINE GYN	OPFAMGYN	1					1
2011	1	FAMILY MEDICINE PEDS	OPFAMPED	70					70
2011	1	FETAL ASSESSMENT RADIOLOGY	FETALASSES	2			451		453
2011	1	HYPERBARIC CHAMBER (RCR)	OPHYPER			3			3
2011	1	LA MARCA LAB WORK	POPLAMA				36		36
2011	1	LABOR & DELIVERY-SDC (ASU)	NS12SDC		1			8	9
2011	1	LAMARCA FAMILY HEALTH GYN	LAMAGYN	10					10
2011	1	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	504					504
2011	1	LAMARCA FAMILY HEALTH OB	LAMAOB	9					9
2011	1	LAMARCA FAMILY HEALTH PEDS	LAMAPED	123					123
2011	1	LAMARCA NUTRITIONAL COUNSEL	LAMADIET				2		2
2011	1	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				156		156
2011	1	OP PEDS HIGH RISK	OPPEDHIRSK	23					23
2011	1	OP PULMONARY FUNCTION TEST	OPPFT				12		12
2011	1	OUT PATIENT ALLERGY ADULT	OPALLERGY	28					28
2011	1	OUT PATIENT ASTHMA ADULT	OPASTHMA	21					21
2011	1	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	11					11
2011	1	OUT PATIENT CARDIOLOGY	OPCARD	118			1		119

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2011	1	OUT PATIENT CHEMOTHERAPY	OPCHEMO	118					118
2011	1	OUT PATIENT DENTAL	OPDENT	806					806
2011	1	OUT PATIENT DERMATOLOGY	OPDERM	21					21
2011	1	OUT PATIENT DIABETIC	OPDIAB	116					116
2011	1	OUT PATIENT EAR NOSE & THROAT	OPENT	115	1				116
2011	1	OUT PATIENT ENDOCRINOLOGY	OPENDO	93					93
2011	1	OUT PATIENT GASTROENTEROLOGY	OPGI	184					184
2011	1	OUT PATIENT GYN	OPGYN	725					725
2011	1	OUT PATIENT GYN BREAST	OPGYNBRST	21					21
2011	1	OUT PATIENT HEMATOLOGY	OPHEMA	56					56
2011	1	OUT PATIENT HEPATITIS C	OPHEPC	18					18
2011	1	OUT PATIENT ID	OPID	220					220
2011	1	OUT PATIENT MEDICAL	OPMED	880	1				881
2011	1	OUT PATIENT NEPHROLOGY	OPNEPH	43					43
2011	1	OUT PATIENT NEUROLOGY	OPNEURO	53					53
2011	1	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	8					8
2011	1	OUT PATIENT OB	OPOB	815	2				817
2011	1	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	36					36
2011	1	OUT PATIENT OPHTHALMOLOGY	OPEYE	169					169
2011	1	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	233					233
2011	1	OUT PATIENT OSTEO	OPOSTEO	22					22
2011	1	OUT PATIENT PAIN MANAGMENT	OPPAIN	66					66
2011	1	OUT PATIENT PEDIATRICS	OPPED	547					547
2011	1	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	12					12
2011	1	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	1					1
2011	1	OUT PATIENT PEDS GI	OPPEDGI	6					6
2011	1	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	32					32
2011	1	OUT PATIENT PEDS PODIATRY	OPPEDPOD	16					16
2011	1	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	158					158
2011	1	OUT PATIENT PHYSICAL THX (RCR)	OPPT	1					1
2011	1	OUT PATIENT PODIATRY	OPPOD	216					216
2011	1	OUT PATIENT PULMONARY	OPPULMO	13			1		14
2011	1	OUT PATIENT RHEUMATOLOGY	OPRHEUM	20					20
2011	1	OUT PATIENT SURGICAL	OPSURG	172				1	173
2011	1	OUT PATIENT THORACIC SURGERY	OPTHORAC	3					3
2011	1	OUT PATIENT UROLOGY	OPGU	214					214
2011	1	OUT PATIENT VASCULAR	OPVASC	69					69
2011	1	OUT PATIENT VASCULAR LAB	OPVASCLAB				67		67
2011	1	OUT PATIENT WOUND CARE	OPWOUND	257					257
2011	1	OUT PT PLASTIC SURGERY/HAND	OPPLAST	103					103
2011	1	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	20					20
2011	1	PRESURGICAL TESTING	PRETEST				199		199
2011	1	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD				117		117
2011	1	PRIVATE OUT PATIENT LAB	POPLAB	1			715		716
2011	1	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				1,730		1,730
2011	1	VASCULAR LAB	VASLAB				33		33
2011	1	WYCKOFF CLINIC LAB WORK	POPCLINIC	2			692		694
2011	2	*******UNKNOWN	U		9				9
2011	2	12 SOUTH ED TRIAGE	NS12ST	1	174		1	1	177
2011	2	4 NORTH SURG DAY CARE(ASU) HD	NS4NH					366	366
2011	2	BUENA VITA LAB WORK	POPBUENAVI				397		397
2011	2	CAMBA BROADWAY HOUSE	POPCAMBA				12		12
2011	2	CARE COACH	POPCARECOA				113		113
2011	2	CATHERIZATION LAB - ASU	NSCATHLAB					7	7

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2011	2	COMMUNITY CARE COACH GYN	COACHGYN				1		1
2011	2	CYTOGENETICS	CYTOGEN				96		96
2011	2	EMERGENCY DEPT FASTTRACK	NSEDF		1,692				1,692
2011	2	EMERGENCY ROOM - ADULT	NSEDA		1,567		1		1,568
2011	2	EMERGENCY ROOM - PEDIATRICS	NSEDP		1,883				1,883
2011	2	ENDOSCOPY SUITE - ASU ONLY	NS10E					161	161
2011	2	FAMILY MEDICINE CLINIC	OPFAMMED	197					197
2011	2	FAMILY MEDICINE GYN	OPFAMGYN	3					3
2011	2	FAMILY MEDICINE PEDS	OPFAMPED	56					56
2011	2	FETAL ASSESSMENT RADIOLOGY	FETALASSES	1			377		378
2011	2	HYPERBARIC CHAMBER (RCR)	OPHYPER			1			1
2011	2	LA MARCA LAB WORK	POPLAMA				36		36
2011	2	LABOR & DELIVERY-SDC (ASU)	NS12SDC		3			12	15
2011	2	LAMARCA FAMILY HEALTH GYN	LAMAGYN	13					13
2011	2	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	452					452
2011	2	LAMARCA FAMILY HEALTH OB	LAMAOB	13					13
2011	2	LAMARCA FAMILY HEALTH PEDS	LAMAPED	114					114
2011	2	LAMARCA NUTRITIONAL COUNSEL	LAMADIET				1		1
2011	2	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				192		192
2011	2	OB GENETIC COUNSELING	OPOBGENETI	5					5
2011	2	OP PEDS HIGH RISK	OPPEDHIRSK	31					31
2011	2	OP PULMONARY FUNCTION TEST	OPPFT				12		12
2011	2	OUT PATIENT ALLERGY ADULT	OPALLERGY	14					14
2011	2	OUT PATIENT ASTHMA ADULT	OPASTHMA	24					24
2011	2	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	4					4
2011	2	OUT PATIENT CARDIOLOGY	OPCARD	125			5		130
2011	2	OUT PATIENT CHEMOTHERAPY	OPCHEMO	113					113
2011	2	OUT PATIENT DENTAL	OPDENT	767					767
2011	2	OUT PATIENT DERMATOLOGY	OPDERM	43					43
2011	2	OUT PATIENT DIABETIC	OPDIAB	153					153
2011	2	OUT PATIENT EAR NOSE & THROAT	OPENT	69					69
2011	2	OUT PATIENT ENDOCRINOLOGY	OPENDO	82					82
2011	2	OUT PATIENT GASTROENTEROLOGY	OPGI	204					204
2011	2	OUT PATIENT GENETIC COUNSELING	OPGENE	1					1
2011	2	OUT PATIENT GERIATRICS	OPGERIATRI	3					3
2011	2	OUT PATIENT GYN	OPGYN	649					649
2011	2	OUT PATIENT GYN BREAST	OPGYNBRST	30					30
2011	2	OUT PATIENT HEMATOLOGY	OPHEMA	49					49
2011	2	OUT PATIENT HEPATITIS C	OPHEPC	27					27
2011	2	OUT PATIENT ID	OPID	235					235
2011	2	OUT PATIENT MEDICAL	OPMED	844					844
2011	2	OUT PATIENT NEPHROLOGY	OPNEPH	63					63
2011	2	OUT PATIENT NEUROLOGY	OPNEURO	87					87
2011	2	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	11					11
2011	2	OUT PATIENT OB	OPOB	695			1		696
2011	2	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	39					39
2011	2	OUT PATIENT OPHTHALMOLOGY	OPEYE	149					149
2011	2	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	207					207
2011	2	OUT PATIENT OSTEO	OPOSTEO	24					24
2011	2	OUT PATIENT PAIN MANAGMENT	OPPAIN	85					85
2011	2	OUT PATIENT PEDIATRICS	OPPED	558					558
2011	2	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	6					6
2011	2	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	9					9
2011	2	OUT PATIENT PEDS GI	OPPEDGI	14					14

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2011	2	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	38					38
2011	2	OUT PATIENT PEDS PODIATRY	OPPEDPOD	18					18
2011	2	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	123					123
2011	2	OUT PATIENT PHYSICAL THX (RCR)	OPPT	2		32			34
2011	2	OUT PATIENT PODIATRY	OPPOD	202					202
2011	2	OUT PATIENT PULMONARY	OPPULMO	24					24
2011	2	OUT PATIENT RHEUMATOLOGY	OPRHEUM	27					27
2011	2	OUT PATIENT SURGICAL	OPSURG	168				1	169
2011	2	OUT PATIENT THORACIC SURGERY	OPTHORAC	2					2
2011	2	OUT PATIENT UROLOGY	OPGU	155					155
2011	2	OUT PATIENT VASCULAR	OPVASC	94					94
2011	2	OUT PATIENT VASCULAR LAB	OPVASCLAB				65		65
2011	2	OUT PATIENT WOUND CARE	OPWOUND	254					254
2011	2	OUT PT PLASTIC SURGERY/HAND	OPPLAST	109					109
2011	2	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	24					24
2011	2	PRESURGICAL TESTING	PRETEST				158		158
2011	2	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD				133		133
2011	2	PRIVATE OUT PATIENT LAB	POPLAB				847		847
2011	2	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				1,685		1,685
2011	2	VASCULAR LAB	VASLAB				27		27
2011	2	WYCKOFF CLINIC LAB WORK	POPCLINIC	2			638		640
2011	3	**********WHMC DENTAL CLINIC	W198	1					1
2011	3	*******UNKNOWN	U		120				120
2011	3	12 SOUTH ED TRIAGE	NS12ST		178		1		179
2011	3	4 NORTH SURG DAY CARE(ASU) HD	NS4NH					443	443
2011	3	BUENA VITA LAB WORK	POPBUENAVI				474		474
2011	3	CAMBA BROADWAY HOUSE	POPCAMBA				12		12
2011	3	CARE COACH	POPCARECOA				135		135
2011	3	CATHERIZATION LAB - ASU	NSCATHLAB					37	37
2011	3	CYTOGENETICS	CYTOGEN				129		129
2011	3	EMERGENCY DEPT FASTTRACK	NSEDF		1,800				1,800
2011	3	EMERGENCY ROOM - ADULT	NSEDA		1,827				1,827
2011	3	EMERGENCY ROOM - PEDIATRICS	NSEDP		2,055				2,055
2011	3	ENDOSCOPY SUITE - ASU ONLY	NS10E					183	183
2011	3	FAMILY MEDICINE CLINIC	OPFAMMED	198					198
2011	3	FAMILY MEDICINE PEDS	OPFAMPED	55					55
2011	3	FETAL ASSESSMENT RADIOLOGY	FETALASSES	14			516		530
2011	3	HYPERBARIC CHAMBER (RCR)	OPHYPER			5			5
2011	3	LA MARCA LAB WORK	POPLAMA				62		62
2011	3	LABOR & DELIVERY-SDC (ASU)	NS12SDC		8			14	22
2011	3	LAMARCA FAMILY HEALTH GYN	LAMAGYN	15					15
2011	3	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	561					561
2011	3	LAMARCA FAMILY HEALTH OB	LAMAOB	17					17
2011	3	LAMARCA FAMILY HEALTH PEDS	LAMAPED	157					157
2011	3	LAMARCA NUTRITIONAL COUNSEL	LAMADIET				6		6
2011	3	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				212		212
2011	3	OB GENETIC COUNSELING	OPOBGENETI	10					10
2011	3	OP PEDS HIGH RISK	OPPEDHIRSK	32					32
2011	3	OP PULMONARY FUNCTION TEST	OPPFT				25		25
2011	3	OUT PATIENT ALLERGY ADULT	OPALLERGY	25					25
2011	3	OUT PATIENT ASTHMA ADULT	OPASTHMA	32					32
2011	3	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	8					8
2011	3	OUT PATIENT CARDIOLOGY	OPCARD	185			4		189
2011	3	OUT PATIENT CHEMOTHERAPY	OPCHEMO	134					134

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2011	3	OUT PATIENT DENTAL	OPDENT	968					968
2011	3	OUT PATIENT DERMATOLOGY	OPDERM	42					42
2011	3	OUT PATIENT DIABETIC	OPDIAB	150					150
2011	3	OUT PATIENT EAR NOSE & THROAT	OPENT	171					171
2011	3	OUT PATIENT ENDOCRINOLOGY	OPENDO	124					124
2011	3	OUT PATIENT GASTROENTEROLOGY	OPGI	220					220
2011	3	OUT PATIENT GENETIC COUNSELING	OPGENE				3		3
2011	3	OUT PATIENT GERIATRICS	OPGERIATRI	3					3
2011	3	OUT PATIENT GYN	OPGYN	749			1		750
2011	3	OUT PATIENT GYN BREAST	OPGYNBRST	27					27
2011	3	OUT PATIENT GYN COUNSELING	OPGYNCOUNS	2					2
2011	3	OUT PATIENT HEMATOLOGY	OPHEMA	52					52
2011	3	OUT PATIENT HEPATITIS C	OPHEPC	17					17
2011	3	OUT PATIENT ID	OPID	286					286
2011	3	OUT PATIENT MEDICAL	OPMED	1,108					1,108
2011	3	OUT PATIENT NEPHROLOGY	OPNEPH	62					62
2011	3	OUT PATIENT NEUROLOGY	OPNEURO	71					71
2011	3	OUT PATIENT OB	OPOB	866	1				867
2011	3	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	33					33
2011	3	OUT PATIENT OPHTHALMOLOGY	OPEYE	177					177
2011	3	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	286					286
2011	3	OUT PATIENT OSTEO	OPOSTEO	33					33
2011	3	OUT PATIENT PAIN MANAGMENT	OPPAIN	100					100
2011	3	OUT PATIENT PEDIATRICS	OPPED	716					716
2011	3	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	16					16
2011	3	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	7					7
2011	3	OUT PATIENT PEDS GI	OPPEDGI	14					14
2011	3	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	41					41
2011	3	OUT PATIENT PEDS PODIATRY	OPPEDPOD	38					38
2011	3	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	219		1			220
2011	3	OUT PATIENT PHYSICAL THX (RCR)	OPPT	1		122			123
2011	3	OUT PATIENT PODIATRY	OPPOD	323					323
2011	3	OUT PATIENT PULMONARY	OPPULMO	44					44
2011	3	OUT PATIENT RHEUMATOLOGY	OPRHEUM	25					25
2011	3	OUT PATIENT SURGICAL	OPSURG	198				3	201
2011	3	OUT PATIENT THORACIC SURGERY	OPTHORAC	7					7
2011	3	OUT PATIENT UROLOGY	OPGU	181					181
2011	3	OUT PATIENT VASCULAR	OPVASC	117					117
2011	3	OUT PATIENT VASCULAR LAB	OPVASCLAB				101		101
2011	3	OUT PATIENT WELL BABY	OPPEDWELL		1				1
2011	3	OUT PATIENT WOUND CARE	OPWOUND	329					329
2011	3	OUT PT PLASTIC SURGERY/HAND	OPPLAST	129					129
2011	3	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	37					37
2011	3	PRESURGICAL TESTING	PRETEST				190		190
2011	3	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD	5			152		157
2011	3	PRIVATE OUT PATIENT LAB	POPLAB				1,197		1,197
2011	3	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				2,400		2,400
2011	3	VASCULAR LAB	VASLAB				24		24
2011	3	WYCKOFF CLINIC LAB WORK	POPCLINIC	3			801		804
2011	4	*******UNKNOWN	U		549				549
2011	4	12 SOUTH ED TRIAGE	NS12ST	1	189		2		192
2011	4	4 NORTH SURG DAY CARE(ASU) HD	NS4NH					407	407
2011	4	BUENA VITA LAB WORK	POPBUENAVI				305		305
2011	4	CAMBA BROADWAY HOUSE	POPCAMBA				6		6

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2011	4	CARE COACH	POPCARECOA				110		110
2011	4	CATHERIZATION LAB - ASU	NSCATHLAB					39	39
2011	4	CYTOGENETICS	CYTOGEN				129		129
2011	4	EMERGENCY DEPT FASTTRACK	NSEDF		1,935				1,935
2011	4	EMERGENCY ROOM - ADULT	NSEDA		1,563				1,563
2011	4	EMERGENCY ROOM - PEDIATRICS	NSEDP		1,939				1,939
2011	4	ENDOSCOPY SUITE - ASU ONLY	NS10E					186	186
2011	4	FAMILY MEDICINE CLINIC	OPFAMMED	165					165
2011	4	FAMILY MEDICINE GYN	OPFAMGYN	2					2
2011	4	FAMILY MEDICINE PEDS	OPFAMPED	55					55
2011	4	FETAL ASSESSMENT RADIOLOGY	FETALASSES	7			441		448
2011	4	HYPERBARIC CHAMBER (RCR)	OPHYPER			3			3
2011	4	LA MARCA LAB WORK	POPLAMA				42		42
2011	4	LABOR & DELIVERY-SDC (ASU)	NS12SDC		1			12	13
2011	4	LAMARCA FAMILY HEALTH GYN	LAMAGYN	11					11
2011	4	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	513					513
2011	4	LAMARCA FAMILY HEALTH OB	LAMAOB	16					16
2011	4	LAMARCA FAMILY HEALTH PEDS	LAMAPED	110					110
2011	4	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				148		148
2011	4	OB GENETIC COUNSELING	OPOBGENETI	10					10
2011	4	OP DIABETIC/ENDOCRINOLOGY CLI	OPDIABENDO	14					14
2011	4	OP PEDS HIGH RISK	OPPEDHIRSK	27					27
2011	4	OP PULMONARY FUNCTION TEST	OPPFT				19		19
2011	4	OUT PATIENT ALLERGY ADULT	OPALLERGY	13					13
2011	4	OUT PATIENT ASTHMA ADULT	OPASTHMA	33					33
2011	4	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	4					4
2011	4	OUT PATIENT CARDIOLOGY	OPCARD	161			1		162
2011	4	OUT PATIENT CHEMOTHERAPY	OPCHEMO	111					111
2011	4	OUT PATIENT DENTAL	OPDENT	892					892
2011	4	OUT PATIENT DERMATOLOGY	OPDERM	28					28
2011	4	OUT PATIENT DIABETIC	OPDIAB	158					158
2011	4	OUT PATIENT EAR NOSE & THROAT	OPENT	117					117
2011	4	OUT PATIENT ENDOCRINOLOGY	OPENDO	92					92
2011	4	OUT PATIENT GASTROENTEROLOGY	OPGI	159					159
2011	4	OUT PATIENT GENETIC COUNSELING	OPGENE	1					1
2011	4	OUT PATIENT GERIATRICS	OPGERIATRI	4					4
2011	4	OUT PATIENT GYN	OPGYN	680					680
2011	4	OUT PATIENT GYN BREAST	OPGYNBRST	36					36
2011	4	OUT PATIENT GYN COUNSELING	OPGYNCOUNS	1					1
2011	4	OUT PATIENT HEMATOLOGY	OPHEMA	61					61
2011	4	OUT PATIENT HEPATITIS C	OPHEPC	29					29
2011	4	OUT PATIENT ID	OPID	239			1		240
2011	4	OUT PATIENT MEDICAL	OPMED	997			1		998
2011	4	OUT PATIENT NEPHROLOGY	OPNEPH	63					63
2011	4	OUT PATIENT NEUROLOGY	OPNEURO	53					53
2011	4	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	8					8
2011	4	OUT PATIENT OB	OPOB	797					797
2011	4	OUT PATIENT OB COUNSELING	OPOBCOUNSE	1					1
2011	4	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	45					45
2011	4	OUT PATIENT OCCUP THX (RCR)	OPOT	1		2			3
2011	4	OUT PATIENT OPHTHALMOLOGY	OPEYE	172					172
2011	4	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	271					271
2011	4	OUT PATIENT OSTEO	OPOSTEO	24					24
2011	4	OUT PATIENT PAIN MANAGMENT	OPPAIN	82					82

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2011	4	OUT PATIENT PEDIATRICS	OPPED	581					581
2011	4	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	13					13
2011	4	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	8					8
2011	4	OUT PATIENT PEDS GI	OPPEDGI	9					9
2011	4	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	35					35
2011	4	OUT PATIENT PEDS PODIATRY	OPPEDPOD	35					35
2011	4	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	213		11			224
2011	4	OUT PATIENT PHYSICAL THX (RCR)	OPPT	2		342			344
2011	4	OUT PATIENT PODIATRY	OPPOD	249					249
2011	4	OUT PATIENT PULMONARY	OPPULMO	29					29
2011	4	OUT PATIENT RHEUMATOLOGY	OPRHEUM	38					38
2011	4	OUT PATIENT SURGICAL	OPSURG	131				21	152
2011	4	OUT PATIENT THORACIC SURGERY	OPTHORAC	4					4
2011	4	OUT PATIENT UROLOGY	OPGU	186					186
2011	4	OUT PATIENT VASCULAR	OPVASC	99			1		100
2011	4	OUT PATIENT VASCULAR LAB	OPVASCLAB				85		85
2011	4	OUT PATIENT WOUND CARE	OPWOUND	286					286
2011	4	OUT PT PLASTIC SURGERY/HAND	OPPLAST	108					108
2011	4	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	28					28
2011	4	PRESURGICAL TESTING	PRETEST				196		196
2011	4	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD	12			174		186
2011	4	PRIVATE OUT PATIENT LAB	POPLAB				1,051		1,051
2011	4	PRIVATE OUT PATIENT RADIOLOGY	POPRAD	2			1,881		1,883
2011	4	VASCULAR LAB	VASLAB				43		43
2011	4	WYCKOFF CLINIC LAB WORK	POPCLINIC	6			759		765
2011	5	*******UNKNOWN	U		599				599
2011	5	12 SOUTH ED TRIAGE	NS12ST		232		2		234
2011	5	4 NORTH SURG DAY CARE(ASU) HD	NS4NH					6	6
2011	5	BUENA VITA LAB WORK	POPBUENAVI				393		393
2011	5	CAMBA BROADWAY HOUSE	POPCAMBA				6		6
2011	5	CARE COACH	POPCARECOA				122		122
2011	5	CATHERIZATION LAB - ASU	NSCATHLAB					41	41
2011	5	CYTOGENETICS	CYTOGEN				125		125
2011	5	EMERGENCY DEPT FASTTRACK	NSEDF		2,245				2,245
2011	5	EMERGENCY ROOM - ADULT	NSEDA		1,651				1,651
2011	5	EMERGENCY ROOM - PEDIATRICS	NSEDP		2,186				2,186
2011	5	ENDOSCOPY SUITE - ASU ONLY	NS10E					189	189
2011	5	FAMILY MEDICINE CLINIC	OPFAMMED	198					198
2011	5	FAMILY MEDICINE GYN	OPFAMGYN	4					4
2011	5	FAMILY MEDICINE PEDS	OPFAMPED	61					61
2011	5	FETAL ASSESSMENT RADIOLOGY	FETALASSES				466		466
2011	5	HYPERBARIC CHAMBER (RCR)	OPHYPER			3			3
2011	5	LA MARCA LAB WORK	POPLAMA				53		53
2011	5	LABOR & DELIVERY-SDC (ASU)	NS12SDC	1	5			11	17
2011	5	LAMARCA FAMILY HEALTH GYN	LAMAGYN	8					8
2011	5	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	464					464
2011	5	LAMARCA FAMILY HEALTH OB	LAMAOB	23					23
2011	5	LAMARCA FAMILY HEALTH PEDS	LAMAPED	117			1		118
2011	5	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				178		178
2011	5	OB GENETIC COUNSELING	OPOBGENETI	5					5
2011	5	OP DIABETIC/ENDOCRINOLOGY CLI	OPDIABENDO	114					114
2011	5	OP PEDS HIGH RISK	OPPEDHIRSK	27					27
2011	5	OP PULMONARY FUNCTION TEST	OPPFT				15		15
2011	5	OUT PATIENT ALLERGY ADULT	OPALLERGY	20					20

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2011	5	OUT PATIENT ASTHMA ADULT	OPASTHMA	27					27
2011	5	OUT PATIENT AUDIOLOGY TESTING	OPAUDIO	2					2
2011	5	OUT PATIENT CARDIOLOGY	OPCARD	140			6		146
2011	5	OUT PATIENT CHEMOTHERAPY	OPCHEMO	125					125
2011	5	OUT PATIENT DENTAL	OPDENT	939					939
2011	5	OUT PATIENT DERMATOLOGY	OPDERM	15					15
2011	5	OUT PATIENT DIABETIC	OPDIAB	94					94
2011	5	OUT PATIENT EAR NOSE & THROAT	OPENT	95					95
2011	5	OUT PATIENT ENDOCRINOLOGY	OPENDO	70					70
2011	5	OUT PATIENT GASTROENTEROLOGY	OPGI	155					155
2011	5	OUT PATIENT GERIATRICS	OPGERIATRI	5					5
2011	5	OUT PATIENT GYN	OPGYN	675			1		676
2011	5	OUT PATIENT GYN BREAST	OPGYNBRST	39					39
2011	5	OUT PATIENT HEMATOLOGY	OPHEMA	69					69
2011	5	OUT PATIENT ID	OPID	210			1		211
2011	5	OUT PATIENT MEDICAL	OPMED	998	1				999
2011	5	OUT PATIENT NEPHROLOGY	OPNEPH	62					62
2011	5	OUT PATIENT NEUROLOGY	OPNEURO	72					72
2011	5	OUT PATIENT OB	OPOB	831	1				832
2011	5	OUT PATIENT OB HIGH RISK	OPOBHR	1					1
2011	5	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	53					53
2011	5	OUT PATIENT OPHTHALMOLOGY	OPEYE	185					185
2011	5	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	294					294
2011	5	OUT PATIENT OSTEO	OPOSTEO	9					9
2011	5	OUT PATIENT PAIN MANAGMENT	OPPAIN	89					89
2011	5	OUT PATIENT PEDIATRICS	OPPED	630					630
2011	5	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	19					19
2011	5	OUT PATIENT PEDS ENDOCRINOLOGY	OPPEDENDO	10					10
2011	5	OUT PATIENT PEDS GI	OPPEDGI	7					7
2011	5	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	41					41
2011	5	OUT PATIENT PEDS PODIATRY	OPPEDPOD	26					26
2011	5	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	202					202
2011	5	OUT PATIENT PHYSICAL THX (RCR)	OPPT	2		8			10
2011	5	OUT PATIENT PODIATRY	OPPOD	284					284
2011	5	OUT PATIENT PULMONARY	OPPULMO	31			4		35
2011	5	OUT PATIENT RHEUMATOLOGY	OPRHEUM	32					32
2011	5	OUT PATIENT SURGICAL	OPSURG	175				416	591
2011	5	OUT PATIENT THORACIC SURGERY	OPTHORAC	1					1
2011	5	OUT PATIENT UROLOGY	OPGU	224					224
2011	5	OUT PATIENT VASCULAR	OPVASC	93					93
2011	5	OUT PATIENT VASCULAR LAB	OPVASCLAB				81		81
2011	5	OUT PATIENT WOUND CARE	OPWOUND	344					344
2011	5	OUT PT PLASTIC SURGERY/HAND	OPPLAST	102					102
2011	5	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	32					32
2011	5	PRESURGICAL TESTING	PRETEST				173		173
2011	5	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD	1			149	1	151
2011	5	PRIVATE OUT PATIENT LAB	POPLAB	4			1,085		1,089
2011	5	PRIVATE OUT PATIENT RADIOLOGY	POPRAD	2			2,091		2,093
2011	5	VASCULAR LAB	VASLAB				39		39
2011	5	WYCKOFF CLINIC LAB WORK	POPCLINIC	3			695		698
2011	6	*******UNKNOWN	U		111				111
2011	6	12 SOUTH ED TRIAGE	NS12ST		38				38
2011	6	BUENA VITA LAB WORK	POPBUENAVI				43		43
2011	6	CARE COACH	POPCARECOA				16		16

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2011	6	CYTOGENETICS	CYTOGEN				16		16
2011	6	EMERGENCY DEPT FASTTRACK	NSEDF		372				372
2011	6	EMERGENCY ROOM - ADULT	NSEDA		252				252
2011	6	EMERGENCY ROOM - PEDIATRICS	NSEDP		335				335
2011	6	ENDOSCOPY SUITE - ASU ONLY	NS10E					18	18
2011	6	FAMILY MEDICINE CLINIC	OPFAMMED	21					21
2011	6	FAMILY MEDICINE PEDS	OPFAMPED	7					7
2011	6	FETAL ASSESSMENT RADIOLOGY	FETALASSES				76		76
2011	6	LA MARCA LAB WORK	POPLAMA				5		5
2011	6	LABOR & DELIVERY-SDC (ASU)	NS12SDC					2	2
2011	6	LAMARCA FAMILY HEALTH MEDICAL	LAMAMED	77					77
2011	6	LAMARCA FAMILY HEALTH PEDS	LAMAPED	24					24
2011	6	MIDDLE VILLAGE FAM. HEALTH CTR	POPMIDVIL				21		21
2011	6	OB GENETIC COUNSELING	OPOBGENETI	3					3
2011	6	OP DIABETIC/ENDOCRINOLOGY CLI	OPDIABENDO	20					20
2011	6	OP PEDS HIGH RISK	OPPEDHIRSK	6					6
2011	6	OP PULMONARY FUNCTION TEST	OPPFT				7		7
2011	6	OUT PATIENT ASTHMA ADULT	OPASTHMA	13					13
2011	6	OUT PATIENT CARDIOLOGY	OPCARD	25					25
2011	6	OUT PATIENT CHEMOTHERAPY	OPCHEMO	25					25
2011	6	OUT PATIENT DENTAL	OPDENT	130					130
2011	6	OUT PATIENT DERMATOLOGY	OPDERM	3					3
2011	6	OUT PATIENT DIABETIC	OPDIAB	18					18
2011	6	OUT PATIENT EAR NOSE & THROAT	OPENT	7					7
2011	6	OUT PATIENT GASTROENTEROLOGY	OPGI	15					15
2011	6	OUT PATIENT GYN	OPGYN	79					79
2011	6	OUT PATIENT GYN BREAST	OPGYNBRST	5					5
2011	6	OUT PATIENT ID	OPID	33					33
2011	6	OUT PATIENT MEDICAL	OPMED	134					134
2011	6	OUT PATIENT NEPHROLOGY	OPNEPH	12					12
2011	6	OUT PATIENT NEUROLOGY	OPNEURO	7					7
2011	6	OUT PATIENT NEURO-SURGERY	OPNEUROSUR	5					5
2011	6	OUT PATIENT OB	OPOB	120					120
2011	6	OUT PATIENT OB POST PARTUM	OPOBPOSTPA	10					10
2011	6	OUT PATIENT OPHTHALMOLOGY	OPEYE	29					29
2011	6	OUT PATIENT ORTHOPEDIC ADULT	OPORTHO	47					47
2011	6	OUT PATIENT PAIN MANAGMENT	OPPAIN	14					14
2011	6	OUT PATIENT PEDIATRICS	OPPED	69					69
2011	6	OUT PATIENT PEDS CARDIOLOGY	OPPEDCARD	2					2
2011	6	OUT PATIENT PEDS NEUROLOGY	OPPEDNEURO	6					6
2011	6	OUT PATIENT PHYSIATRY CLINIC	OPPHYS	41					41
2011	6	OUT PATIENT PHYSICAL THX (RCR)	OPPT			1			1
2011	6	OUT PATIENT PODIATRY	OPPOD	78					78
2011	6	OUT PATIENT SURGICAL	OPSURG	36				73	109
2011	6	OUT PATIENT UROLOGY	OPGU	29					29
2011	6	OUT PATIENT VASCULAR	OPVASC	22					22
2011	6	OUT PATIENT VASCULAR LAB	OPVASCLAB				11		11
2011	6	OUT PATIENT WOUND CARE	OPWOUND	40					40
2011	6	OUT PT PLASTIC SURGERY/HAND	OPPLAST	21					21
2011	6	OUTPATIENT NUTRITIONAL COUNSEL	OPDIET	6					6
2011	6	PRESURGICAL TESTING	PRETEST				26		26
2011	6	PRIVATE OUT PATIENT CARDIOLOGY	POPCARD				22		22
2011	6	PRIVATE OUT PATIENT LAB	POPLAB				155		155
2011	6	PRIVATE OUT PATIENT RADIOLOGY	POPRAD				308		308

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2011	6	VASCULAR LAB	VASLAB				3		3
2011	6	WYCKOFF CLINIC LAB WORK	POPCLINIC		.		97		97
				140,350	96,804	1,562	92,172	**10,714**	341,602

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

Memorandum

Date: July 6, 2011

To: Board Members

From: Kevin A. Schunke,
UCD Telemedicine Project Manager

Subject: UCD Telemedicine Project - Second Annual Report to the Legislature

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Assembly Bill 329, carried by Assembly Member Nakanishi in 2007, authorized the Medical Board of California to establish a pilot program to expand the practice of telemedicine in California. The purpose of the pilot is to develop methods, using telemedicine, to deliver health care to persons with a chronic disease. The pilot also shall develop information on the best practices for chronic disease management services and techniques and other health care information as deemed appropriate.

The bill requires the Board to report to the Legislature, with findings and recommendations, within one calendar after the commencement date of the pilot. However, in developing the parameters of the pilot, the Board realized that a one-year pilot was not feasible, valuable results would not be recognized, nor could feasible recommendations be made in such a short time frame.

A first report was submitted to the Legislature in July 2010. It is posted and available on the Board's web site.

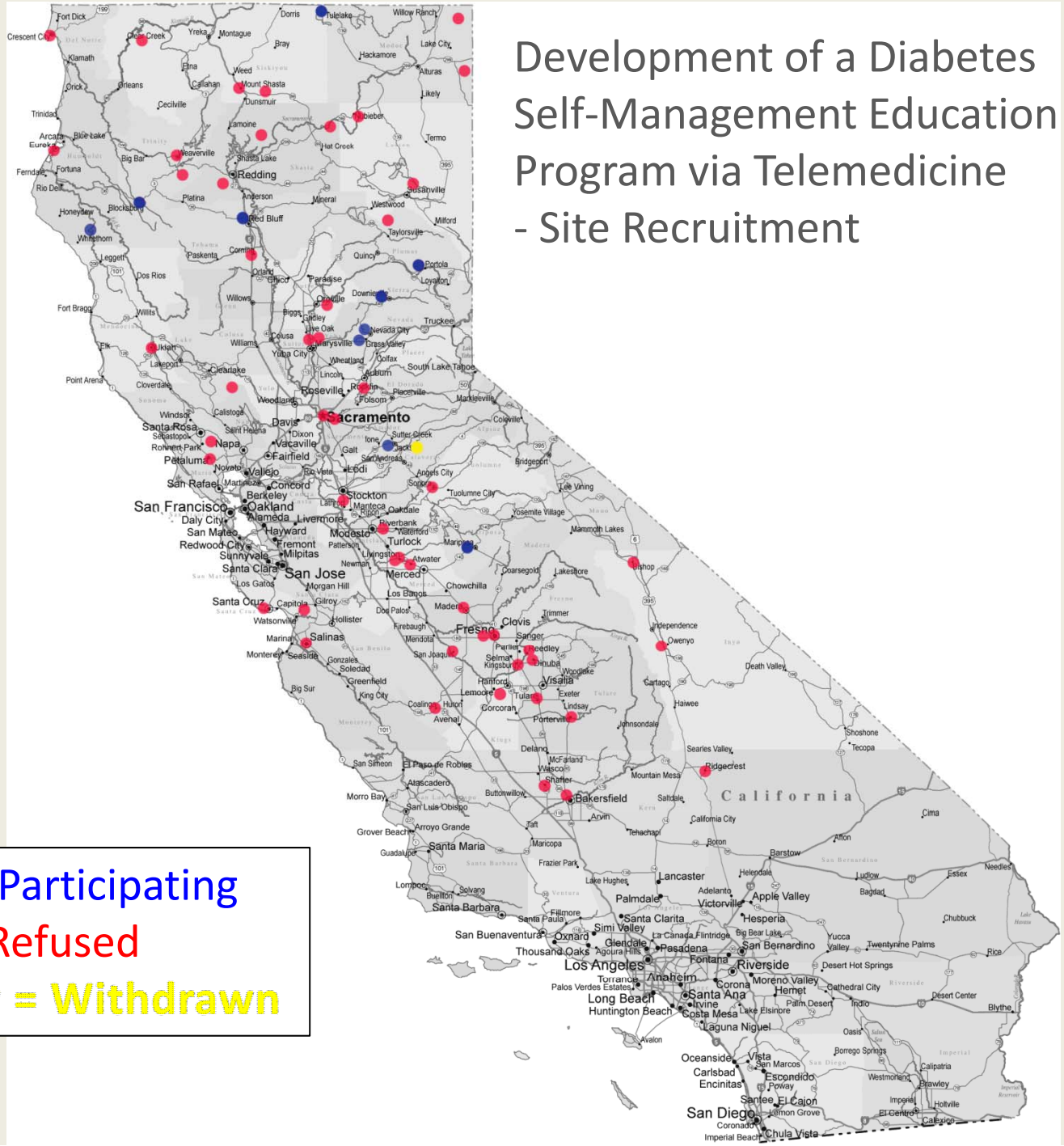
In your Board packet, you have the second annual report presented to the legislature earlier this month. This report only presents a summary of the milestones and achievements recognized during the second year of this three-year contract. The final report, expected in Fall 2012, will include a summary of the pilot and evidence-based recommendations.

In the long term, the pilot strives for an outcome that documents improved methods of teaching personal health care maintenance to a patient with a chronic disease and, with this increased knowledge, it is hoped that objective lab data from the pilot will reflect the improvements in the patient's self-managed care of the disease.

Dr. Jim Nuovo from the University of California, Davis is principle investigator of the team guiding this project. Dr. Nuovo and the members of his team presented a summary of the first year of the project at the Board meeting last July and will attend the upcoming meeting to present the findings and experiences of the pilot's second year.

If you have any questions about this agenda item, please contact me at (916) 263-2368 or via email at kevin.schunke@mbc.ca.gov.

Development of a Diabetes Self-Management Education Program via Telemedicine - Site Recruitment



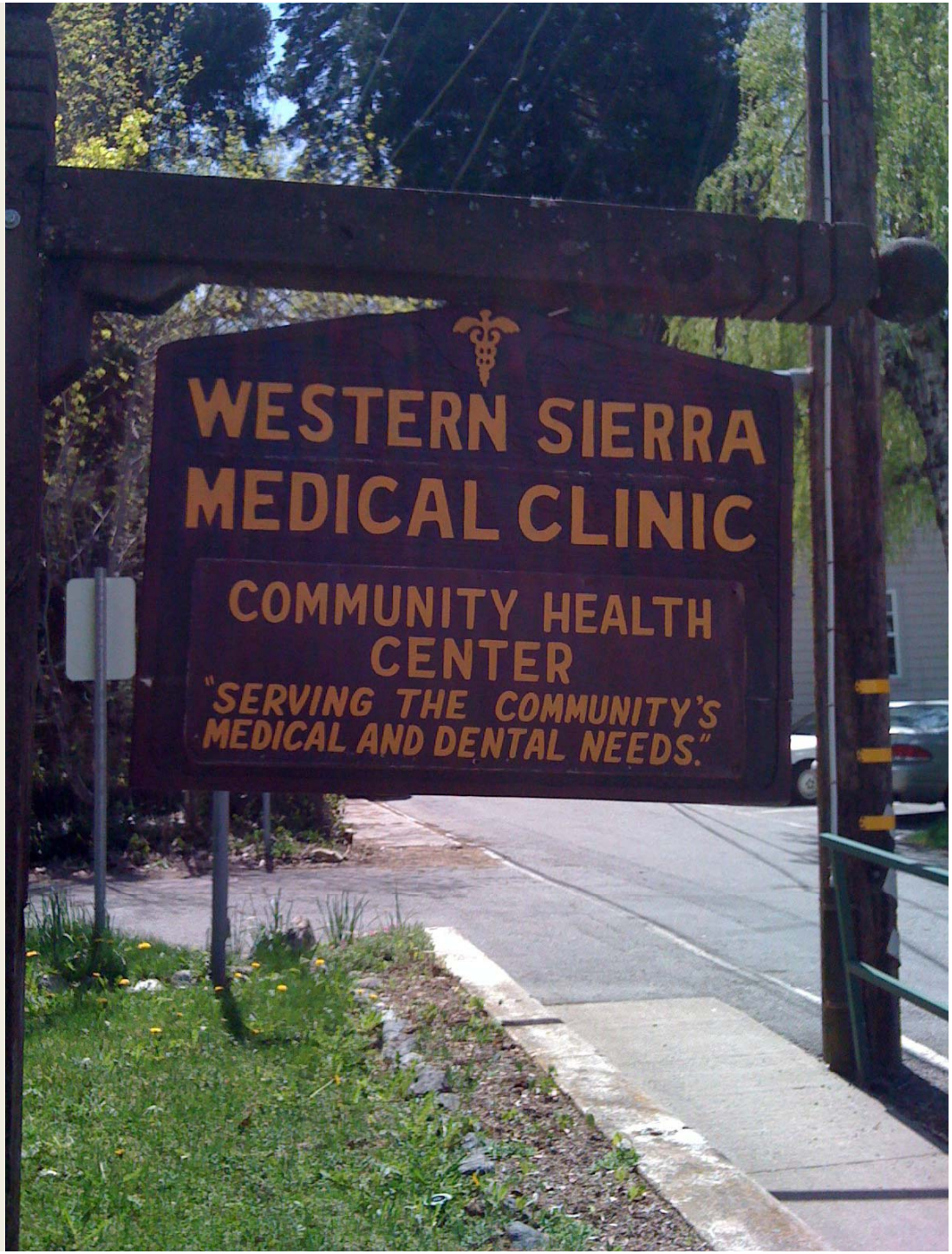
Blue = Participating

Red = Refused

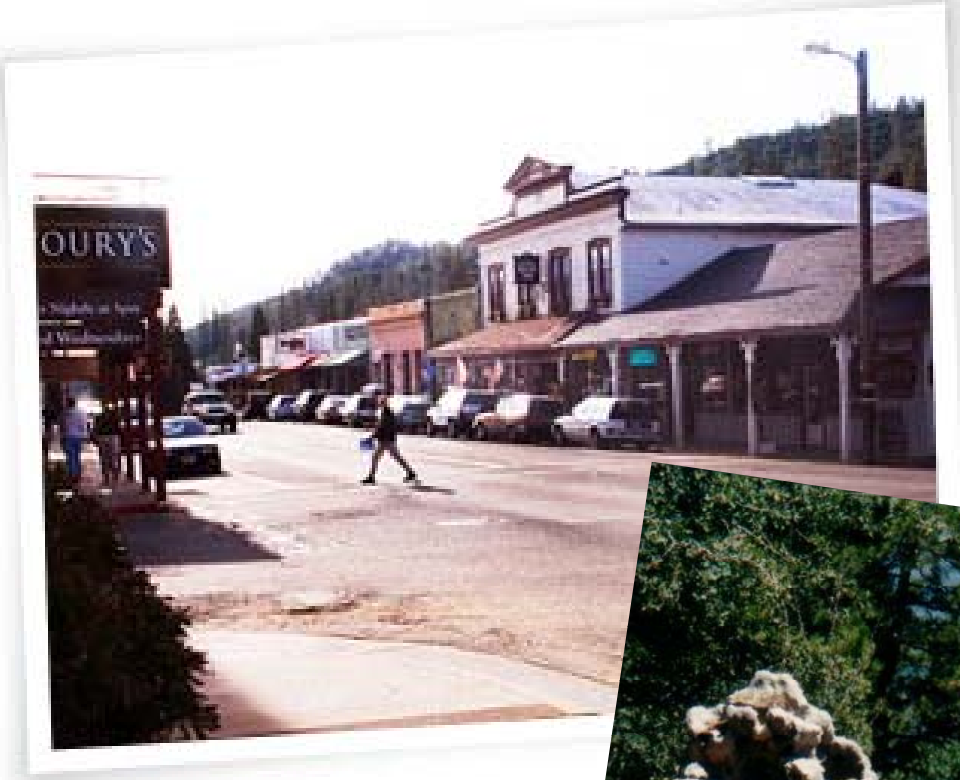
Yellow = Withdrawn

Driving to Western Sierra Medical Clinic

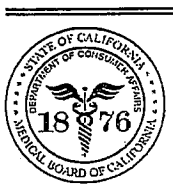
Downieville, CA
Population : 282 (2010)



Mad River, CA
Population: 897 (July 2007)



Mariposa, CA
Population: 1438 (July 2007)



MEDICAL BOARD OF CALIFORNIA
Executive Office

July 1, 2011

The Honorable Curren Price, Chair
Senate Committee on Business,
Professions, and Economic Development
State Capitol, Room 2053
Sacramento, CA 95814

The Honorable Mary Hayashi, Chair
Assembly Committee on Business,
Professions, and Consumer Protection
State Capitol, Room 3013
Sacramento, CA 95814

Dear Senator Price:
Dear Assembly Member Hayashi:

This report is submitted pursuant to Business and Professions Code Section 2028.5, which was enacted by Assembly Bill 329/Nakanishi (Chap. 386, Stats. of 2007).

AB 329 authorized the Medical Board of California (Board) to establish a pilot program to expand the practice of telemedicine in California. The purpose of the pilot is to develop methods, using telemedicine, to deliver health care to persons with a chronic disease. The pilot also shall develop information on the best practices for chronic disease management services and techniques and other health care information, as deemed appropriate.

The bill requires the Board to make a report to the Legislature, with findings and recommendations, within one calendar year after the commencement date of the pilot. That report, dated July 10, 2011, is available at: http://www.mbc.ca.gov/licensee/telemedicine_pilot_program.html.

The report was required by law to include an evaluation of the improvement and affordability of health care services and the reduction in the number of complications achieved by the pilot. However, as is explained in the report, the Board entered into a contract for a three-year pilot; thus, the 2010 report and the attached report only present a summary of the milestones and achievements recognized during the first two years of the pilot. A full summary and evaluation will be submitted in the final report to be prepared next year.

If the Board can be of further assistance, please contact me at (916) 263-2389.

Sincerely,

Linda K. Whitney,
Executive Director

cc: Bill Gage, Principle Consultant, Senate Comm. on Business, Professions and Economic Development
Ross Warren, Principle Consultant, Assembly Comm. on Business, Professions, and Consumer Protection
Anna M. Caballero, Secretary, State and Consumer Services Agency
Brian J. Stiger, Acting Director, Dept. of Consumer Affairs
Members, Medical Board of California

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

Second Annual Report to the Legislature

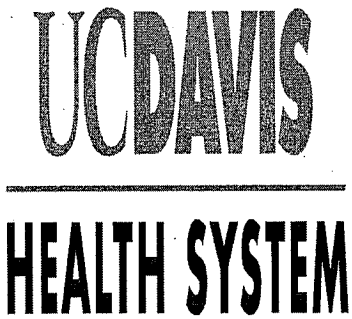
AB 329 (Nakanishi, 2007)

"Development of

Diabetes Self-Management Education Program

via Telemedicine for Patients in

Rural, Underserved Communities in California"



Administered by

University of California, Davis

Funded by

Medical Board of California

Submitted July 2011

Executive Summary

Assembly Bill 329/Nakanishi (Chap 386, Stats. of 2007) authorized the Medical Board of California (Board) to establish a Telemedicine Pilot Program ("pilot") to expand the practice of telemedicine. AB 329 envisioned a one-year pilot and required the Board to make recommendations regarding its findings to the Legislature within one calendar year of the commencement date of the pilot program. However, upon entering into initial discussions with interested parties, the Board quickly realized that a one-year pilot was not feasible, valuable results would not be recognized, nor could feasible recommendations be made in such a short time frame.

As implementation of the bill came to fruition, the Board determined that a contractor would develop a pilot that will deliver health care and education to diabetes patients in rural, underserved communities in California. The contractor would play a significant role in developing the three annual reports evaluating the effectiveness of the pilot.

Pilot Overview

On July 1, 2009, the Board entered into a contract with the University of California, Davis (UCD), of which the UCD Health System (UCDHS) is a major partner. The UCDHS Chronic Disease Management Program (CDM), in collaboration with the UCD Center for HealthCare Policy and Research (CHPR) and UCDHS Center for Health and Technology (CHT), was to develop a telemedicine model for the provision of modern diabetes self-management education and training classes for patients with diabetes living in a 33-county area of rural, underserved communities in northern and central California.

It was determined that the classes offered would meet the current recommendations of the American Diabetes Association (ADA) and will be taught by health educators. In addition, this pilot was defined to study the impact of offering additional follow-up health coaching to class participants via a toll-free telephone line, internet "blogging," or secure email. Data will be collected on the level of patient participation, patient clinical outcomes, patient and provider satisfaction, and project costs in order to evaluate the effectiveness and cost-efficiency of the program. The pilot will occur over a three-year time period to allow for sufficient time to measure outcomes.

I. Focus of the Pilot Program

A. Diabetes

Although the legislation does not specifically identify which chronic disease to target, it was decided that the pilot will focus on diabetes, a serious medical condition impacting many Californians.

The incidence of diabetes in the United States is soaring. The Centers for Disease Control (CDC) reported in 2008 that 24 million people in the U.S. are affected by diabetes, an increase of more than 3 million people in approximately two years.[1] In California, it is estimated that nearly 2 million people have diabetes with a statewide prevalence rate of 6.2%, and increasing to 15.1% for those age 65 and older.

In addition, there are disparities in the incidence rate between various racial and ethnic populations. After adjusting for population age differences, the CDC-estimated rate of

diagnosed diabetes is 11.8% for African Americans and 10.4% for Hispanics (11.9% for Mexican Americans) compared to 7.5% for Asian Americans and 6.2% for Caucasians.[2]

Finally, the economic cost of diabetes is enormous. In California, the cost of health care for patients with diabetes is estimated to be approximately $12 billion a year which includes an estimated $3.4 billion for over 300,000 diabetes related hospitalizations.[3]

1. Centers for Disease Control and Prevention, Diabetes Public Health Resource, 2008. Fact Sheet Press Release, Available at: http://www.cdc.gov/media/pressrel/2008/r080624.htm, Accessed January 15, 2009.
2. He, G, Albright, A, Black, K, Lopez-Payan, S, "2005 Diabetes in California Counties: Prevalence, Risk Factors and Resources, http://www.caldiabetes.org. Accessed January 13, 2009.
3. Wagner EH, Sandhu N, Newton KM, McCulloch, DK, Ramsey SD, Grothaus, LC, Effect of Improved Glycemic Control on Health Care Costs and Utilization. JAMA, 2001, 285(2), 182-189.

B. Geographic Focus Area

For this pilot, the focus is on a 33 county area in northern and central California where the UCDHS CHT currently has telemedicine partners based in nearly 80 different clinics, practices, and hospitals serving rural and medically underserved communities. The number of health care sites will increase in the next few years due to the California Federal Communications Commission's Pilot Project, which will fund development of the California Tele-health Network (CTN), and the passage of Proposition 1D (in 2006), which provides for a telemedicine equipment loan program. This service area included in this proposal stretches from the Oregon border in the north, the coast on the west, the Nevada border on the east, and down the Central Valley through Merced County. In this service area, 25 of the 33 counties have a diabetes incidence rate that exceeds the state average of 6.2%.

C. Chronic Care Model and Self-Management

In the past decade, there has been an accelerating shift in the approach to caring for patients with chronic illnesses from the more traditional reactive approach to care that is planned and proactive. The Chronic Care Model, which is now widely accepted as "best practice," advocates a comprehensive, coordinated approach to care that is patient-centered and evidence-based. By coordinating health system improvements around clinical information systems, evidence-based care, delivery system improvements, and the provision of patient self-management support, the goal of the model is for "productive interactions" between an informed, empowered patient and a prepared, proactive practice team.

For this pilot, UCD planned to develop and test educational interventions that focus on two parts of the model: 1) improving access to patient self-management support resources and 2) improving provider knowledge on evidence-based care. The goal of the ***first*** educational effort is on activating, educating and training patients to better manage their diabetes. It recognizes the central role of the patient as the one who does the majority of the day-to-day work of health management and makes the majority of decisions in dealing with his illness. Thus, there is a goal to teach patients not only information about their illness but how to take this information and use it to solve problems that come up in their daily lives and includes individualized approaches based on the diverse cultures of the patient population. The desired outcome is for patients to gain a greater sense of confidence and self-efficacy with respect to their diabetes. In the process, however, it must be recognized that a patient's readiness to manage his care

can vary over time so it is important to meet them "where they're at." The goal of the ***second*** educational effort is to provide primary care physicians, via telemedicine, with the most current knowledge and care management strategies to support the provision of evidence-based care.

D. Health Coaching

Health coaching is quickly emerging as a new approach of partnering with patients to enhance self-management strategies for the purpose of preventing exacerbations of chronic illness and supporting lifestyle and behavior change. A health coach is a specially trained educator who can provide information and support patients to make informed decisions and manage their health intelligently. Motivating patients to change health-related behaviors is challenging and a health coach can, through forming an alliance with a patient, help them work towards change.

II. Organizational Experience

A. Chronic Disease Management Program (CDM)

The CDM began in 2002 with a grant from the Robert Wood Johnson Foundation (to the Department of Family and Community Medicine) and, since 2003, has been supported by the UCDHS to continue and expand the work. The goal is to improve the quality of care provided to all patients with chronic illnesses; diabetes is one of the three chronic illnesses targeted. The initial focus has been on developing system-wide clinical information infrastructure (e.g. patient registries and electronic medical records [commonly referred to as "EMR"] tools), patient self-management resources, and active consultation with physicians and clinic staff teams around clinic redesign.

One of UCDHS' greatest successes has been in the area of patient self-management education. In 2008, four different diabetes courses were taught, totaling nearly 200 class sessions a year. The Diabetes Self-Management Education program applied for and received a certificate of recognition from the American Diabetes Association (ADA), a rigorous recognition process requiring programs to meet the highest educational standards. The ADA recognized series is titled "In Charge and In Control." The UCDHS program has been recognized since 2003.

In years 2008-2009, 276 patients were tracked; they had taken the four week "In Charge and In Control" class. Comparing patients' Hemoglobin A1C ("Hemoglobin A1C" is a laboratory test reflecting overall diabetes control for the past 3 months) and LDL ("low density lipid" level which is a marker associated with patients with diabetes risk factors for cardiac complications) lab values immediately before taking the class and 90-180 days following the class, there was a *statistically significant ($p=<0.001$) decrease* in mean Hemoglobin A1C from 8.3 to 7.4 and mean LDL from 112.0 to 100.4 In 2007, UCDHS also explored the feasibility of extending access to these classes within the Primary Care Network via videoconferencing. Patients attending the class at the remote site reported high satisfaction with the class and technology.

B. Center for Health and Technology (CHT)

The CHT began in 1992 and has grown to be an internationally-recognized leader in the use of telecommunications technology to improve the delivery of health care. CHT

partners with approximately 80 hospitals and clinics throughout rural northern California, providing patients and their physicians with access to over 30 medical specialties and subspecialties through the use of telecommunications technologies. CHT has completed over 13,000 telemedicine video-based clinical consultations since the program began. For this pilot, CHT will provide technical consultation and assessment of the rural practice sites participating in this pilot and provide the videoconferencing linkage for the educational classes.

C. Center for Healthcare Policy and Research (CHPR)

The CHPR was founded in 1994 with the mission of facilitating research, promoting education, and informing stakeholders about health and health care policies. The CHPR brings together the talents of researchers representing a broad spectrum of disciplines from the School of Medicine, the main Davis Campus, and other organizations. With this multi-disciplinary approach, the CHPR helps investigators examine questions pertinent to health services access, delivery, cost and outcomes, with an emphasis on health care policy. It also provides the administrative resources and technical expertise crucial to implementing this kind of focused, collaborative research. For this pilot, the CHPR will provide contract management, evaluation and administrative support.

D. Office of Continuing Medical Education (OCME)

The OCME offers physicians and other health care providers educational opportunities that foster excellence in patient care. Accredited by the national Accreditation Council for Continuing Medical Education, the OCME provides both traditional and innovative modes of learning to physicians throughout northern California. Most recently, OCME has begun utilizing new learning modalities through innovative communication technologies including interactive remote video teleconferencing and CME self-study modules and courses on the Internet. For this pilot, OCME is providing consultation in the use of these new modalities and CME credit for the classes offered.

III. UC Davis Executive Summary

The pilot has been in existence for two years as of June 30, 2011. The work completed has enabled the project team to recruit patient participants, engaging in self-managed care courses and individual health coaching, and recruited professionals to participate in continuing medical education courses. In addition, the project team has gained new knowledge and understanding relevant to working in collaboration with rural clinics using telemedicine.

To date, the pilot has remained below budget. Less than the number of planned sites and program participants have been recruited. The project team has explored new avenues to increase participation in all aspects of the pilot. The data results show the majority of participants experience a positive shift in knowledge and confidence in the self management of diabetes after participating in the self managed care class.

In addition, over 84% of participants indicated they were satisfied with the telemedicine experience. Over 76% of participants indicated they would take a telemedicine course in the future (see tables in Appendix A). This report details the accomplishments, barriers and lessons learned related to recruitment, participation, telemedicine infrastructures, barriers and successes working with rural clinics using telemedicine to deliver courses in self- manage care and continuing medical education.

IV. Year Two of the Pilot Project

The intention of this annual report is to provide an update and evaluation of the work in progress for the "Development of Diabetes Self-Management Education Program via Telemedicine for Patients in Rural, Underserved Communities in California" pilot, which is administered by the UCD and funded by the Board.

AB 329 envisioned a one-year pilot and required the Board to make recommendations regarding its findings to the Legislature within one calendar year of the commencement date of the pilot program. However, upon entering into initial discussions with interested parties, the Board quickly realized that a one-year pilot was not feasible, valuable results would not be recognized, nor could feasible recommendations be made in such a short time frame.

Since the actual contract took effect and was negotiated for three years, this is the second report to the Legislature. In order to comply with the spirit of the enacting legislation to have a report submitted to the Legislature by July 1 of each year, this report covers the second period from May 1, 2010 to April 30, 2011. UCD will play a significant role in developing the last subsequent annual report evaluating the effectiveness of the pilot. That final report will be submitted during the fall of 2012, after the end of the third and final year of the pilot, to include an evaluation of the entire pilot and to prepare evidence-based recommendations.

Under the direction of Dr. James Nuovo, the Principal Investigator, the project team core members have met on a monthly basis with the project manager from the Board to ensure our continued movement forward in tandem as the pilot and its momentum increases. The project team has effectively organized and laid the foundation for the success of the pilot. A collaboration of efforts has been established between the Board and UCD departments including CDM, CHT, CHPR, OCME, and various rural prime network member clinics.

The UCD project team core members have worked with internal evaluation experts, statistical experts, and research project staff to implement the data collection forms and the coaching efforts.

a. The telemedicine Diabetes Self-Management Education Curricula was developed through the collaborative efforts of the project staff subject matter experts and the health coaches. The curricula were piloted with a group of 9 patients with diabetes at UCD Medical Center. This test included the curricula and the telemedicine aspect of health educators conducting the educational process via telemedicine.
b. This period represents the second year the established and approved Diabetes Self-Management Education Curricula has been implemented.
c. In preparation for health coaching efforts as well as managing ongoing questions or concerns from clinics and class participants, a toll-free number has been established for the pilot through the CDM. This toll-free line has been available to participants during year two of the pilot.

Financially, the pilot team has spent 70% of its second year funds through April 30 2011. The team forecasts a total of 85% of the budgeted funds for year two will be expensed

by the end of fiscal year two on June 30, 2011. These lower-than-anticipated expenditures are attributed to several factors:

1. Personnel expenses were less than forecasted due to the hiring process for filling vacancies
2. Fewer sites and participants than anticipated

The following is an outline of accomplishments by April 30, 2011:

Accomplishments as of April 30, 2011

Staffing

1. During this period one of our health coaches left the team to work abroad. We hired a replacement health educator who is bilingual and has been trained.

Institutional Review Board (IRB): *[An IRB is a committee that has been formally designated to approve, monitor, and review biomedical and behavioral research involving humans with the aim to protect the rights and welfare of the research subjects.]*

1. The original IRB approval was obtained November 20, 2009. The renewal was approved in November, 2010.
    a. A total of 22 modifications have been processed during this reporting period.
        i. Each time a new site is added to the process, a modification is required to include new site champions to the protocol.
    b. All consent and project forms have been translated to Spanish and approved by the IRB.

Clinic Sites

1. Invitations to Participate: The pilot has generated invitations to a total of 70 locations. New site contacts have remained, on average, three per month. Geographically the site invitation was expanded to include the Central Valley in an effort to engage a more diverse population and to potentially recruit more Spanish-speaking participants
    a. 59 Health Centers/Clinics/Hospitals with 1 or more locations
    b. 8 Associations/Networks
    c. 2 Consortiums/Coalitions
    d. 1 County
2. Recruitment: Timing for Acceptance or Rejection of Participation:
    a. Rejection of participation has taken 3-12 months from initial contact
    b. Acceptance of participation has taken 2-9 months from initial contact
3. Participating Sites: To date a total of 8 sites have been recruited and participated in the pilot:
    a. Sierra Family Medical, Nevada City, CA
        i. 8 completed classes, 33 participants, 1 site champion, site work finalized
    b. Western Sierra Medical Clinic, Downieville, CA
        i. 2 completed classes, 12 participants, 1 site champion, site work finalized
    c. Eastern Plumas Health Care, Portola, CA
        i. 5 completed classes, 2 classes pending, 22 participants, 3 site champions, site work active

d. Karuk Tribal Health Clinic, Happy Camp, CA
    i. 1 class completed, 3 participants, 1 site champion, site work completed but clinic withdrew from the pilot
e. Lassen Medical Group, Red Bluff, CA
    i. 5 classes completed, 2 classes pending, 31 participants, 2 site champions, site work active
f. Tulelake Health Center, Tulelake, CA
    i. 2 classes completed, 1 class pending, 12 participants, 2 site champions, site work active
g. Miners Family Health Center, Grass Valley, CA
    i. 1 class completed, 1 class pending, 4 participants, 1 site champion, site work active
h. John C. Fremont Healthcare District, Mariposa, CA
    i. 0 classes completed, 1 class pending, 0 participants, 1 site champion, site work active

Curriculum Development and Implementation

1. During this reporting period, the "Living Well with My Diabetes" booklet has been used at each telemedicine class and has been well received. Using the booklet as a guide during the telemedicine class, the patients are able to follow the curricula with the coaches and take the booklet home with them as a review guide and reference.
2. The "Living Well with My Diabetes" has been successfully translated to Spanish and telemedicine classes in Spanish are in the process of being scheduled for patients.

Coaching Curriculum Development and Implementation

1. Protocols for health coaching have been developed and documented.
2. The coaching efforts were implemented during this period.
3. Health coaching is offered to every other telemedicine class; health coaches offer this resource at the end of the class and patients are asked to accept or decline the opportunity in writing. Those interested in health coaching are asked to give optimal times and days of the week for coaching telephone calls.
4. Coaching duration is two months with four calls, each lasting 10-20 minutes.
5. Coaches have English and Spanish educational materials to mail to patients.
6. Process procedures for phone calls were developed and guidelines for calls were established.
7. A plan was designed for calls not answered and maximum numbers of calls per patients.
8. HIPAA guidelines governing patient privacy were followed regarding messages and call-backs.
9. Data is collected on each patient receiving health coaching.
    a. Data includes: dates, length of calls, behavior change goals identified and patient confidence level of each behavior change
10. If patient identifies perceived barriers to change these are documented.
11. The heath coach describes the level of engagement by the patient and notes if educational materials are mailed.

CME

1. The CME component has been finalized and is being implemented.
2. A total of 3 CME courses have been completed during this review period.
    a. Managing Cardiovascular Risk in Patients with Diabetes held January 18, 2011 from Noon – 1:00 pm

b. Insulin Initiation, Evaluation, Titration held March 30, 2011 from 7:30 am-8:30 am
c. Self-Management Principals and Tools held April 26, 2011 from 5:00 pm-6:00 pm

3. A total of 16 people have engaged in the CME events, 12 CME course participants have been processed for credit.

Evaluation

1. The provider satisfaction survey has been completed.
2. An initial evaluation of data collected has been completed.

Preliminary Data/Evaluation Results: Overview

We continue to collect valuable data daily. However, the preliminary summary results indicate that overall participants were satisfied with the following:

1. The telemedicine experience
2. The capacity of the equipment, i.e., sound, visual size and quality of picture
3. The delivery and quality of the curriculum

Over 76% of participants indicate they would participate in a telemedicine course in the future. On average, with 100-105 participants who completed the pre- and post-education surveys, the majority of participants demonstrated a positive change in their educational information, knowledge of factors that impact their diabetic condition and their ability to manage their diabetes. A total of 46 of the 6-8 week follow-up surveys have been received. The data from the 6-8 week follow-up information indicates, on average, a positive shift in knowledge, ability to manage diabetes and some slight increase in confidence related to caring for themselves and their diabetes. Program-to-date demographic data illustrates that the average participant is 62 years of age, Caucasian, and has had diabetes for more than five years. Data tables are available for review in the appendices of this report.

During this second period we have learned some interesting and valuable lessons that we share as lessons learned. We believe these can prove to be invaluable as we continue to develop the program at its highest quality and effectiveness for all in the future.

Note-worthy lessons learned

1. Site Recruitment
   a. The average recruitment of sites is taking longer than anticipated.
   b. Identified reasons for non-participation:
      i. Adequate diabetes education resources already available on site
      ii. Inundated with other projects – particularly electronic medical record ("EMR") implementation
      iii. Equipment limitations (pole style or inoperable or missing)
      iv. Concerns regarding physician credentialing for telemedicine services
      v. Space limitations – inadequate space for groups
      vi. Inconveniently located televideo equipment
      vii. Staffing shortages
      viii. Time commitment
      ix. No outpatient clinics
      x. Generally no interest

c. Working with existing collaborative groups like Health Alliance of Northern California (HANC) has proven very effective for spawning interest, engaging and recruiting sites.

2. Site Champions
    a. Time: Site champions are busy with regular clinical duties and this project is aggregated into their existing work.
    b. Communication: Due to the busy nature of the site champion's work, the communication connection between the champions and the health coaches takes on average five attempts.
    c. Perception: In some cases site champions seem to perceive low class turn out rates as a negative related to their performance.
    d. Support: Sites may have one or more than one champion. Sites have mostly declined offers from the team to provide assistance with their patient outreach, reminder calls, and letter generation or follow up.
3. Chart Audits
    a. A total of two chart audit visits have been completed.
    b. The chart audit process was smooth; the sites were helpful and cooperative. The health coaches noted a larger than anticipated number of "other" chronic conditions to be recorded that are impacting participants.
    c. Both electronic and paper medical records existed at the sites.
    d. The initial audit of electronic records was more time consuming than the paper chart audit.
4. Classes
    a. High no-show rates, typically up to 50% or higher.
    b. Classes are two hours in length, but participants become antsy after 1 ½ hours of class.
    c. The nutrition section of the class seems to be the most interesting to the participants.
    d. Patient feedback from classes is positive.
    e. Quality of the technical connectivity can negatively affect participants and coaches.
5. Coaching
    a. Initially coaching opportunities do not seem to spark significant interest in participants.
    b. Initially coaching has been described by participants as:
        i. An additional component from which they can benefit
        ii. An additional component for which they don't have time
6. Telecom
    a. Equipment - Most of the sites are using older equipment that is no longer supported by the manufacturer. This has caused both poor audio and/or video issues as well as interoperability issues with the systems UCDHS is using.
    b. Encryption - Older equipment lacks the ability to encrypt communication, which is required for this project. Extensive network configurations were required in order to establish Virtual Private Network (VPN) tunnels between UCDHS and the remote sites using the public Internet.
    c. Connectivity - More and more sites are relying on the Internet for their telemedicine connectivity. However, not only is the Internet unreliable, this has placed a higher demand on the need for encryption.

   d. Support – some sites contract out for technical service so onsite technical knowledge may be limited. Further, due to funding issues, some locations have lost their technical support.
7. Surveys
   a. Some patients require assistance from site champions to complete the surveys.
   b. Some patients have not enrolled in classes due to the number of surveys
   c. 6-8 week follow-up surveys are more challenging. Obtaining results from these surveys requires more effort including follow-up via mail and telephone.
   d. One survey question has a high number of no responses. Based on the way the question is listed on the survey, participants may not have understood they were to circle one of the options, which led to a low number of reporting on this question.
8. CME
   a. Physician survey of topics indicate interest in the subjects offered.
   b. Overall site and attendee registration has been low.
   c. Most attendees to the events are clinical support staff (RNs, MAs, etc); very few physicians attend.
   d. Poor telecom connectivity at one site has prevented attendance.
9. Debriefing Interviews
   a. 2 Site Debriefing Interviews have been completed.
   b. Site champions are willing and able to conduct a 30-minute telephone interview.
   c. Site champions are forthcoming and insightful.
   d. Information gathered will likely be valuable in identifying trends, barriers and needs for the future of televideo education.
10. General
   a. Duration of time to complete project in each site greater than anticipated.
   b. Rural sites are highly impacted and resources are in high demand.
   c. Rural sites are in need of greater support.
   d. Relationships of people at a site has an impact on the process and success of the project.
11. Project Relationships: Influences and Effects (see diagram that follows)

A main goal of this pilot was to describe and assess the feasibility of providing a diabetes self management education program via telemedicine to rural patients. As an initial first step to describe the feasibility, we have modeled the interconnected relationships in this pilot (figure 1). The model illustrates the complexity involved in the engagement of rural clinics and recruitment of patients for televideo self-management classes. It also provides a visual representation of the numerous points where the pilot is vulnerable to miscommunication or disruptions.

There are three main groups that must be linked for a successful pilot: UCDHS project staff, clinic site staff, and patients. The blue boxes represent the UCDHS support units all of whom rely on each other to manage various aspects of the pilot. This internal, united front includes the expertise of seven different departments and approximately 18 professionals, who each play a unique role in executing the behind the scenes work-flow necessary for outreach, site support, tele-connectivity, patient-centered learning events and CME learning events. Like all teams, these relationships are dependent on cooperation as well as individual accountability,

timeliness, communication and follow through. To date, we have found that the communication within UCDSH has been strong.

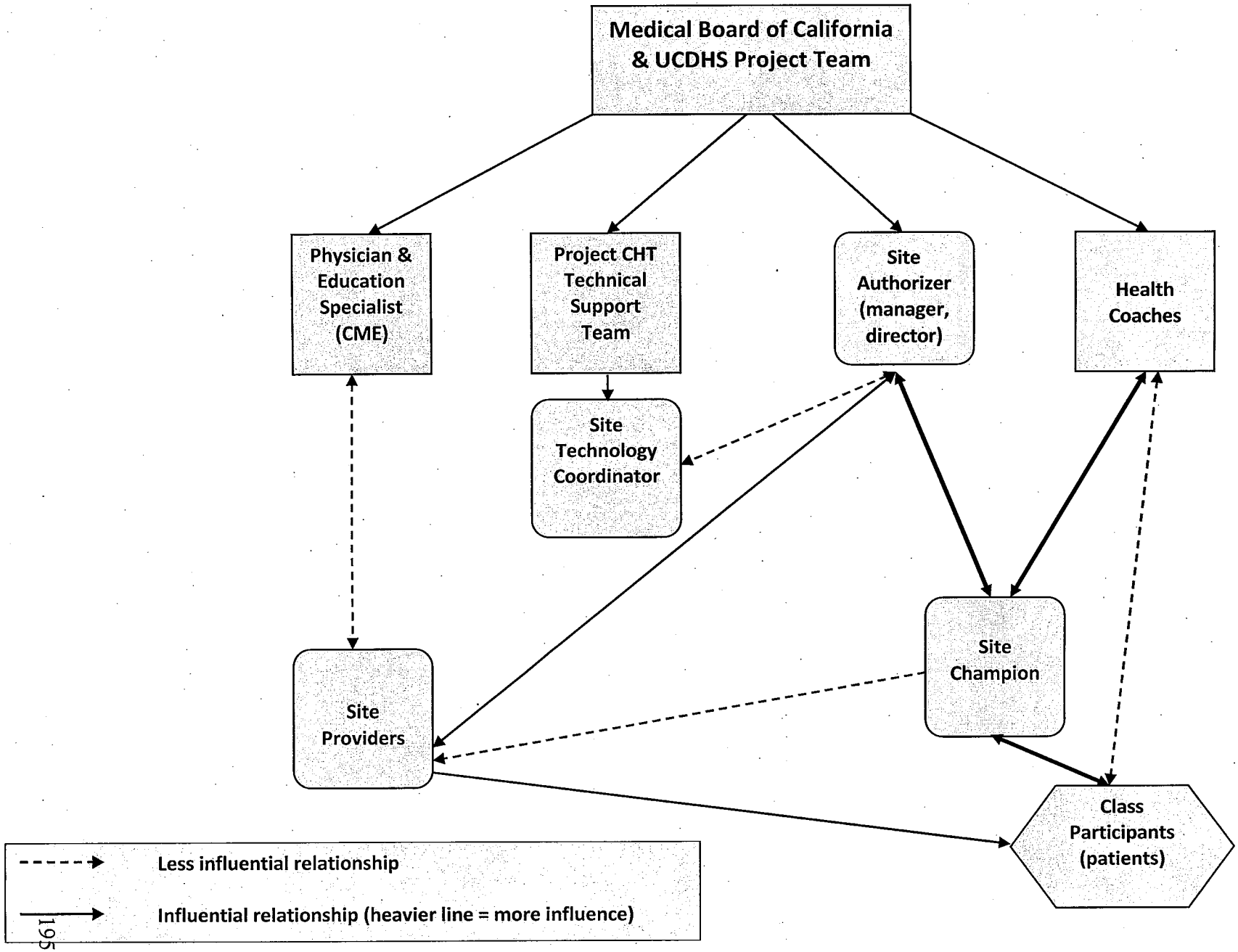
The off-white boxes represent the rural clinical staff engaged in the pilot. Each of the boxes represents several persons who are all dependent upon each others' expertise to successfully conduct the work necessary to recruit patients and coordinate on-site televideo classes for patients. As shown in the diagram, the relationships between UCDHS and the clinic staff are sometimes direct (as is the case between the technical support team and the site technology coordinator) and other times it is indirect (for instance, relationships between site providers and site champions are one step removed from the UCDHS project team). We have found that the directness of the relationship can impact oversight and communication between the project staff and clinic.

The pink box represents the patients who are contacted, engaged and taught in a televideo self-management class. There are a number of relationships that connect to patients, but the project team has a somewhat loose connection to the patients, which has negatively impacted recruitment.

The model, in addition to providing a visual of the connections among groups, also illustrates the strength of those relationships. In the model some relationships are identified as more influential than others, as noted by the heavier lines. For example, the health coaches have direct communication with the site champions (as indicated by the darkened line), but limited communication and influence over the patients who participate in the education program (as indicated by the dashed line).

The goal with constructing this model is to help us assess the project flow and determine areas where communication and oversight might be tightened in future projects. For instance, in some sites the site champion has struggled getting patients. If a project was designed so that the project team had more direct oversight in choosing the site coordinator (rather than going through the site authorizer), we might be able to achieve more buy-in from the coordinator, which may lead to more successful patient outreach (see the relationship flow chart attached).

Medical Board of California & UC Davis, 2009-2012
"Diabetes Self-Management Education for Rural and Underserved Populations"
Project Relationships: Influences and Effects



Goals for May 1, 2011 to June 30, 2012

IRB

1. Continue to submit and process IRB modifications for newly recruited sites or as needed.
2. Process the renewal in November 2011.

Clinic Site

1. Continue to recruit clinical sites.
2. Continue to conduct chart audits at sites where site work is completed.
3. Continue to conduct telephone debriefing interviews at conclusion of sites involvement.
4. Continue to work with and support site champions to successfully implement the pilot at their site.

Classes

1. Continue to conduct classes in English and Spanish.
2. Continue to aim for seven classes per site.

Curriculum Development

1. Continue to monitor curriculum usage and feedback.

CME

1. Continue to deliver CME courses.

Health Coaching

1. Continue to offer health coaching to every other class.
2. Conduct health coaching in English and Spanish.

Evaluation

1. Continue to conduct additional evaluation of pre, post and follow data collected from participants and sites for the Diabetes Self-Managed Care Education and CME courses.
2. Begin preparation of final report due Fall, 2012

Appendix A – Data Tables

Surveys:

About Me Survey
Note: 115 people completed surveys

Subject	Reported Data	Reported Data	Reported Data
Participants	56% Male	44% Female	115 Participants
Age	Average 62.9 yrs	Youngest 20 yrs	Oldest 89 yrs
Average years with Diabetes	5+ years 46%	1-5 years 31%	Less than a year 15%
Received diabetes education	63% = yes	25% = no	12%-no answer or declined to answer

Ethnicity	Percentage
Caucasian	79%
Latino/Hispanic	6%
Native American	6%
Asian/Pacific Islander	1.7%
African American	1%
Other	5%

Participant Telemedicine Satisfaction Survey
Note: 115 people completed surveys

Question Surveyed	Strongly Agree	Agree	Overall Agree Percentage
Satisfied with the telemedicine class	43%	41%	84%
Comfortable talking/using telemedicine video	57%	32%	89%
Understood information given in the class	53%	41%	94%
Picture on the screen was easy to see	53%	32%	85%
Can hear the educators	56%	31%	87%
Educators were polite	75%	18%	93%
Educators were knowledgeable and skillful	55%	31%	86%
Overall Telemedicine Experience satisfactory	60%	23%	83%
Willing to take a telemedicine course in the future	76%		76%

Verbal comments and suggestions for improvement from participants

1. Better voice quality, larger class space, larger screen, more practice, round table discussions

Additional comments

1. Class was excellent, learned a lot, I am impressed with telemedicine, I appreciated the class, thank you, I truly understand a lot better, food, carbs, portions effects on overall health

Pre-post Education Surveys
Scoring is 1 through 5 with 1 being "Very hard" and 5 being "Not at all hard"
Pre = 115 people surveyed, Post 105 people surveyed, 6-8 week follow up 46 people surveyed

How hard do you think the following things are to do regarding management of your diabetes?

Manage your Diabetes?

Score	Pre	Post	6-8 week Follow up
1	18%	13%	4%
2	19%	13%	19%
3	22%	21%	37%
4	17%	34%	28%
5	9%	17%	10%

Read Food Labels?

Score	Pre	Post	6-8 week Follow up
1	12%	2%	0%
2	3%	2%	2%
3	18%	11%	8%
4	14%	14%	28%
5	45%	59%	60%

Exercise Daily?

Score	Pre	Post	6-8 week Follow up
1	17%	11%	15%
2	11%	12%	23%
3	27%	18%	30%
4	19%	21%	15%
5	18%	24%	13%

Check Your Feet Daily?

Score	Pre	Post	6-8 week Follow up
1	6%	1%	0%
2	3%	4%	4%
3	10%	10%	2%
4	10%	14%	21%
5	61%	60%	67%

Take medications as prescribed?

Score	Pre	Post	6-8 week Follow up
1	1%	0%	2%
2	1%	0%	2%
3	2%	1%	2%
4	12%	12%	17%
5	71%	77%	76%

Check your blood sugar?

Score	Pre	Post	6-8 week Follow up
1	4%	2%	4%
2	6%	2%	6%
3	6%	7%	8%
4	20%	12%	10%
5	51%	62%	67%

Keep Doctor's appointments?

Score	Pre	Post	6-8 week Follow up
1	12%	0%	0%
2	1%	1%	0%
3	2%	2%	0%
4	7%	2%	8%
5	82%	85%	89%

Education Specific questions

Pre-post Education Surveys
Scoring was 1 through 5 with 1 being "No knowledge" and 5 being "A lot of knowledge"
Pre = 115 people surveyed, Post 105 people surveyed, 6-8 week follow up 46 people surveyed

How much do you know about the following?

The effect of carbohydrates on your blood sugar?

Score	Pre	Post	6-8 week Follow up
1	17%	3%	6%
2	16%	5%	7%
3	22%	13%	15%
4	24%	37%	43%
5	14%	33%	25%

Reading food labels?

Score	Pre	Post	6-8 week Follow up
1	8%	2%	0%
2	14%	3%	2%
3	15%	10%	15%
4	33%	34%	41%
5	23%	41%	41%

Using portion size to improve your blood sugar?

Score	Pre	Post	6-8 week Follow up
1	12%	3%	0%
2	16%	6%	2%
3	25%	12%	17%
4	26%	37%	52%
5	14%	33%	28%

The benefits of activity and exercise on diabetes?

Score	Pre	Post	6-8 week Follow up
1	4%	1%	0%
2	11%	2%	2%
3	22%	12%	17%
4	30%	36%	30%
5	26%	41%	50%

The importance of checking your feet daily?

Score	Pre	Post	6-8 week Follow up
1	11%	4%	2%
2	8%	2%	2%
3	18%	12%	21%
4	25%	23%	15%
5	31%	50%	58%

The benefits of blood sugar management on reducing long term problems such as nerve damage, eye damage, heart damage, etc?

Score	Pre	Post	6-8 week Follow up
1	16%	3%	2%
2	10%	2%	8%
3	21%	16%	19%
4	20%	29%	43%
5	26%	40%	26%

Pre-6/8 Week follow up My Self-Care Behaviors and Confidence
Note: 46 completed the 6-8 week follow-up surveys

What is the hardest thing that you face in managing your diabetes?

Question	Pre	6-8 week Follow up
Access to information about diabetes	14%	3%
The cost of caring for diabetes	14%	6%
I am overwhelmed with my diabetes	17%	2.5%

Confidence Questions

How confident are you that you can do the things that are important to manage your diabetes?

Score	Pre	6-8 week Follow up
Not Confident	4%	0%
Not/Somewhat Confident	7%	2%
Somewhat Confident	31%	38%
Somewhat/very confident	17%	29%
Very Confident	32%	25%

How important is it to you to manage your diabetes?

Score	Pre	6-8 week Follow up
Not Confident	1%	0%
Not/Somewhat Confident	2%	4%
Somewhat Confident	11%	13%
Somewhat/very confident	16%	15%
Very Confident	59%	63%

Other Self-Care information:
A total of 109 responses

How many times in the last 12 months have you?

Item	0	1-3	4-7	7-9	10+
Been to the emergency room due to diabetes	84%	4%	1%	1%	0%
Been admitted to the hospital due to diabetes	87%	4%	0%	0%	0%
Had a doctor check your feet	29%	44%	12%	3%	2%

In the last 12 month have you:

Item	Yes	No
Had an eye exam by an eye doctor	62%	31%
Had two dental check-ups with a dentist	46%	46%
Received a flu shot	54%	38%

Depression Scales
A total of 115 people surveyed

Over the past two weeks how often have you been bothered by the following problems?

Question	Not at all	Several Days	More than half the days	Nearly everyday
Pre-Little or no interest or pleasure in doing things	50%	22%	10%	7%
6/8 week-Little or no interest or pleasure in doing things	60%	15%	4%	13%
Pre-Feeling down, depressed or hopeless	56%	21%	11%	2%
6/8 week-Feeling down, depressed or hopeless	68%	8%	6%	6%

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 20, 2011

ATTENTION: Medical Board Members

SUBJECT: Petition to Repeal Section 1349 of Title 16 of the California Code of Regulations

STAFF CONTACT: Kurt Heppler, Staff Legal Counsel

EXECUTIVE SUMMARY:

Issue

The matter before the Board is a petition to repeal Section 1349 of Title 16 of the California Code of Regulations (Section 1349), which relates to partnerships between physician and doctors of podiatric medicine. Section 1349 is attached for your convenience.

Pursuant to the provisions of section 11340.7 of the Government Code, the Board may: 1) grant the petition, which means that the Board would commence the regulatory process to repeal section 1349; 2) deny the petition, which means that section 1349 would remain intact; or 3) grant other relief or take other action that may be warranted.

Legislative and Regulatory Background

Prior to 1995, state law authorized physicians to practice in partnerships provided that the other members of the partnership were physicians. The same was true for doctors of podiatric medicine (DPMs), who could partner with other DPMs. Section 1349 was consistent with state law because it prohibited partnerships between these two licenses types where fees were combined or shared. State law did not explicitly authorize blended partnerships between physicians and DPMs.

In 1995, the California Legislature amended section 2416 of the Business and Professions Code (section 2416) to authorize these 'blended' partnerships provided that the majority of partners and partnership interests in the partnership are physicians. Section 2416 also constrains the practice and voting power of the DPMs within a blended partnership.

The petitioner, the California Podiatric Medical Association (CPMA), asserts that given the change in the law, section 1349, which has been in effect for decades, no longer has statutory support and must be repealed. CPMA states that its members would like to form partnerships with physicians and that section 1349 is an unsupported impediment to that formation process.

Business Combinations

As most members are aware, physicians may practice as a sole proprietor, in a partnership, or in a medical corporation. Physicians are not permitted to practice in a general (lay) corporation because public policy dictates that lay persons may not direct the practice of medicine. (See Bus. & Prof. Code, § 2400.)

The same analysis may be applied to partnerships. Under a general partnership, all partners are to receive a share of the profits but also have an equal role in directing the operation of the business. (Corp. Code, § 16401, subds. (b) and (d)) Public policy would not be best served by having lay partners direct the partnership's practice of medicine.

As mentioned earlier and consistent with public policy, physician-DPM partnerships have statutory limitations, as follows: (1) a majority of the partners and partnership interests in the partnership are physician[s] and surgeons or osteopathic physicians and surgeons, and (2) *a partner who is not a physician and surgeon shall not practice in the partnership or vote on partnership matters related to the practice of medicine that are outside his or her scope of practice.* (Bus. & Prof. Code, § 2416.) (*Emphasis added.*)

There is some uncertainty regarding the meaning of the "no practice" language of section 2416. The proponents of the petition and a previous opinion by the Department of Consumer Affairs Legal Office suggest that the no practice limitation means that DPMs can actually practice in the partnership but cannot exceed the scope of their license. Any other reading, they argue, would lead to an absurd result: a podiatrist could form a partnership (with the requisite number of physicians and surgeons) in which he or she could not practice. On the other hand, one could argue that a licensee's practice should always be limited to the scope of his or her license and that a business arrangement or business combination does not alter that scope. Furthermore, the language of subdivision (b) of section 2416 is not grammatically consistent with proponents' argument since the phrase 'outside the scope of his or her practice' would presumably only apply to voting on specific partnership interests.

Recommendations

Whenever the Board exercises its licensing, regulatory or disciplinary functions, public protection shall be its highest priority. (See Bus. & Prof. Code, § 2001.1.) Candidly, the repeal of a regulation that has been on the books for several decades is certainly a significant act.

Members may want to consider alternatives to the outright repeal of section 1349, including:

1) Directing staff to hold an interested parties meeting to study the matter further, perhaps consult with the Osteopathic Medical Board of California and the Board of Podiatric Medicine, then bring the results of those efforts back to the Board;

2) Directing staff to begin the process of amending section 1349 to prohibit fee sharing partnerships between physicians and surgeons and DPMs that do not conform to the provisions of section 2416;
3) Endeavoring to resolve the inconsistency of the statute first and then addressing the regulatory issue.

Please note that neither first two alternatives nor the outright repeal of section 1349 resolves the statutory construction issue. I would be happy to address any questions you may have.

BROAD & GUSMAN, LLP
ATTORNEYS AT LAW

June 28, 2011

Via Facsimile: (916) 263-2387

Linda Whitney, Executive Director
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Re: Petition by California Podiatric Medical Association to Repeal 16 CCR §1349

Dear Ms. Whitney:

On behalf of the California Podiatric Medical Association, we are writing to request that the California Medical Board repeal 16 CCR §1349. That regulation forbids "combining" or "sharing" of fees" as between podiatrists and physicians even in partnerships. Such prohibition is fundamentally incompatible with the Legislature's authorization of physician-podiatrist partnerships, specifically, Bus. & Prof. Code §2416, which expressly authorizes partnerships between podiatrists and physicians. Accordingly, 16 CCR §1349 should be repealed.

Section1349 states:

> Nothing in Section 2416 of the code or this article shall be construed to authorize a partnership agreement in which fees are combined or shared between a physician and surgeon(s) and a podiatrist(s) or any other licensed professional, not a physician and surgeon.

The reference in that regulation to B & P Code §2416 is to a *prior* version, which did *not* authorize partnerships between podiatrists and physicians. That prior version provided:

> Physicians and surgeons and podiatrists may conduct their professional practices in a partnership or group of physicians and surgeons or a partnership or group of podiatrists, respectively.

In 1995, the legislature reversed course via Senate Bill 609 (Rosenthal), which changed the law expressly to authorize physician-podiatrist partnerships. B & P Code §2416 now provides as follows:

1127 11TH Street, Suite 501
Sacramento, CA 95814
(916) 442-5999
Fax (916) 442-3209

> Physicians and surgeons and doctors of podiatric medicine may conduct their professional practices in a partnership or group of physician and surgeons or a partnership or group of doctors of podiatric medicine, respectively. Physician and surgeons and doctors of podiatric medicine may establish a professional partnership that includes both physician and surgeons and doctors of podiatric medicine, if both of the following conditions are satisfied:
>
> (a) A majority of the partners and partnership interests in the professional partnership are physician and surgeons or osteopathic physician and surgeons.
>
> (b) Notwithstanding Chapter 2 (commencing with Section 15001) of Title 1 of the Corporations Code, a partner who is not a physician and surgeon shall not practice in the partnership or vote on partnership matters related to the practice of medicine that are outside his or her scope of practice. All partners may vote on general administrative, management, and business matters.

The California Medical Association supported SB 609. (Senate Floor Analysis, September 6, 1995)

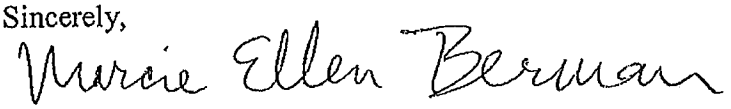
Senate Bill 609 was sponsored by the California Medical Board. As explained in the July 10, 1995, Assembly Health Committee Bill Analysis, "[e]xisting law authorizes physicians and podiatrists to form professional corporations, but not partnerships." The Medical Board's intent in altering B & P Code §2416 presumably was to conform the law governing podiatrist-physician partnerships to the more permissive law governing podiatrist-physician professional corporations.

At its core, a partnership is a type of business arrangement whereby revenues and expenses are shared. Thus, "[a] person who receives a share of the profits of a business is presumed to be a partner in the business" even in the absence of an express partnership agreement. (Corp. Code § 16202(c)(3)) And, unless otherwise agreed to by a partnership, "[e]ach partner is entitled to an equal share of the partnership profits and . . . is chargeable with a share of the partnership losses in proportion to the partner's share of the profits." (Corp. Code § 16401(b))

No California statute forbids any sort of "combining" or "sharing" fees as between podiatrist-physician partners. Indeed, except for the limitations set forth in B & P Code §2416 subsections (a) and (b), the California Code's treatment of podiatrist-physician partnerships is no different from its treatment of partnerships composed exclusively of physicians or exclusively of podiatrists.

Clearly, 16 CCR §1349 is irreconcilably incompatible with governing statutory law. Because that regulation contravenes California law, the California Podiatric Medical Association respectfully requests that it be repealed. Both the California Medical Association and the California Orthopedic Association have informed us that they are in accord with this petition.

Sincerely,



Marcie Ellen Berman,
on behalf of the California Podiatric Medical Association

California Physician Workforce Presentation

Dean Grafilo is an Associate Director in Government Relations with the California Medical Association. He formerly served as Chief of Staff for Asm. Warren T. Furutani and prior to that as a Senior Assistant for Assembly Majority Leader Alberto Torrico for three years. Before working in the Assembly, Dean helped to organize working families in Seattle, Honolulu and San Francisco for the Service Employees International Union and the International Longshore Warehouse Union.

Yvonne Choong is an Associate Director in the Center for Medical and Regulatory Policy with the California Medical Association. She previously worked at the University of Southern California's School of Policy, Planning and Development directing policy outreach and the governance policy program. She has also worked as an analyst for the Judicial Council of California and the California Legislative Analyst's office.

5 Issues Facing California's Physician Workforce

California Medical Association
Physicians dedicated to the health of Californians

Mark Kashtan & Christina Lee

Presented to the Medical Board of California
July 29, 2011

Issue 1: The Physician Pipeline

Medical School

- California has the #1 retention rate for medical school graduates in the nation (62%)

- However, only 41% of medical students from California are able to attend an in-state medical school

- As a result, only 26% of active patient care physicians in California were educated in-state

CMA
California Medical Association

Issue 1: The Physician Pipeline

Graduate Medical Education

- California has the #2 retention rate for medical residents in the nation (69%)
- However, California ranks 32nd among states in its resident-to-population ratio (25.1/100k vs. a national average of 35.7/100k)
- Medicare funding for GME has been frozen since 1997
- Medi-Cal funding for GME is undersized and unreliable

CMA
California Medical Association

Issue 2: Practice Environment

- CA has the 4th lowest Medicaid (Medi-Cal) rates in the US, paying on average 56% of the Medicare fee schedule

- CA has the 4th highest cost-of-living in the country, at 132% of the national average

- PPACA: will expand Medi-Cal to 1.7 million currently uninsured Californians, and subsidizes coverage for 1.4 million more

- MICRA keeps medical liability insurance premiums low

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Issue 3: Primary Care Shortage

- 74% of CA's 58 counties have an undersupply of primary care physician's according to COGME standards
- Primary care physician's make up 34% of California's physician workforce
- Likewise, primary care residencies currently represent about 1/3rd of GME positions
- Primary care residencies draw lower levels of interest among graduating medical students compared to other specialties

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California Medical Association

Issue 3: Primary Care Shortage

- Public medical school tuition increased 11.1% annually from 2001 to 2006 and continues to grow

- 86% of medical students are now graduating with outstanding loans, and the average amount of debt for a medical student graduating in 2009 was $156,456

- PCP's average 70% of the median income for all doctors

- PCP's in CA make only 88% of the national average income

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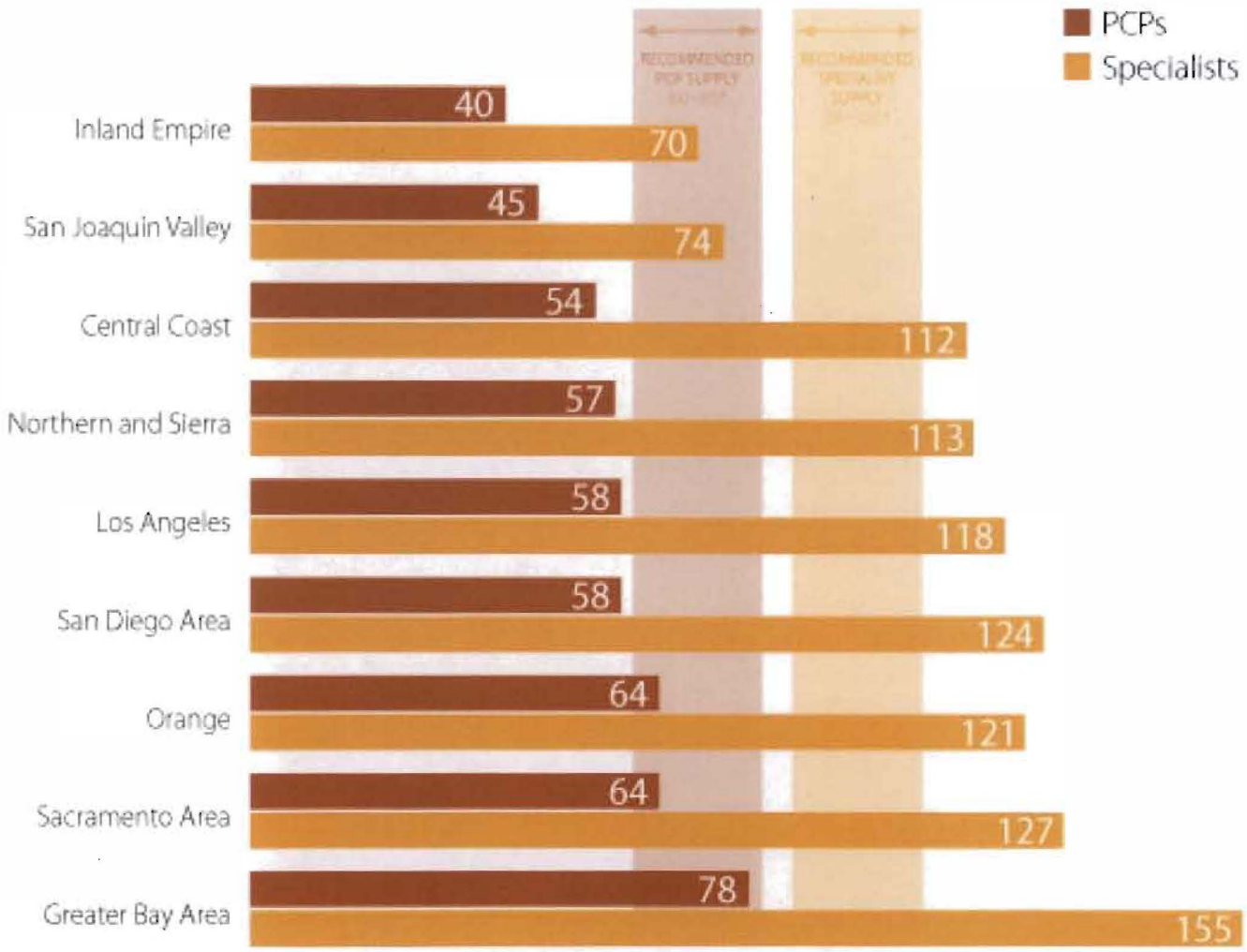
California Medical Association

Active PCPs and Specialists per 100,000 Population,

California Regions, 2008



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Issue 4: Geographical Distribution

- The distribution of physicians across California is extremely uneven
- There are over 200 distinct areas and populations in California designated as Medically Underserved
- There is considerable overlap between Medically Underserved Areas and regions with a high proportion of Medi-Cal patients
- In 2008, only 57% of physicians were able to accept new Medi-Cal patients due to low reimbursement rates

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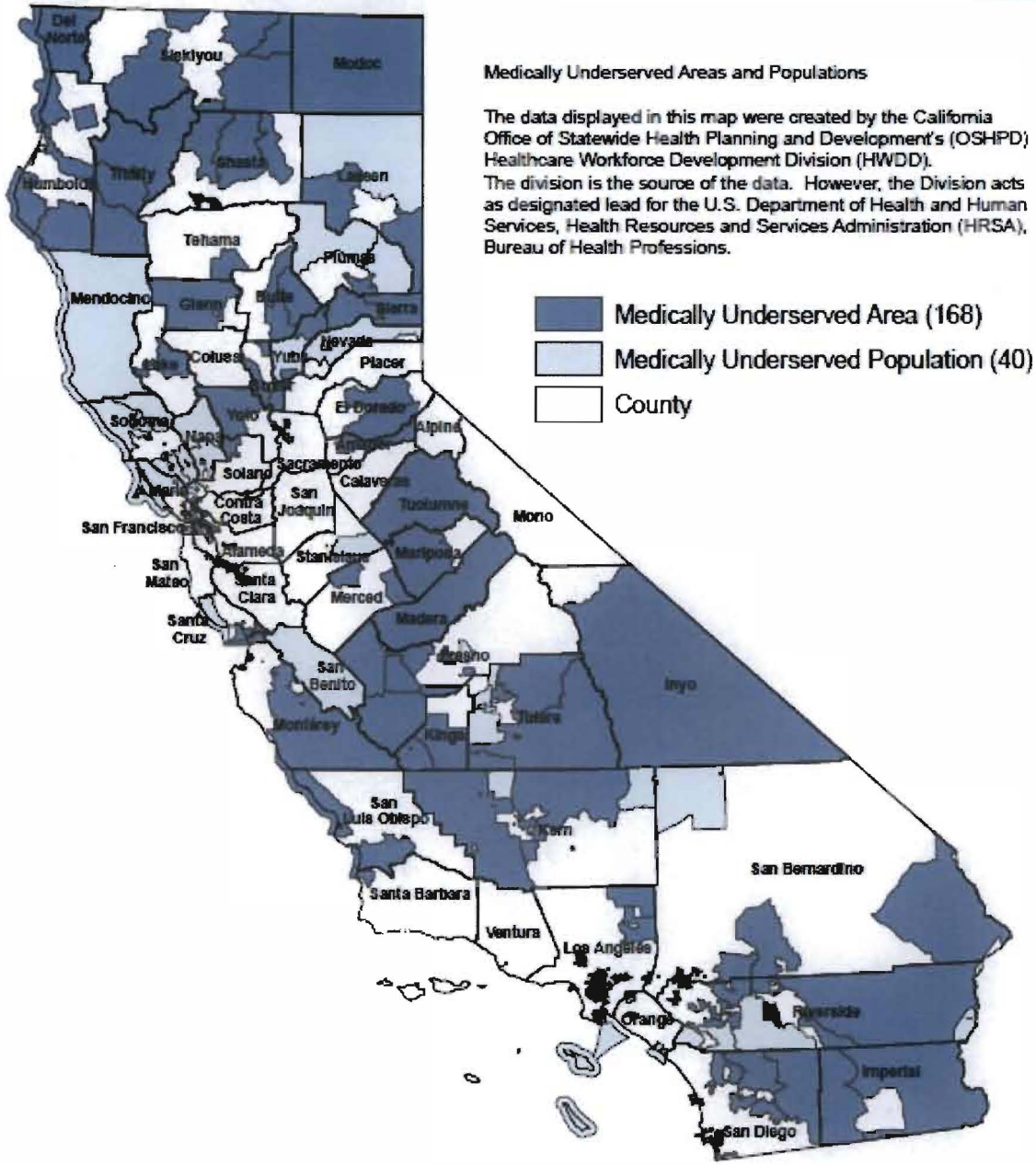

Medically Underserved Areas and Populations

October 2010

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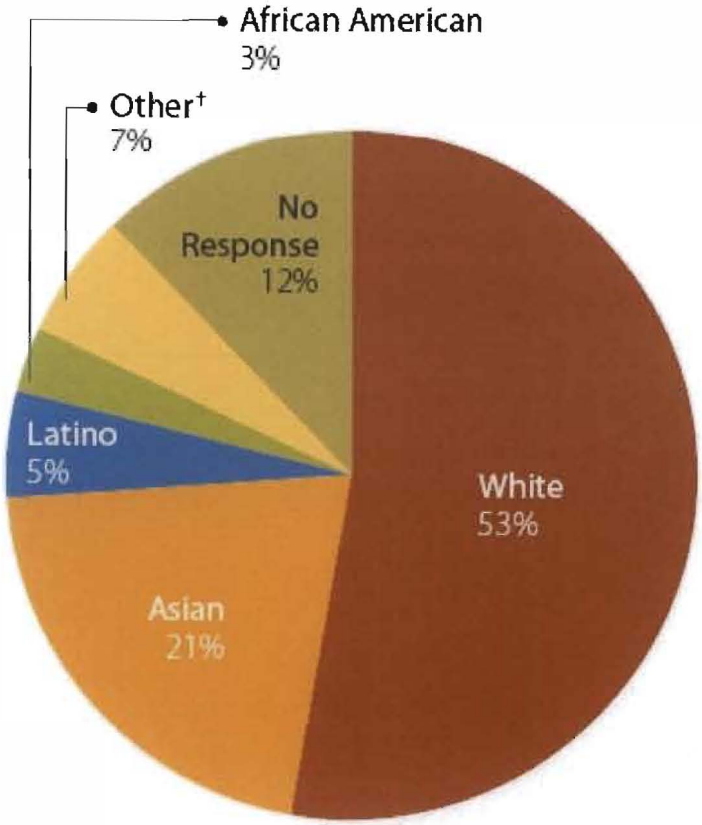
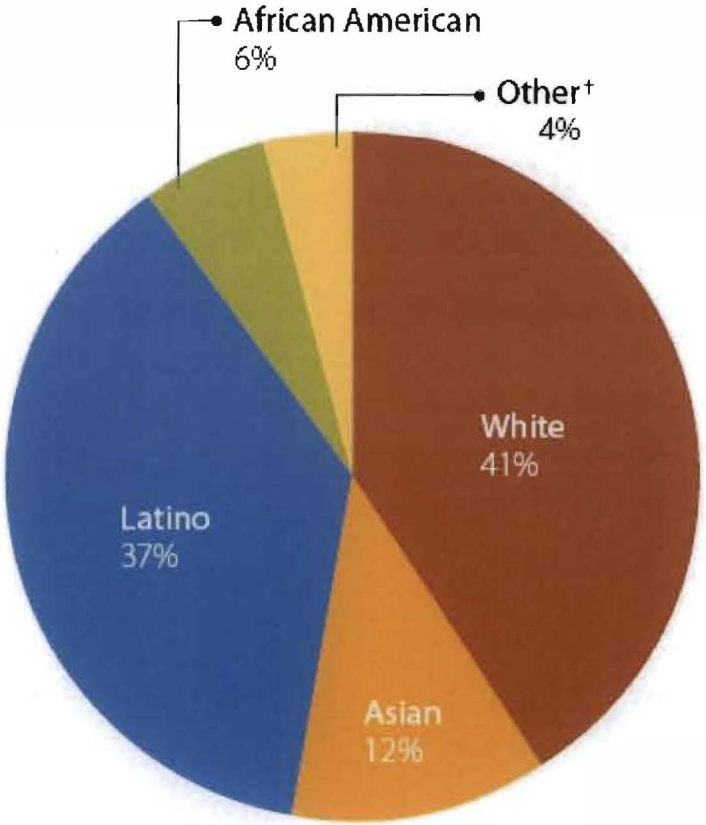
California Medical Association

Issue 5: Ethnic and Racial Diversity

PHYSICIANS*



CALIFORNIA POPULATION



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California Medical Association

Issue 5: Ethnic and Racial Diversity

- Minority physicians are more likely to practice in primary care and work in low income areas and underserved communities

- Studies indicate that many minority patients prefer physicians of their own race and ethnicity because of:
  - Belief in better and more personal care
  - Language barriers
  - Culturally competent care

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What Strategies Are Being Discussed?

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Issue 1: The Physician Pipeline

- Increase medical school enrollment in California
  - Expand class sizes at existing schools
  - Build new schools (UC Riverside and UC Merced)

- Expand the number of residency slots in California
  - Short term: independent sources of GME funding
  - Long term: federal reform of the Medicare funding freeze and the Medicaid FMAP formula
  - Long term: new primary source of GME funding (All Payer?)

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Issue 2: Practice Environment

- Uphold the MICRA cap to contain medical liability insurance premiums

- Increase Medi-Cal payments

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Issue 3: Primary Care Shortage

- Increase scholarships/grants for medical students to reduce medical education debt
- Increase compensation for primary care services
- Develop a shortened primary care education track

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California Medical Association

Issue 4: Geographical Distribution

- Expand existing state loan repayment programs for PCPs and specialists working in underserved areas
- Increase Medi-Cal payments (Again!)
- Expand medical schools' rural training programs
- Develop rural and community-based residency programs

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California Medical Association

Issue 5: Ethnic and Racial Diversity

- Recruit more students from underserved communities
  - Premedical advising services for youths
  - Clinical mentorship opportunities
  - Post-baccalaureate premedical programs
- Reduce financial barriers
  - Stop tuition hikes
  - Offer more scholarships and grants to students with ethnically and economically diverse backgrounds
- Develop medical education programs and continuing medical education courses that focus on culturally competent care

CMA
California Medical Association

California's Health Care Workforce Development and Planning

Medical Board of California Meeting
July 29, 2011

Angela Minniefield, Deputy Director
Office of Statewide Health Planning and Development

"Equitable Healthcare Accessibility for California"

What is the Office of Statewide Health Planning and Development (OSHPD)?

- One of 13 departments within the California Health and Human Services Agency
- Administers programs which endeavor to implement the vision of "Equitable Healthcare Accessibility for California" including:
  - Analyzing California's healthcare infrastructure
  - Promoting a diverse and competent healthcare workforce
  - Providing information about healthcare outcomes
  - Assuring the safety of buildings used in providing healthcare
  - Insuring loans to encourage the development of healthcare facilities
  - Facilitating development of sustained capacity for communities to address local healthcare issues
- Has administered health workforce development programs and provided grant funding to address health workforce diversity, supply and distribution issues since the late 1970's

OSHPD Health Workforce Development Activities

- **Increase health workforce supply** and **support existing health workers** through the Health Professions Education Foundation's numerous scholarship and loan repayment programs; and the State Loan Repayment Program funded by the National Health Service Corps
- **Enhance Health Care Workforce Education and Training** through the Song-Brown Health Care Workforce Training Program
- Support **innovations** in healthcare delivery through the Health Workforce Pilot Program

OSHPD Health Workforce Development Activities

- **Strengthen primary care and other workforce improvements** through the California Student and Residents Experience and Rotations in Community Health, The California SEARCH (Cal-SEARCH), in partnership with the California Area Health Education Center and the California Primary Care Association
- **Improve access to healthcare services** through the Shortage Designation Program by preparing recommendations for health professional shortage area designations

California's Health Workforce Challenges:

- Shortage of health professionals
- Maldistribution of health professionals
- Lack of racial/ethnic diversity
- Insufficient number of bilingual professionals
- Constraints on capacity of educational programs
- Scope of practice laws
- Reimbursement policies
- The recession
- Increase demand for healthcare services

Patient Protection and Affordable Care Act Elements of Title V

- Support innovations in Healthcare Workforce Preparation
- Increase the Supply of the Healthcare Workforce
- Enhance Health Workforce Education and Training
- Support the Existing Healthcare Workforce
- Strengthen Primary Care and Other Workforce Improvements
- Improve Access to Healthcare Services

State Partnership for Health Care Reform

To focus on the implementation of health care reform in California, the Office of Statewide Health Planning and Development (OSHPD) partnered with the California Workforce Investment Board (CWIB) to develop a comprehensive strategy for workforce development. OSHPD and CWIB received a planning grant to begin the work that is focused on health professions education, training, and workforce development provisions in Title V of PPACA

Health Workforce Development Council

- Established August 17, 2010 as a Special Committee of the CWIB
- Mission is to expand California's health workforce to provide access to quality health care for all Californians
- Tasked with understanding the current and future workforce needs of California health delivery system, and development of a comprehensive strategy to meet those needs
- Provides a forum for broad stakeholder engagement
- Ensures public deliberation is informed by the expertise and perspective of the industry, education, health professionals, philanthropy, health advocates, economic development, elected officials, the public workforce system and organized labor
- Currently focused on activities related to the HRSA funded Health Workforce Planning Grant received in September 2010

California Receives a Health Workforce Development Planning Grant

Background:

- The implementation and provision of exemplary health care for all Californians as envisioned under the Affordable Care Act of 2010 will require extraordinary levels of collaboration and cooperation between multiple players. In order to meet the burgeoning workforce demands expected by 2014, a broad system of public workforce and educational programs, working in partnership with the private and public health industry, will need to be organized, resourced and provided with timely and accurate projections of demands across multiple segments of the health care delivery system.

Health Workforce Development Planning Grant Requirements

- Analyze State labor market information to create health career pathways for students and adults, including dislocated workers
- Identify current and projected high demand State or regional healthcare sectors for purposes of planning career pathways
- Identify existing Federal, State, and private resources to recruit, educate or train, and retain a skilled health care workforce and strengthen partnerships
- Describe the academic and health care industry skill standards for high school graduation, for entry into postsecondary education, and for various credentials and licensure
- Describe State secondary and postsecondary education and training policies, models, or practices for the healthcare sector, including career information and guidance counseling
- Identify Federal or State policies or rules to developing a coherent and comprehensive health workforce development strategy and barriers and a plan to resolve these barriers

Regional Focus Groups

- 11 regional focus groups
- Total of 388 participants representing a diverse group of healthcare stakeholders from 41 counties across California.
- Focus group participants identified 4 emerging global themes:
  - Alignment of Education/Training with industry Standards
  - Collaboration/Partnerships
  - Cultural Competency/Diversity
  - Career Pipelines

Health Workforce Development Council Career Pathways Sub-Committee

The Committee is charged with developing statewide planning recommendations that address the following six areas:

- Existing and potential health career pathways that may increase access to primary care
- Existing education and training capacity and infrastructure to accommodate the career pathways needed to increase access to primary care
- Academic and healthcare industry skill standards for high school graduation, entry into postsecondary education, and various credentials and licensure

Health Workforce Development Council Career Pathways Sub-Committee (Continued)

- Availability of career information and guidance counseling to existing and potential health professions students and residents
- Big picture issues around recruitment, retention, attrition, transfer, articulation and curricular disconnects, and the identification of policies needed to facilitate the progress of students between education segments in California
- Need for pilot/demonstration projects in eligible health personnel categories, or new health personnel categories.

Health Workforce Development Council Career Pathways Sub-Committee (Continued)

- The Career Pathway Sub-Committee reviewed the pathways for the following 8 professions:
  - Primary Care Physicians
  - Primary Care Nurses
  - Clinical Lab Scientists
  - Medical Assistants
  - Community Health Workers/Promotores
  - Public Health Professionals
  - Social Workers
  - Alcohol and Other Drug Abuse Counselors

Recommendations Identified throughout Planning Process

- Education:
  - Expand and institutionalize the effective us of “holistic” file review in admissions.
  - Increase partnerships between educational institutions and healthcare providers to increase the quality of health workforce transition to practice programs.
  - Deepen the integration of cultural sensitivity and responsiveness into training program climate, teaching and skill development.

- Data Collection:
  - Establish a central database of interested candidate for primary care careers at all stages of the pipeline and communication tools for ongoing promotion of primary care, financing options and support program opportunities.
  - Establish mechanism through the OSHPD Clearinghouse and Primary Care Initiative to provide timely ongoing tracing and reporting to measure progress toward goals and inform adjustment of strategies.

Recommendations Identified throughout Planning Process

- Policy:
  - Develop new CDE standards and model curriculum aligned with industry needs and increase opportunities for student exposure, service learning and training.
  - Create Federal policies that support the training of incumbent healthcare workers; create interdisciplinary core competency standards in healthcare training programs; and create policies to support the integration of healthcare professions education in primary and secondary education.
  - Increase funding and promotion of scholarship and loan repayment program for priority professions.
  - Mandate cultural competency training and certification for new and incumbent healthcare workers.

Recommendations to Address Barriers for Primary Care Physicians

- Increase primary care career awareness among students, advisors, parents, policymakers and the general public.
- Increase recruitment and retention of primary care team members in CA, particularly for the safety net and underserved areas.
- Strengthen training program access and support to increase the numbers and diversity of CA primary team members and preparation for practice in emerging delivery models.
- Increase the number of CA based primary care residencies in non-acute setting and in areas of unmet need, and increase the number of graduates who enter primary care.
- Develop supportive payment and policies that increase attractiveness of primary care as a career path and retention.

Stakeholder Engagement:

- Health Workforce Development Council Meetings
- Technical Assistance (TA) Calls
- Stakeholder Meetings
- Other Statewide Organizations and Initiatives
- OSHPD's New HCR Website

  www.oshpd.ca.gov/reform/ will engage stakeholders by providing them with:
  - Announcements on TA Calls and upcoming meetings
  - Funding Opportunities
  - Workgroup activities
  - Resources (links to important health workforce development resources)

Contact:

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MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 8, 2011

ATTENTION: Medical Board Members

SUBJECT: Strategic Planning

STAFF CONTACT: Janie Cordray, Consulting Research Specialist

EXECUTIVE SUMMARY:

The Medical Board is embarking on a new strategic planning process. In preparation, many of you participated in phone interviews about your ideas for a successful process and what should be incorporated into the next plan.

On Wednesday, July 27th, the Executive Committee will be discussing the results of the interviews and giving direction to staff on how to proceed. Committee members will review the 2008 Strategic Plan's mission and goals but also review the new ideas and suggestions for objectives. They will then identify the ideas provided by members they believe have merit to pursue and staff can develop these into objectives.

After Wednesday's meeting, staff will incorporate the issues identified by the members, and create an outline for discussion at the Board Meeting on Friday, July 29th. The full Board membership will be given an opportunity to provide input on the ideas presented, and provide feedback to the Executive Committee and staff about their views for the strategic plan and the process.

Between the July and November Board Meetings, another Executive Committee meeting will be scheduled to work on refining the plan outline based upon the input received. If a consensus has been reached, there will be a half-day meeting scheduled with the full Board in November. Staff is anticipating that the full membership will reach a consensus on most of the important issues at the November meeting, enabling staff to present a fully written plan for adoption at the February 2012 Board meeting.

You may find it interesting to review the memo to the Executive Committee in their meeting packet which will be mailed under separate cover. It summarizes the interviews with the members, staff survey responses, and ideas of former Executive Directors. Attached to this memo is the Board's 2008 Strategic Plan for your review prior to the meeting.

I will be assisting the members and staff throughout the planning process, and will serve as a scribe and repository for members' ideas. If you have any suggestions throughout the process, please feel free to contact me by email at janie.cordray@mbc.ca.gov.

2008

Medical Board of California

Strategic Plan 2008

MEDICAL BOARD OF CALIFORNIA

STRATEGIC PLAN 2008

Developed 2008

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Protecting the Public
Promoting Wellness

INTRODUCTION

The Medical Board of California (Board) is mandated to make public protection its first priority. This mandate is articulated in Business and Professions Code Section 2001.1, which states:

> ***Protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions.***

While the mandated functions of the Board generally fall into two categories, licensing and discipline, there are other, more broadly defined issues relating to healthcare that impact the protection of the public. Acknowledging that California's healthcare landscape is ever changing, that the current environment of healthcare delivery is under great strain, and that the business of medicine may contribute to preventing access to healthcare or promote substandard care, this plan addresses issues beyond the simple issuing of licenses and rendering of disciplinary actions.

MISSION

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

GOALS AND OBJECTIVES

Professional Qualifications
Promote the professional qualifications of medical practitioners by setting requirements for education, experience, and examinations, taking into account the states needs for more physicians, particularly in underserved populations; and promoting physician wellness.

Regulations and Enforcement
Protect the public by effectively enforcing laws and standards to deter violations.

Consumer Education
Increase public awareness of Board's Mission, activities and services.

Organizational Relationships
Improve effectiveness of relationships with related organizations to further Board's Mission and goals.

Organizational Effectiveness
Enhance organizational effectiveness and systems to improve service.

Goal 1: Professional Qualifications

Promote the professional qualifications of medical practitioners by setting requirements for education, experience, and examinations, taking into account the state's need for more physicians, particularly in underserved populations; and promoting physician wellness.

Objectives

- Assure greater compliance of CME requirements.
  Measure: Improve compliance with CME requirements.

- Develop a plan for addressing access to care and the shortage of doctors that is appropriate to the Board's Mission and resources.
  Measure: Determine impact of the Board's plan to address access to healthcare.

- Create a plan to assist in addressing medical errors as appropriate to the Board's Mission and resources.
  Measure: Development of an educational program to inform medical students and physicians of medical errors and consequences with a recommendation of this as curriculum or CME.

- Develop an on-line educational program on cultural and linguistic competency.
  Measure: Determine the number of physicians using this program to enhance their skills and satisfaction with the course.

- Ensure that qualified internationally trained physicians are allowed to obtain license exemption under Business and Professions Code 2168 through the work of the Special Programs Review Committee.
  Measure: Site audits indicate these physicians are compliant with regulation and a decrease of complaints on this group.

- Ensure international medical schools meet the Board's requirements for recognition.
  Measure: Site inspections indicate compliance.

- Promote physician wellness by providing an on-line educational programs and links to other resources.
  Measure: Determine the number of physicians using these resources.

Goal 2: Regulation and Enforcement

Protect the public by effectively enforcing laws and standards to deter violations.

Objectives

- Submit vertical enforcement report to the Legislature by December 2007 and implement the vertical enforcement model long term.
  Measure: Report submitted and vertical enforcement model fully integrated including implementation of fully interoperable information technology software used by the Department of Justice.

- 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.

- 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.

- 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.

Goal 3: Consumer Education

Increase public awareness of the Board's Mission, activities and services.

Objectives

- 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.

- Recognition of excellence in medicine by California physicians
  Measure: Ensure annual award of recognition given to recipient.

- 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.

Goal 4: Organizational Relationships

Improve effectiveness of relationships with related organizations to further the Board's Mission and goals.

Objectives

- 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.

- Develop a plan for Supervising Investigators to meet with legislative staff in district offices.
  Measure: Increased awareness of the Board by legislative district offices.

Goal 5: Organizational Effectiveness

Enhance organizational effectiveness and systems to improve service to constituents.

Objectives

- Develop better ways of assessing Board "customer satisfaction" and implement changes that would better serve applicants, licensees and the public.
  Measure: High levels of satisfaction reported by customers who receive services or who access information on the Board's Web site.

- 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.

- Implement the restructuring of the Board to ensure greater communication and synergy between enforcement and licensing divisions of the Board.
  Measure: Implementation is completed and all board members are educated regarding all Board issues.

- Perform a complete evaluation of the Licensing Program to identify areas for improvement.
  Measure: Evaluation completed and any recommendations for efficiency are implemented.

- 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.

- Develop consumer and licensee focused educational programs made available on-line 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.

- 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.

Conclusion

This plan seeks improve the efficiency and effectiveness of the Board to assure protection of the public and provide better service to licensees and consumers. This Board is also committed to making wellness of physicians a priority for the Medical Board of California.

Medical Board of California

Department of Consumer Affairs

July 29, 2011

To: Members of the Board

From: Janie Cordray, Consulting Research Specialist JC

Subject: **Strategic Planning Progress**

As reported in your meeting materials, the Board is embarking on a new strategic planning process. On Wednesday, the Executive Committee met to discuss an outline prepared by staff. (See Executive Committee meeting packet, materials for agenda # 4) The outline was a compilation of ideas and suggestions of board members and staff obtained from interviews and surveys conducted in June.

The Committee reviewed the mission statement, goals and ideas for objectives proposed to be included in the 2012 Strategic Plan. They reached a consensus on the following, and are asking the full Board to weigh-in with their opinions.

Mission:

The Committee was of the opinion that the mission statement adopted in the 2008 strategic plan continues to be relevant, and that it should remain in the 2012 plan. It reads:

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

In the preparatory interviews, some members had voiced concerns that the portion "and to promote access to quality medical care through the Board's licensing and regulatory functions," might be beyond the function and ability of the Board. The Committee was of the opinion that it simply stated "promote" rather than "ensure" and therefore was appropriate to Board's authority and mandates, and should remain intact.

Goals:

The Strategic Planning Committee proposed that there be some amendment to the 2008 goals as outlined in the report to the Executive Committee. (Agenda # 4 in the Executive Committee meeting packet). In summary, the Executive Committee was of the opinion that the following should be the goals for the 2012 plan:

1. **Professional Qualifications:** Promote the professional qualifications of medical practitioners by setting requirements for education, experience, and examination.
2. **Regulations and enforcement:** Protect the public by effectively enforcing laws and standards to deter violations.
3. **Consumer and Professional Education:** Increase Public Awareness of the Board, its mission, activities and services.
4. **Organizational Relationships:** Improve effectiveness of relationships with related organizations to further the Board's mission and goals.
5. **Organizational Effectiveness:** Evaluate and enhance organizational effectiveness and systems to improve service.
6. **Access to Care, Workforce, and Public Health:** Understanding the implications of Health Care Reform and evaluating how it may impact access to care and issues surrounding healthcare delivery, as well as promoting public health, as appropriate to the Board's mission in exercising its licensing, disciplinary and regulatory functions.

Ideas for Objectives:

The Executive Committee reviewed the ideas from Board members and staff that were selected by the Strategic Planning subcommittee for discussion. These ideas or concepts were selected as those with the potential to be developed in to objectives for the Strategic Plan. As a result, the Executive Committee has selected the following to be developed into objectives:

1. *Goal: Professional Qualifications: Promote the professional qualifications of medical practitioners by setting requirements for education, experience, and examination.*

    - Examine and identify methods to ensure physicians remain current.
    - Current CME should be examined. The Board should invite organizations that accredit CME (such as the ACCME, IMQ, or ABMS Boards and their member societies) to educate the members on how requirements have changed, what is required for course accreditation, what is done to ensure compliance, and so forth. In addition, the whole concept, practice, and the requirements should be evaluated to determine if they are relevant to keeping physicians current, including elements of the training that promote education in cultural issues that affect medical practice. Obtain and present to the Board membership statistical data on the scope of CME in California, as well as compliance data from the Board's audits.
    - Conduct a study to define what is necessary to promote safe re-entry into medical practice after extended absences.
    - Establish a committee to examine the FSMB Maintenance of Licensure initiative to study what should be adopted in California, and how it can collaborate with the FSMB and ABMS certifying boards.
    - Develop a plan to conduct a comprehensive review of international schools to ensure the Board has accurate information in order to identify those that may need site visits or additional information.

Also, names and locations should be updated in instances where schools have moved and changed their names. Part of this review should include an update of the schools' application process, updating the surveys and evaluations, determining if application fees cover the Board's cost, and identifying ways to expedite the approval process.

- Conduct a study of disciplinary actions, taking into consideration individual professional qualifications, including the performance of disciplined physicians while they were in training.

2. *Goal: Regulations and enforcement: Protect the public by effectively enforcing laws and standards to deter violations.*

    - Develop a plan to conduct a complete review of all laws and regulations relating to licensing to identify which are no longer relevant, and what needs to be added or eliminated. Identify requirements that may no longer be necessary to the safety of practice but may be serving as barriers for qualified applicants, as well as simply updating requirements to be congruent with current educational environments.
    - Develop a plan to conduct a complete review of all laws and regulations relating to enforcement to identify those that are no longer useful, and augment those that are needed for public protection. Identify the Board's regulatory authority for promulgating new regulations and also identify those issues that require legislation.
    - Conduct a review of the Vertical Enforcement model to assure uniform implementation in all offices and identify any redundancies that are increasing cost without producing benefits. Part of this review should include examining enforcement timelines to identify which areas may delay the process.

- Examine complaint handling priorities. Educate members on how complaints are prioritized, as well as the legislatively mandated priorities. Determine if there is a need to change the priorities.
- Study disciplinary cases and final decisions to identify trends or issues that may signal dangerous practices or risks.
- Examine the Expert Reviewer Program and policies to determine how it may be improved, including recruitment, evaluation of experts, opportunities for education, and policies governing the Board's use of experts.
- Identify opportunities to better educate experts and Administrative Law Judges/Hearing Officers.
- Work to clarify the Board's responsibility to regulate Outpatient Surgery Centers, and obtain the resources to be effective.
- Examine Board responsibilities that could be eliminated or moved to a more appropriate board, bureau, or program. (Midwives, Registered Dispensing Opticians, Research Psychoanalysts, approval of non-ABMS specialty boards, etc.)

A member of the public offered the following suggestion:

- Examine the trend of the decline of reports required by Business & Professions Code Section 805.

3. *Goal: Consumer and Professional Education: Increase Public and Professional Awareness of the Board, its mission, activities and services.*

- Improve and expand professional educational outreach, including outreach to students and new graduates, about the laws and regulations that govern medical practice. Utilize the website and newsletters to inform licensees of issues relating to legal responsibilities, changes in law and regulation, practice patterns and tools (telemedicine, translation methods and opportunities, etc.), issues of public health and cultural and linguistic literacy. Educate physicians about complying with the law. Initiate programs to

promote the Board's information and programs to its licensees. If resources permit, send every physician a new handbook with license renewals (at present, they are only sent to new licensees). Perhaps re-establish a speakers' bureau, expand the newsletter, and conduct outreach to various organizations such as hospitals and practice groups.

- Improve public education by expanding current outreach efforts and initiating more outreach programs to educate the public on the Board's programs, the rights of patients, and how to file complaints.
- Identify more effective methods to promote the Expert Reviewer Program to recruit qualified physicians.
- Evaluate the appropriateness and effectiveness of the Physician Recognition Award, and the methods used to promote nominations.
- Establish a more assertive approach in communicating with the media to educate consumers and publicize disciplinary cases and criminal investigations, including those done in cooperation with other agencies.
- Expand the newsletter to better educate physicians, if the cost is not too great.
- Evaluate and improve the Board's website.
- Expand the Board's website to create a portal that provides an intuitive and searchable web experience. Develop more online services and surveys to help improve the Board's programs.
- Examine how the Board might provide training to the profession via the Internet, including hosting webinars on subjects of importance to public protection and public health.
- Establish a method of holding public briefings taught by legal or enforcement personnel on disciplinary cases, the laws violated, and other issues of importance to the profession and public.

4. *<u>Goal: Organizational Relationships</u>: Improve effectiveness of relationships with related organizations to further the Board's mission and goals.*

    - Improve relationships with elected officials and their staffs. Build and tighten collaborative relationships to work toward common goals– create partnerships on areas of common interests.
    - Work with California medical schools and training programs on common needs and goals. Create a better partnership with them on educational issues beyond licensing requirements, such as those relating to professionalism, ethics, unprofessional behavior, etc.
    - Work to establish better relationships with the accreditation agencies, associations representing hospitals and medical groups, professional associations and societies, the Federation, Federal government agencies, and other state agencies, including Department of Consumer Affairs and State & Consumer Services Agency.
    - Improve educational outreach to hospitals, health systems, and similar organizations about the Board and its programs. Educate the profession not only about the Medical Board, but all of the health boards in DCA. Re-establish a speakers' bureau or some other outreach for this purpose.

5. *<u>Goal: Organizational Effectiveness</u>: Evaluate and enhance organizational effectiveness and systems to improve service.*

    - Conduct a review of all outside agencies' billing (Department of Consumer Affairs, Attorney General, Office of Administrative Hearings, etc.) to identify redundancies, save money, and promote better efficiency.
    - Conduct an annual review of all of the Committees established by the Board to determine if they are still needed, if they are fulfilling the purpose for which they were established, and determine if they

should continue, be eliminated, or be merged with other committees.

- Evaluate and enhance organizational effectiveness through the establishment of criteria for a periodic self-evaluation procedure.
- Establish a means of better educating staff about the Board's activities and priorities set by the membership, including encouraging field staff to attend meetings, and board members to visit field offices when they are at or near the location of Board meetings.
- Establish a means of better educating the Board membership about operational activities by providing tours of headquarters, district or regional offices when they are at or near the location for Board meetings.

6. *Goal: Access to Care, Workforce, and Public Health: Understanding the implications of Health Care Reform and evaluating how it may impact access to care and issues surrounding healthcare delivery, as well as promoting public health, as appropriate to the Board's mission in exercising its licensing, disciplinary and regulatory functions.*

- Educate the Board on the new healthcare reform law and how it may impact physicians' practice, workforce (possible shortages), and utilization of allied healthcare professionals.
- Study and identify appropriate methods to deal with the evolving medical practice environment in how it effects patient care, such as examining methods to deal with workforce shortages, scope of practice of physician extenders, technological changes (including use of diagnostic and communication technologies), licensing requirements, among other relevant issues to be identified.
- In general, identify issues and areas in which the Board may assist in promoting better public health.

Future Work to be Completed by the Subcommittee on Strategic Planning, the Executive Committee and Board:

At the Friday, July 29th meeting, members will be asked to review the above outline of the Executive Committee, and asked for their concurrence so that staff may move forward in drafting a strategic plan for future discussion by the members.

Once there is a conceptual consensus of the ideas presented, staff will work to draft fully formed objectives that are measurable, including developing benchmarks and methods of evaluation. (These will serve as a blueprint for staff to develop action plans and reporting methods.)

Between the July and October Board meetings, the subcommittee and Executive Committee will meet to provide input to staff on refining the plan outline, developing objectives, and identifying measurement methods and evaluations. Once they have completed their work, the first draft of the plan will be presented to the full Board membership. If a consensus has been reached, there will be a half-day meeting scheduled with the full Board in October. Staff is anticipating that the full membership will reach agreement on most of the important issues at the October meeting, enabling staff to present a fully written plan for adoption at the February 2012 Board meeting.

I will be serving as scribe and repository of the Board and staff's ideas. If at any time members have ideas or suggestions, they are invited to contact me by e-mail at: janie.cordray@mbc.ca.gov.